

Q&A Session for APG Payment Methodology for Laboratory Providers

Date: Thursday, September 23, 2010

Q: Do labs that contract with clinics have to be enrolled in the Medicaid program. What about labs that do not contract with clinics? Must they be enrolled in Medicaid?

A: Laboratories that contract with clinics do not have to be enrolled in the Medicaid program. Laboratories that do not contract with clinics must be enrolled in Medicaid.

Q: A lab is packaged within an APG and no separate line item payment is allowed (e.g. core renal dialysis APG). If the clinic opts for the lab to bill direct to Medicaid would the lab submit claims for all labs regardless of whether any tests are packaged?

A: Yes, all lab tests provided by a laboratory to a non-contracting D & TC should be billed to Medicaid directly; the laboratory should not bill the clinic.

Q: If a laboratory provides a carve-out service, does the APG clinic still have to list the carve-out service codes on the clinic claim?

A: No, the clinic does not list the carve-out services on the clinic claim. The laboratory bills Medicaid fee-for-service for carved out services.

Q: Can a referring lab bill for reference testing?

A: A referring lab should bill the clinic (if the clinic elected to contract for ancillary services) or the Medicaid fee schedule (if the clinic did not elect to contract for ancillary services). This also applies to non-APG situations when the referring laboratory has a subsidiary ownership relationship with a reference laboratory. The referring laboratory can bill for the reference testing in these cases too.

Q: Can a clinic initially opt out of APGs and a year later opt back into APGs?

A: DTC clinics can't opt out of APGs. Only FQHCs can opt out of APGs. FQHC's must notify DOH by November 1 of each year of any change of status to opt in or out of APGs for the following calendar year.

Q: Our facility has established patient's that have yearly well visits. The provider orders lab tests prior to the actual clinic visit so that laboratory testing results are reviewed at the visit. How should the laboratory tests be billed under APGs?

A: The lab tests should be reported on the APG claim for the medical visit that occurs subsequent to the lab test order. In this case, the ancillaries would most likely have a date of service prior to the clinic date of service.

Q: How will a laboratory know that a Medicaid claim has been paid to the clinic? Will this information be included in the remittance statement?

A: No, the clinic should keep track of the payment that has been made by the clinic to the lab. If the laboratory submitted a claim for the same service to Medicaid then the laboratory is subject to a disallowance.

Q: What is the date of the implementation of the APG ancillary policy for D & TC's?

A: The projected implementation date for the ancillary billing policy for D & TC APG claims is 4/1/11.

Q: How is billing completed for clinics performing Point of Care Testing and tests sent out to contract labs?

A: For point of care testing the 90 modifier is included on the claim for in-house laboratory testing. The 90 modifier must also be reported on the APG claim for all ancillary lab and radiology procedure codes when the D & TC has chosen the contracting option.

Q: Are renal dialysis clinics required to contract for laboratory services?

A: Under APG's, renal dialysis D & TC clinics are not required to contract for laboratory services. These facilities may choose the non-contracting option. If a renal dialysis clinic does opt to contract with a laboratory facility for the completion of laboratory testing, the D & TC must notify Medicaid by 2/28/11.

Q: How does the clinic identify the lab test CPT codes that they need to report on their APG claim?

A: The laboratory must provide the clinic with the CPT codes of the lab tests that were performed.

Q: When are we to begin using the 90 modifier on APG claims?.

A: D&TC providers will begin using modifier 90 on APG claims on with dates of service on and after April 1, 2011.

Q: If the D & TC clinic doesn't include ancillary services on its claim, will this prevent payment to the lab for the services billed directly to Medicaid ?

A: No, there is no payment link between the clinic claim and the fee-for-service claim.

Q: If a clinic chooses the non-contract option, but uses the modifier 90 on the lab claim will the clinic be reimbursed ?

A: D&TC clinic providers that code a lab procedure with modifier 90 on the APG clinic claim will be reimbursed for the lab procedure. Non-contracting clinics should not use the 90 modifier other than for lab tests they perform on-site.

Q: How is the payment reduction for a DTC not coding modifier 90 on a packaged ancillary calculated?

A: The payment reduction is based on the negative of the weight for the packaged APG.

Q: Is a modifier 90 required on an ordered ambulatory claim if services are ordered from a private physician?

A: An ordered ambulatory claim is not subject to APG's and the 90 modifier is not required on the claim.

Q: Can a laboratory submit a claim first to avoid timely filing issues if the clinic does NOT file the claim within timely filing?

A: Yes, a laboratory providing services to a non-contracting clinic can bill Medicaid immediately upon sending out the test results.