



Administrative Code

Title 23: Medicaid Part 219 Laboratory

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Title 23: Division of Medicaid

Part 219: Laboratory Services

Part 219 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

Independent laboratory providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

- A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPES),
- B. Written confirmation from the IRS confirming the tax identification number and legal name, and
- C. CLIA certificate and completed Certification form, if applicable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E; Social Security Act § 1902(a)(9)(c)

Rule 1.2: Independent Laboratory Services

Medicaid does not reimburse independent laboratories for lab procedures performed for beneficiaries during a hospital inpatient stay. The per diem rate that the hospital receives is considered to cover all services provided during the inpatient stay. Independent lab reimbursement must be obtained from the hospital.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(3)

Rule 1.3: Routine Venipuncture

Medicaid covers routine venipuncture performed for the purpose of obtaining a blood sample for laboratory testing as follows:

- A. Routine venipuncture must be billed with appropriate procedure code.
- B. Physicians, nurse practitioners, physician assistants, hospitals, and independent laboratories are covered one (1) for routine venipuncture only if the blood sample is drawn and all of it is referred to a separate, non-affiliated laboratory. If all or part of the sample is retained for a test to be performed in the facility where the venipuncture was performed, the physicians, nurse practitioners, physician assistants, hospitals, and independent laboratories are not covered for the venipuncture.
- C. EPSDT screening providers are covered for routine venipuncture when performed for lead

screening and/or RPR screening only if the blood sample is drawn and all of it is referred to a separate, non-affiliated laboratory. If all or part of the sample is retained for a test to be performed in the facility where the venipuncture was performed, the provider is not covered for the venipuncture.

- D. The Mississippi State Department of Health (MSDH), Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers who are reimbursed an encounter rate are not covered separately for performance of routine venipuncture during the same encounter.
- E. Finger/heel/ear sticks that are performed for the purpose of collecting blood specimens or obtaining blood specimens via a partially or completely implantable venous access device are not covered.
- F. Dialysis facilities will not be reimbursed outside the composite rate.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Independent Diagnostic Testing Facilities and Other Independent Mobile Diagnostic Units

- A. Medicaid only covers Independent Diagnostic Testing Facilities (IDTF), or other independent mobile diagnostic units, including portable x-ray providers, for services provided to dual-eligible beneficiaries. Outpatient testing and diagnostic services are covered when ordered by the beneficiary's physician and billed by an approved Medicaid provider, limited to physicians, physician clinics, Federally Qualified Health Centers, Rural Health Clinics, and county health department clinics.
- B. An IDTF is defined by the Centers for Medicare and Medicaid Services (CMS) as "a fixed location, a mobile entity, or an individual non-physician practitioner. It is independent of a physician's office or hospital." These providers perform diagnostic tests such as ultrasounds, echocardiograms, pulmonary function tests, neurological and neuromuscular tests, x-rays, cardiac monitoring, and nuclear medicine.
- C. Medicaid covers for a physician to contract with an IDTF or other independent mobile diagnostic unit to provide technical services and, assuming that there are no Stark II or other anti-kickback statute violations, allows for a claim to be filed for either the technical component or the complete procedure if the physician also interprets the procedure.
- D. The physician contracting with an IDTF or other independent mobile diagnostic unit may not be employed by or own any part of the IDTF or other independent mobile diagnostic unit.
- E. IDTFs and other independent mobile diagnostic units may not pay an additional fee to any physician when they perform the technical component of the procedure.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.33

Rule 1.5: Trofile Assay

- A. The “Trofile Assay” is covered for beneficiaries who are HIV-positive and diagnosed with Acquired Immune Deficiency Syndrome (AIDS) who have evidence of viral replication and HIV-1 strain resistance to multiple anti-retroviral agents.
- B. Medicaid covers “Trofile Assay” for beneficiaries age sixteen (16) and over with the following restrictions/guidelines:
 - 1. The assay is to be obtained only in anticipation of treatment of HIV/AIDS patients with CCR5 antagonist agents who:
 - a) Are “treatment experienced” defined as having been previously treated with anti-retroviral regimen(s),
 - b) Have never received Maraviroc/Selzentry or other CCR5-antagonist agents, and
 - c) Have been deemed to have “virologic failure,” or failed to obtain sufficiently low HIV viral loads despite prior appropriate anti-retroviral therapy.
 - 2. Medicaid covers one (1) assay per beneficiary, per lifetime. Repeated testing or testing in follow-up of therapy with CCR5 agents is not covered.
 - 3. The treating physician has expertise in Infectious Diseases and/or treating HIV patients with anti-retroviral agents; or the treating physician has consulted with an Infectious Disease physician prior to requesting the assay.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Paternity Testing

- A. Medicaid defines paternity testing as any laboratory test used to establish the genetic relationship between an alleged father and a child.
- B. Medicaid does not cover Paternity testing.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Qualitative Drug Screening

- A. Medicaid will cover medically necessary qualitative drug screens for:
 - 1. Suspected drug overdose, and one (1) or more of the following conditions are present:
 - a) Unexplained coma,

- b) Unexplained altered mental status,
 - c) Severe or unexplained cardiovascular instability, or cardiotoxicity,
 - d) Unexplained metabolic or respiratory acidosis,
 - e) Unexplained head trauma with neurological signs and symptoms, and/or
 - f) Seizures with an undetermined history.
2. Beneficiaries who present with clinical signs/symptoms of substance abuse.
 3. High risk pregnancy, only when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does not consider a qualitative drug screen as a routine component of assessment.
 4. EPSDT services, only when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does not consider a qualitative drug screen as a routine component of assessment.
 5. Beneficiaries who are locked into a Beneficiary Health Management Program to assure compliance.
- B. The appropriate procedure chemistry codes must be used for quantitation of drug screens and procedure therapeutic drug assays for therapeutic drug levels. All diagnosis codes must support medical necessity for the drug screen.
- C. Non-covered Services:
1. Medicaid does not cover qualitative drug screens for the following:
 - a) To screen for the same drug with both a blood and a urine specimen simultaneously,
 - b) For medicolegal purposes,
 - c) For employment purposes,
 - d) For the active treatment of substance abuse, including monitoring for compliance, or
 - e) As a component of medical examination for administrative purposes.
- D. Documentation Requirements
1. The ordering/referring provider must retain documentation supporting medical necessity in the medical record. All tests must be ordered in writing, and all drugs/drug classes to

be screened must be indicated in the order. A copy of the lab results must be retained in the medical record.

2. If the provider rendering the service is other than the ordering/referring provider, the provider rendering the service must maintain hard copy documentation of the ordering/referring provider's order for the test and the lab results. The order must include clinical indication/medical necessity in addition to all drugs/drug classes to be screened.
3. Records must be documented and maintained in accordance with Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121