SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.21 LABORATORY

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

LABORATORY

Using Preferred Reference Labs

All network providers **must** refer members to preferred reference lab vendors when lab services are needed and are not performed in the provider's office. Providers who do not adhere to these referral guidelines may be subject to penalties as described in their provider contracts.

Please refer to the preferred lab requirements listed below to ensure your patients receive the maximum benefits to which they are entitled.

Preferred Labs

We use a preferred lab program with multiple statewide and regional lab vendors. Laboratory services provided to Blue Cross members **must** be submitted to a preferred reference laboratory in the member-patient's network, if not performed in your office.

For the most current list of statewide and regional reference labs and full details on laboratory requirements for our Preferred Care PPO products, please refer to the Preferred Care PPO Preferred Reference Lab Guide. For HMO Louisiana products, please refer to the HMO Louisiana Reference Lab Guide. These guides are available in the "Resources" section of our Provider page. You may also use our online provider directories available on our website to locate preferred reference lab draw sites.

Contact preferred reference labs directly to obtain the necessary forms for submitting lab services for your Blue Cross patients.

Requirements for Providers

Preoperative lab services rendered before an inpatient stay or outpatient procedure may be performed by Preferred Care PPO or HMO Louisiana participating hospitals or the member's selected hospital but otherwise should be sent to one of our preferred reference labs.

If you perform laboratory testing procedures in your office, you must bill claims in accordance with your Clinical Laboratory Improvement Act (CLIA) certification. We require that a copy of your CLIA certification be provided along with your Louisiana Standardized Credentialing Application (LSCA) when applying for credentialing or recredentialing with Blue Cross. Providers who do not collect specimens in their offices may refer their Blue Cross patients to a preferred reference lab draw site in the member-patient's network.

Lab Testing Policies

Providers must adhere to our lab testing policies. No payment will be owed to providers for services that do not adhere to our lab testing policies and providers may not bill a member for any unpaid amounts for services that do not adhere to our lab testing policies. Providers can review the billing policies and guidelines online. Visit www.bcbsla.com and look under the Helpful Links section at the bottom of the page. Click on "Lab Reimbursement Policies." Note: Laboratory services, tests and procedures provided in emergency room, hospital observation and hospital inpatient settings are excluded from our lab testing policies.

Our lab testing policies apply to all fully insured, Federal Employee Program (FEP) and BlueCard® (out-of-area) members. Self-funded groups may be subject to our lab testing policies. Always verify authorization requirements and member benefits on iLinkBlue, prior to rendering services.

In-office Lab List

HMO Louisiana and HMO Louisiana select networks providers may perform the following selection of lab tests (CPT codes shown) in their CLIA-certified offices.

80305	81015	82948	83861	85014	86485	87275	87590	88312	89190
80306	81025	82951	84030	85018	86490	87276	87591	88313	89220
80307	82044	82952	84112	85025	86510	87426	87635	88314	89230
80320	82247	82962	84132	85027	86580	87428	87636	88329	
80321	82270	83013	84437	85032	86756	87430	87660	88331	
80322	82272	83014	84702	85610	87172	87480	87804	88332	
81000	82274	83026	84830	85651	87177	87490	87807	88333	
81001	82565	83036	85007	85652	87205	87491	87811	88334	
81002	82570	83037	85008	86308	87210	87502	87880	88341	
81003	82947	83518	85013	86403	87220	87510	88311	88342	

Out-of-state Labs

If you refer your patients to a reference lab that is not in Louisiana, the out-of-state reference lab must be a participating provider for the member's plan in the state where the specimen is drawn in order for the member to receive the highest level of member benefits. If you are collecting the specimen* and sending the specimen to an out-of-state reference lab, please ensure that the out-of-state reference lab you are using is participating in the member-patient's network, otherwise your patient will be subject to a much higher cost share for this service or receive no benefits at all. In addition, providers who do not adhere to these referral guidelines may be subject to penalties as described in their provider contracts.

Scenario

An independent laboratory receives and processes the Louisiana member's blood specimen. The member's blood was drawn in Louisiana* but processed in Texas by a reference lab. The out-of-state reference lab should file the claim to Blue Cross and Blue Shield of Louisiana; the service area where the specimen was drawn. Before referring the member, please ensure that the Texas reference lab is participating with Blue Cross and Blue Shield of Louisiana in order for the member to receive the highest level of benefits.

** Providers should file the claim to the Blue Cross and Blue Shield plan in the state where the specimen is drawn.*

Ordering Provider Requirements

The ordering/referring provider's first name, last name and NPI are required on all laboratory claims. Claims received without the ordering/referring provider's information will be returned and the claim must be refiled with the requested information. If you are CLIA certified to provide lab services in your office and you are billing Blue Cross for these services, please include the ordering provider name and NPI information on the claim form.

Please enter the ordering/referring provider's information for paper and electronic claims as indicated below.

Paper Claims:

- CMS-1500 Health Insurance Claim Form: Block 17B

Electronic 837P, Professional Claims:

- Referring Provider - Claim Level: 2310A loop, NM1 Segment
- Referring Provider - Line Level: 2420F loop, NM1 Segment
- Ordering Provider - Line Level: 2420E loop, NM1 Segment

Reference Lab Billing

Blue Cross requires reference laboratory services to be billed on a CMS-1500 claim form or an 837P electronic claim.

Pass-Through Billing

Blue Cross does not permit pass-through billing. Only the performing provider should bill for services. You may only bill for lab services that you perform in your office. For more detailed information, see the Pass-through Billing and Billing for Services Not Rendered section of this manual.

Place of Service Billing for Lab Services

The place of service code for all clinical and anatomical laboratory services should reflect the type of facility where the patient was located when the specimen was taken, regardless of whether a global, technical or professional component of the service is being billed.

For example:

- If an independent laboratory bills for a lab sample where the sample was taken in its own laboratory, place of service 81 (reference lab) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in an inpatient hospital setting, place of service 21 (inpatient hospital) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in an outpatient hospital setting, place of service 22 (outpatient hospital) would be reported.
- If a provider/an independent laboratory bills for a test on a sample taken in a physician office setting, place of service 11 (office) would be reported.

As a reminder, the referring provider name and NPI should always be listed on claims for laboratory services.

Special Arrangements

Special arrangements for weekend or after-hour pickups may not be available at all preferred reference labs. Please contact the preferred reference labs directly to make special arrangements.

Provider Inquiries and Satisfaction

Providers can access member's benefits, eligibility and allowable charges using our self-service tools: iLinkBlue (www.bcbsla.com/ilinkblue), Interactive Voice Recognition (IVR) 1-800-922-8866 and HIPAA transactions.

Please let us know if any quality issues arise so we can work with the appropriate lab to improve service and ensure that you and your patients receive the service you expect and deserve.

Genetic Testing

Prior authorization should be obtained before generic testing services are rendered. Genetic testing performed 30 days after the lab draw will be subject to the retrospective review; whether a claim has been filed or not. Authorization penalties will apply.

Authorization requests submitted within 30 days of the lab draw will be considered a pre-claim, post-service review. Prior authorization penalties will not apply.

All genetic testing is subject to medical necessity review regardless of whether it is pre- or post-claim.