INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Laboratory Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: October 27, 2016	Semiannual update: • Reorganized and edited text throughout for clarity • Added a note box with MCE contact information • Updated the *Reimbursement Methodology for Laboratory Services* section • Updated the *Coding and Billing Procedures for Laboratory Services* section • Updated the *Lab Panels* section • Removed *Laboratory Services Related to Blood or Blood Products* section • Updated the *Lead Testing* section	FSSA and HPE

Table of Contents

Introduction....1
Clinical Laboratory Improvement Amendment Regulations....1
Hospital Outpatient Defined for Laboratory Services....2
Independent Diagnostic Testing Facilities....2
Reimbursement Methodology for Laboratory Services....2
Coding and Billing Procedures for Laboratory Services....3
Billing for Professional and Technical Components....3
Multiple Component Rebundling....4
Policies and Procedures for Laboratory Services....4
Specimen Collection....4
Handling Conveyance....4
Interpretation of Clinical Laboratory Services....4
Lab Panels....5
HIV Testing....5
Lead Testing....6

> *Note:* *For policy information regarding coverage of laboratory services, see the Medical Policy Manual at indianamedicaid.com.*

Introduction

The Indiana Health Coverage Programs (IHCP) defines a *laboratory* as any facility that performs laboratory testing on specimens derived from humans to provide information for the diagnosis, prevention, and treatment of disease, or for information about impairment or assessment of health. IHCP providers must order all laboratory services in writing and include a condition-related diagnosis that necessitates the laboratory services.

> *Note:* *For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, providers must contact the appropriate managed care entity (MCE) for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide available at indianamedicaid.com.*

Clinical Laboratory Improvement Amendment Regulations

To receive reimbursement from the IHCP for laboratory services falling under Clinical Laboratory Improvement Amendment (CLIA) regulations, the provider must have a valid copy of the CLIA certificate on file with the contractor and must bill only lab codes allowed by the certificate. For more information about CLIA, see the *Provider Eligibility* section of the *Provider Enrollment* module or contact the Indiana State Department of Health (ISDH) at (317) 233-7502. Table 1 lists provider types subject to CLIA rules.

Table 1 – CLIA Provider Types

CLIA Code	Description
01	Hospitals, type/specialty 010–012
04	Rehabilitation facilities
05	Home health agencies
06	Hospices
08	Clinics, type/specialty 080–085
11	Mental health, type/specialty 110–111
13	Public health agencies
14	Podiatrists
15	Chiropractors
28	Laboratories, type/specialty 280–281
30	End-stage renal disease clinics
31	Physicians, all types/specialties

See the Centers for Medicare & Medicaid Services (CMS) *CLIA* page at cms.gov for information about the procedures that are eligible for reimbursement under specific CLIA certificates. For more information, go to the *CLIA* page and select **Categorization of Tests**.

Hospital Outpatient Defined for Laboratory Services

The IHCP defines *hospital outpatient* as a member whom the hospital has not admitted as an inpatient but who is registered in hospital records as an outpatient and receives services directly from the hospital. If personnel not employed by the hospital take a tissue sample, blood sample, or specimen and send it to the hospital for tests, the IHCP classifies the tests as *nonpatient* (rather than outpatient) hospital services, because the patient did not directly receive services from the hospital.

Independent Diagnostic Testing Facilities

An independent diagnostic testing facility (IDTF) is a diagnostic testing facility (entity) that is independent of a physician's office or hospital (that is, it is not owned by a hospital, individual physician, or physician group). An IDTF furnishes diagnostic tests and does not use test results to directly treat patients. IDTFs are distinguished from facilities that provide similar services by their ownership structure and the types of services they perform. IDTFs must be enrolled in Medicare before enrolling in the IHCP.

Example of non-IDTF: A radiologist-owned or hospital-owned office that bills for professional interpretations and rarely bills for purchased interpretations or technical components only of diagnostic tests is *not* an IDTF.

An IDTF must employ one or more supervisory physicians who are proficient in the performance and interpretation of each type of diagnostic procedure performed by the IDTF. A physician group practice cannot be considered a supervisory physician. In accordance with *Code of Federal Regulations 42 CFR 410.33 (b)(2),* Medicare IDTFs have discretion in determining the qualifications required of a supervisory physician if the physician is not certified in a medical specialty.

IDTF services are billed on a *CMS-1500* professional claim form or the 837P electronic transaction with place-of-service code 81 – *Independent laboratory*.

Reimbursement Methodology for Laboratory Services

Most clinical diagnostic laboratory procedures performed in a physician's office, by an independent laboratory, or by a hospital laboratory for outpatients are reimbursed at the submitted charge or the rate on the IHCP Fee Schedule, whichever is lower.

For laboratory procedures on the Medicare Physician Fee Schedule that do not have relative value units (RVUs), IHCP reimbursement is based on the Medicare Clinical Laboratory Fee Schedule or manual pricing methodology, if a rate has not yet been established by Medicare.

Some procedures do not have RVUs on the Medicare Physician Fee Schedule because the procedure meets one of the following criteria:

- Associated with special restrictions
- Carrier-priced
- Excluded from the definition of physician services
- Excluded from the Medicare Fee Schedule
- Noncovered by Medicare
- Not valid for Medicare

For laboratory procedures not covered by the Medicare Physician Fee Schedule as not meeting the definition of physician-provided services, the IHCP reimburses from the Medicare Clinical Laboratory Fee Schedule. For codes for which Medicare has not yet established a specific rate in the Medicare Physician

Fee Schedule or in the Medicare Clinical Laboratory Fee Schedule, the IHCP reimburses through manual pricing until Medicare assigns a rate.

Pursuant to Section *1903(i)(7)* of the *Social Security Act*, Medicaid reimbursement for individual clinical laboratory procedures cannot exceed the Medicare rate of reimbursement. In accordance with the clinical laboratory reimbursement methodology set out in *Indiana Administrative Code 405 IAC 5-18-1* and in the approved Medicaid State Plan, the IHCP adopts the Medicare rates for any clinical laboratory procedure code for which the IHCP's current reimbursement rate exceeds the Medicare rate. This analysis is performed typically at the beginning of each calendar year; thus, any rate changes are effective for dates of service on or after January 1 of the current year.

Coding and Billing Procedures for Laboratory Services

When billing laboratory services, providers should use the pathology and laboratory guidelines noted in the Current Procedural Terminology (CPT®[1]) and Healthcare Common Procedure Coding System (HCPCS) codes. Clinical diagnostic laboratory services include all laboratory tests listed in CPT codes 80047 through 89331, as well as some G, P, and Q codes listed in the HCPCS Level II Code book.

Laboratory services must be ordered in writing by a physician or other practitioner authorized to do so under state law. Laboratories performing the services must bill the IHCP (or the appropriate managed care entity) directly, unless otherwise approved.

Note:	*Regulations require that the laboratory analyzing the specimen submit the charge to the IHCP. It is not appropriate for a physician to bill using modifier 90 for a laboratory service that was analyzed by an outside laboratory.*

Providers may submit only one claim when providing multiple laboratory services. If the provider administers the procedure to a member more than one time in the same day, the provider should bill it as only one line item, with an indication of the number of units of service given that day.

Hospitals must bill laboratory services on the *UB-04* claim form using the most appropriate HCPCS or CPT code. Revenue codes billed without the appropriate HCPCS or CPT procedure code are denied.

Providers must bill the professional component of a laboratory service performed in an outpatient hospital setting on the *CMS-1500* claim form or an 837P transaction with the appropriate HCPCS or CPT code and **26** modifier.

See the *Claim Submission and Processing* module for general billing instructions.

Note:	*Hospice providers must not include costs for services such as laboratory and x-rays with the attending physician's billed charges. The daily hospice care rates that the IHCP pays include these costs, which are expressly the responsibility of the hospice provider.*

Billing for Professional and Technical Components

Some clinical diagnostic laboratory procedures have both professional and technical components of service. A physician typically performs the professional component of the lab procedure. The IHCP reimburses the physician for the professional component when the physician bills the appropriate CPT lab code along with modifier 26 – *Professional component*.

[1] *CPT copyright 2015 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

When billing only the technical component of the procedure, providers should append modifier TC – *Technical component* to the appropriate CPT lab code. When billing for both professional and technical components of service, providers should use no modifiers.

Providers should bill the appropriate lab code only. The Medicare Physician Fee Schedule at cms.gov includes information about lab codes billed using these modifiers.

Multiple Component Rebundling

As part of the Multiple Component Rebundling enhanced code auditing, the IHCP applies component rebundling logic to physician and institutional claims. This claim-editing process identifies claims containing two or more procedure codes used to report individual components of a service when a single, more comprehensive procedure code exists that more accurately represents the service performed. During component rebundling, individual unbundled procedures will be denied.

Policies and Procedures for Laboratory Services

The following sections include coverage, billing, and reimbursement information for various types of laboratory services.

For information about laboratory services related to renal dialysis, see the *Renal Dialysis Services* module. For information about genetic testing coverage and billing, see the *Genetic Testing* module. For newborn screening blood tests, see the *Inpatient Hospital Services* module. For prenatal laboratory services, see the *Obstetrical and Gynecological Services* module. For laboratory services covered under the Family Planning Eligibility Program, see the *Family Planning Eligibility Program* module.

Specimen Collection

The IHCP allows a minimal fee for separate charges made by physicians, independent laboratories, or hospital laboratories for drawing or collecting specimens. The IHCP covers these services only when the provider draws a blood sample through venipuncture or collects a urine sample by catheterization. Providers must itemize specimen collection fees when billing for them. The IHCP allows only one charge per day for each patient for venipuncture. The IHCP allows a charge for catheterization for each patient encounter and does not limit this service per day.

Handling Conveyance

The IHCP allows a fee for physicians, chiropractors, and podiatrists for handling and conveying a specimen to a laboratory, in accordance with *405 IAC 5-18-2(c)*. The IHCP reimburses providers for no more than two conveyance fees (CPT procedure codes 99000 and 99001) per member, per provider, on the same date of service. Providers can charge this fee only if the physician, chiropractor, or podiatrist has an expense involved in conveyance.

Interpretation of Clinical Laboratory Services

The CMS has identified certain procedures as clinical lab tests that frequently require a laboratory physician to interpret. The physician can bill these codes with the 26 modifier. The IHCP covers consultative pathology services for clinical laboratory tests if the claim meets the following conditions:

- The patient's attending physician requested the service in writing.
- The service relates to a test that lies outside the clinically significant normal or expected range in view of the condition of the patient.

- The service results in a written narrative report in the patient's medical record.
- The service requires the exercise of medical judgment by the consulting physician.

See the *Clinical Lab Procedure Codes That Allow Interpretation* table in *Laboratory Services Codes* on the *Code Sets* page at indianamedicaid.com for a list of the clinical laboratory CPT codes for which the IHCP reimburses for interpretation. The IHCP follows Medicare guidelines for the CPT clinical lab codes that allow interpretation.

Providers report the technical and professional components separately to ensure proper reimbursement. Providers bill the IHCP for the technical component of the clinical lab procedure reporting the base code only, without modifier TC. If providers bill the modifier TC at the claim detail, the IHCP must deny the claim. Providers should report the interpretation service with the CPT code and modifier 26. For example, providers performing the technical component and interpretation of CPT code 84165 report CPT code 84165 for the technical component and report the CPT code modifier combination 84165 26 for the interpretation.

Lab Panels

Organ- or disease-oriented lab panels were developed to allow for coding of a group of tests. Providers are expected to bill the lab panel when all the tests listed within each panel are performed on the same date of service. When one or more of the tests within the panel are not performed on the same date of service, providers may bill each test individually. Providers may not bill for a panel *and* all the individual tests listed within that panel on the same day. However, *other* tests performed in addition to those listed on the panel on the same date of service may be reported separately, in addition to the panel code. Providers must follow CPT coding guidelines when reporting multiple panels. For example, providers cannot report basic panel code 80048 with comprehensive panel code 80053 on the same date of service, because all the lab tests in 80048 are components of 80053.

HIV Testing

Effective June 1, 2015, the IHCP revised its coverage policy regarding human immunodeficiency virus (HIV) testing as follows: "Routine laboratory testing for HIV is covered by the IHCP when it is done to establish an HIV diagnosis."

The United States Preventive Services Task Force (USPSTF) has found evidence that identification and treatment of HIV infection is associated with a markedly reduced risk for progression to acquired immune deficiency syndrome (AIDS), AIDS-related events, and death in individuals with immunologically advanced disease. Providers are encouraged to follow these USPSTF guidelines:

- Clinicians should screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
- Screen all adolescents and adults once to identify persons who are already HIV-positive, with repeated screenings for:
  - Those who are known to be at risk for HIV infection
  - Those who are actively engaged in risky behaviors
  - Those who live or receive medical care in a high-prevalence setting (defined as a geographic location or community with an HIV seroprevalance of at least 1%)
- Persons at very high risk, defined by the USPSTF, should be screened at least annually.
- Persons at increased risk should be screened at least every three to five years.
- Routine rescreening may not be necessary for individuals not at increased risk after they have been found to be HIV-negative.

Lead Testing

For lead testing in the office setting, the coverage and reimbursement rate for code 83655 includes tests administered using filter paper and handheld testing devices. Providers should bill using the appropriate procedure code and modifier combination:

- 83655 – *Lead, quantitative; blood*
- 83655 U1 – *Lead, using filter paper*
- 83655 U2 – *Lead, handheld testing device*

See the *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch* module for more information about lead testing policies and procedures for EPSDT-eligible members.