



# Florida Medicaid

## **Laboratory Services Coverage Policy**

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Agency for Health Care Administration

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## Table of Contents

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<b>1.0</b>	<b>Introduction .....</b>	<b>1</b>
1.1	Description .....	1
1.2	Legal Authority .....	1
1.3	Definitions .....	1
<b>2.0</b>	<b>Eligible Recipient .....</b>	<b>2</b>
2.1	General Criteria .....	2
2.2	Who Can Receive .....	2
2.3	Coinsurance, Copayment, or Deductible .....	2
<b>3.0</b>	<b>Eligible Provider .....</b>	<b>2</b>
3.1	General Criteria .....	2
3.2	Who Can Provide .....	2
<b>4.0</b>	<b>Coverage Information .....</b>	<b>2</b>
4.1	General Criteria .....	2
4.2	Specific Criteria .....	3
4.3	Early and Periodic Screening, Diagnosis, and Treatment .....	3
<b>5.0</b>	<b>Exclusion .....</b>	<b>3</b>
5.1	General Non-Covered Criteria .....	3
5.2	Specific Non-Covered Criteria .....	3
<b>6.0</b>	<b>Documentation .....</b>	<b>3</b>
6.1	General Criteria .....	3
6.2	Specific Criteria .....	3
<b>7.0</b>	<b>Authorization .....</b>	<b>4</b>
7.1	General Criteria .....	4
7.2	Specific Criteria .....	4
<b>8.0</b>	<b>Reimbursement .....</b>	<b>4</b>
8.1	General Criteria .....	4
8.2	Specific Criteria .....	4
8.3	Claim Type .....	4
8.4	Billing Code, Modifier, and Billing Unit .....	4
8.5	Diagnosis Code .....	4
8.6	Rate .....	4

## 1.0 Introduction

### 1.1 Description

Florida Medicaid laboratory services provide clinical testing of bodily fluids, tissues, or other substances.

#### 1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render laboratory services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.

#### 1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of laboratory services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

### 1.2 Legal Authority

Laboratory services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440, 441, and 493
- Chapter 483, Florida Statutes (F.S.)
- Rule Chapter 59A-7 and Rule 59G-4.190, F.A.C.

### 1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

#### 1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

#### 1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

#### 1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

#### 1.3.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

#### 1.3.5 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

### **1.3.6 Recipient**

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

## **2.0 Eligible Recipient**

### **2.1 General Criteria**

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

### **2.2 Who Can Receive**

Florida Medicaid recipients requiring medically necessary laboratory services. Some services may be subject to additional coverage criteria as specified in section 4.0.

### **2.3 Coinsurance, Copayment, or Deductible**

Recipients are responsible for the following copayment, unless the recipient is exempt from copayment requirements or the copayment is waived by the Florida Medicaid managed care plan in which the recipient is enrolled. For information on copayment requirements and exemptions, please refer to Florida Medicaid's copayment and coinsurance policy:

- \$1.00 per independent laboratory visit, per day
- \$2.00 per practitioner office visit, per day
- \$3.00 per federally qualified health center visit, per day
- \$3.00 per rural health clinic visit, per day

## **3.0 Eligible Provider**

### **3.1 General Criteria**

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

### **3.2 Who Can Provide**

- Practitioners licensed within their scope of practice to perform this service
- Independent laboratories licensed in accordance with Chapter 483, F.S.
- County health departments administered by the Department of Health in accordance with Chapter 154, F.S.
- Federally qualified health centers approved by the Public Health Service
- Rural health clinics certified by Medicare

Providers may only render services for which they have the appropriate Clinical Laboratory Improvement Amendments (CLIA) certification in accordance with 42 CFR, Part 493.

## **4.0 Coverage Information**

### **4.1 General Criteria**

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

#### **4.2 Specific Criteria**

Florida Medicaid reimburses for the following services in accordance with the American Medical Association's Current Procedural Terminology (CPT) and the applicable Florida Medicaid fee schedule(s), or as specified in this policy:

- Chemistry
- Clinical cytogenetics
- Diagnostic immunology
- Genetic carrier screening
- Hematology
- Histocompatibility
- Immunohematology
- Microbiology
- Pathology

##### **4.2.1 Newborn Screenings**

Florida Medicaid reimburses the state laboratory for mandated tests specified in section 383.14, F.S.

#### **4.3 Early and Periodic Screening, Diagnosis, and Treatment**

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

### **5.0 Exclusion**

#### **5.1 General Non-Covered Criteria**

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

#### **5.2 Specific Non-Covered Criteria**

Florida Medicaid does not reimburse for the following:

- Multiple organ and disease panels that contain duplicate components
- Repeat tests as a result of provider error
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy

### **6.0 Documentation**

#### **6.1 General Criteria**

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

#### **6.2 Specific Criteria**

There is no coverage-specific documentation requirement for this service.

## 7.0 Authorization

### 7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

### 7.2 Specific Criteria

There are no specific authorization criteria for this service.

## 8.0 Reimbursement

### 8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

### 8.2 Specific Criteria

Providers must indicate the date a specimen was collected as the date of service on the claim form.

### 8.3 Claim Type

Professional (837P/CMS-1500)

### 8.4 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

#### 8.4.1 Modifier

Providers must include the following modifiers, as appropriate, on the claim form:

- 26 Professional component performed by a different provider than the technical component
- 91 Repeat clinical diagnostic laboratory test, distinct or separate from a panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values
- TC Technical component performed by a different provider than the professional component
- QW CLIA waived tests on the CMS list that indicate CLIA standards are waived in the office setting

Providers may not include both the TC and 26 modifiers on the claim form for a single procedure.

#### 8.4.2 Unlisted Procedure Codes

Specialized independent laboratory providers may include the assigned, unlisted procedure codes specified in the applicable Florida Medicaid fee schedule(s), when billing for specific technologies.

Providers must submit documentation supporting medical necessity with the claim until the technology is assigned a permanent CPT code.

### 8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

### 8.6 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's Web site at <http://ahca.myflorida.com/Medicaid/review/index.shtml>.