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 Blue Cross and Blue Shield of Louisiana makes 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.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.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 our policies. Louisiana Blue 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 are proprietary and confidential and may constitute trade secrets.

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 Louisiana Blue 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 Louisiana Blue 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 credentialing packet when applying for credentialing or recredentialing. Providers who do not collect specimens in their offices may refer their Louisiana Blue 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.lablue.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	87276	87591	88312	89190
80306	81025	82951	84030	85018	86510	87426	87635	88313	89220
80307	82044	82952	84112	85025	86580	87428	87636	88314	89230
80320	82247	82962	84132	85027	86756	87430	87637	88329	
80321	82270	83013	84437	85032	87172	87480	87660	88331	
80322	82272	83014	84702	85610	87177	87490	87804	88332	
81000	82274	83026	84830	85651	87205	87491	87807	88333	
81001	82565	83036	85007	85652	87210	87502	87811	88334	
81002	82570	83037	85008	86308	87220	87510	87880	88341	
81003	82947	83518	85013	86403	87275	87590	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 Louisiana Blue; the service area where the specimen was drawn. Before referring the member, please ensure that the Texas reference lab is participating with Louisiana Blue 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 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

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

Pass-Through Billing

Louisiana Blue 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.lablue.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

Effective July 1, 2024, Lousiana Blue partnered with Carelon to help ensure our members have access to appropriate genetic testing. All members are reviewed by Carelon for genetic testing with the exception of Federal Employee Program (FEP) members. FEP members are not included in the program and will continue to be handled through Louisiana Blue.

- **Only ordering physicians and their staff members may submit prior authorization requests.** Servicing/laboratory providers cannot submit requests but are encouraged to verify that prior authorization has been obtained before performing a test for a Louisiana Blue member. Servicing/laboratory providers can verify prior authorization using the Carelon MBM Provider Portal.
- Providers should obtain an authorization number before performing any genetic tests.

- Retrospective requests may be initiated up to two business days after testing start date. Failure to contact Carelon for genetic testing prior authorization may result in claim denial.
- When requesting a prior authorization for genetic testing, please complete the date of service field with the date that the laboratory will likely begin the testing process.

Do NOT use the date the sample is collected unless the test is being performed by the laboratory on that same day. If you do not know the exact test date, please enter an estimated date that is one to three days after the sample is scheduled to arrive at the laboratory; doing so will facilitate approvals in the vast majority of situations. Louisiana Blue requires that prior authorization requests are submitted before testing; therefore, requests submitted after testing may be denied.

Proprietary Lab Analyses (PLA)

In alignment with CPT guidelines, when a proprietary lab service has a PLA code, the service should be reported with the applicable PLA code. CPT codes other than the applicable PLA code should not be used to report the service. The PLA code includes all services required for the analysis (such as cell lysis and all nucleic acid work), so the proprietary lab service should not be billed with any additional CPT codes.

Genomic Sequencing Procedures (GSP) and Multianalyte Assays with Algorithmic Analyses (MAAA)

In alignment with CPT guidelines, when a molecular test analyses gene(s) that appear in multiple code descriptors, only the single code corresponding to the most specific test for the primary disorder (e.g., oncologic diagnosis, germline condition, syndrome) should be billed. Multiple codes should not be reported for the same gene(s).

Requirements for Special Pathology Stains and Immune Stains

Claims for special pathology stains (e.g., CPT codes 88312, 88313, 88314, 88319) and immune stains (e.g., CPT codes 88341, 88342, 88344, 88346) are not eligible for reimbursement without documentation in the medical record from a pathologist. The pathologist's record must document the recommendation or order for the stain and attest to its medical necessity based on microscopic examination of the initial pathology specimen. Special stain and immune-stain services that do not include this documentation are not eligible for reimbursement.

Requirements for Submitting Claims for the Technical Component (TC) of a Laboratory Service

In order for claims for the technical component of a laboratory service (e.g., pathology stain procedures) to be eligible for reimbursement, a corresponding claim must be received by PLAN from a Network Provider for the professional services of the same laboratory service.