

Chapter 11

Laboratory/Pathology, Radiology, and Diagnostic Services

Laboratory/pathology, radiological, and diagnostic services enable physicians and other licensed practitioners to identify the existence, nature, or extent of illness, injury, or health deviation in a patient.

Contrast Material: The phrase “with contrast” represents contrast material administered intravascularly or intra-articularly injections for image enhancement.

Laboratory: A facility that performs laboratory testing on specimens derived from humans for the purpose of providing information on diagnosis, prevention care, health assessment, or treatment of diseases or impairments.

Panel Codes: Groups of laboratory tests (components) that are frequently performed together. Tests included in each panel are listed by name with the Current Procedural Terminology (CPT) code identified in parenthesis. In order to report a panel code, all listed tests must be performed.

Pathology: A service requiring additional medical interpretive decision, consisting of a written report performed by a pathologist, at the request of a physician.

Professional Component: A physician’s exam (when indicated), performance or supervision, interpretation, or written report of a diagnostic test.

Provider Performed Microscopy Procedures (PPMP): Allows physician office laboratories to perform a limited number of microscopy procedures. Certified PPMP-approved procedures are subject to change at any time.

Radiology: Radioactive substance’s radiant energy for the diagnostic and treatment of disease by means of both ionizing and non-ionizing radiation.

Technical Component: Includes the personnel and materials, including contrast media and drugs, film or xerography, space, equipment, or other facilities.

Waived Complexity: The Centers for Medicare & Medicaid Services (CMS) has identified a number of simple laboratory procedures that can be performed in the physician offices after obtaining a Certificate of Waiver. Waived tests are subject to change at any time, so review all Medicare mailing for changes to waived tests.

Laboratory/Pathology Services

Covered Services

PrimeWest Health covers all laboratory tests paid under the Clinical Laboratory Improvement Amendments ([CLIA Certificate Fee Schedule](#)) from (CMS).

To be eligible for PrimeWest Health payment as a laboratory/pathology service, the service must be all of the following:

1. Ordered and provided by or under the direction of a physician or other licensed practitioner of healing arts within the scope of practice as defined by state law
2. Provided in a hospital or independent laboratory
3. Directly related to the diagnosis and treatment of a member’s health status
4. Authorized under the laboratory’s CLIA certification

PrimeWest Health follows Medicare guidelines. All hospitals and physician owned and free-standing laboratories require CLIA certification. Claims will be denied for lab services provided by laboratories without CLIA certification or if the CLIA certification number is not on file with PrimeWest Health.

Eligible Providers

To be eligible as a provider of laboratory services, a vendor must be certified under CMS' [CLIA](#) program.

Providers of lab services must have their CLIA certificate number current and up to date with their most recent level of certification on file with PrimeWest Health. If you did not indicate your certificate number on your PrimeWest Health enrollment application, or your office has obtained a certificate since your original enrollment, please provide PrimeWest Health Provider Enrollment with the following information:

1. Provider name
2. PrimeWest Health provider number
3. CLIA certificate number
4. CLIA certificate expiration date

Send or fax this information to:

PrimeWest Health
2209 Jefferson St, Ste 101
Alexandria, MN 56308
Fax: 1-320-762-8750

It is the responsibility of providers to keep their CLIA certification number current and up to date with their most recent level of certification on file with PrimeWest Health.

Clinical Laboratory Improvement Amendment (CLIA)

Congress passed CLIA in 1988, establishing a minimum quality of standards for all laboratory testing to ensure high quality of testing regardless of the laboratory location.

PrimeWest Health follows Medicare guidelines. All hospitals and physician owned and free-standing laboratories require CLIA certification. PrimeWest Health will not cover lab services provided by laboratories without CLIA certification.

CMS CLIA Requirements

CMS requires all providers performing laboratory testing to register with the CLIA program. Direct inquiries about CLIA certification to CMS.

Use the [CMS website](#) as a means to obtain current information about CLIA certification as CMS updates its site on a regular basis. CLIA waiver tests, provider performed microscopy procedures (PPMPs), and tests required under CLIA edit are subject to change at any time. Refer to the CMS web page on [How to Apply for a CLIA Certificate](#), which also includes the CMS [Clinical Laboratory Improvement Amendments \(CLIA\) Application for Certification](#) and instructions.

Provider-performed Microscopy Procedures (PPMP)

[PPMP](#) laboratories must meet only the following requirements under CLIA:

1. Enroll in the CLIA program
2. Pay applicable certificate fees biennially
3. Certain quality and administrative requirements

Laboratories with a PPMP certification and those granted CLIA waiver status may perform PPMP tests. Certified PPMP-approved procedures are subject to change at any time.

CLIA Waiver Tests

Waived laboratories must meet only the following requirements under CLIA:

1. Enroll in the CLIA program
2. Pay applicable certificate fees biennially
3. Follow manufacturer's test instructions

Laboratories with waiver certification (certification type 2) are approved to bill only for waiver tests.

To bill CLIA waiver tests, the procedure code must have the modifier QW. Do not use the CLIA number on the claim form.

Technical Component of Surgical Pathology

The technical component of surgical pathology and supplies is not subject to CLIA requirements. When providing only these services, do not apply for CLIA certification. Billing for the technical component of a lab test includes the following:

1. The slide preparation for interpretation by the physician
2. Other usual pre-slide preparation

Do not use modifiers 22 and 52 on pathology codes. Use the TC modifier when billing for CPT pathology codes (88300 – 88399).

Automated Multichannel Laboratory Organ or Disease Oriented Panels

The organ and disease panel codes represent chemistry tests that are frequently performed in combination on automated multichannel equipment. When combinations of these tests are provided for a member on the same date, claims submitted to PrimeWest Health are subject to a payment cap specified by CMS for the Medicare program.

The organ and disease panel codes are defined in the Physician's CPT manual. If other tests are performed in addition to those indicated for a particular panel, report the tests on individual lines on the claim along with CPT panel codes 80048 – 80090 (codes are subject to change yearly per CPT and American Medical Association).

All multichannel laboratory tests performed on the same member on the same date must be submitted on one claim. Billing the complete automated chemistry panel is advisable, if all tests are done.

Do not separately report individual laboratory tests that are components of a multichannel test analysis.

If subsequent tests are provided for the same member on the same date, submit a replacement claim on a separate claim, and include the additional tests on one claim.

PrimeWest Health will process Medicare crossover claims as submitted per Medicare's billing instructions in the [Medicare Claims Processing Manual](#).

Handling/Specimen Collection

Effective for dates of services January 1, 2012 forward, PrimeWest Health will not reimburse for collection of blood by venipuncture (CPT 36416), capillary (CPT 36415), or access port (CPT 36591 and 36592) in conjunction with another service. These services are incidental and included in the primary service.

PrimeWest Health will cover the collection and handling (if applicable) for each type of specimen listed below, per member, per day:

1. Routine venipuncture for collection of specimens; use 36415 (for dates of service on and after January 1, 2012, the above policy applies)
2. Collection of Pap smears; use CPT Q0091
3. Catheterization for collection of a specimen, single patient, homebound/nursing facilities; use CPT P9612
4. Catheterization for collection of a specimen, multiple patients; use CPT P9615
5. Newborn screening for metabolic disorder

A “handling fee” for laboratory specimens will be paid when the laboratory provider requests a **lead collection kit** from the Minnesota Department of Health (MDH). Enter MDH’s Unique Minnesota Provider Identifier (UMPI) in the “Rendering Provider” field on your claim.

Laboratory Services in a Physician's Office

PrimeWest Health requires all physician office laboratories to be CLIA certified in order to receive payment. CLIA regulations include the conditions that all laboratories must meet to be certified to perform testing on human specimens under CLIA. Claims will be denied for physician office laboratories that do not meet CLIA requirements, either because the laboratory’s CLIA certificate has expired, the billed test is not covered by the laboratory’s CLIA certificate, or the services rendered are outside the effective dates of the CLIA certificate.

Payment for a laboratory service performed in a CLIA certified physician’s laboratory will not exceed the amount paid for similar services performed in an independent laboratory. Physicians may also send laboratory specimens to independent or outpatient hospital laboratories.

Reference (Outside) Lab

Providers may choose to bill for laboratories services sent to a reference lab by indicating the reference lab’s National Provider Identifier (NPI) as the rendering provider on the 837P claim. The claim service line must include the following:

1. Lab procedure code
2. Place of service 81 (independent lab)
3. Modifier 90 (reference lab)

Reference laboratories must be CLIA certified for the level of services they are providing.

Independent Pathologist Services

Independent pathologists do not need CLIA certification; the laboratory requires CLIA certification.

Pathology and Laboratory (CPT codes 80049 – 89399): If a pathologist must review a test result and render an opinion, the modifier 26 should be attached to indicate that only a professional component was provided. On a global code, if the CPT code is defined as a professional service, do not use modifier 26.

1. Independent pathologists who bill for the professional component of laboratory services must indicate the hospital’s or independent laboratory’s NPI as the rendering provider.
2. Use modifier 26 and modifier 90 in the modifier field.
3. If modifier 90 is used, the system will look at the rendering provider field for CLIA certification.
4. Do not use CLIA numbers on claims to PrimeWest Health.

Modifiers

Modifier 59: Used for distinct procedural services such as multiple services submitted by a laboratory for the same member on the same day. These situations usually involve microbiology where samples or cultures are taken from a patient from different anatomical sites or different wounds, use the same CPT code, and are tested on the same day.

Modifier 90 references (outside) laboratory identifies laboratory procedures performed by a CLIA certified lab other than the treating or reporting physician.

Modifier 91: Used to indicate a repeat clinical diagnostic laboratory test (CPT code) on the same date of services, at different intervals to obtain subsequent, additional test results. Bill laboratory services in units that are run on the same day and **not** repeated. The 91 modifier may only be used for laboratory tests paid under the clinical laboratory fee schedule. For example: repeating an arterial blood sample or potassium at different intervals on the same day.

The 91 modifier can be used to bill repeat laboratory services, except for the following CPT codes: Q0111 (non-inclusive list).

The 91 modifier may **not** be used when:

1. There are standard CPT/Healthcare Common Procedure Coding System (HCPCS) codes available that describe a series of results (e.g., glucose tolerance tests, evocation/suppression tests, etc.);
2. Tests are run to confirm initial results due to testing problems with the specimen or equipment; and/or
3. A normal, one-time, reportable result is required.

When billing pathology codes, modifiers 76, 77, and 91 are allowed. Modifiers 22 and 52 cannot be used when billing pathology codes.

Billing in Units

Bill laboratory tests that are not repeats in units. Do not use the repeat modifier. For example, bill blood, urine, and other cultures in “units of.” Multiple organism IDs should also be billed in “units of.”

Pap Smear Billing

PrimeWest Health covers one professional and one technical component for Pap smear testing, per specimen per day.

1. For the professional component, bill either of these codes: 88141, P3001, G0124, or G0141.
2. For the technical component, bill **one** CPT or HCPCS code.
3. For Pap smear collection, use Q0091.

Cytogenetic Testing

PrimeWest Health covers cytogenetic testing performed on any PrimeWest Health member. Documentation in the medical record must reflect the medical necessity for the testing. All claims submitted for payment of cytogenetic testing must contain the specific diagnosis related to the tests being performed. Use the most specific ICD-9 code available. (Some cytogenetic tests require authorization. For example: chromosome analysis). Bill cytogenetic testing in units.

PrimeWest Health does **not** cover cytogenetic testing for the following:

1. Legal, paternity, or informational purposes, unless it is medically necessary for the member to receive

cytogenetic testing

2. Family members who are not PrimeWest Health members
3. Fetus testing

Genetic Testing

All genetic testing requires Service Authorization before it is performed.

PrimeWest Health covers genetic mutation testing for breast and cervical cancer susceptibility when certain criteria are met. Service Authorization is needed prior to BRCA genetic mutation testing.

Genetic Testing Modifier: Used to define the type of genetic test being completed. Genetic code modifiers **are always required when reporting genetic lab CPT codes** (molecular diagnostic procedures 83890 – 83914 and cytogenetic procedures 88230 – 88299).

Modifier 76: Used to indicate the same physician repeated the same service or procedure within the same day or whenever the circumstance warrants it. Use this modifier to indicate that a repeated service or procedure was necessary and that it does not represent a duplicate bill. An explanation of the medical necessity for the repeat procedure is necessary.

Modifier 77: Used to indicate a different physician repeated the same service or procedure, usually within the same day. An explanation of the medical necessity for the repeat procedure is necessary.

Modifier 90 (reference [outside] laboratory): Used to identify laboratory procedures performed by a CLIA certified lab other than the treating or reporting physician.

Modifier 91: Used to indicate a repeat clinical diagnostic laboratory test (CPT code) on the same date of services, at different intervals to obtain subsequent, additional test results. Bill laboratory services in units that are run on the same day and **not** repeated. The 91 modifier may only be used for laboratory tests paid under the clinical laboratory fee schedule (for example: repeating an arterial blood sample or potassium at different intervals on the same day).

Repeat modifier 76, 77, and 91 may not be used when:

1. There are standard CPT/HCPCS codes available that describe a series of results (e.g., glucose tolerance tests, evocation/suppression tests, etc.)
2. Tests are run to confirm initial results due to testing problems with the specimen or equipment
3. For any other reason when a normal, one-time, reportable result is required

Modifier 92 (alternative laboratory platform testing): Used when laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use disposable analytical chamber. Only to be used with HIV testing CPT codes 86701 – 86703.

Modifier 99 (multiple modifiers): Used when multiple modifiers are needed to fully describe a service. If more than one modifier is necessary on a code, also apply modifier 99.

When billing pathology codes, modifiers 76, 77, and 91 are allowed. Modifiers 22 and 52 cannot be used when billing pathology codes.

Oncotype Dx Testing for Breast Cancer

Oncotype Dx testing is a 21 gene assay test, which aims to help breast cancer patients and their physicians determine whether adjuvant chemotherapy would be beneficial. **For dates of service on or after January 1, 2012**, testing is considered medically indicated for members with all of the following breast cancer characteristic:

1. Stage I or II breast cancer
2. Breast tumor is estrogen-receptor positive
3. Breast tumor is HER2-receptor negative
4. Tumor size 0.6 – 1 cm with moderate/poor differentiation or unfavorable features, or tumor size is greater than 1 cm
5. Negative lymph nodes (nodes with micrometastases greater than 2 mm in size)
6. Test result will be used to guide decision making about adjuvant chemotherapy

Lead Toxicity Testing

The lead toxicity screening test consists of a capillary or venous blood lead test, hemoglobin (Hgb), hematocrit (HCT), and other age-appropriate exams or tests (as noted in the schedule of age-related screening standards). Refer to the Child and Teen Checkup (EPSDT) section of Chapter 9, [Children's Services](#), for more information pertaining to lead toxicity testing.

The following lead testing services are **not** covered:

1. Paint chip, water, and soil testing
2. Assessments performed by a registered environmental health specialist/sanitarian

Heavy Metal Screen

Heavy metal screens require Service Authorization prior to the screening to determine medical necessity.

Laboratory Testing for HIV Tropism (Trofile)

HIV Tropism testing is considered medically necessary for selecting patients for treatment with HIV co-receptor antagonists.

Tropism testing is covered for patients who meet all of the following criteria:

1. Antiretroviral treatments have failed
2. There is evidence of viral replication
3. There is a diagnosis of 042

Report HIV Tropism testing using CPT code 87999 with a description of HIV Tropism. Limit of once per lifetime.

Drug Testing

This test reports qualitative screening to detect the presence of specific drugs or classes of drugs.

1. Use CPT codes 80100 – 80103 to report qualitative screening to detect the presence of specific drugs or class of drugs. Code 80100 is a drug screen for multiple drug classes, chromatographic method. Code 80101 is a single drug class method. One specimen is used to screen for several different drug types. This test screens for common classes of drugs. Drug screening is used to identify drug toxicity and drug abuse. The

screen reports what drugs are present in the specimen and in which class the drug belongs (e.g., tricyclic antidepressants, phenothiazines, amphetamines, barbiturates, cannabinoids, methadone).

2. When drugs or a single drug is detected, use code 80102 to confirm the drug type present in the drug screen, which is separately reported
3. Use the confirmatory drug test (80102) to report illegal substances or those required by law.
4. Use the appropriate CPT procedure codes when the specific drug being tested is known. Quantitative screening tests are coded by procedure. Refer to the “Chemistry Section in the CPT guide or the “Therapeutic Drug Assay” section of the CPT guide.

Drug screening for routine work related issues or testing related to chemical dependency treatment are not covered.

Radiology/Diagnostic Services

Eligible Providers

To be eligible as a provider of independent X-ray services or portable X-ray services, a vendor must be certified by CMS for participation in the Medicare program.

Covered Services

To be eligible for PrimeWest Health payment for radiology or diagnostic services, the service must meet all of the following criteria:

1. Be ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of practice as defined by state law
2. Be provided in a facility other than a hospital outpatient department or clinic, if an independent service
3. Meet the requirements for certification by Medicare
4. Be directly related to the diagnosis and treatment of a member’s health status

Professional Component

The professional component of a radiology procedure includes the professional services of the physician and the following:

1. Examination of patient when indicated
2. Performance or supervision of the procedure
3. Interpretation
4. Written report of the examination

The professional component is applicable in an encounter when the physician submits a charge for professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities.

Technical Component

The technical component of a radiology procedure code includes the personnel and materials, including the following:

1. Contrast media and drugs
2. Film or xerography
3. Space
4. Equipment
5. Other facilities

Oral and/or rectal contrast administration alone does not qualify as a study “with contrast.”

Total Components

Total components include both technical and professional components and are covered by PrimeWest Health. Do not use modifiers when billing for the total components.

Mammography

PrimeWest Health covers medically necessary mammography services. PrimeWest Health has no age restriction on diagnostic mammograms if there is a medical condition. For Medicaid members, PrimeWest Health will cover a screening mammogram at age 40 and then annually after the age of 40. For Medicare members, PrimeWest Health will cover one screening mammogram between the ages of 35 and 39, and annually after age 40.

All facilities (hospital, outpatient department, clinic, radiology practice, mobile unit, physician’s office, or other facility) providing diagnostic and screening mammography services are required to have Food and Drug Administration (FDA) certification under the Mammography Quality Standards Act (MQSA). No facility may conduct an examination or procedure involving mammography unless the facility has obtained an MQSA certificate.

Use “V” diagnosis codes when billing mammography screening services.

1. Principal diagnosis code for non-high risk: V76.12.
2. Principal diagnosis for high risk: V76.11.
3. Applicable secondary diagnosis codes: V10.3, V16.3, or V15.89.

Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI)

PrimeWest Health covers medically necessary MRIs, CT scans, bone density studies, MRIs for angiography, Magnetic Resonance Spectroscopy (MRS), Positron Emission Tomography (PET), and brain mapping. PrimeWest Health does not require prior authorization for imaging (except for gastrointestinal tract imaging and breast MRI, see below). PrimeWest Health will periodically perform audits of claims paid for this service. In the event it is determined medical necessity for the imaging was not met, PrimeWest Health will re-adjudicate the claim. If a facility continues to perform imaging services and medical necessity is not met, that facility will be required to obtain a Service Authorization **prior to** performing this service.

Gastrointestinal Tract Imaging (e.g. Capsule Endoscopy)

PrimeWest Health requires authorization prior to performing intraluminal gastrointestinal tract imaging (91110, 91111)

Breast MRI

A Service Authorization is needed before performing a breast MRI (77058, 77059, C8903, C8904, C8905, C8906, C8907, C8908, 0159T). Scans that use intravenous MR contrast agents and specialized breast coils must be used in all cases.

For MRI of the breast for screening purposes, provide the following information with the authorization request:

1. Age
2. Previous diagnosis of breast cancer, including carcinoma in situ
3. Presence of mutation in BRCA1 or BRCA2
4. Presence of another genetic syndrome linked to high risk of breast cancer

5. Family history of breast cancer. Indicate if it is member's first-degree relatives or second-degree relatives (on the same side of the family) and include age of diagnosis, family history of ovarian cancer, and any other high-risk indication (example: Jewish ancestry).
6. History of exposure to heavy doses of ionizing radiation to chest, particularly during youth/adolescence
7. Documentation of member's ovarian cancer, diagnosed at any age
8. Previous diagnosis of atypical hyperplasia or neoplasia

For MRI of the breast for diagnostic purposes, provide documentation of any of the following clinical situations with authorization request:

1. Suspected occult primary tumor of the breast in a patient with axillary nodal adenocarcinoma and negative physical exam and mammography
2. Presurgical planning before and after neoadjuvant chemotherapy to permit tumor localization and characterization
3. Presurgical planning for clinically localized breast cancer amenable to conservation therapy to evaluate the presence of multicentric disease
4. Posteriorly located breast tumors to determine the extent of tumor invasion of the chest wall

Independent Diagnostic Testing Facility (IDTF)

MHCP follows [CMS General Coverage and Payment Policies](#) for IDTF providers

Non-Covered Services

CPT or HCPCS procedure codes performed by an IDTF that are solely therapeutic are not covered.

Billing

Independent Diagnostic Testing Facility (IDTF)

Submit the NPI assigned to the ordering physician on your 837P claim format.

When appropriate, bill the TC modifier on diagnostic procedures with a technical component.

For diagnostic testing performed entirely at the patient's location, use that location as the place of service. When one or more aspects of the diagnostic testing is performed at the IDTF, the IDTF is the place of service.

Computerized Tomography and MRI

When more than one provider is involved in providing and billing a procedure, the providers must establish a written agreement as to which component each provider will bill.

For example, a physician bills for the professional component of the service he/she provided (bill in the 837P format), while the hospital bills for the technical component (on the 837P or 837I format). Or, the hospital bills for the total component (professional and technical), and the physician does not bill, but rather is paid by the hospital. Both the physician and the hospital cannot be paid for both components.

When a physician or clinic is billing for services performed, and the equipment is owned by either the physician or clinic, the service cannot be separated into a technical and professional component.

CPT or HCPCS (level 1, 2, and 3 codes and modifiers when required) must be used on all claims.

Claims submitted for payment of CT and MRI scans must have a specific medical diagnosis. Use the most

complete and highest level of specificity ICD-9 CM diagnosis code. PET scans are billed using CPT coding.

Professional Component

The professional component represents the professional services of the physician visit, which includes all of the following:

1. Examination of the patient
2. Performance or supervision of the procedure
3. Interpretation
4. Written report

Inpatient professional component services should be billed on the 837P claim format using a 26 modifier. When a service is rendered to a hospital inpatient, use the inpatient hospital place of service code following Medicare guidelines as defined in the *Medicare Claims Processing Manual*.

For professional services that state supervision and interpretation only, use modifier 26 when appropriate. If the CPT code is defined as the professional component only, do not use modifier 26.

When a physician provides the professional component of an outpatient service, he/she may only bill the professional component using a 26 modifier.

The professional component is applicable in any duration in which the physician submits a charge for professional services.

Report the appropriate place of service.

Injection of contrast material is part of the “with contrast” CT, MRI, and MRA procedures.

Technical Component

The technical component includes the charges for personnel, materials, usual contrast media, drugs, film or xenograft, space, equipment, and other facility charges, but excludes the cost of radioisotopes and low osmolar contrast materials.

The technical component of all inpatient services is included in the inpatient diagnosis related group (DRG) and billed on the 837I claim form.

For a provider transporting his/her own equipment to another site, the technical components may be billed by the provider owning the equipment. To identify a charge for the technical component, enter the procedure code with a TC modifier.

Use the TC modifier only when appropriate. If a CPT code is defined as the technical component only (of a service), do not use the TC modifier.

Injection of contrast material is part of the “with contrast” for CT, CTA, MRI, and MRA procedures.

Total Components

Total components include the technical and professional component. Use the appropriate procedure code without a modifier.

Interventional Radiologic Procedures and Diagnostic Studies with Injection

These types of procedures include professional, technical, and injection components.

Use of radiopharmaceuticals is regulated by the Nuclear Regulatory Commission (NRC) under strict procedures and guidelines. People administering radiopharmaceuticals should have either a license from the NRC or be credentialed by an institution having a board license from the NRC.

Professional Component: Bill the appropriate procedure code that states supervision and interpretation only, and use modifier 26.

Technical Component: Bill the appropriate procedure code that states supervision and interpretation only, and use the TC modifier.

Injection Component: Bill radiology procedures using the appropriate CPT code that indicates “with contrast,” if available. Contrast media provided in a hospital must be billed with the appropriate CPT or HCPCS code on the 837I claim form.

Contrast Material: Bill separately using the most appropriate HCPCS code.

Contrast Media Provided in an Inpatient Hospital: Bill the appropriate CPT or HCPCS code on the 837I claim form.

Legal References

MN Rules part [9505.0305](#) (Laboratory and X-ray Services)

MN Rules part [9505.0445](#) (Payment Rates)

State Medicaid Manual, Section 4385 B

[42 CFR 440.30](#) (Other Laboratory and X-ray Services)

[42 CFR 441.17](#) (Laboratory Services)

[42 CFR 441.56](#) (Required Activities)

[42 CFR 493](#) (Laboratory Requirements)