REIMBURSEMENT

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

Independent laboratories may only receive reimbursement for laboratory services when they directly perform, or supervise, the service. When submitting claims, providers must use the most appropriate Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code representing the service performed.

Providers must follow guidelines indicated in the pertinent CPT manual, unless specifically directed otherwise by the department.

Limitations on select services are indicated on the Fee Schedule, in provider manuals, or both.

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

- 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 made at the lower of billed charges or the Medicaid fee on file, minus the amount which any third party coverage would pay.