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

i. 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.

ii. 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 and recipient diagnosis.

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

1. Only one presumptive test performed by direct observation or instrument assisted direct observation may be billed per recipient per day with a maximum of twenty presumptive tests per 12 rolling months.
    a. If the recipient should require more than twenty presumptive tests per 12 rolling months, a prior authorization would be required.
    b. A presumptive drug test utilizing instrument chemistry analyzers requires prior authorization.
2. Only one definitive drug test is permitted per recipient per 12 rolling months.
    a. If the recipient should require more than one definitive test per 12 rolling months, a prior authorization would be required.
    b. Definitive testing is only covered to confirm an unexpected result or identify drugs or metabolites that cannot be detected on a presumptive drug screen.
    c. Definitive testing should be based on the recipient's presentation and history and only include what is needed for safe pain management.

iv. 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.

v. 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.

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

vii. 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.

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

ix. 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.

h. Collection of a capillary blood specimen (e.g. finger, heel, or ear stick) when it is part of or integral to the test procedure (e.g. a bleeding or clotting time).

i. Physician services related to deviation from standard blood banking procedures (e.g. use of outdated blood or Rh incompatible units).

j. Microdissection by laser capture.

k. Caffeine halothane contracture test.

l. Routine use (e.g. serial testing) of genotype and/or phenotype testing in individuals without virologic failure or suboptimal viral response or with viral loads maintained at an undetectable level on a current medication regime.

m. HIV tropism test:

1. Subsequent to a prior mixed or dual tropism test result; or

2. Testing performed more than twice in a recipient's lifetime.

n. Blood typing for paternity testing.

o. Gene expression profiling, except when it is medically necessary as a prognostic assay to identify recipients diagnosed with breast cancer who are likely to respond to systemic chemotherapy when utilizing Onco*type* DX™, as defined in Policy Attachment #08-02.

p. Molecular testing except for BRCA1/BRCA2 testing services for:

1. Individuals without a personal history of breast and/or ovarian cancers, considered to be high risk as defined in Policy Attachment #08-01 or as otherwise defined by the US Preventive Services Task Force;

2. Women with a personal history of breast and/or ovarian cancer with a personal history of breast cancer as defined in Policy Attachment #08-01 or as otherwise defined by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines; or

3. Men with a personal history of breast cancer as defined in Policy Attachment #08-01 or as otherwise defined by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines.

803.1B PROVIDER RESPONSIBILITY

Providers must:

1. Verify recipients Medicaid eligibility and program benefit. Medicaid Fee-For-Service (FFS) will not reimburse for laboratory procedures performed for Medicaid or NCU recipients in managed care. Managed care plans may have their own authorization requirements. See Chapter 3600.

2. Have appropriate state licensure or registration from the state where the laboratory is located, as applicable.

3. Have current and appropriate Clinical Laboratory Improvement Amendments (CLIA) certification for the level of laboratory tests performed.

4. Except in the case of provision of emergency laboratory services, have a valid Provider Contract with the Nevada DHCFP and Nevada Medicaid enrollment number or be an affiliate of an in-state laboratory that has a valid Medicaid enrollment number.

   An out-of-state laboratory providing covered, emergency medical laboratory services to a Medicaid or NCU recipient is exempt from the enrollment process for these services as long as the provider is enrolled as a Medicaid provider and is licensed to provide the laboratory service in the provider's home state.

5. Be in compliance with all applicable federal, state and local laboratory requirements.

6. Be in compliance with all Nevada Medicaid State Manual policies.

7. Be in compliance with claim and billing requirements specified in MSM Chapter 100, the QIO-like vendor/Medicaid and NCU billing manual, and the most recent version of the Current Procedural Terminology and the Healthcare Common Procedure Coding System manuals.

8. Include on all claims the highest level of code specificity in accordance with the most current International Classification of Diseases, Clinical Modification manual related to the laboratory test performed. If a diagnosis or narrative diagnosis is not submitted by the prescribing practitioner, a laboratory must request this information from the physician/ practitioner who ordered the service.

9. Specify the current CLIA number of the laboratory performing the test on all claims, except when billing for CLIA exempt tests.

10. Only bill for laboratory services that the laboratory is currently licensed/registered and certified to perform.

11. Ensure each recipient's laboratory record contains the following information:

    a. Identification number of the specimen;

    b. Name or any other means of confidentially identifying the person from whom the specimen was taken;

    c. Name of the prescriber and, if applicable, the referring laboratory that submitted the specimen;

    d. Date the specimen was collected by the prescriber or laboratory;

    e. Date the specimen was received in the laboratory;

    f. Condition of unsatisfactory specimens when received (e.g. broken, leaked, hemolyzed, or turbid);

    g. Test performed;

    h. Date the test was performed;

i. Results of the test and the date of reporting; and

j. Name and address of the laboratory where any specimen is referred, if applicable.

12. Ensure that there is a written report on file for laboratory and pathology services that have a professional component requiring physician interpretation, whether or not "with interpretation and report" is stated in the code description of the service provided.

13. Maintain a quality-control program and make results of proficiency testing programs available to Nevada Medicaid or the QIO-like vendor upon request.

14. Appropriately bill for organ or disease-oriented panels.

    a. When a provider performs all of the constituent procedures of a covered panel, the provider must submit a claim for the panel rather than for each constituent procedure separately.

    b. The provider must not define a panel differently than the CPT criteria, and all of the constituent procedures must be medically necessary or medically indicated.

    c. When a provider performs some but not all of the constituent procedures of a panel, the provider must submit a claim for the constituent procedures separately.

    d. When a provider performs more procedures than are included in a panel, the provider may submit a claim for the additional procedures separately.

803.1C PRIOR AUTHORIZATION

The ordering physician must obtain prior authorization for the following services, except for Medicare/Medicaid dual eligible recipients who are still eligible for Medicare benefits:

1. Genotype and phenotype assay testing for recipients with chronic HIV infection prior to initiation of highly active antiretroviral therapy.

2. Laboratory tests referred by a physician office laboratory directly to an out of state laboratory.