TABLE OF CONTENTS

CHAPTER NINE

INDEPENDENT LABORATORY SERVICES

Chapter 9. Independent Laboratory Services

Rule No. 560-X-9-.01. Independent Laboratory Services- General.

The Alabama Medicaid Agency will pay for services provided by independent laboratories that are enrolled by contract under the following conditions:

(a) The services must be medically necessary.

(b) The patient must be eligible for Medicaid at the time the services are rendered.

Authority: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 440.30. Rule effective October 1, 1982. Amended June 5, 1983, July 9, 1984, October 15, 1990, January 15, 1991. Effective date of this amendment October 13, 1998.

Rule No. 560-X-9-.02. Covered Services

Laboratory services are professional and technical laboratory services - (a) ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by state law; (b) ordered by a physician but provided by a referral laboratory; (c) provided in an office or similar facility other than a hospital outpatient department or clinic; and (d) provided by a laboratory that meets the requirements for participation in Medicare.

(a) Laboratory services are restricted to those that are described by procedures in the CPT manual (80000 series) or one of the locally assigned HCPCS codes used only by Medicaid to supplement the listing in the CPT manual.

(b) Providers will be paid only for covered services which they are certified to perform and which they actually perform.

(c) Physicians who send specimens to independent laboratories for analysis, and laboratories that provide specimen collection services for referral to other laboratories, may bill a collection fee. This fee shall not be paid to any provider that has not actually collected the specimen from the patient.

(d) Routine venipuncture for collection of laboratory specimens may be billed only when sending blood specimens to another site for analysis. The collection fee may not be billed if the lab work is done at the same site the specimen was drawn, or in a lab owned, operated, or financially associated with the site in which the specimen was drawn.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 CFR, Section 440.30.
History: Rule effective October 1, 1982. Amended October 15, 1990; January 15, 1991; October 13, 1998.
Amended: Filed September 21, 2000; effective December 11, 2000

Rule No. 560-X-9-.03. Participation Requirements

Independent laboratories must meet the following requirements for participation in the Alabama Medicaid program:

(a) Be certified for participation with Medicare.

(b) Have a valid CLIA certification (i.e., clinical labs).

(c) Have a Physician's Supervisory Certification and utilize certified technicians for ultrasounds, Doppler services, and non-invasive peripheral vascular studies (i.e., physiological labs).

(d) Must be independent of any hospital, clinic, or physician's office.

(e) Be licensed in the state where located, when it is required by that state.

(f) Submit to routine audits by Medicaid.

(g) Complete an application with all required attachments.

(h) Sign a provider agreement.

(i) Sign a Direct Deposit Authorization.

(j) Sign a Civil Rights Statement of Compliance.

(k) Effective date of enrollment will be the date of issuance of license. If licensure is not required in the state of residence, the effective date of enrollment will be the date of CLIA certification. However, providers who request enrollment more than 120 days after the above applicable date will be enrolled on the first day of the month the request for enrollment is received.

Author: Ginger Collum, Program Manager, Clinic/Ancillary Services
Statutory Authority: State Plan; 42 C.F.R Section 440.30; 493.2; Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended October 15, 1990, January 15, 1991, October 13, 1998. Amended: Filed December 17, 2001, effective March 15, 2002.

Rule No. 560-X-9-.04.Reserved.

Rule No. 560-X-9-.05. Reserved.

Rule No. 560-X-9-.06. Claims Filing Guidelines

(1) For time limits on claims submission~~,~~ refer to the Medicaid Provider Manual, Independent Laboratory chapter.

(2) Claims for lab services must contain a valid diagnosis code.

(3) Claims submitted must contain the provider number of the lab that actually performed the service. Claims must not be submitted using any other provider's number, such as the provider number of the referring physician or hospital.

(4) All organ and disease oriented panels must include the tests listed with no substitutions. If only part of the tests included in a defined panel are performed, the panel

code should not be reported. If additional tests to those indicated in a panel are performed, those tests should be reported separately in addition to the panel code. If two panels overlap, the physician or laboratory will be required to unbundle one of the panels and bill only for the tests that are not duplicative.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR, Section 405.401, et seq.
History: Rule effective October 13, 1998. Amended: Filed September 21, 2000; effective December 11, 2000.

Rule No. 560-X-9-.07. Reserved

Rule No. 560-X-9-.08. Third Party Payment Procedures

For guidelines on submitting claims to Medicaid when a third party is involved, refer to the Medicaid Provider Manual, Independent Laboratory chapter.

Author: Lynn Sharp, Associate Director, Policy Development Unit
Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR, Section 401, et seq.
History: Rule effective October 13, 1998. Amended: Filed September 21, 2000; effective December 11, 2000.

Rule No. 560-X-9-.09. Sending Bills and Statements to Medicaid Recipients

(1) Providers should not send recipients bills or statements for covered services once the recipient has been accepted as a Medicaid patient.

(2) Providers may send a notice to the recipient stating their claim is still outstanding if the notice indicates in bold letters, "**THIS IS NOT A BILL**".

(3) Providers are responsible for follow-up with the fiscal agent or Medicaid on any billing problems or unpaid claims.

(4) Providers agree to accept the amount paid by Medicaid as payment in full.

(5) Recipients are not responsible for the difference between charges billed and the amount paid by Medicaid for covered services.

(6) Recipients may be billed only for the allowable copayment amount, for services not covered by Medicaid, or when benefits have been exhausted.

(7) Providers may not deny services to any eligible recipient due to the recipient's inability to pay the allowable copayment amount.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Sections 447.15, 447.50, 447.55. Rule effective October 13, 1998.

Rule No. 560-X-9-.10. Reserved.
Rule No. 560-X-9-.11. Reserved.

Rule No. 560-X-9-.12. Non-Covered Services

Medicaid will not pay packing and handling charges for referred laboratory services. Payment for referred tests will be made to the referred laboratory only at the normal rate. This policy shall be monitored through postpayment review by Medicaid.

Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 440.30, & 440.50; Deficit Reduction Act of 1984. Rule effective October 1, 1982. Amended November 11, 1985, January 8, 1986, October 15, 1990, January 15, 1991, October 13, 1992. Effective date of this amendment October 13, 1998.