



# Florida Medicaid

## Independent Laboratory Coverage and Limitations Handbook

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Agency for Health Care Administration







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April 18, 2007

Dear Medicaid Independent Laboratory Services Provider:

The Florida Medicaid Independent Laboratory Services Coverage and Limitations Handbook was updated effective January 2007. The handbook was revised to include Medicaid's genetic testing policies.

The following pages were replaced in the enclosed handbook:

Updated Pages
Update Log
Table of Contents
Chapter 2, pages 2-1 and 2-5 through 2-7

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder  
Chief, Bureau of Medicaid Services



# UPDATE LOG

## INDEPENDENT LABORATORY COVERAGE AND LIMITATIONS HANDBOOK

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### ***How to Use the Update Log***

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#### **Introduction**

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

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#### **Explanation of the Update Log**

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.  
Effective Date is the date that the update is effective.

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#### **Instructions**

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Medicaid Provider General Handbook.

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UPDATE NO.	EFFECTIVE DATE
Mar2000—Revised Handbook	April 2000
Mar2000—Errata	April 2000
January 2001	January 2001
January 2002—Replacement Pages	January 2002
March 2003—Replacement Pages	March 2003
Oct2003—Revised Handbook	October 2003
Jan2005-1—Remove Appendix E	January 2005
Jan2007—Replacement Pages	January 2007



# INDEPENDENT LABORATORY COVERAGE AND LIMITATIONS HANDBOOK

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## INTRODUCTION TO THE HANDBOOK

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### **Overview**

#### **Introduction**

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

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#### **Background**

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

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#### **Legal Authority**

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

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#### **In This Chapter**

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
Characteristics of the Handbook	iii
Handbook Updates	iii

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**Handbook Use and Format**

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<b>Purpose</b>	<p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.</p>
<b>Provider</b>	<p>The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p>
<b>Recipient</b>	<p>The term “recipient” is used to describe an individual who is eligible for Medicaid.</p>
<b>General Handbook</b>	<p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p>
<b>Coverage and Limitations Handbook</b>	<p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p>
<b>Reimbursement Handbook</b>	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
<b>Chapter Numbers</b>	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
<b>Page Numbers</b>	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
<b>White Space</b>	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

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***Characteristics of the Handbook***

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**Format**

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

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**Information Block**

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

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**Label**

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

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**Note**

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

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**Topic Roster**

Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

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***Handbook Updates***

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**Update Log**

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update No." and the "Effective Date".

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**Handbook Updates**, continued

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**How Changes Are Updated**

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

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**Numbering Update Pages**

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

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**Effective Date of New Material**

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

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**Identifying New Information**

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

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**New Label**

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

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**New Label and New Information Block**

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

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**New Material in an Existing Information Block**

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

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**New or Changed Paragraph**

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

| Paragraph with new material. |

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# CHAPTER 1

## INDEPENDENT LABORATORY PROVIDER QUALIFICATIONS AND ENROLLMENT

**Overview**

**Introduction**

This chapter describes the Independent Laboratory Program and provider licensure and certification requirements.

**Legal Authority**

Medicaid independent laboratory services are authorized by Title XIX of the Social Security Act and the Code of Federal Regulations, Title 42, Parts 440.30, 441.16, and 493. The state authority is established in Chapters 409, 455, and 483, Florida Statutes and Chapter 59G, Florida Administrative Code.

**In This Chapter**

This chapter contains:

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**Purpose and Definitions**

**Purpose**

The Medicaid independent laboratory program provides for payment of medically necessary clinical laboratory procedures provided in freestanding laboratory facilities.

**Purpose of This Handbook**

This handbook is intended for use by independent laboratories that provide services to Medicaid recipients. It must be used in conjunction with the Medicaid Provider Reimbursement Handbook, the CMS-1500, which contains specific procedures for submitting claims for payment and the Medicaid Provider General Handbook, which contains general information about the Medicaid program.

**Clinical Laboratory**

A clinical laboratory is a facility that examines materials taken from the human body for the purpose of providing information to assist in the diagnosis, prevention, or treatment of disease or assessment of health.

***Purpose and Definitions***, continued

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**Freestanding Laboratory**

A freestanding or independent facility is one that is not controlled, managed or supervised by:

- A hospital or a hospital's organized medical staff, or
- The treating health care practitioner.

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**Rural Health Clinic Laboratory**

If a rural health clinic practitioner owns, manages or supervises a laboratory separate from the rural health clinic's laboratory, the separate laboratory is considered to be freestanding for the purposes of this handbook.

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***Provider Qualifications and Enrollment***

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**General Enrollment Requirements**

Providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, they must follow the specific enrollment requirements that are listed in this section.

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**Eligible Laboratories**

To enroll as a Medicaid independent laboratory provider, a laboratory must be a freestanding clinical laboratory certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and licensed by the state of Florida.

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**Site Visit Policy**

In accordance with 409.907(7), Florida Statutes, providers may be subject to random onsite inspections before enrollment.

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**Out-of-State Laboratories**

A freestanding clinical laboratory located outside Florida is eligible to enroll as an independent laboratory provider if the facility is CLIA certified and licensed by the state of Florida. Freestanding laboratories located in Alabama and Georgia that regularly provide service to Florida Medicaid recipients must meet the same requirements.

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**Qualified at the Time of Enrollment**

Independent laboratory providers must meet all the provider requirements and qualifications and their laboratories must be fully operational before they can be enrolled as Medicaid providers.

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**Provider Requirements**

**General Requirements**

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, independent laboratory providers are also responsible for complying with the provisions contained in this section.

**Provider Responsibility**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitation handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent EDI help desk at 800-829-0218.

**CLIA Certification**

An independent laboratory provider must maintain certification under CLIA. Providers must notify the Medicaid fiscal agent within 60 days of any changes in their CLIA certification status and the test specialties they have been certified to perform.

**Specialty and Subspecialty Certification**

A laboratory facility must be certified by the Centers for Medicare and Medicaid Services (CMS) to perform the specialties or subspecialties of tests billed to Medicaid as of the date the tests are performed.

Note: See Appendix A in Chapter 2 of this handbook for a list of laboratory certification test specialties and subspecialties.

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**Provider Requirements**, continued

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**State Licensure**

An independent laboratory provider must maintain current clinical laboratory licensure from the state of Florida.

Note: Additional information on clinical laboratory licensure and certification may be obtained from the Agency for Health Care Administration, Laboratory Licensure Unit at (850) 487-3063.

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**Termination of Providers**

Medicaid will terminate the provider agreement and disenroll any independent laboratory provider who fails to maintain (1) CLIA certification appropriate for the tests performed, or (2) a current clinical laboratory license from the state of Florida.

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**Multiple Locations**

Separate laboratory facilities require separate CLIA certification and state licensure even if they are operated under the same management.

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## CHAPTER 2 INDEPENDENT LABORATORY COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

**Overview**

**Introduction**

This chapter describes the clinical laboratory services provided by an independent laboratory that are covered by Florida Medicaid. It also describes limited and excluded services.

**In This Chapter**

This chapter contains:

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**Covered Services**

**Introduction**

The Medicaid independent laboratory services program reimburses only the independent laboratory services described in this handbook.

Covered procedures are those that are accepted by leading authorities, such as the Centers for Disease Control or other national organizations, and which can be billed using a Healthcare Common Procedure Coding System (HCPCS) procedure code.

**Covered Services**, continued

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**Service Requirements**

Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service, and are:

- Individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Not experimental or investigational;
- Reflective of the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide;
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

Note: See the Glossary in the Florida Medicaid Provider General Reimbursement Handbook for the definition of medically necessary.

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**Request for Laboratory Services**

The laboratory must maintain requests for specific laboratory tests on file with copies of the report of the test results.

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**Laboratory Service Request Forms**

When a laboratory has special panels and profiles on their request forms, it must allow health care practitioners to specify which particular tests or studies are medically necessary and ordered.

Medicaid reimburses only those laboratory tests that are medically necessary, regardless of the other test results that may be part of the laboratory's panels or profiles.

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**In-State Authorization**

Laboratory services may be authorized by a doctor of medicine or osteopathy licensed to practice in Florida as well as other licensed health care practitioners authorized within the scope of their practice to order clinical laboratory tests.

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**Out-of-State Authorization**

In an emergency or with prior authorization, a doctor of medicine or osteopathy licensed in another state may request laboratory tests for an eligible Florida Medicaid recipient who is temporarily out of state.

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**Covered Services**, continued

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**Recipient Status**

The independent laboratory provider is responsible for determining that a recipient is Medicaid eligible and whether the recipient is enrolled in MediPass or an HMO on the date of service. The date of service for independent laboratories is considered to be the date the tests were ordered on the laboratory service form.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook, for information on determining an individual's Medicaid eligibility and MediPass or HMO enrollment status.

Note: See Chapter 1 of the Medicaid Provider Reimbursement Handbook, CMS-1500, for information on the date of service.

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**Fee Schedule**

Medicaid reimburses independent laboratory providers for the services listed in the Independent Laboratory Procedure Codes and Fee Schedule.

Note: See Chapter 3, Appendix E in this handbook for the Independent Laboratory Procedure Codes and Fee Schedule.

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**Technical and Professional Components**

The independent laboratory that provides the services must perform both the technical and professional components of the service. The technical component is the test procedure. The professional component is the provision of a complete report to the ordering practitioner that gives all the test results and identifies those test results that are outside the normal range.

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**Family Planning Waiver Services**

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**Family Planning Waiver Services**

The family planning waiver extends eligibility for family planning services for 24 months to postpartum women who have had a Medicaid-financed delivery or pregnancy-related service within two years prior to the date of losing Medicaid eligibility.

Note: See Chapter 3 in the Florida Medicaid Provider General Handbook for additional information on Family Planning Waiver Services.

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**Family Planning Waiver Services**, continued

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**Family Planning Waiver Covered Services**

Recipients are eligible for all the Medicaid-covered family planning services, family-planning related pharmacy services, antibiotics and vaginal antifungals and anti-infectives to treat sexually-transmitted diseases (STDs), sterilization, colposcopy, and transportation to family planning services.

Note: See Appendix D in this chapter for a list of laboratory services covered under the Family Planning Waiver.

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**Excluded Services**

All Medicaid services other than those listed above are excluded.

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**Family Planning Waiver Diagnosis Codes**

Claims for extended family planning laboratory services must be submitted with one of the following diagnosis codes related to family planning services and sexually transmitted diseases:

- 634.0-634.9 Spontaneous abortion
  - 054.0-054.9 Genital herpes
  - 078.0-078.19 Diseases due to viruses and chlamydiae
  - 079.88, 079.98 Disease due to chlamydiae
  - 090.3-099.9 Other venereal diseases
  - 112.0-112.9 Candidiasis
  - 131.0-131.9 Trichomoniasis
  - V25.09 Other family planning advice
- 

**Daily Frequency Limits**

All outpatient laboratory procedures are assigned a maximum daily units of service limit.

Note: See the "Units" column in Appendix E, Chapter 3, in this handbook for the daily limit for each covered laboratory procedure.

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**Monthly or Annual Frequency Limits**

Certain procedures have monthly or annual limits. Some of the limits do not apply when a recipient has a certain diagnosis. When a limit does not apply because the recipient has a certain diagnosis, the provider must enter the diagnosis code on the claim to indicate that the procedure is exempt from the limit.

Note: See Appendix C in this chapter for a list of procedure codes with monthly or annual limits and procedure codes that are exempt from the limits for recipients with certain diagnoses.

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**Genetic Testing**

**Purpose of Preconception and Prenatal Genetic Carrier Screening Laboratory Testing**

Asymptomatic recipients may receive genetic carrier screening laboratory testing services to determine the recipient's risk of passing on a particular genetic mutation in X-linked and autosomal-recessive conditions. Genetic carrier screening laboratory testing services are performed to identify recipients who are themselves unaffected but are at risk for passing the condition to their off-spring.

**Covered Services**

Medicaid reimburses for preconception and prenatal genetic carrier screening laboratory tests that are accepted by the American College of Medical Genetics and that can be billed using Healthcare Common Procedure Coding System (HCPCS) procedure codes.

The laboratory testing method must be considered to be a proven method for the identification of a genetically-linked inheritable disease (i.e., the genotypes to be detected by a genetic test must be shown by scientifically valid methods to be associated with the occurrence of a disease, and the observations must be independently replicated and subject to peer review).

**Service Requirements**

Preconception and prenatal genetic carrier screening laboratory tests must be ordered by a licensed health care practitioner authorized within the scope of his practice to order genetic carrier screening laboratory tests.

The laboratory must maintain requests for the specific laboratory tests on file with copies of the report of the test results.

The recipient must be eligible for Medicaid on the date of service.

**DNA-Based Preconception and Prenatal Genetic Laboratory Services Limitations**

The molecular diagnostics codes are reimbursed for preconception and prenatal DNA-based genetic testing when performed as a study to determine the genetic carrier status.

## **Limitations**

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### **Introduction**

All procedures must be ordered by the treating health care practitioner, be medically necessary and be listed on the Independent Laboratory Procedure Codes and Fee Schedule (Appendix E) in this handbook to be covered by Medicaid.

In addition, Medicaid limits the frequency with which a procedure may be reimbursed for a given recipient and date of service. Medicaid also limits the coverage of certain test procedures to recipients with specific diagnoses. Exceptions to limits can be allowed when medically necessary.

Note: See Appendix C in this chapter for procedure codes with frequency limits.

Note: See "Procedures Priced by Report" in Chapter 3 in this handbook for instructions on requesting an exception to the limits.

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### **Organ and Disease Panels**

Effective January 1, 1998, the Centers for Medicare and Medicaid Services (CMS), adopted eleven test combinations, referred to as panels, for billing purposes. When all of the individual component tests that make up a particular panel are ordered and performed, Medicaid will reimburse for the panel but not for the individual tests.

When the components of one panel are duplicated in another panel, only one panel code may be billed. Individual tests not included in the panel may be billed separately.

Note: See Appendix B in this chapter for the list of panels, the panel procedure codes, and the individual tests that constitute each panel.

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**Limitations**, continued

**Duplicate Billing Not Allowed**

The provider may not bill for the following duplicate procedures:

1. When the components of one panel are included in another panel, only one panel code may be billed. For example, procedure code 80051 Electrolyte Panel, contains four specific chemistry tests while procedure code 80048 contains those same four tests plus four additional tests. If all eight tests contained in the Basic Metabolic Panel (80048) are performed, only procedure code 80048 may be billed.
2. When a laboratory performs a qualitative antibody or antigen procedure measuring multiple analytes using a single assay strip, reimbursement is limited to only one of the analytes.
3. Coding for infectious agent antigen detection by nucleic acid direct probe technique, amplified probe technique or quantification may be billed under only one procedure code. Additional molecular diagnostic codes 83890—83912 may not be billed in conjunction with the direct, amplified or quantification procedure codes, unless it is for a separate and distinct test for the same recipient on the same day of service.

**Automated Multichannel Tests**

Effective January 1, 1998, the Centers for Medicare and Medicaid Services (CMS), deleted the previously covered automated multichannel tests codes, 80002—80019 and G0058—G0060.

**Exclusions**

**Excluded Procedures**

Any laboratory procedure not listed in the Independent Laboratory Procedure Code Fee Schedule in this handbook is not reimbursable by Medicaid.

**Prohibited Referrals**

Medicaid may not reimburse an independent laboratory facility for a test ordered by a practitioner who has, or whose family has, an ownership or financial interest in the facility or who receives compensation for requesting laboratory services from that facility.

**Specimen Collection**

Medicaid does not reimburse independent laboratory providers for venipuncture, collection, handling or transportation of specimens.

**Provider Error**

Medicaid does not reimburse for tests repeated due to provider error.



**APPENDIX A**  
**INDEPENDENT LABORATORY SERVICES**  
**LABORATORY CERTIFICATION SPECIALTIES**

<b>PRIMARY TEST CATEGORIES</b>	<b>CLIA SPECIALTY CODE</b>	<b>SUBSPECIALTY CATEGORIES</b>	<b>CLIA SUBSPECIALTY CODE</b>
Histocompatibility	010	(Not Applicable)	—
Microbiology	100	Bacteriology Mycobacteriology Mycology Parasitology Virology Microbiology/Other	110 115 120 130 140 150
Diagnostic Immunology	200	Syphilis Serology General Immunology	210 220
Chemistry	300	Routine Chemistry Urinalysis Endocrinology Toxicology Chemistry/Other	310 320 330 340 350
Hematology	400	(Not Applicable)	—
Immunohematology	500	ABO Group and Rh Group Typing Antibody Detection/Transfusion Antibody Detection/Non-Transfusion Antibody Identification Compatibility Testing Immunohematology/ Other	510 520 530 540 550 560
Pathology	600	Histopathology Oral Pathology Cytology	610 620 630
Clinical Cytogenetics	900	(Not Applicable)	—



**APPENDIX B**  
**INDEPENDENT LABORATORY SERVICES**  
**PANEL COMPONENTS AND PROCEDURE CODES**

<b>Panel Name and Procedure Code</b>	<b>Description of Individual Panel Components</b>	<b>Procedure Code</b>
Basic Metabolic Panel Procedure Code 80048	Calcium Carbon dioxide Chloride Creatinine Glucose Potassium Sodium Urea Nitrogen (BUN)	82310 82374 82435 82565 82947 84132 84295 84520
Electrolyte Panel Procedure Code 80051	Carbon dioxide Chloride Potassium Sodium	82374 82435 84132 84295
Comprehensive Metabolic Panel Procedure Code 80053	Albumin Bilirubin, total Calcium Carbon dioxide (bicarbonate) Chloride Creatinine Glucose Phosphatase, alkaline Potassium Protein, total Sodium Transferase, alanine amino (ALT)(SGPT) Transferase, aspartate amino (AST)(AGOT) Urea Nitrogen (BUN)	82040 82247 82310 82374 82435 82565 82947 84075 84132 84155 84295 84460 84450 84520
Obstetric Panel Procedure Code 80055	Hemogram, automated, and manual differential WBC count (CBC) OR Hemogram and platelet count, automated, and automated complete differential WBC count (CBC) Hepatitis B surface antigen (HbsAg) Antibody, rubella Syphilis test, qualitative (eg. VDRL, RPR, ART) Antibody screen, RBC, each serum technique Blood typing, ABO AND Blood typing, Rh (D)	85022  85025  87340 86762 86592 86850 86900 86901

**Appendix B, Panel Components and Procedure Codes**, continued

<b>Panel Name and Procedure Code</b>	<b>Description of Individual Panel Components</b>	<b>Procedure Code</b>
Lipid Panel Procedure Codes 80061	Cholesterol, serum, total Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) Triglycerides	82465 83718 84478
Renal Function Panel Procedure Code 80069	Albumin Calcium Carbon dioxide (bicarbonate) Chloride Creatinine Glucose Phosphorus inorganic (phosphate) Potassium Sodium Urea nitrogen (BUN)	82040 82310 82374 82435 82565 82947 84100 84132 84295 84520
Acute Hepatitis Panel Procedure Code 80074	Hepatitis A antibody (HAAb), IgM antibody Hepatitis B core antibody (HbcAb), IgM antibody Hepatitis B surface antigen (HbsAg) Hepatitis C antibody	86709 86705 87340 86803
Hepatic Function Panel Procedure Code 80076	Albumin Bilirubin, total Bilirubin, direct Phosphatase, alkaline Protein, total Transferase, alanine amino (ALT) (SGPT) Transferase, aspartate amino (AST) (SGOT)	82040 82247 82248 84075 84155 84460 84450

**APPENDIX C**  
**INDEPENDENT LABORATORY SERVICES**  
**PROCEDURE FREQUENCY LIMITS**

<b>Procedure Code</b>	<b>Frequency Limit</b>	<b>Diagnosis Exceptions</b>	<b>Procedure Code</b>	<b>Frequency Limit</b>	<b>Diagnosis Exceptions</b>
80061	10PY		83655	4PY	
82103	1PY		83690	10PY	
82108	1 PY	ESRD (585)	83715	4PY	
82128	2PY		83718	4PY	
82131	2PY		83719	4PY	
82150	10PY		83721	4PY	
82175	1PY		83785	1PY	
82180	1PY		83825	1PY	
82300	1PY		83885	1PY	
82306	3PY		83902	6PY	
82307	3PY		83930	2PY	
82380	2PY		83970	2PY	ESRD (585)
82390	1PY		84066	3PY	
82465	4PY		84134	2PY	
82495	1PY		84153	8PY	
82525	1PY		84165	2PY	
82552	2PY		84252	1PY	
82607	2PY		84255	1PY	
82728	2PY	ESRD (585)	84425	1PY	
82746	2PY	ESRD (585)	84436	10PY	
82784	4PY		84439	6PY	
82785	12PY		84443	12PY	
83010	4PY		84446	1PY	
83015	1PY		84466	4PY	ESRD (585)
83020	1PY		84478	3PY	
83540	4PY	ESRD (585)	84479	12PY	
83550	4PY	ESRD (585)	84480	6PY	
83625	4PY		84590	1PY	

KEY: 1PY = 1 per year; 2MO = 2 per month, etc.  
 ESRD = End Stage Renal Disease

**Appendix C, Procedure Frequency Limits, continued**

Procedure Code	Frequency Limit	Diagnosis Exceptions	Procedure Code	Frequency Limit	Diagnosis Exceptions
84630	1PY		86692	3PY	
85044	4PY		86701	3PY	
85660	1PY		86702	3PY	
86003	12PY		86701	3PY	
86005	12PY		86702	3PY	
86038	2PY		86703	3PY	
86039	2PY		86706	3PY	ESRD (585)
86060	3PY		87015	2MO	
86063	2PY		87040	4PY	
86140	2PY		87045	2MO	
86160	2PY		87070	4PY	
86161	2PY		87075	4PY	
86162	2PY		87076	4PY	
86225	3PY		87077	4PY	
86235	3PY		87081	4PY	
86255	3PY		87086	8PY	
86316	3PY		87088	8PY	
86317	3PY		87101	4PY	
86318	3PY		87106	4PY	
86430	2PY		87177	2MO	
86431	2PY		87181	4PY	
86631	3PY		87184	8PY	
86632	3PY		87186	8PY	
86644	3PY		87187	8PY	
86645	3PY		87205	4PY	
86677	3PY		87210	4PY	
86687	3PY		87220	4PY	
86688	3PY		87340	4PY	ESRD (585)
86689	1PY				

KEY: 1PY = 1 per year; 2MO = 2 per month, etc.  
 ESRD = End Stage Renal Disease

**APPENDIX D**  
**INDEPENDENT LABORATORY SERVICES**  
**FAMILY PLANNING WAIVER LABORATORY SERVICES**

Type Of Test	Description Of Individual Panel Components	Procedure Code
Urinalysis	By dipstick; non-automated, with microscopy By dipstick; automated, with microscopy By dipstick; non-automated, without microscopy By dipstick; automated, without microscopy Qualitative or semiquantitative Bacteriuria screen, by kit Bacteriuria screen, microscopic only Urine pregnancy test, by visual color comparison	81000 81001 81002 81003 81005 81007 81015 81025
Chemistry	Glucose; quantitative Gondotropin, chorionic (hCG); quantitative Gondotropin, chorionic (hCG); qualitative	82947 84702 84703
Hematology and Coagulation	Blood count; manual differential WBC count Hemoglobin Hematocrit, other than spun	85007 85018 85014
Immunology	Fluorescent antibody; screen each antibody (HIV & Herpes) Neutralization test, viral Rubella screen (IgG) Tuberculosis, intradermal Tuberculosis, tine test Syphilis test; qualitative (e.g., VDRL, RPR, ART) Syphilis test; quantitative HTLV or HIV antibody, confirmatory test (western blot) Herpes simplex, non-specific type test Herpes simplex, type I HIV-1 HIV-1 and HIV-2, single assay Hepatitis B surface antibody (HbsAb) Hepatitis Be antibody (HbeAb) Rubella titer Antibody; Treponema Pallidum (Syphilis Confirmatory) Hepatitis C Antibody	86255 86382 86403 86580 86585 86592 86593 86689 86694 86695 86701 86703 86706 86707 86762 86781 86803

**Appendix D, Family Planning Waiver Laboratory Services**, continued

Type Of Test	Description Of Individual Panel Components	Procedure Code	
Microbiology	Culture, bacterial, definitive; any other source (GC)	87070	
	Culture, bacterial, any source; anaerobic (isolation)	87075	
	Culture, presumptive, pathogenic organisms, screening only	87081	
	Culture, bacterial, urine; quantitative, colony count	87086	
	Culture, bacterial; with isolation and presumption identification of isolates, urine	87088	
	Culture, chlamydia	87110	
	Dark field examination	87164	
	Neisseria gonorrhoeae smear	87205	
	Smear, primary source, with interpretation; (chlamydia)	87206	
	Smear, primary source, wet mount isolation, with stain	87210	
	Virus identification; tissue culture inoculation & observation	87252	
	Hepatitis B surface antigen (HBsAg)	87340	
	Hepatitis Be antigen (HBeAg)	87350	
	Candida species, direct probe technique	87480	
	Candida species, amplified probe technique	87481	
	Chlamydia trachomatis, direct probe technique	87490	
	Chlamydia trachomatis, amplified probe technique	87491	
	Gardnerella vaginalis, direct probe technique	87510	
	Gardnerella vaginalis, amplified probe technique	87511	
	Hepatitis B virus, direct probe technique	87515	
	Hepatitis B virus, amplified probe technique	87516	
	Hepatitis C virus, direct probe technique	87520	
	Hepatitis C virus, amplified probe technique	87521	
	Herpes simplex virus, direct probe technique	87528	
	Herpes simplex virus, amplified probe technique	87529	
	Neisseria gonorrhoeae, direct probe technique	87590	
	Neisseria gonorrhoeae, amplified probe technique	87591	
	Papillomavirus, human, direct probe technique	87620	
	Papillomavirus, human, amplified probe technique	87621	
	Cytopathology	Cytopathology, cervical or vaginal (any system physician interpret)	88141
		Cytopathology, cervical or vaginal (preservative fluid)	88142
Cytopathology, cervical or vaginal (manual screen & re-screen)		88143	
Cytopathology, cervical or vaginal (manual screen & computer)		88150	
With manual cytotech screening under physician supervision		88152	
Cytopathology, slides (manual screen & re-screen)		88153	
Cytopathology, slides (manual screen & computer re-screen)		88154	
Cytopathology, smears, with definitive hormonal eval.		88155	
Cytopathology (Bethesda, manual screening)		88164	
Cytopathology (Bethesda, manual screen & re-screen)		88165	
Cytopathology (Bethesda, manual screen & computer re-screen)		88166	
Cytopathology (Bethesda, cell selection)	88167		

## CHAPTER 3 INDEPENDENT LABORATORY PROCEDURE CODES AND SPECIAL SITUATION CODES

### **Overview**

#### **Introduction**

This chapter describes the procedure codes, maximum fees, and daily limits for services covered by the independent laboratory program. Procedures that require a report in order to be priced and reimbursed are also identified.

#### **In This Chapter**

This chapter contains:

TOPIC	PAGE
Reimbursement Information	3-1
Procedures Priced By Report	3-2
How To Read the Procedure Codes and Fee Schedule	3-3

**Note:** See the Florida Medicaid Provider Reimbursement Schedule for the Independent Laboratory procedure codes and fee schedules. The Reimbursement Schedule is available on the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Fees.

### **Reimbursement Information**

#### **Source of Procedure Codes**

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) Levels 1 and 2. Both levels are part of the nationally standardized code sets.

Level 1 codes are based on the Current Procedural Terminology, Fourth Edition, (CPT) book and are a systematic listing and coding of procedures and services performed by physicians and other health care providers. Each procedure or service is identified by a five digit numeric code. CPT codes and descriptions are copyrighted 2005 by the American Medical Association. All rights reserved.

Effective October 16, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation. All previously used "local codes" can no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service on or after October 16, 2003. For dates of services prior to October 16, 2003, the provider must use procedure codes that were payable at that time. Please refer to Appendix E for the valid codes for Florida Medicaid services effective October 16, 2003.

**Reimbursement Information**, continued

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**Copayment**

Medicaid recipients, who are not otherwise exempt, are responsible to pay a \$1.00 copayment per provider, per day for independent laboratory services.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for additional information on the copayment.

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**Procedures Priced By Report**

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**Introduction**

This section describes those categories of laboratory services for which a report must be submitted with the claim for reimbursement. Specific report requirements are also described.

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**Unlisted Procedure**

A claim for reimbursement for a clinical laboratory procedure that is not specifically described in the CPT must be submitted with a report describing the procedure and documenting the medical necessity for the procedure.

The CPT codes designated for reporting unlisted procedures are:

- 81099 (unlisted urinalysis procedure)
  - 84999 (unlisted chemistry procedure)
  - 85999 (unlisted hematology and coagulation procedure)
  - 86999 (unlisted transfusion medicine procedure)
  - 87999 (unlisted microbiology procedure)
  - 88199 (unlisted cytopathology procedure)
  - 88299 (unlisted cytogenetic study)
  - 89399 (unlisted miscellaneous pathology test)
- 

**Unpriced Procedures**

Reimbursement amounts for unpriced laboratory procedures are determined by a medical consultant based on the report submitted with the claim. Unpriced procedures are included on the Independent Laboratory Procedure Codes and Fee Schedule and may be identified by the "0.00" in the maximum fee column and an "R" in the "Spec" column.

Note: See Appendix E, Independent Laboratory Procedure Codes and Fee Schedule, in this chapter for the unpriced procedures.

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***Procedures Priced By Report***, continued

**Report Contents**

A claim for an unlisted or unpriced procedure or exception to a service limit must be accompanied by a detailed written report from the laboratory that performed the service that documents:

- The purpose of the test, including the diagnosis code provided by the requesting physician;
- The specific steps required to perform the test;
- The equipment time and supply quantity used;
- The personnel skill, expertise and time required;
- The number of times the test was performed with a rationale for frequency exceeding the established daily limit;
- A breakdown of the professional and technical costs incurred; and
- If an unlisted procedure code is used, a complete description of the procedure performed.

***How to Read the Procedure Codes and Fee Schedule***

**Introduction**

The independent laboratory procedure code fee schedule is a table listing the procedure codes associated with Medicaid reimbursable laboratory services, their descriptions, maximum Medicaid fee, and daily limits.

The information that follows identifies and describes the individual column headings, reading from left to right.

Note: See Appendix E of this chapter for the Independent Laboratory Procedure Codes and Fee Schedule.

**Code**

This column identifies the five-digit procedure codes associated with the covered services. The codes are listed in ascending order.

**Description**

This column describes the test or laboratory procedure associated with the five-digit procedure code.

**Max**

The amount that appears in this column is the maximum amount that Medicaid will pay for the complete procedure that consists of the performance of the test procedure and the report to the ordering health care practitioner.

***How to Read the Procedure Codes and Fee Schedule***, continued

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**Units**

The number in this column indicates the daily limit for the procedure. Annual and monthly procedure frequency limits established for some procedures are not included on the fee schedule, but are listed in Appendix C, Procedure Frequency Limits.

Note: See Appendix C in Chapter 2 of this handbook for the annual and monthly procedure frequency limits.

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**Spec**

This column indicates when special billing instructions apply to the procedure. An "R" in this column means the provider must file a paper claim and attach a report.

Note: See Report Contents in this chapter for a description of report requirements.

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## APPENDIX E

### RESERVED

Note: See the Florida Medicaid Provider Reimbursement Schedule for the fee schedules. The Reimbursement Schedule is available on the CD-Rom and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Fees.







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