Laboratory and Radiology Services

This policy only applies to the performance of laboratory and radiology procedures in a provider's office (i.e., other than a hospital or independent laboratory).

Provider Requirements

Providers may only receive reimbursement for laboratory and radiology services that they personally perform or supervise.

Clinical Laboratory Improvement Amendments (CLIA) Certification

Providers must include a valid CLIA number on all claims submitted for laboratory services, including CLIA waived tests.

CLIA claim edits are applied to all claims for laboratory services. Claims are edited to ensure payment is not made to providers who:

- Do not have a CLIA certificate;
- Render services outside the effective dates of the CLIA certificate; and
- Submit claims for services not covered by their CLIA certificate.

Louisiana Medicaid maintains a current provider CLIA file. Providers must submit a copy of the CLIA certification to the fiscal intermediary's Provider Enrollment Unit. (See Appendix A for contact information).

Once the CLIA certification has been added to the file, certification updates are made automatically via the Centers for Medicare and Medicaid Services (CMS) Online Survey, Certification and Reporting (OSCAR) process and are sent to Louisiana Medicaid without further provider involvement.

Providers with regular accreditation, partial accreditation, or registration certificate types are allowed by CLIA to submit claims for all laboratory procedure codes. Providers with waiver or provider-performed microscopy (PPM) certificate types will only be reimbursed for certain laboratory procedure codes in connection with those certificate types, as approved by CMS.

To submit claims for laboratory procedure codes outside of their restricted certificate types, providers with waiver or PPM certificates must obtain the appropriate certificate through the Louisiana Department of Health's Health Standards Section.

Claim payments are only made for dates of service falling within the particular certification dates governing those services.

Providers must add the QW modifier to the procedure code for all CLIA waived tests.

CLIA information can be obtained at: https://ldh.la.gov/page/3766

Covered Services

Medicaid covers medically necessary laboratory and radiology services needed to diagnose and appropriately treat a specific condition, illness, or injury. Screening laboratory and radiology services are only considered medically necessary if recommended as Grade A or B by the United States Preventive Services Taskforce, specified in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, or as otherwise specified in Medicaid policy.

For laboratory services, when multiple laboratory tests are conducted simultaneously, for example as part of a profile, battery, or panel, each individual test must be medically necessary for the profile, battery, or panel to be considered medically necessary.

Specimen Collection

Providers collecting specimens as part of an evaluation and management service and forwarding them to an outside laboratory are not separately reimbursed for collection of the specimen. The collection of the specimen is considered incidental to the evaluation and management service.

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 12 total tests per member per calendar year. Testing more than fourteen definitive drug classes per day is not medically necessary. Definitive drug testing is limited to individuals with an unexpected positive or unexpected negative finding on presumptive drug testing, or if there is a clinical reason to detect a specific substance or metabolite that would be inadequately detected through presumptive drug testing;

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

- Universal drug testing (screening) in a primary care setting is not covered. Drug testing without signs or symptoms of substance use, or without current controlled substance treatment, is not covered.

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.

Positron Emission Tomography

Positron emission tomography, with or without computed tomography, is covered when medically necessary. For oncologic conditions, coverage is in accordance with National Comprehensive Cancer Network guidelines.

Proprietary Laboratory Analyses

Proprietary Laboratory Analyses (PLA) testing is covered when used for the particular "brand" respiratory panel kit as stated within the Current Procedural Terminology (CPT) codebook. PLA codes must be used with the specific device or kit. *"Services should not be reported with any other CPT code and other CPT codes should not be used to report services that may be reported with that specific PLA code."*

The expectation is that the procedure codes are billed in accordance with CPT guidelines.

Reimbursement for Laboratory and Radiology Procedures

Reimbursement is made at the lower of the billed charges or the fee on file, minus the amount that any third party coverage would pay. For laboratory services, reimbursement shall not exceed 100 percent of the current year's Medicare allowable.

Providers shall not submit claims for both the professional component and the full service for the same patient for the same laboratory or radiology service on the same date of service.

To receive reimbursement for the full service, the provider must own or lease, and have on the premises, the necessary equipment. Reimbursement for the full service encompasses both the use of the equipment and the provider's professional service.

Certain procedures are a combination of a professional component and a technical component. When the professional component is reported separately, providers may bill the procedure code with the appropriate modifier to denote only the professional component. Louisiana Medicaid does not reimburse for the technical component separately.