MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

July 26, 2018

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 800 – LABORATORY SERVICES

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 800 – are proposed to update language, definitions and limitations for drug screening and testing. Presumptive drug screens are limited to one per day with a maximum of 20 tests per 12-rolling months. Only three definitive drug screens are permitted per recipient per 12-rolling months. Should more than three be needed, a prior authorization is required.

Entities Financially Affected: Hospital, Outpatient (Provider Type (PT) 12), Special Clinics (PT 17), Physician/Osteopath (PT 20), Certified Registered Nurse Practitioner, Nurse (PT 24), Laboratory – Pathology/Clinic (PT 43), School Based Services (PT 60), Nurse Midwife (PT 74), and Physician's Assistant (PT 77).

Financial Impact on Local Government: Unknown at this time.

These changes are effective August 1, 2018.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
CL MSM Chapter 800 – Laboratory Services	MTL 15/14 MSM Chapter 800 – Laboratory Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
803.1A.1.p.1	**Coverage and limitations**	Added language to clarify the requirements of the presence of a drug or drug class for when to conduct a drug screen.
803.1A.1.p.2	**Coverage and limitations**	Added language to clarify the referring physician must indicate in a written order, each drug or drug class being tested.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
803.1.A.1.p.3	**Coverage and limitations**	Added language to clarify structures of screening of drugs including presumptive and definitive. This includes the maximum number of 20 presumptive and the maximum number of three definitive drugs screens that can be performed in a 12-month rolling period.
803.1.A.1.p.4	**Coverage and limitations**	Added language that standing orders for presumptive drug screens may be utilized.
803.1.A.1.p.5	**Coverage and limitations**	Added language that procedure codes should only be reported with a quantity of one per episode of care.
803.1.A.1.p.6	**Coverage and limitations**	Added language that testing for the same drug with a blood and urine specimen simultaneously is not covered.
803.1.A.1.p.7	**Coverage and limitations**	Added language that drugs screens not meeting medical necessity are not covered.
803.1.A.1.p.8	**Coverage and limitations**	Added language that routine drug screens are not covered unless used in conjunction with an extended course of treatment for substance abuse disorders.
803.1.A.1.p.9	**Coverage and limitations**	Added language that drug confirmation tests are not eligible to be separately reported under any procedure code, unlisted or otherwise.

803 POLICY

803.1 Nevada Medicaid and Nevada Check Up (NCU) reimburse for medically necessary, diagnosis related, covered laboratory services provided to all eligible recipients.

Nevada Medicaid and NCU provide outpatient clinical laboratory services through one or more independent clinical laboratories, physician office laboratories, clinics and hospital-based laboratories.

803.1A COVERAGE AND LIMITATIONS

1. Covered Services:

   a. Except for specific laboratory tests identified under non-covered services, the Division of Health Care Financing and Policy (DHCFP) reimburses organ or disease oriented panels, therapeutic drug assays, evocative/suppression testing, clinical pathology consultations, urinalysis, chemistry, hematology and coagulation, immunology, tissue typing, transfusion medicine, microbiology, cytopathology, cytogenic, surgical pathology, total transcutaneous bilirubin, and tests specified under, "Other Procedures" in the most recent version of Current Procedural Terminology (CPT). Reference the Nevada Medicaid and NCU billing guidelines for Provider Type 43, Laboratory, Pathology/Clinical, for covered CPT codes.

   b. Follow-up testing performed by either the discharging hospital laboratory and/or the newborn's physician for newborns discharged with a hyperbilirubinemia diagnosis.

   c. Ova and parasite testing for medically appropriate diagnosis.

   d. An arterial blood drawing fee for Arterial Blood Gases (ABG) performed by physicians and/or respiratory therapists.

   e. Specialized or unique testing which cannot be performed within the State and catchment area laboratories referred to a reference laboratory. Reference Section 803.1C.2 regarding prior authorization requirements.

   f. Genotype and Phenotype assay testing for recipients:

      1. With an acute (new or recent) Human Immunodeficiency Virus (HIV) diagnosis upon entry into HIV care and/or prior to the initiation of antiretroviral therapy;

      2. Presenting with documented virologic failure after initiation of antiretroviral therapy; or

3. Demonstrating documented suboptimal suppression of viral load after initiation of antiretroviral therapy.

g. One venipuncture specimen collection fee per patient, per date of service, specifically when the specimen is sent directly from a physician's office laboratory or clinic to an independent clinical laboratory for testing.

h. Laboratory tests associated with the Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Healthy Kids Program) screening examination referenced in Medicaid Services Manual (MSM) Chapter 1500. The associated costs of the hematocrit and urine "dip stick" with the exception of metabolic screening (e.g. Phenylketonuria (PKU)) and sickle cell screening fees, are included as part of the fee for EPSDT.

i. Metabolic screening (e.g. PKU) tests are referred to the Nevada State Public Health Laboratory.

j. Sickle cell screens are referred to an independent clinical laboratory.

k. Serological or rapid-test HIV testing during the first and/or third trimester of pregnancy or during childbirth performed in accordance with Nevada Revised Statute (NRS) 442.600 – 442.660.

l. An HIV rapid test for newborns (including infants in foster care) when the mother has not been tested for HIV prior to or during the delivery or if the mother's HIV status is unknown postpartum.

m. Serologic testing for syphilis in the first and third trimester of pregnancy in accordance with NRS 442.010.

n. Semen analysis, motility and count following a vasectomy procedure, not including Huhner test, is limited to the CPT code is specified in the DHCFP's/Quality Improvement Organization (QIO)-like vendor billing manual.

o. HIV tropism testing, not meeting criteria specified in 803.1A.2.m.

p. Drug Screening and Testing

1. Drugs or drug classes for which screening is performed should only reflect those likely to be present based on the recipient's medical history, current clinical presentation or risk potential for abuse and diversion.

2. Each drug or drug class being tested for must be indicated by the referring physician in a written order and reflected in the patient's medical record. This information must be patient-specific and accurately reflect the need for each test and must include the specific drugs being screened including recipient diagnosis.

3. Current coding for testing of drugs relies on a structure of screening (known as presumptive screening) and may be followed by quantitative measurements (known as definitive testing) that identifies the specific drug or drugs and quantity in the recipient.

    a. Only one presumptive test performed by direct observation or instrument assisted direct observation may be billed per recipient per day within a maximum of 20 presumptive test per 12-rolling months.

        1. If the recipient should require more than 20 presumptive tests per 12-rolling month, a prior authorization is required.

        2. A presumptive drug test utilizing instrument chemistry analyzers requires prior authorization.

    b. Only three definitive drug tests are permitted per recipient per 12-rolling months.

        1. If the recipient requires more than three definitive tests per 12-rolling month, a prior authorization is required, meeting medical necessity.

        2. Definitive testing is only covered to confirm an unexpected result or identify drugs or metabolites that cannot be detected on a presumptive drug screen.

        3. Definitive testing should be based on the recipient's presentation and history and only include what is needed for safe pain management.

4. Standing orders for presumptive drug screens may be utilized, but must be individualized for each member, signed and dated by the treating practitioner and updated every 30 days. Standing orders are not permitted for definitive drug screens.

5. Procedure codes should be reported with a quantity of one per episode of care, regardless of the number of collection/testing items used, the number of procedures and/or the drug classes screened.

6. Testing for the same drug with a blood and urine specimen simultaneously is not covered.

7. Drug screening for pre-employment or employment purposes, medicolegal and/or court ordered that do not meet medical necessity and/or drug screenings for participation in school or military are not covered.

8. Routine drug screening is not covered unless used in conjunction with an extended course of treatment for substance use disorders. Specific intervals, at which recipient test should be performed, based on their individual needs, must be documented in the member's medical record with their treatment plan.

9. Drug confirmation tests are not eligible to be separately reported under any procedure code, unlisted or otherwise.

2. Non-Covered Services

Laboratory tests listed in the most recent, annually updated CPT publication which are not benefits include:

a. Post mortem examination codes.

b. Reproductive medicine procedures, except as indicated in 803.1.A.1.m.

c. Handling/conveyance fees (e.g. urine, stool cultures, pap smears).

d. Medicaid and NCU Managed Care recipients (laboratory tests are the sole responsibility of the managed care provider).

e. Those services deemed inappropriate to a probable diagnosis are not covered. Services deemed inappropriate will be reviewed for possible recoupments.

f. All unlisted laboratory codes except for the unlisted microbiology code used to bill phenotype assay tropism testing only.

g. Routine venipuncture by a provider testing the laboratory specimen or referring the laboratory specimen to an affiliate laboratory.