

PROTOCOLS FOR LABORATORY PROVIDERS

Type of Services Provided

Services provided by Laboratory providers, acting within the scope of their practice as authorized by California law, are covered for Santa Barbara Health Initiative (SBHI), San Luis Obispo Health Initiative (SLOHI), Healthy Families Program (HFP), Healthy Kids (HK), Prenatal PLUS 2 (PP2), and In-Home Supportive Services (IHSS) members include the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other types of examination of materials derived from the human body, for purposes of diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.

Covered Laboratory Benefits

- Maternity Care: laboratory testing, includes genetic and alpha-fetoprotein testing
- Outpatient hospital and other outpatient facilities: Diagnostic services includes laboratory services
- Inpatient hospital services: include laboratory services;
- Diabetes management and treatment: includes outpatient services and laboratory testing
 - For SBHI including at a minimum: Cholesterol, triglycerides, microalbuminuria, HD/LDL, and Hemoglobin A-1C (Glycohemoglobin)
- And for IHSS members: Inpatient rehabilitation services: include ancillary services.

Laboratory providers will be responsible for first determining the eligibility of members to receive services, for meeting the elements of laboratory services and for documenting services as indicated below, and, in order to receive payment, for submitting claim forms to CenCal Health.

Access

Member may access laboratory services in the following settings: hospital/inpatient in both acute and rehabilitation hospitals; outpatient hospital and other outpatient facilities, for pregnancy and maternity care, when receiving services under the diabetes management and treatment benefit, and as directed by physicians and other health professionals.

Eligibility

Laboratory providers must confirm that the member presenting in his/her office is eligible for services under CenCal Health and is assigned to the referring PCP for the month in which it is to render services. This can be accomplished by verifying eligibility through one of CenCal Health's systems. Information regarding eligibility is in the Member Services Section of this Provider Manual.

In the event the member is not eligible under the program(s) administered by CenCal Health, payment for any services provided to the member will not be the responsibility of CenCal Health.

Documentation of Services

Laboratory providers shall document services by completing a claim form and submitting the form to CenCal Health. Laboratory providers shall also provide documentation to the member’s PCP.

Authorizations

Referral Authorization Forms (RAFs) are not required for any laboratory service that does not require a Treatment Authorization Request (TAR) or Authorization Request (AR) or an Authorization Request (AR). For some services, TARs or ARs are required to be approved by the Authority if the services are beyond the limitations set for the benefit. Please refer to the RAF and TAR/AR sections of this Provider Manual for more information.

Specific Authorization of Laboratory Services

Laboratory services which are provided in a setting in which required authorization would be obtained by the facility, i.e. an inpatient hospital setting, would not require additional authorization.

Billing for Covered Services

Laboratory providers bill CenCal Health for the laboratory services it has provided to the eligible member. In the event the member has other coverage, or third-party liability is involved, the Laboratory provider shall follow the terms and conditions of its Agreement with CenCal Health, or as indicated in “Other Health Coverage” in the Claims Section of this Provider Manual.

Laboratory Services	<ul style="list-style-type: none"> • Maternity Care • Inpatient hospital • Outpatient hospital and other outpatient facilities • Diabetes management and treatment
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- Laboratory provider shall bill using Provider’s appropriate billing number
- The ICD-9-CM diagnosis code(s) of the member’s condition must be on the claim
- An approved modifier must be included
- For IHSS only- If member’s condition is related to employment, then CMS-1500 box 10a must be checked “YES”;
- For IHSS only- If member’s condition is related to an auto accident, then CMS-1500 box 10b must be checked “YES”

Co-insurance

Co-insurance for laboratory services for the following members should be collected at the time the service is rendered:

IHSS members: no separate co-insurance for maternity care, inpatient hospital or diabetes management and treatment; 20% co-insurance for outpatient hospital and other outpatient facilities

HFP/HK/PP2 members: no co-insurance

Procedures Codes

SBHI & SLOHI- Laboratory Providers who have rendered Covered Services to eligible SBHI and SLOHI Members shall submit Claim forms within one (1) year of the date of service, in accordance with the provisions of Section 4.6 of the Agreement. However, Claims submitted

after six (6) months will be reduced to 75% of the allowable, and those submitted after nine (9) months from the date of service will be reduced to 50% of the allowable.

Laboratory Provider shall bill for services using procedure codes referenced in Title 22, CCR, S51507.1, or as indicated in the EDS Medi-Cal Provider Manual.

HF/HK/PP2 and IHSS- Laboratory Provider should submit Claims within one hundred and eighty (180) Days of the date of service.

Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Billing Codes. Laboratory Provider shall bill for services for HF/HK/PP2 and IHSS Members within the acceptable range of CPT and/or HCPCS billing codes as established in the most recently published American Medical Association's (AMA) CPT guide and/or the HCPCS guide as published by the federal Department of Health and Human Services (HHS).

IHSS Reimbursement for Laboratory Services

Laboratory provider shall be reimbursed for covered services rendered to members as follows:

The lesser of (a) allowable billed charges, less applicable member per visit co-insurance **or** (b) Contract Rate, less applicable member per visit co-insurance; subject to submission of complete claims.

The Contract Rate for laboratory CPT codes shall be 100% of the applicable Medicare Fee Schedule for CPT codes with an established Medicare rate. For CPT codes without an established Medicare rate, the Contract Rate shall be 100% of CenCal Health's Fee Schedule.

SBHI & SLOHI Reimbursement for Laboratory Services

Laboratory Provider and its Subcontractors agree and understand that they will accept the State Medi-Cal rate in effect at the time of service, or CenCal Health's rate in effect at the time of service, whichever is higher.

Laboratory Provider may request rate information for specified reimbursement codes for its specialty by contacting the Provider Services Department or a Claims Representative, or by accessing the Procedure Pricer on CenCal Health's website www.cencalhealth.org for CenCal Health rates and on the Medi-Cal website for Medi-Cal rates.