IMPORTANT!

Molina Provider News:

Laboratory Services Billing and Reimbursement Tip Sheet

Florida Medicaid laboratory services provide clinical testing of bodily fluids, tissues, or other substances. An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy. Provider(s) must verify each recipient's eligibility each time a service is rendered.

Quest Diagnostics is Molina's preferred in-network provider for laboratory services.

Molina's policies allow only certain lab tests to be performed in a provider's office. All other lab testing must be referred to an in-network laboratory provider that is a certified, full-service laboratory, offering a comprehensive test menu that includes routine, complex, drug, genetic testing and pathology. A list of those lab services that are allowed to be performed in the Provider's office is found on the Molina website at www.MolinaHealthcare.com.

Claims for tests performed in the provider's office, but not on Molina's list of allowed in-office laboratory tests will be denied.

Prior Authorization

Prior authorization is not required for in-network laboratory services. Non-par providers must request prior authorization.

Claims

Submission

Providers must submit claims, whether paper or electronic, within 6 months of the date of service. Claims may be submitted:

- Electronically, via the Molina Web Portal: https://provider.molinahealthcare.com
- Electronically, via a clearinghouse, Payer ID #51062
- On paper to:

Molina Healthcare PO Box 22812 Long Beach, CA 90801

When Molina is secondary, claims, whether paper or electronic, must be submitted within 90 days from the final determination by the primary insurance carrier. If Medicare is the primary carrier, claims must be submitted to Molina within 36 months from discharge or one (1) year from Medicare's determination, whichever is later.

Before filing a claim, please review the following:

- Member eligibility and ID#
- Claim's timely filing
- Primary versus secondary insurance
- Patient Liability has been confirmed through DCF documentation or the DCF website
- Rendered services are covered
- Rendered services were authorized

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Reimbursement

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered.

Providers must include the following **modifiers**, as appropriate, on the claim form:

- 26 Professional component performed by a different provider than the technical component
- 91 Repeat clinical diagnostic laboratory test, distinct or separate from a panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values
- TC Technical component performed by a different provider than the professional component
- QW CLIA waived tests on the CMS list that indicate CLIA standards are waived in the office setting

Providers may not include both the TC and 26 modifiers on the claim form for a single procedure.

Florida Medicaid does **not** reimburse for the following:

- Multiple organ and disease panels that contain duplicate components
- Repeat tests as a result of provider error
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy

For additional information, please visit the resources listed below and our website at www.molinahealthcare.com.

Thank you for your continued care to our Members!

Molina Healthcare of Florida

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Provider Resources

Medicaid Provider General Handbook

https://ahca.myflorida.com/medicaid/review/General/59G_5020_Provider_General_REQUIREMENTS.pdf

Medicaid Provider Handbook, Coverage Policies, and Fee Schedules

https://ahca.myflorida.com/medicaid/review/Promulgated.shtml

FL Medicaid Laboratory Services Coverage Policy

https://ahca.myflorida.com/medicaid/review/specific_policy.shtml

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