Laboratory and Radiology Services

This chapter provides only the policy regarding the performance of laboratory and radiology procedures in a physician's office.

Physicians may bill for laboratory and radiology services covered by Louisiana Medicaid only if a properly completed OFS Form 24 is included in their Medicaid enrollment file. This form must list all radiology and laboratory equipment and the capabilities of such equipment. Any time an equipment change occurs within the office, a new OFS Form 24 must be completed and sent to the fiscal intermediary's Provider Enrollment Unit. The new information must be on file prior to billing for the services rendered by such equipment. (See Appendix A for the Provider Enrollment Unit's contact information and Appendix B for a copy of the OFS Form 24).

Providers are not to bill Louisiana Medicaid for the full service of radiological/laboratory services that are not performed in their own offices. Tests which are sent to other facilities for processing are not to be billed to Louisiana Medicaid.

Clinical Laboratory Improvement Amendments Certification

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 rendering services outside the effective dates of the CLIA certificate; and
- Providers submitting 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's (CMS's) 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 bill for all lab codes. Providers **should not** include their CLIA certification number on claim forms.

Providers with waiver or provider-performed microscopy (PPM) certificate types may be paid for only those waiver and/or PPM codes approved for billing by CMS.

Providers with waiver or PPM certificate wishing to bill for codes outside their restricted certificate types shall obtain the appropriate certificate through the Louisiana Department of Health's Health Standards Section.

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

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

Providers are notified of additions and deletions to the CLIA file through the Louisiana Medicaid *Provider Update* and remittance advice messages.

CLIA information can also be obtained using the CLIA link on the Louisiana Medicaid website. (See Appendix A for web address).

Specimen Collection

Physicians collecting specimens during the course 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.

Positron Emission Tomography Scans for Oncologic Conditions

Positron emission tomography (PET) scans are covered services which require prior authorization, and must be consistent with Medicaid's clinical guidelines and medical necessity criteria for oncologic indications. The medical necessity criteria can be found at PET Scan Medical Necessity Criteria. Procedure must be performed within 30 days of receiving prior authorization.

Combination Studies PET/Computed Tomography (CT)

The combination of PET and CT scans into a single system (PET/CT) may be considered for oncologic indications where a PET scan is considered medically necessary and specific anatomical identification is required to guide clinical management.

Prior Authorization

The following documentation is required for prior authorization of PET scans and PET/CT combination studies for oncologic conditions:

- Completed PA request form; and
- Documentation of medical necessity includes all of the following:
  - The primary diagnosis name and International Classification of Diseases (ICD) code(s) for the condition requiring PET imaging;
  - All secondary diagnosis name(s) and ICD code(s) pertinent to comorbid condition(s);
  - The most recent medical evaluation, including a summary of the medical history and the last physical exam (clinical information must be submitted by the recipient's treating oncologist);
  - Laboratory and pathology reports pertinent to a diagnosis of malignant neoplasm or carcinoma;
  - Risk factors or comorbid conditions;
  - The patient's treatment plan, including a description of the type and dates of any anti-tumor therapy; and
  - Any additional clinical information that supports the coverage criteria and that is requested by the Prior Authorization Unit.

Billing for Laboratory and Radiology Procedures

Providers must use the most appropriate Healthcare Common Procedure Coding System (HCPCS)/*Current Procedural Terminology* (CPT) code representing the service performed when submitting claims to Louisiana Medicaid. Guidelines indicated in the pertinent CPT manual shall be followed when billing for these services unless otherwise specifically directed in writing by Louisiana Medicaid.

It is the intent of Louisiana Medicaid that no more than the full service for a procedure be reimbursed. **Physicians may not bill for both the professional component and the full service for the same patient for the same service when billing for radiology or laboratory procedures.**

The physician must own or lease (and have on the premises) the equipment necessary to perform the "technical" aspect of the service when billing Louisiana Medicaid for full service. Payment for full service encompasses both the use of the equipment and the physician's professional services.

Certain procedures are a combination of a physician component and a technical component. When the physician 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.

Non Invasive Prenatal Testing

Non Invasive Prenatal Testing (NIPT) is a genetic test, which uses maternal blood that contains cell-free fetal deoxyribonucleic acid (DNA) from the placenta. NIPT is completed during the pre-natal period of pregnancy to screen for the presence of some common fetal chromosomal abnormalities. Common types of chromosomal abnormalities (aneuploidies and microdeletions) in fetuses include:

- Trisomy 21 (Down syndrome);
- Trisomy 18 (Edwards syndrome); and
- Trisomy 13 (Patau syndrome).

NIPT is considered medically necessary once per pregnancy for pregnant women over the age of 35, and for women of all ages who meet one or more of the following high-risk criteria:

- Abnormal first trimester screen, quad screen or integrated screen;
- Abnormal fetal ultrasound scan indicating increased risk of aneuploidy;
- Prior family history of aneuploidy in first (1st) degree relative for either parent;
- Previous history of pregnancy with aneuploidy; and
- Known Robertsonian translocation in either parent involving chromosomes 13 or 21.

Note: 1st degree relative is defined as a person's parent, children, or sibling.

NIPT is NOT covered for women with multiple gestations.

This service is subject to Medical Review. Providers must submit all required documentation to support the above high-risk criteria, along with a hard copy claim to the Department's fiscal intermediary. Failure to provide the required documentation, or if the documentation submitted fails to meet the above listed criteria, will result in denial of the payment for this service.

Prenatal Lab Panels

The obstetric panel code is payable only once per pregnancy.

A complete urinalysis is payable only once per pregnancy per recipient per billing provider unless substantiated by a diagnosis such as those currently found in the *International Classification of*

Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) category of "Other Diseases of Urinary System" or "Infections of the genitourinary tract in pregnancy". All lab work must be substantiated by appropriate diagnosis code.

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.

Reimbursement for Laboratory Procedures

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

Reimbursement for Radiology Services

Reimbursement for radiology services shall be the lower of billed charges or the fee on file, minus the amount that any third party coverage would pay. (See Appendix A for information on how to access the fee schedule).