Payment Policy: Concert Laboratory Payment Policy

Reference Number: LA.CG.PP.01
Effective Date: 4/12/25
Last Review Date: 12/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Application
Independent Labs, Qualified Hospital Laboratory, Referring Laboratory, Reference Laboratory, Facilities

Policy Description
All providers billing for laboratory services must bill according to the Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI), and the American Medical Association (AMA)

This policy addresses laboratory services and applies to codes billed in an outpatient setting from the following sections in the AMA CPT/HCPCS manual:

- Pathology and Laboratory Procedures (80000 Codes)
- Category III Multianalyte Assays with Algorithmic Analyses (MAAA) (M codes)
- Proprietary Lab Analysis (PLA) (U codes)
- HCPCS level I codes for lab tests (G and S codes)

All providers billing for laboratory services must include standard information on the claim, or services may be denied:

- Include ordering and rendering provider information on all claim transactions.
- Include appropriate and accurate diagnosis codes, related to the procedure performed, per the International Classification of Diseases (ICD) coding system created by the World Health Organization (WHO). Header codes (3 digit ICDs) may lack specificity to determine coverage in some instances and may be denied for insufficient specificity.
- Include the date and place of service on all claim transactions. Place of Service codes will be used to distinguish outpatient testing from testing provided within the Emergency Department or as a part of an inpatient hospital stay

All providers billing for laboratory services must bill according to coding standards set by the American Medical Association (AMA), or services may be denied:

- Current Procedural Terminology (CPT) Coding must be consistent with American Medical Association (AMA) coding guidance below:
    - Codes are determined based on the attributes of the testing performed, not based on the clinical indication of the member/enrollee.
    - If the laboratory has obtained an approved Proprietary Laboratory Analyses (PLA) code, the PLA code must be used
    - If a test qualifies for a panel code(s) according to descriptions set by the AMA, the panel code(s) must be used.

  - If an appropriate panel code does not exist, either a single unit of 81479 or codes associated with individual components of the panel may be used.
  - Only one unit of the miscellaneous, non-specific code 81479 may be billed per test.

- Codes may be used when the date of service falls after the listed effective date and prior to the date of retirement.
- Only one unit of the miscellaneous, non-specific code 81479 may be billed per test.
- Proprietary codes may be used only for the specific test to which the code is assigned.
- Modifier codes should be used when appropriate. This includes but is not limited to *repeat* testing, testing performed on multiple specimens, and testing for multiple species.
- If a code(s) falls under an NCCI procedure-to-procedure edit, modifiers must ONLY be used when appropriate and Modifier 59 may be used only if no other appropriate modifier describes the service

Hospitals are allowed by Medicaid to contract with an independent laboratory for performance of outpatient laboratory services. However, it is the responsibility of the hospital to ensure that both the physician who performs the professional service and the laboratory that performs the technical service meet all state and federal requirements. One such requirement is that both the physician and laboratory have a valid Clinical Laboratory Improvement Amendments (CLIA) number.

When a hospital contracts with a free-standing laboratory for the performance of the technical service only, it is the responsibility of the hospital to pay the laboratory. The laboratory cannot bill Medicaid because there is no mechanism in the system to pay a technical component only to a free-standing laboratory.

Reimbursement
Reimbursement and coverage will be based on the Louisiana Medicaid Fee Schedule.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only and may not support medical necessity. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

References
1. American Medical Association. *Current Procedure Terminology* (CPT®). 2023

2. Medicaid National Correct Coding Initiative (NCCI) Tool https://www.cms.gov/outreach-and-education/mln/educational-tools/mln9018659-how-to-use-the-medicaid-ncci/ncci-medicaid/chapter-4_filtering-the-ncci-data-tables/

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Converting to LHCC Concert Genetic Payment Policy.	12/20/24	3/12/25	4/12/25

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this payment policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this payment policy, and additional clinical policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This payment policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.