51529 Pathology Services

(a)

This section applies to all laboratory services excluding those performed for hospital inpatients and billed as part of the hospital cost reimbursement billing, and excluding those tests with rates incorporated in section 51503(b). (1) Payment shall be made only for tests performed by standard procedures and techniques commonly employed by clinical laboratories. No payment shall be made to any provider for a laboratory test performed by a laboratory that is not qualified for reimbursement under the Medicare program (Title XVIII) for that test. (2) Reimbursement for laboratory tests shall be the least of the following:(A) The amount billed. (B) The charge to the general public. (C) 80 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar services. (3) Reimbursements pursuant to this section shall be made only to a provider who actually performed the pathology services. No provider shall bill the Medi-Cal program for pathology services, including collection and handling services, the provider did not actually perform. For purposes of this section, services shall be deemed to have been performed by the provider if the services are performed by the provider personally, or by an employee of the provider. (4) Reimbursement for collection and handling of specimens is payable only in accordance with the following:(A) The specimen is a blood sample. (B) The specimen is forwarded to an outside laboratory. (C) The following code is billed:

Code 99000: Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory. Code 99000 includes any or all of the following: Single or multiple venipuncture, capillary puncture or arterial puncture with one or more tubes, centrifugation and serum separation, freezing, refrigeration, preparation for air transportation or other special handling procedures, supplies, registration of patient or specimen, and third party billing. (D) Reimbursement shall be made for only one collection and handling procedure per day per provider for each beneficiary. (E) Reimbursement shall be the least of the following: 1. The amount billed 2. The charge to the general public 3. Medicare's maximum allowance. (5) Laboratory services necessary for chronic outpatient hemodialysis in renal dialysis centers and community hemodialysis units are payable only when billed by the renal dialysis center or community hemodialysis units.

(1)

Payment shall be made only for tests performed by standard procedures and techniques commonly employed by clinical laboratories. No payment shall be made to any provider for a laboratory test performed by a laboratory that is not qualified for reimbursement under the Medicare program (Title XVIII) for that test.

(2)

Reimbursement for laboratory tests shall be the least of the following:(A) The amount billed. (B) The charge to the general public. (C) 80 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

(A)

The amount billed.

(B)

The charge to the general public.

(C)

80 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar services.

(3)

Reimbursements pursuant to this section shall be made only to a provider who actually performed the pathology services. No provider shall bill the Medi-Cal program for pathology services, including collection and handling services, the provider did not actually perform. For purposes of this section, services shall be deemed to have been performed by the provider if the services are performed by the provider personally, or by an employee of the provider.

(4)

Reimbursement for collection and handling of specimens is payable only in accordance with the following:(A) The specimen is a blood sample. (B) The specimen is forwarded to an outside laboratory. (C) The following code is billed: Code 99000: Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory. Code 99000 includes any or all of the following: Single or multiple venipuncture, capillary puncture or arterial puncture with one or more tubes, centrifugation and serum separation, freezing, refrigeration, preparation for air transportation or other special handling procedures, supplies, registration of patient or specimen, and third party billing. (D) Reimbursement shall be made for only one collection and handling procedure per day per provider for each beneficiary. (E) Reimbursement shall be the least of the following: 1. The amount billed 2. The charge to the general public 3. Medicare's maximum allowance.

(A)

The specimen is a blood sample.

(B)

The specimen is forwarded to an outside laboratory.

(C)

The following code is billed: Code 99000: Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory. Code 99000 includes any or all of the following: Single or multiple venipuncture, capillary puncture or arterial puncture with one or more tubes, centrifugation and serum separation, freezing, refrigeration, preparation for air transportation or other special handling procedures, supplies, registration of patient or specimen, and third party billing.

(D)

Reimbursement shall be made for only one collection and handling procedure per day per provider for each beneficiary.

(E)

Reimbursement shall be the least of the following: 1. The amount billed 2. The charge to the general public 3. Medicare's maximum allowance.

1.

The amount billed

2.

The charge to the general public

3.

Medicare's maximum allowance.

(5)

Laboratory services necessary for chronic outpatient hemodialysis in renal dialysis centers and community hemodialysis units are payable only when billed by the renal dialysis center or community hemodialysis units.

(b)

Newborn screening for heritable disorders mandated by law and prenatal screening for birth defects shall be reimbursed at the rate as established by the

Department of Health Care Services pursuant to regulations as provided in sections 6508 and 6529, Title 17, California Code of Regulations.

(c)

Any combination of two or more tests which are performed together on automated laboratory equipment shall be billed and reimbursed as an automated test.

(d)

No reimbursement shall be made by the Medi-Cal program for any service which comes within the definition of laboratory services or clinical laboratory services unless the provider of service and all other persons or entities performing, supervising, consulting on, or directing the laboratory or clinical laboratory services for which reimbursement is sought from the Medi-Cal program are in compliance with the requirements of section 51211.2.

(e)

If the Department determines that a provider of service no longer substantially meets the requirements for participation because one or more condition level deficiencies, as defined in 17 CCR 1029.55, exist; or immediate jeopardy, as defined in 17 CCR 1029.95, exists; or the license, registration or approval has been temporarily suspended, as defined in 17 CCR 1029.173, the Department may in lieu of, or in addition to, any other available sanction, and prior to hearing, temporarily suspend a provider of service from the Medi-Cal program and not pay all or part of the Medi-Cal and Medicaid reimbursements to which the provider would otherwise be entitled, provided that in the opinion of the Director such action is necessary to protect the public welfare or the interests of the Medi-Cal program. The Department shall follow the procedures identified in 17 CCR 1067.15 in taking such action. If it is determined upon judicial review that immediate jeopardy did not exist or if an adjudicatory hearing results in a final

decision that condition level deficiencies did not exist, the provider of service may submit claims for the period of time for which the provider of service was temporarily suspended. Reimbursement of such claims shall be made to the same extent it would have been made if the provider of service had not been temporarily suspended and the claim had been submitted timely.