COVERED SERVICES

Medicaid reimburses laboratories only for those services certified by the Clinical Laboratory Improvement Amendments (CLIA) regulations to perform and for those services ordered by a physician or other qualified licensed practitioner. Medicaid covers only those medically necessary laboratory tests needed to diagnose and appropriately treat a specific condition, illness, or injury.

Physicians may bill for laboratory services only when they personally perform or supervise the test.

Hospitals are allowed by Medicaid to contract with an independent laboratory for performance of outpatient laboratory services. However, it is the responsibility of the hospital to ensure that both the physician who performs the professional service and the laboratory that performs the technical service meet all state and federal requirements. One such requirement is that both the physician and laboratory have a valid CLIA number.

When a hospital contracts with a freestanding laboratory for the performance of the technical service only, it is the responsibility of the hospital to pay the laboratory. The laboratory cannot bill Medicaid because there is no mechanism in the system to pay a technical component only to a freestanding laboratory.

Prenatal Lab Panel Services

Prenatal lab panel services must be billed utilizing standard Physicians' Current Procedural Terminology (CPT) codes from the Organ or Disease Oriented Panels subheading in the Pathology and Laboratory section of the CPT.

Only one prenatal lab panel claim shall be billed per recipient per pregnancy (270 days) per billing provider.

Drug Testing

Louisiana Medicaid covers presumptive and definitive drug testing under the following parameters:

- Presumptive drug testing is limited to 24 total tests per member per calendar year. Providers are to consider the methodology used when selecting the appropriate procedure code for the presumptive testing;

- Definitive drug testing is limited to 18 total tests per member per calendar year. Testing more than fourteen definitive drug classes per day is not reimbursable; and

- No more than one presumptive and one definitive test will be reimbursed per day per recipient, from the same or different provider

Providers should bill using the appropriate procedure code. Current fee schedules for laboratory procedures can be found by accessing the below link or at www.lamedicaid.com, under the "Fee Schedules" link.

https://www.lamedicaid.com/provweb1/fee_schedules/Lab_Rad_FS.pdf

These services may be subject to post payment review. Non-compliance with written policy may result in recoupment and additional sanctions, as deemed appropriate by Louisiana Medicaid.

Exclusions

Any laboratory procedure not listed in the Fee Schedule is not reimbursable by Medicaid. (See Appendix A for Fee Schedule information).

Limitations

Screening or routine laboratory testing, except as specified for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, or by Medicaid policy, is not a benefit. Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the recipient's specific condition are considered random screening and are not covered. Multiple laboratory tests carried out as part of the evaluation of the recipient, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered.