



MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 219
Laboratory

Table of Contents

Title 23: Division of Medicaid.....	1
Part 219: Laboratory Services	1
Part 219 Chapter 1: General	1
Rule 1.1: Provider Enrollment Requirements	1
Rule 1.2: Independent Laboratory Services	1
Rule 1.3: Routine Venipuncture.....	1
Rule 1.4: Independent Diagnostic Testing Facilities and Other Independent Mobile Diagnostic Units.....	2
Rule 1.5: Trofile Assay	3
Rule 1.6: Paternity Testing.....	3
Rule 1.7: Qualitative Drug Screening	3
Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	5
Rule 1.9: Genetic Testing.....	5
Rule 1.10: Tuberculosis (TB) Testing.....	6

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

The Division of Medicaid does not reimburse independent laboratories for lab procedures performed for beneficiaries during an inpatient hospital stay. The All Patient Refined Diagnosis-Related Group (APR-DRG) payment that the hospital receives is considered to cover all services provided during the inpatient hospital stay. The hospital is responsible for reimbursement to independent laboratories.

Source: SPA 2012-008; Miss. Code Ann. §§ 43-13 117, 121.

History: Revised Miss. Admin. Code Part 219, Rule 1.2 to correspond with SPA 2012-008 (eff. 10/01/2012) eff. 05/01/2014.

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

Medicaid will cover medically necessary qualitative drug screens for:

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.

Beneficiaries who present with clinical signs/symptoms of substance abuse.

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.

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.

Beneficiaries who are locked into a Beneficiary Health Management Program to assure compliance.

- 6. Beneficiaries prescribed certain medications as part of a treatment plan that requires testing according the Mississippi Board of Medical Licensure.

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.

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 legal purposes that are unrelated to medical treatment and not medically necessary such as, but not limited to screenings ordered by the court or law enforcement,
 - 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.

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; 73-43-11.

History: Revised eff. 11/01/2024.

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

Rule 1.9: Genetic Testing

- A. The Division of Medicaid defines genetic testing as a type of genetic analysis to confirm or rule out suspected genetic disorders.
- B. The Division of Medicaid covers genetic testing when medically necessary to establish a diagnosis when:
 1. The beneficiary has significant clinical features suggestive of a genetic disorder,
 2. The result of the test will directly impact clinical management and guide treatment being delivered to the beneficiary, and
 3. After completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

- C. The Division of Medicaid defines genetic screening as a type of genetic analysis to identify risk of genetic disorders.
- D. The Division of Medicaid covers genetic screening as a pregnancy related service to support the health of the pregnant woman and fetus when:
 - 1. The screening has not been performed previously during the same pregnancy
 - 2. The beneficiary received all of the necessary information to make an informed decision and did not decline the screening.
- E. The Division of Medicaid does not cover genetic testing or screening:
 - 1. If considered to be experimental, investigational or unproven,
 - 2. For the purpose of determining ancestry, or
 - 3. Other purposes not specifically defined that are not diagnostic in nature.
- F. Prior authorization is required for genetic testing and screening procedures as determined by the Division of Medicaid.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2026; New Rule eff. 10/01/2014.

Rule 1.10: Tuberculosis (TB) Testing

- A. The Division of Medicaid covers the following tuberculosis (TB) tests when a beneficiary has an increased risk for TB infection, as determined by the Centers for Disease Control and Prevention (CDC) and state law, and is administered in compliance with CDC recommendations and guidelines:
 - 1. Mantoux tuberculin skin test (TST), and
 - 2. Interferon-gamma release assays (IGRA).
- B. The Division of Medicaid providers must have a documented treatment plan for a beneficiary with a positive tuberculin skin test to include:
 - 1. A medical evaluation, including chest x-ray and clinical assessment, and
 - 2. An evaluation for a course of treatment for latent TB infection.

- C. The Division of Medicaid does not cover TB testing for the routine screening of beneficiaries in the absence of specific risk factors for TB.
- D. Staff who read TB skin tests must be certified by the Mississippi State Department of Health (MSDH) TB Certification Program.
- E. The provider must refer beneficiaries with a positive TB test to the MSDH Tuberculosis Program.
- F. The Division of Medicaid providers must document the following:
 - 1. The medical necessity for TB testing,
 - 2. TST information which must include the following:
 - a) Manufacturer and lot number of the injected antigen,
 - b) Expiration date of solution,
 - c) Dose administered,
 - d) Injection site,
 - e) Signature or initials of the person who administered the TST,
 - f) Size of induration in millimeters (mm),
 - g) Date and time the test was read,
 - h) Reader's signature and initials, and
 - i) Any adverse reactions.
 - 3. Referral to the MSDH Tuberculosis Program for beneficiaries with positive TB tests.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

