PROVIDER REIMBURSEMENT GUIDANCE			
Laboratory & Pathology Services			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
02/10/2022	04/01/2022	04/01/2022	02/01/2022

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

Payment Policy Summary

The following policy outlines Commonwealth Care Alliance's (CCA) reimbursement methodology for laboratory and related services. This includes, but is not limited to, services such as venipuncture, laboratory services performed in a facility setting, laboratory handling, surgical pathology, and clinical pathology consultations.

Reimbursement Guidelines:

CCA does not permit providers to bill for laboratory services that are not ordered by a physician or other qualified practitioner. CCA will only issue payment for services ordered by a physician or qualified practitioner. CCA recognizes qualified practitioners as eligible providers practicing within the scope of their licensure.

Effective January 1, 2022, all claims for items and services that are a result of an order or referral must include the applicable qualifier, ordering/referring provider's name, and valid NPI. On a CMS-1500 claim form (02-12) or electronic equivalent: The referring or ordering physician's name must be submitted in the appropriate place on the claim form (i.e., Box 17 on CMS form).

Excluded Services

The Plan does not reimburse:

- laboratory services related to or associated with alternative, holistic, naturopathic, and/or functional health medicine.
- Drug testing that is required for reasons unrelated to the care of the member, including but not limited to:
  - Court-ordered o Forensic or criminal situations
  - Administrative or social service investigations or proceedings
  - Workplace or school compliance screening
  - Residential monitoring purposes- Testing as required for or as part of participation in an inpatient or intermediate care substance use disorder program (e.g., monitoring while in inpatient withdrawal management, a residential facility, partial hospital program, or intensive outpatient program)
  - Routine testing (i.e., testing at every visit)
  - Blanket Orders, defined as a test request that is not for a specific patient; rather, it is an identical order for all patients in a clinician's practice without individualized decision making at every visit.
  - Routine standing orders for all patients in a physician's practice are not reasonable and necessary.
  - Drug testing of two different specimen types from the same patient on the same date of service for the same drugs/metabolites/analytes.
  - Urine drug testing that is performed without a clear treatment role and decision-making response to either a positive or negative result.
- Laboratory and pathology services submitted with unlisted CPT codes without prior authorization.
- Genetic testing services that are not prior authorized.

Place of Service

CCA will use codes outlined in the Centers for Medicaid and Medicare Services (CMS) Place of Service (POS) Codes for Professional Claims Database to determine whether the performed laboratory services are reimbursable. CCA's policy considers the following POS codes as facilities: POS 19, 21, 22, 23, 24, 26, 31, 34 51, 52, 55, 56, 57 and 61. All other POS are considered non-facility.

Date of Service

CCA recognizes the date of service (DOS) on a claim for a laboratory test as the date the Specimen was collected. If the Specimen was collected over multiple calendar days, the DOS is the date collection ended.

Reference Laboratory and Non-Reference Laboratory Providers:

- Per CMS guidelines, Reference Laboratories reporting laboratory services using a modifier 90 are eligible for reimbursement.
    - Conversely, non-reference laboratory Physicians or Other Qualified Health Care Professionals reporting laboratory services with a modifier 90 are ineligible for reimbursement
- Physicians or Other Qualified Health Care Professionals who own laboratory equipment and conduct testing are eligible for reimbursement but must report the service without appending modifier 90.
- Reimbursement of clinical laboratory services reported on a CMS 1500 Health Insurance Claim Form (or the electronic equivalent) requires a valid Federal Clinical Laboratory Improvement Amendments (CLIA) Certificate Identification number.

Duplicate Laboratory Charges

Same Individual Physician or Other Health Care Professional:

When Duplicate Laboratory Services are submitted from the Same Individual Physician or Other Health Care Professional only a single service is reimbursable.

The use of a modifier 91 can be applied to indicate repeat procedures completed by the Same Individual Physician or Other Qualified Health Care Professional. According to CMS and CPT guidelines, Modifier 91 can be used to indicate necessary repeat procedures, e.g., multiple blood tests that are required at various times throughout the same day.

Multiple Physicians or Other Health Care Professionals:

When multiple Physicians or Other Health Care Professionals report the same Laboratory Service, only one provider will be reimbursed.

Reference Laboratory and Non-Reference Laboratory Providers:

If both the Reference and Non-Reference Laboratory submit claims for the same service(s), only the Reference Laboratory service is considered reimbursable.

Independent Laboratory, Reference Laboratory and Referring Laboratory:

Duplicate services are not reimbursable unless one of the laboratory's appends a modifier 91 to the code(s) submitted.

Anatomic Pathology Services and Purchased Diagnostic Services:

If the purchaser and supplier who performed the service both bills Duplicate Laboratory Services, only one service will be reimbursed. However, if modifier 59, XE, XP, XS, XU or 91 is appended both may be reimbursed.

CCA policy follows the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPFS) Professional Component/Technical Component (PC/TC) indicators 1, 6, and 8 to identify laboratory services that are eligible as Purchased Diagnostic Tests.

- PC/TC Indicator 1: Physician Service Codes (modifier TC and 26 codes)
- PC/TC Indicator 6: Laboratory Physician Interpretation Codes
- PC/TC Indicator 8: Physician Interpretation Codes

Documentation Requirements for Reporting Laboratory Services

Based on CMS guidelines, the Physician or Other Qualified Health Care Professional caring for the patient must order all diagnostic laboratory tests or services, using the results to manage the patient's condition. Tests ordered by someone other than the Physician or Other Qualified Health Care Professional may not be reimbursed.

The Physician or Other Qualified Health Care Professional must clearly denote all tests or services to be performed. See below for documentation examples.

- A signed order or requisition listing the specific test(s) or service(s)
- An unsigned order or requisition listing the specific test(s) or service(s), and an authenticated medical record (e.g., progress notes or office notes) supporting the physician's intent to order the test(s) or service(s) (for example, "order labs," "check blood," "repeat urine"
- An authenticated medical record (e.g., office notes or progress notes) supporting the Physician or Other Health Care Professional's intent to order specific test(s) or service(s)
- Electronic requisitions are acceptable when the laboratory can demonstrate the order(s) was received through a standardized electronic process

Urine Drug Testing for Substance Abuse Disorder

The testing frequency must meet medical necessity and be documented in the clinician's medical record.

- For patients with 0 to 30 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 presumptive UDT per week. More than 3 presumptive panels in one week are not reasonable and necessary and not allowed.
- For patients with 31 to 90 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 UDT per week. More than 3 presumptive UDT in one week is not reasonable and necessary and not allowed.
- For patients with > 90 consecutive days of abstinence, presumptive UDT is expected at a frequency of 1 to 3 UDT in one month. More than 3 physician directed UDT in one month is not reasonable and necessary and not allowed.

Urine Drug Testing

Urine drug testing should not routinely include a panel of all drugs prone to abuse. Tests should be focused on detecting the specific drugs of concern, and frequency of testing should be at the lowest level to detect presence of drugs bearing in mind the reasons for which the drug is being screened.

Medical Record Documentation: Medical records must document the medical necessity of billed services and must be made available to CCA. Upon a request for medical records to ensure compliance with CCA's requirements, copies of test results alone without complete signed and dated orders, supported rationale for testing, and lack of test results of associated presumptive testing prior to ordering definitive testing will be considered incomplete documentation to support billing.

Laboratory Services Performed in a Facility Setting

CCA's policy follows the CMS National Physician Fee Schedule (NPFS) Professional Component/Technical Component (PC/TC) indicators 3 and 9 to identify laboratory services that are not reimbursable to an Independent Laboratory.

- PC/TC indicator 3: Technical Component Only Codes
- PC/TC indicator 9: PC/TC Concept Not Applicable

Laboratory Handling

CPT codes for Laboratory handling and conveyance (99000, 99001, and HCPCS code H0048) are included in the overall management of a patient and are reimbursed together.

Definitions:

Definitions	
Independent Laboratory	An Independent Laboratory is a facility separate from either an attending or consulting physician's office and separate from a hospital that qualifies as an emergency hospital. An Independent Laboratory must satisfy Federal and State certification, while meeting proficiency testing requirements outlined in the Clinical Laboratories Improvement Act (CLIA).
Reference Laboratory	A Reference Laboratory is a facility that receives a specimen from another laboratory and then performs the actual test(s) on the provided specimen.

Codes

CPT Code Section
National Physician Fee Schedule Relative Value File
Clinical Laboratory Fee Schedule

Audit and Disclaimer Information

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, procedures, and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

References

CCA Website

CMS Website

National Physician Fee Schedule Relative Value File

Clinical Laboratory Fee Schedule

CMS Place of Service Database

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

Policy Timeline Details

1. Drafted: October 2021
2. Approved:
3. Implemented: