Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XIX. Other Services

Subpart 3. Laboratory and Radiology

Chapter 41. Enrollment

§4101. Physician Office Services

A. Payment is limited to laboratory and diagnostic testing performed in a physician's office. Claims for these tests will be paid only when the physician has on file with the Provider Enrollment Section, a complete list of the laboratory and diagnostic equipment, the capabilities of such equipment, and permits verification of this data in accordance with the provider agreement.

B. Only those physicians who desire to claim reimbursement for laboratory or diagnostic tests performed in their offices need to complete and return the form. The laboratory and diagnostic equipment which needs to be reported is that equipment which is not common to all physician offices and for whose use there are specific CPT-IV codes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 8:75 (February 1982), repromulgated LR 28:1023 (May 2002).

Chapter 43. Billing and Reimbursement

Subchapter A. Billing

§4301. Laboratory Testing Services

A. Independent and hospital laboratories who furnish laboratory services may bill a nominal amount for the collection of a patient specimen. However, only one collection fee per patient encounter will be permitted.

B. Physicians may bill for laboratory services only when they personally perform or supervise the test. Hospital laboratories will no longer be reimbursed for outpatient or nonpatient laboratory services furnished under arrangements with independent laboratories or other hospitals, except where the hospital performed some of the tests. Where a hospital performs some of the tests and refers the specimen to another hospital or independent laboratory, either the hospital may bill for all tests or the hospital and the reference laboratory may each bill for the service they provide.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), P.L. 98-369, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 5:388 (December 1979), amended LR 8:75 (February 1982), LR 8:144 (March 1982), LR 10:1034 (December 1984), LR 12:679 (October 1986), LR 22:107 (February 1996), repromulgated (for LAC) LR 28:1024 (May 2002).

§4303. Provider Claim Requirements

A. Definition

Claim—a single document line identifying the services and/or charges for services for a single recipient from a single provider.

B. Providers shall submit all original claims no later than 12 months from the date of service.

C. The provider shall be allowed up to two years from the date of service to provide adequate billing information to the fiscal intermediary necessary for adjudicating the claim. Any claim for which the fiscal intermediary has not received documentation necessary for adjudication within two years from the date of service shall be denied.

D. Providers shall be required to submit any adjustments within 120 days of adjudication of a claim. This requirement shall not apply to adjustments arising from Third Party Liability or Patient Liability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 5:388 (December 1979), amended LR 10:599 (August 1984), LR 13:578 (October 1987),), repromulgated (for LAC) LR 28:1024 (May 2002).

§4305. Automated, Multichannel Test and Panel Billing

A. Procedure Code 84478 (Triglycerides) is included in the list of automated, multichannel tests enumerated under the heading "Automated, Multichannel Tests" in the 1995 issuance of the Physicians' Current Procedural Terminology.

B. A panel code (80002-80019) must be billed after the performance of the first, rather than the second, automated, multichannel test.

C. If more than one of the codes listed below is billed by the same billing provider for the same recipient for the same date of service, the first billing will be paid and the second will be denied with the message, "Multi blood tests billed; to be combined to panel."

82040	82250	82251	82310	82315	82320
82325	82330	82374	82435	82465	82565
82947	83615	83620	84060	84075	84100
84132	84155	84295	84450	84455	84460
84465	84520	84525	84550	83624	83610
82555	84478	82550	84160		

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 8:75 (February 1982), amended LR 10:1034 (December 1984), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:219 (March 1996),), repromulgated (for LAC) LR 28:1024 (May 2002).

§4307. Hepatic Function Panel and General Health Panel

A. If individual tests and panel codes are billed for the same recipient for the same date of service by the same billing provider, the first billing will be paid and the second billing will be denied with the message "Blood component billed with panel code."

B. The panel codes begin with 80002 and extend through 80019 and include panel codes 80050 and 80058. The individual codes included in this edit are the ones listed under §4305.C of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:219 (March 1996), repromulgated (for LAC) LR 28:1024 (May 2002).

§4309. Hematology

A. Incorrect billings of hematology components, indices and profiles will be denied with the message, "Hematology components/indices/profiles billed incorrectly."

B. Only one of codes 85021 - 85027 shall be paid to the same billing provider for the same recipient for the same date of service. A second billing of any of these codes on the same date of service for the same recipient by the same billing provider will be denied. Code 85021 should be billed by itself or one of 85022, 85023, 85024, 85025 or 85027 should be billed.

C. The billing of more than two of the hematology component codes (85007, 85014, 85018, 85041, 85048, 85595) by the same billing provider for the same recipient for the same date of service will result in denial of the third code in this group as a profile code should be billed if more than two tests in this group are performed.

D. The billing of one of the above profile codes (85021 - 85027) and one or more of the component codes 85014, 85018, 85041 or 85048 by the same billing provider for the same recipient for the same date of service will result in payment of the first billing and denial of the second as the component codes are included in the profile codes.

E. The billing of code 85007 and codes 85022 and/or 85023 on the same date of service for the same recipient by the same billing provider will result in payment of the first claim and denial of the second. Procedure code 85007 is included in codes 85022 and 85023.

F. A billing of code 85595 and codes 85023, 85024, 85025 and/or 85027 by the same billing provider for the same recipient for the same date of service will result in payment of the first claim and denial of the second claim. Procedure code 85595 is included in codes 85023, 85024, 85025 and 85027.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:219 (March 1996), repromulgated (for LAC) LR 28:1024 (May 2002).

§4311. Panel Codes

A. A billing of more than one panel code (80002 - 80019, 80050 and 80058) on the same date of service for the same recipient by the same billing provider will result in denial of the second billing with the message, "Max allowed. One panel per day per billing provider."

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:219 (March 1996), repromulgated (for LAC) LR 28:1025 (May 2002).

§4313. Prenatal Lab Panel Services

A. Prenatal lab panel services must be billed utilizing standard Physicians' Current Procedural Terminology (CPT) codes from the Organ or Disease Oriented Panels subheading in the Pathology and Laboratory section of the CPT.

B. Only one prenatal lab panel claim shall be billed per recipient per pregnancy (270 days) per billing provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:219 (March 1996), repromulgated (for LAC) LR 28:1025 (May 2002), amended LR 29:1485 (August 2003).

§4315. Urinalysis

A. A billing of code 81000 and one or more of 81002, 81003, or 81015 by the same billing provider for the same recipient for the same date of service will result in denial of the second billing with the message, "Urinalysis billed incorrectly" because 81002, 81003 and 81015 are inappropriate with 81000.

B. A billing of code 81002 and 81003 on the same date of service for the same recipient by the same billing provider will result in denial of the second claim with the same message because the descriptions of the two codes are contradictory.

C. A billing of code 81001 and 81002, 81003 or 81015 on the same date of service for the same recipient by the same billing provider will result in denial of the second claim as the descriptions of the latter three codes are contradictory to that of code 81001.

D. A billing of code 81000 and 81001 on the same date of service for the same recipient by the same billing provider

will result in denial of the second claim as the two codes have contradictory descriptions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:219 (March 1996), repromulgated (for LAC) LR 28:1025 (May 2002).

§4317. Panels and Component Codes within Panels

A. A billing of panel code 80050 and component codes 80012 - 80019, 85022, 85025 and/or 84443 by the same billing provider on the same date of service for the same recipient will result in denial of the second claim with the message, "Billed panel and individual code within panel."

B. A billing of panel code 80058 and component codes 82040, 82250, 84075, 84450 and/or 84460 by the same billing provider on the same date of service for the same recipient will result in denial of the second billing with the same message.

C. If panel code 80059 is paid, component codes 86287, 86291, 86289, 86296, and 86302 will not also be paid on the same date of service for the same recipient to the same billing provider.

D. Subsections A - C of this Section also apply to panel codes 80061, 80072, 80090, 80091, 80092 and their components.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 49:1008(A), and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:219 (March 1996), repromulgated (for LAC) LR 28:1024 (May 2002).

§4319. X-Ray Equipment Portage Billing

A. Standard Health Care Financing Administration Common Procedure Codes (HCPCS) modifiers shall be used to bill for x-ray portage fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1026 (May 2004).

Subchapter B. Reimbursement

§4329. Laboratory Services (Physicians and Independent Laboratories)

A. Providers should use the most appropriate healthcare common procedure coding system (HCPCS)/current procedural terminology (CPT) code representing the service performed when submitting claims to Medicaid.

B. Guidelines indicated in the pertinent CPT manual are to be followed when billing for these services unless specifically directed otherwise by the department.

C. Limitations on select services are indicated on the published fee schedules and/or in provider manuals.

D. Reimbursement for clinical laboratory procedures shall not exceed 100 percent of the current year's Medicare allowable. Reimbursement of clinical laboratory services shall be paid at the lower of billed charges or the fee on file, minus the amount which any third party coverage would pay.

E. Those services not subject to the Medicare fee schedule shall continue to be reimbursed to physicians and independent laboratories based on the published Medicaid fee schedule or billed charges, whichever is lower.

F. Effective for dates of service on or after February 26, 2009, the reimbursement rates for laboratory services shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

G. Effective for dates of service on or after August 4, 2009, the reimbursement rates for laboratory services shall be reduced by 4.7 percent of the fee amounts on file as of August 3, 2009.

H. Effective for dates of service on or after January 22, 2010, the reimbursement rates for laboratory services shall be reduced by 4.42 percent of the fee amounts on file as of January 21, 2010.

I. Effective for dates of service on or after August 1, 2010, the reimbursement rates for laboratory services shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

J. Effective for dates of service on or after January 1, 2011, the reimbursement rates for laboratory services shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

K. Effective for dates of service on or after July 1, 2012, the reimbursement rates for laboratory services shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

L. Office of Public Health Uncompensated Care Payments

1. Effective for dates of service on or after July 1, 2012, the department shall provide the Office of Public Health (OPH) with Medicaid payment of their uncompensated care costs for services rendered to Medicaid recipients. The Office of Public Health shall certify public expenditures to the Medicaid Program in order to secure federal funding for services provided at the cost of OPH.

2. The OPH will submit an estimate of cost for services provided under this Chapter.

a. The estimated cost will be calculated based on the previous fiscal year's expenditures and reduced by the estimate of payments made for services to OPH under this Chapter, which will be referred to as the net uncompensated care cost. The uncompensated care cost will be reported on a quarterly basis

3. Upon completion of the fiscal year, the Office of Public Health will submit a cost report which will be used as

a settlement of cost within one year of the end of the fiscal year.

a. Any adjustments to the net uncompensated care cost for a fiscal year will be reported on the CMS Form 64 as a prior period adjustment in the quarter of settlement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), P.L. 98-369, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1025 (May 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1897 (September 2009), LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3028 (October 2011), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:95 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:1284 (May 2013).

§4331. Medicare Part B

A. The Medicare payment is compared to the Medicaid rate on file for procedure codes on Medicare Part B claims.

1. If the Medicare payment exceeds the Medicaid rate, the claim is adjudicated as a paid claim with a zero payment.

2. If the Medicaid rate exceeds the Medicare payment, the claim is reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment.

B. If the Medicaid payment is reduced or eliminated as a result of applying the limit of the Medicaid maximum payment, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), P.L. 98-369, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2622 (November 2000), repromulgated (for LAC) LR 28:1025 (May 2002).

§4333. Outpatient Hospital Laboratory Services Reimbursement

A. Hospitals are reimbursed for outpatient laboratory services as follows.

1. The reimbursement rates paid to outpatient hospitals for laboratory services subject to the Medicare Fee Schedule shall be increased by 10 percent of the rate on file as of September 15, 2002.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Service Financing, LR 23:414 (April 1997), promulgated (for inclusion in the LAC) LR 28:1026 (May 2002), amended LR 29:1096 (July 2003).

§4334. Radiology Services

A. Providers should use the most appropriate healthcare common procedure coding system (HCPCS)/current procedural terminology (CPT) code representing the service performed when submitting claims to Medicaid.

B. Guidelines indicated in the pertinent CPT manual are to be followed when billing for these services unless specifically directed otherwise by the department.

C. Limitations on select services are indicated on the published fee schedules and/or in provider manuals.

D. Reimbursement of radiology services shall be the lower of billed charges or the fee on file, minus the amount which any third party coverage would pay.

E. Effective for dates of service on or after February 26, 2009, the reimbursement rates for radiology services shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

F. Effective for dates of service on or after August 4, 2009, the reimbursement rates for radiology services shall be reduced by 4.7 percent of the fee amounts on file as of August 3, 2009.

G. Effective for dates of service on or after January 22, 2010, the reimbursement rates for radiology services shall be reduced by 4.42 percent of the fee amounts on file as of January 21, 2010.

H. Effective for dates of service on or after August 1, 2010, the reimbursement rates for radiology services shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

I. Effective for dates of service on or after January 1, 2011, the reimbursement rates for radiology services shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

J. Effective for dates of service on or after July 1, 2012, the reimbursement rates for radiology services shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1897 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3029 (October 2011), LR 39:1284 (May 2013).

§4335. Portable Radiology Services

A. Providers should use the most appropriate healthcare common procedure coding system (HCPCS)/current procedural terminology (CPT) code representing the service performed when submitting claims to Medicaid.

B. Reimbursement of portable radiology services shall be the lower of billed charges or the fee on file, minus the amount which any third party coverage would pay.

C. Effective for dates of service on or after February 26, 2009, the reimbursement rates for portable radiology services shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

D. Effective for dates of service on or after August 4, 2009, the reimbursement rates for portable radiology services shall be reduced by 4.7 percent of the fee amounts on file as of August 3, 2009.

E. Effective for dates of service on or after January 22, 2010, the reimbursement rates for portable radiology services shall be reduced by 4.42 percent of the fee amounts on file as of January 21, 2010.

F. Effective for dates of service on or after August 1, 2010, the reimbursement rates for portable radiology services shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

G. Effective for dates of service on or after January 1, 2011, the reimbursement rates for portable radiology services shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

H. Effective for dates of service on or after July 1, 2012, the reimbursement rates for portable radiology services shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 30:1026 (May 2004), amended LR 35:1898 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3029 (October 2011), LR 39:1284 (May 2013).

§4337. Radiation Therapy Centers

A. Radiation therapy centers are reimbursed fee for service according to the appropriate procedure code.

B. Reimbursement for radiation therapy center services shall be the lower of billed charges or the fee on file, minus the amount which any third party coverage would pay.

C. Effective for dates of service on or after February 26, 2009, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

D. Effective for dates of service on or after August 4, 2009, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 4.7 percent of the fee amounts on file as of August 3, 2009.

E. Effective for dates of service on or after January 22, 2010, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 4.42 percent of the fee amounts on file as of January 21, 2010.

F. Effective for dates of service on or after August 1, 2010, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

G. Effective for dates of service on or after January 1, 2011, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

H. Effective for dates of service on or after July 1, 2012, the reimbursement rates for radiology services provided by radiation therapy centers shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1898 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3029 (October 2011), LR 39:1284 (May 2013).

Chapter 45. Radiology Utilization Management

§4501. General Provisions

A. Radiology utilization management establishes provisions requiring prior authorization for certain outpatient high-tech imaging.

B. Prior authorization (PA) is based on best evidence medical practices as developed and evaluated by board-certified physician reviewers, including board-certified radiologists and additional physical specialists who will assist in the claim evaluation process.

1. Services requiring PA will be noted on the Medicaid fee schedule and shall include, but are not limited to, the following radiology service groups:

a. magnetic resonance (MR);

b. positron emission tomography (PET);

c. computerized tomography (CT); and

d. nuclear cardiology.

C. Reimbursement for these services is contingent upon prior authorization.

D. The following Medicaid recipients are excluded from radiology utilization management:

1. Family Planning Waiver recipients;

2. LaCHIP Affordable Plan recipients;

3. Program of All Inclusive Care for the Elderly (PACE) recipients;

4. Native American recipients; and

5. recipients who have primary health insurance coverage provided by:

a. Medicare; or

b. a private health insurance carrier.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2758 (December 2009), amended LR 36:1781 (August 2010).