Automated Medical Payments

Medicaid Bulletin

Colorado Title XIX

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Medicaid bulletins contain important policy and billing information and should be shared promptly with billing staff.

Bulletins supplement information in the Medicaid Provider Manual and should be retained with the provider manual for reference. Retain all bulletins until published notification advises that the information is obsolete or reproduced in subsequent bulletins or provider manual updates.

Please direct questions about bulletins and billing information to Medicaid Provider Services.

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Laboratory HCFA and local codes

The Colorado Medicaid Program uses the Health Care Financing Administration's (HCFA) Common Procedural Coding System (HCPCS) to identify Medicaid services. HCPCS include codes in the *Physicians' Current Procedural Terminology* (CPT), codes developed by HCFA and the local Medicare carrier, and "local" codes developed specifically for the Colorado Medicaid Program.

This is the HCFA and local code bulletin for laboratory services. CPT codes and the codes in this bulletin are effective for services provided on and after January 1, 1999. This document is a replacement of Medicaid Bulletin B9802310 (02/98). Insert this bulletin into the Medicaid Provider Manual for reference. Coding updates and revisions will also be published in Medicaid bulletins.

Please read the following information carefully:

With few exceptions, Colorado Medicaid claims must be submitted electronically through the Automated Medical Payments (*AMP*) system.

- Providers consistently submitting fewer than 10 claims per month may submit paper claims using the information and instructions in the Medicaid Provider Manual.
- Claims that, by federal or state policy or regulation, require the submission of supporting claim documentation must be submitted on paper with appropriate attachments.

AMP claims: All AMP interactive submissions for laboratory services are submitted on the electronic Colorado 1500 laboratory format. Complete the place of service field using the codes identified in the help screens.

Paper claims: If paper claim submission is required, independent laboratories must submit charges on the Colorado 1500 claim form. Hospital laboratories must submit charges on the UB-92 paper claim form, using both HCPCS and revenue codes.

Code Column: HCFA and local codes consist of a letter followed by four numbers. Codes authorized for the Medicaid program may not correspond to codes approved for Medicare billing. This list identifies the HCFA and local codes approved for billing the Colorado Medicaid Program. HCFA codes that are not identified in this listing are not benefits of the Colorado Medicaid Program.

Fees for blood drawing and specimen collection or handling are not reimbursable to laboratories. *AMP claims for non-payable procedure codes are rejected. Do not submit detail lines for procedure codes which are not payable to laboratory providers.*

Narrative column: When appropriate, the procedural description defines the billing unit.

Benefit column: The notation “yes” indicates this service is a benefit of the Colorado Medicaid Program.

Comments Column: Expands on the description, identifies special billing instructions.

Modifiers: Procedure code modifiers describe circumstances which may change or alter payment. The following modifiers are valid for laboratory codes and must be used when applicable (Modifiers that impact pricing are identified by "**"):

-TC**	Technical component	Use when the technical component is performed separately.
-26**	Professional component	Use with diagnostic codes to report professional component services (reading and interpretation) billed separately from technical component services. Report separated professional and technical component services only if different providers perform the professional and technical portions of the procedure. Read CPT descriptors carefully. Do not use modifiers if the descriptor specifies professional and technical components.
-XL	Specimen handling & conveyance from one laboratory to another	Use to certify that the necessary laboratory equipment was not functioning or that the lab is not certified to perform the test.
-QR	Repeat clinical diagnostic test	Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test value(s) (separate specimens taken in separate encounters).

Note: By regulation, the provider who actually performs the laboratory procedure is the only one who is eligible to bill and receive payment. Physicians may only bill for tests actually performed in their office or clinic. Tests performed by independent laboratories or hospital outpatient laboratories must be billed by the performing laboratory. To receive Medicaid payment, independent and hospital laboratories must be state certified and Medicaid enrolled.

In accordance with the Federal Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), effective September 1, 1992, the Colorado Medicaid Program requires that all providers of clinical laboratory services obtain a CLIA certificate of waiver or certificate of registration to perform and receive payment for laboratory testing services.

CPT lists tests that can be and frequently are done as groups and combinations ("profiles") on automated multichannel equipment. Multichannel clinical laboratory tests CPT codes 80002-80019 and G0058-G0060 were deleted effective 12/31/97. For organ or disease oriented panels (check CPT narrative), use the appropriate code in the range 80049-80092. Tests included in the panel are not to be performed or billed separately when ordered in a group/combination. Panels must be billed with one unit of service.

In accordance with Section 1903(i)(7) of the Social Security Act, Medicaid shall not expend funds for clinical diagnostic laboratory services in excess of the amount that would be recognized under Medicare. Providers therefore may not bill the Medicaid Program for specific tests for which a claim for the same test, inclusive in a panel or multichannel test, has been or will be submitted. Reimbursement received as a result of incorrect billing is subject to recovery.

Please direct questions about billing or the use of this listing to Medicaid Provider Services at the telephone numbers listed on the first page of this bulletin.

Code	Narrative	Benefit	Comments
G0026	Fecal Leucocyte examination	Yes	
G0107	Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations	Yes	Bill with 1 unit of service.
G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	Yes	Effective 01/01/99
G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	Yes	Effective 01/01/99
G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	Yes	Effective 01/01/99
G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	Yes	Effective 01/01/99
G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening by cytotechnologist under physician supervision	Yes	Effective 01/01/99
G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	Yes	Effective 01/01/99
G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	Yes	Effective 01/01/99
G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	Yes	Effective 01/01/99
P2028	Cephalin flocculation, blood	Yes	

Code	Narrative	Benefit	Comments
P2029	Congo red, blood	Yes	
P2031	Hair analysis (excluding arsenic)	Yes	
P2033	Thymol turbidity, blood	Yes	
P7001	Culture, bacterial, urine; quantitative, sensitivity study	Yes	
Q0111	Wet mounts, including preparations of vaginal, cervical or skin specimens	Yes	
Q0112	All potassium hydroxide (KOH) preparations	Yes	
Q0113	Pinworm examinations	Yes	
Q0114	Fern test	Yes	
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous	Yes	
Y8085	ANA Profile, includes: ANA, Anti-DNA, Anti-SM, Anti-RPN, Anti-SSA, Anti-SSB	Yes	
Y8160	Coagulation panel	Yes	