

Benefit Criteria for Pathology and Laboratory Services-Organ or Disease Oriented Panel to Change For Texas Medicaid February 1, 2016

Effective for dates of service on or after February 1, 2016, benefit criteria for pathology and laboratory services-organ or disease oriented panels will change for Texas Medicaid.

The procedure codes in the table below will be a benefit only as a total component when provided by:

Nurse practitioner, clinical nurse specialists, physician assistant, physician, and certified nurse midwife providers for services rendered in the office setting;

Hospital, nephrology (hemodialysis, renal dialysis), and renal dialysis facility providers for services rendered in the outpatient hospital setting; or

Independent/privately-owned laboratory providers for services rendered in the independent laboratory setting.

Procedure Codes								

Note: The procedure codes above do not require prior authorization for Fee-For-Service.

Procedure codes 80055 and 80081 are limited to female clients who are 10 through 55 years of age. Only one service for procedure code 80055 *or* one service for procedure code 80081 will be reimbursed per pregnancy.

Procedure code 80061 is limited to once per rolling year, by any provider, when performed as part of a preventative care medical checkup.

The reimbursement for the complete panel procedure code represents the total payment for all automated laboratory tests that are covered under that panel combined; including any other automated tests billed for the client for the same date of service (DOS). The Texas Medicaid allowable fee for the individual components of the complete laboratory panel will not exceed the automated test panel (ATP) fee for the total number of automated tests that are billed for the client for the same DOS.

When all of the components of the panel are performed, the complete panel procedure code must be billed. When only two or more components of the panel are performed, the individual procedure codes for each laboratory test may be billed.

Documentation Requirements

All services are subject to retrospective review. Documentation in the client's medical record must be maintained by the physician and support the medical necessity for the services provided.

Providers are encouraged to reference the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely" lists to determine appropriateness of laboratory tests.