REIMBURSEMENT

Lab services do not require prior authorization. However, some lab services, as indicated on the Fee Schedule, require medical review to receive payment. (See Appendix A for Fee Schedule information)

Providers should use the most appropriate Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code representing the service performed when submitting claims to Medicaid.

Guidelines indicated in the pertinent CPT manual are to be followed when billing for these services unless specifically directed otherwise by the department.

Limitations on select services are indicated on the published fee schedules and/or in provider manuals.

Clinical Laboratory Improvement Amendments (CLIA) claim edits are applied to all claims for lab services that require CLIA certification. Those claims that do not meet the required criteria will deny. Claims are edited to ensure payment is not made to:

- Providers who do not have a CLIA certificate,
- Providers submitting claims for services rendered outside the effective dates of the CLIA certificate, and
- Providers submitting claims for services not covered by their CLIA certificate.

Reimbursement for clinical laboratory procedures shall not exceed 100 percent of the current year's Medicare allowable. Reimbursement of clinical laboratory services shall be paid at the lower of billed charges or the fee on file, minus the amount which any third party coverage would pay.

Those services not subject to the Medicare fee schedule shall continue to be reimbursed to physicians and independent laboratories based on the published Medicaid fee schedule or billed charges, whichever is lower. (See Appendix A for Fee Schedule information)