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MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 55

LABORATORY SERVICES

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55.01 **DEFINITIONS**

55.01-1 Laboratory Services

Laboratory services ordered by or under the direction of a physician or a licensed practitioner of the healing arts within the scope of his or her practice as defined by state law; and provided by a laboratory that is in compliance with the pertinent sections of 22 M.R.S.A. §2011 *et seq.* (Maine Medical Laboratory Act) and the rules and regulations promulgated thereunder, meets the requirements for participation in Medicare and is in compliance with the rules implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88).

55.01-2 Medical/Clinical Laboratory

Any institution, building or place which provides through its ownership or operation an organization which employs methods and instruments for the examination of blood, tissues, secretions, and excretions of the human body or any function of the human body in order to diagnose disease, follow the course of disease, aid in the treatment of such disease, or detect drugs or toxic substances or which produces information used as a basis for health advice or which purports to offer such examinations unless otherwise provided by law.

55.01-3 Physician's Office Laboratory

A laboratory operated by a physician or group practice exclusively to provide laboratory services for its own patients that is in compliance with the pertinent Sections of 22 M.R.S.A. §2011 *et seq.* and the rules and regulations promulgated thereunder and meets the requirements for participation in Medicare and is in compliance with the rules implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88).

55.01-4 Group Practice Laboratory

A laboratory established for the mutual use of physician or group practice owners, is considered an independent clinical laboratory (See 55.01-3 and 55.01-5).

55.01-5 Independent Clinical Laboratories

An independent clinical laboratory is one which is not under direct jurisdiction of a hospital or the patient's attending physician. For reimbursement under Title XIX, the independent laboratory must be certified as an independent clinical laboratory in accordance with the

Medicare conditions of participation and must be licensed under the provisions of 22 M.R.S.A. §2011 *et seq.* and the rules and regulations promulgated thereunder and be in compliance with the rules implementing the Clinical Laboratory Improvement Amendments (CLIA 88).

55.02 ELIGIBILITY FOR CARE

The following individuals are eligible for coverage of laboratory services as set forth in this Manual:

- A. Categorically needy Medicaid recipients, whose eligibility is shown on the Medical Eligibility Card as MM, and
- B. Medically needy Medicaid recipients, whose eligibility is shown on the Medical Eligibility Card as MI.

55.03 DURATION OF CARE

Each Title XIX recipient is eligible for as many covered services as are medically necessary. The Department reserves the right to request additional information to evaluate and determine medical necessity.

55.04 COVERED SERVICES

55.04-1 General Provisions

A covered service is a service for which payment can be made by the Department.

Laboratory services which are specifically defined in the Department's Allowances for Physician Services Chapter III, Section 90, and are medically necessary for diagnosis and control of a medical condition, are covered services. These services must be ordered by a physician or other licensed practitioner authorized to order lab services within the scope of his or her license and be consistent with good medical practice.

55.04.2 Bundling or Grouping of Laboratory Tests

Included in the Allowances for Laboratory Services is a list of tests that are frequently done as a group (profile) on automated equipment. For any combination of these tests, the provider shall use the code which correctly designates the number of tests included in the profile. The

provider shall not “unbundle” and bill separately for tests included as part of a group (profile or panel) that pay at a lower rate. Use the Physicians’ Current Procedural Terminology (CPT) Manual Codes for the proper Automated, Multichannel Tests, and for the proper Organ or Disease Oriented Panels.

As noted in Section 55.07(B) Medicaid will pay no more than the lowest amount payable by Medicare. Therefore, in those cases where the Medicaid allowance for a procedure exceeds the Medicare allowance, the program will pay the lowest Medicare-allowed rate.

55.05 POLICIES AND PROCEDURES

55.05-1 Physician's Office Laboratory

Physicians in private practice will be reimbursed only for those laboratory services provided in his/her office by the physician or the office staff, using the office equipment and supplies.

When only laboratory services are provided, an office visit charge may not be made.

55.05-2 Referrals

For necessary laboratory services not done in the physician's office, the physician may make a written referral to:

- A. The laboratory department of a hospital;
- B. An independent laboratory.

The physician may not charge for making the referral.

The provider of the service is to charge the Department of Health and Human Services directly and provide a written report of test results to the physician.

Prohibition on referrals. Except as provided in federal rule, a physician who has a financial relationship with an entity, or who has an immediate family member who has a financial relationship with the entity, may not make a referral to that entity for the furnishing of clinical laboratory services for which payment otherwise may be made under Medicaid.

55.05-3 Proficiency Testing

The provider of the laboratory service shall participate in an on-going program of proficiency testing as described in 22 M.R.S.A. §2025 and the rules and regulations promulgated thereunder and the rules implementing the CLIA 88. Failure to demonstrate satisfactory participation to the Department of Health and Human Services Public Health Laboratory shall result in the provider being ineligible for reimbursement by the Medicaid program for those laboratory services found not to be in compliance.

55.05-4 Bulk Purchase Discounts

Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before a consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of the individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing the billable costs is required.

All purchase discounts are reductions in cost and must be reflected in the amount billed the Department by the provider for Laboratory Services performed by a third party. The Department will pay only the lower of either the price established for said service in the Medicaid fee schedule, or the price actually paid by the provider to the third party for the service. The Department reserves the right to audit the provider's fiscal records in order to verify the proper application of any purchase discounts to the reduction of billable costs.

55.05-5 Requirements for Out-of-State Providers

Out-of-state laboratories, while not subject to the Department's proficiency testing program, are required to be Medicare certified and licensed by the Health Care Financing Administration under the Clinical Laboratory Improvement Amendment of 1988.

55.05-6 Surveillance and Utilization Review

A. The Division of Surveillance and Utilization Review, Bureau of Medical Services, monitors the medical services provided and determines the appropriateness and necessity of the services.

- B. The Department and its professional advisors regard the maintenance of adequate client records as essential for the delivery of quality care. In addition, providers should be aware that these records are key documents in conducting post payment reviews. In the absence of proper and complete client records, no payment will be made and payments previously made may be recovered in accordance with Chapter I, of the MaineCare Benefits Manual.
- C. The Department requires that client records and other pertinent information will be transferred, upon request and with the client's signed release of information, to other providers involved in the client's care.
- D. Upon request, the provider will furnish to the Department, without additional charge, the clinical records, or copies thereof, corresponding to and substantiating services billed by that provider.

55.06 **CONFIDENTIALITY**

The disclosure of information regarding individuals participating in the Medicaid program is strictly limited to purposes directly connected with the administration of the Medicaid program. Providers shall maintain the confidentiality of information regarding these individuals in accordance with 42 CFR §431 *et seq.* and other applicable sections of state and federal law and regulation.

55.07 **REIMBURSEMENT**

The MaineCare rates are posted in the fee schedule on the MaineCare website. Rates other than drug prices for new or changed codes (any CPT or HCPCS code) are determined based on the following lowest benchmark:

- A. The fee for service rate is set at fifty-three percent (53%) of the lowest level in the current Medicare fee schedule for Maine in effect at that time; or
- B. The lowest amount allowed by Medicare Part B for Maine area "99" non-facility fee schedule; or
- C. The provider's usual and customary charge.

In accordance with Chapter I, of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other source that is available for payment of a rendered service prior to billing the Medical Assistance Program.

55.08 **COPAYMENT**

55.08-1 Copayment Amount

- A. A copayment will be charged to each Medicaid recipient receiving services. According to the following schedule, the amount of the copayment shall not exceed \$1.00 per day for services provided,

Copayment Amount

Medicaid Payment for Services	Recipient Copayment
\$10.00 or less	\$.50
\$10.01 - or more	\$1.00

- B. The recipient shall be responsible for copayments up to \$10.00 per month whether the copayment has been paid or not. After the \$10.00 cap has been reached, the recipient shall not be required to make additional copayments and the provider shall receive full Medicaid reimbursement for covered services.
- C. No provider may deny services to a recipient for failure to pay a copayment. Providers must rely upon the recipient's representation that he or she does not have the cash available to pay the copayment. A recipient's inability to pay a copayment does not, however, relieve him/her of liability for a copayment.
- D. Providers are responsible for documenting the amount of copayments charged to each recipient (regardless of whether the recipient has made payment) and shall disclose that amount to other providers, as necessary, to confirm previous copayments.

55.08-2 Copayment Exemptions: No copayment may be imposed with respect to the following services:

- A. Family planning services and supplies;
- B. Services furnished to individuals under twenty-one (21) years of age;
- C. Services furnished to any individual who is an inpatient in a hospital, skilled nursing facility, nursing facility, ICF-MR, or other medical institution, if that individual is required, as a condition of receiving services in that institution, to spend for costs of medical care all but a minimal amount of his or her income required for personal needs;

- D. Services furnished to pregnant women, including services provided during the three months following the end of a pregnancy;
- E. Emergency services, i.e.: when failure to provide the service could reasonably be expected to:
 - 1. place the recipient's health in serious jeopardy,
 - 2. cause serious impairment to bodily functions, or
 - 3. cause serious dysfunction of any bodily organ or part.
- F. Services furnished to an individual of a Health Maintenance Organization in which he or she is enrolled.
- G. Recipients in State custody.
- H. Recipients living in a Boarding Home or Foster Home.

Medicaid recipients exempt from copayment requirements are identified by a "NO" in the copay column on the recipient's Medical Eligibility Card.

See Section 55.09 for billing instructions for copayment exemptions.

55.08-3 Copayment Disputes

If a recipient believes that he or she is exempt from a copayment, disputes the amount of the copayment, or has been denied a service for failure to make a copayment, he or she may contact the Department for assistance in resolving that dispute. Complaints should be directed to the Assistant Director, Bureau of Medical Services.

55.09 **BILLING INSTRUCTIONS**

- A. Billing must be accomplished in accordance with the Department's "Instructions for Completion HCFA 1500 (01/84)" and Chapter III Section 90 of the MaineCare Benefits Manual, "Physician Services".

55.09 **BILLING INSTRUCTIONS** (cont.)

- B. In order to receive full Medicaid reimbursement for claims submitted for a service that is defined as an exemption in Section 55.08-2, the diagnosis code "EMR" must be included in addition to the primary diagnosis.
- C. All services provided on the same day must be submitted on the same claim form for Medicaid reimbursement.