CHAPTER IV

COVERED SERVICES, LIMITATIONS, AND PAYMENT

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COVERED SERVICES

General Information

The Commonwealth of Virginia's State Plan for Medical Assistance provides coverage for "other laboratory and X-ray services." This includes services provided by independent laboratories for all recipients eligible under the Medicaid Program. The category "other laboratory and X-ray services" means professional and technical laboratory and radiological services. These services are to be ordered by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law.

A physician's direction or certification is required for the coverage of independent laboratory services.

DMAS requires the use of Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and codes and definitions published in the most recent Physicians' Current Procedural Terminology (CPT) in billing for covered services. The CPT manual may be obtained from:

Order Department: OP054192
American Medical Association
P. O. Box 10950
Chicago, IL 60610

Coverage

Payment for laboratory and x-ray services will be made directly to the provider actually performing the service (i.e., physician, independent laboratory, or other participating facility). The laboratory may bill for the handling and/or conveyance of specimens sent to another laboratory by using CPT/HCPCS procedure code 99001. Only one specimen handling fee is allowed per specimen. Laboratory procedures performed by outside sources at no charge to the practitioner or laboratory are not to be billed to Medicaid.

Whenever laboratory tests are performed that are generally part of a profile, the maximum payment is the appropriate automated profile rate, regardless of how the specimen is tested. This includes, but is not limited to, chemistry and hematology testing:

- The CPT/HCPCS coding system delineates tests that are frequently done as part of a chemistry profile. When **two** or more of these lab tests are performed on the same specimen, in any combination, the lesser automated rate is to be billed regardless of how the specimen is tested. CPT/HCPCS codes 80002-80019 are to be used, and the code used must correlate with the number of tests performed. Only one panel code is to be used per specimen. If only one

procedure is performed, use the appropriate CPT/HCPCS procedure code which describes the individual test.

- Whenever **four** or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code is to be used (85021-85031). CPT/HCPCS codes 85021-85030 are to be used when specimens are tested using automated equipment, and CPT/HCPCS code 85031 is to be used when specimens are tested manually.

- If fewer than four components of a hemogram are performed, they are to be billed using the appropriate individual CPT/HCPCS codes.

Payment for the following tests will be made only to a **pathologist**, **hospital laboratory**, or a **participating laboratory**. Specimens for the tests listed below may also be sent to the State Laboratory:

86171 Complement fixation tests, each (e.g., cat scratch fever, coccidioidomycosis, histoplasmosis, psittacosis, rubella, streptococcus MG, syphilis)

87116 Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); any source, isolation only

87117 Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); concentration plus isolation

87118 Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); definitive identification, per organism (does not include isolation and/or concentration)

87190 Sensitivity studies, antibiotic; tubercle bacillus (TB, AFB), each drug
87250 Virus, inoculation of embryonated eggs, suitable tissue culture, or small animal, includes observation and dissection

Screening Mammography

Screening mammography of asymptomatic women for the early detection of breast cancer is covered according to the schedule below. Claims for mammography services for women determined to be at high risk, according to accepted medical practices that are performed at the screening frequency for high risk, must be coded for unusual service (Code 22) and must include an attachment providing a brief explanation of the high-risk condition.

Age	Risk Category	Screening Frequency
35-39	All women	One screening mammogram (baseline)
40-49	Low risk	One mammogram every other year (At least 23 months must have elapsed since the month of the last screening.)
40-49	High risk	One mammogram each year (At least 11

		months must have elapsed since the month of the last screening.)
50 and over	All women	One mammogram each year (At least 11 months must have elapsed since the month of the last screening.)

Limitations

The following laboratory service specifically **excluded** from coverage and payment:

- Sensitivity studies when a culture shows no growth or urine cultures with contaminant growth (103 or less) - Payment will be made only for the culture.

PAYMENT FOR SERVICES

General Information

DMAS will pay only the independent laboratory or hospital for laboratory and x-ray services ordered by a physician and performed by the laboratory or hospital. Funds are **not** available to pay a physician for any laboratory or x-ray service performed by the laboratory or hospital.

Payment Methodology

The Deficit Reduction Act of 1984 requires Medicare to establish fee schedules for clinical laboratory procedures, including specimen handling and collection. Federal regulations (42 CFR 447.342) limit Medicaid reimbursement to no more than the amount allowed by Medicare for the same procedure. Therefore, Medicaid reimbursement for clinical laboratory procedures will not exceed the Medicare fee schedule. In the past, some laboratory fees exceeded the Medicare allowance. Effective for dates of service on and after January 1, 1998, laboratory fees that exceed what Medicare allowance will be reduced to the Medicare rate.

Payment for laboratory services is the **lowest of**:

- The Program's fee schedule;
- The provider's charges; or
- The National Clinical Laboratory fee cap, implemented July 1, 1986.

Federal regulation 42 CFR 447.15 requires providers to accept Medicaid payment as payment in full for the service required.

Cost Sharing

Services billed by independent laboratories are not subject to the cost-sharing requirements applicable to some other services provided under the Virginia Medicaid Program. Therefore, independent laboratories must not collect copayments from

Medicaid recipients.

Third-Party Liability

Since Medicaid is always the payer of last resort, the provider is required to seek payment from any other sources where the recipient may have coverage for the services provided before billing Medicaid. Information regarding other sources can be obtained from the recipient or from the Medicaid ID card. Information showing payments collected from other sources must be included on the Medicaid invoice. Supplementation shall be made by the Medicaid Program when necessary, but the combined total payment from all insurance shall not exceed the amount payable under Medicaid had there been no other insurance.

Insurance information and the recipient's 12-digit eligibility number should be supplied by the physician ordering the laboratory or x-ray service.

The Deficit Reduction Act of 1984 requires independent and hospital laboratories to accept Medicare assignment. The Medicare intermediary/carrier will pay the lesser of 100 percent of the fee schedule amount (no coinsurance or deductible is applied) or the allowable charge by the provider for all assigned claims for clinical laboratory procedures. **Medicaid is the payer of last resort.** The Medicare payment of 100 percent of the Medicare fee schedule or 100 percent of charges, whichever is less, is a third-party source of payment for clinical laboratory procedures. Therefore, independent laboratories should accept Medicare assignment for clinical laboratory procedures with no billings to Virginia Medicaid for these procedures where the patient is Medicare/Medicaid-eligible.

The Medicaid Program will not make payments for a recipient covered by Workers' Compensation.

Liability Insurance For Accidental Injuries

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid recipients who receive medical care as the result of injuries caused by the negligence of another. If a recipient is treated as the result of an accident and the Virginia Medicaid Program is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in the Virginia Code Section 8.01-66.9.

When the provider bills and accepts payment by Virginia Medicaid in liability cases, the provider, under federal regulations, must accept Virginia Medicaid payment as payment in full. However, providers can initially choose to bill the third-party carrier or file a lien in lieu of billing Virginia Medicaid.

Medicare Catastrophic Coverage Act of 1988

[Effective Date: January 1989]

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State

Medicaid Programs to expand the coverage of services to certain low income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Recipients in this group are eligible only for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the recipient's copayment, on allowed charges for **all** Medicare-covered services. They will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY--QMB--MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for **all** Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this manual. This group will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED."

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

Submission of Claims for Nonresident Aliens

Chapters I and III contain information on the coverage and eligibility requirements for nonresident aliens. To submit a claim for covered emergency services for a nonresident alien :

- Complete the appropriate Medicaid billing form (and any other required forms) in the usual manner.
- Attach a copy of the completed Emergency Medical Certification Form to the invoice. Other relevant documentation to justify the approval has already been submitted and reviewed and therefore does not need to be duplicated with this claim.
- Submit the claim using the preprinted envelopes supplied by Medicaid or by mailing the claim directly to the appropriate post office box.

NOTE: The same procedures apply for adjusted or voided claims.

All claims for nonresident aliens will pend for certification to verify that they were related to the emergency situation which has been approved. All claims not related to the emergency treatment will be denied. The documentation for a denied claim will be kept by Medicaid for 180 days from the date of receipt to allow for the appeal process for those services which are not approved.