Handbook for Providers of Laboratory Services

Chapter L-200
Policy and Procedures For Laboratory Services

Illinois Department of Healthcare and Family Services

Issued May 2016

Chapter L-200
Laboratory Services

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Foreword

Purpose

This handbook, along with recent provider notices, will act as an effective guide to participation in the Department's Medical Programs. It contains information that applies to fee-for-service Medicaid providers. It also provides information on the Department's requirements for enrollment and provider participation.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes. Updated handbooks are posted on the Provider Handbooks page of the website.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive e-mail notification~~,~~ when new provider information has been posted by the Department.

Providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) systems are available.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565.

Acronyms and Definitions

Department of Healthcare and Family Services (HFS) or (Department): The Department of Healthcare and Family Services (HFS) or (Department) is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs, including All Kids, FamilyCare, Veterans Care, and Health Benefits for Workers with Disabilities (HBWD)

Document Control Number (DCN): A fifteen-digit number assigned by the Department to identify each claim that is submitted by a provider. The format is CCYYDDDLLSSSSSS.

CC	First 2 digits of the century claim was received.
YY	Last 2 digits of year claim was received.
DDD	Julian date (pdf) claim was received.
LL	Document Control Line Number (most commonly 15 for paper, 16 for paper with attachment, 17 for paper with override, 22 for electronic, 23 for electronic Medicare crossover).
SSSSSS	Sequential Number.

Fee-for-Service: A payment methodology in which reimbursement is considered for each service provided

HCPCS: Healthcare Common Procedure Coding System

HFS 2360 (pdf): The Department of Healthcare and Family Services Health Insurance Claim Form.

HFS 2432: The Split Billing Transmittal for MANG Spenddown Program Form issued by the Department of Human Services.

HFS 3797 (pdf): The Department of Healthcare and Family Services Medicare Crossover Invoice.

HFS 2211 (pdf): The Department of Healthcare and Family Services Laboratory/Portable X-ray Invoice.

Identification Card or Notice: The card issued by the Department to each person or family who is eligible under Medical Assistance, All Kids, FamilyCare, Veterans Care, Health Benefits for Workers with Disabilities (HBWD) and Qualified Medicare Beneficiaries (QMB) who are not eligible for Medical Assistance, but are eligible for Department consideration of Medicare coinsurance and deductibles.

National Provider Identifier (NPI): The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For healthcare providers, this identifier is referred to as the National Provider Identifier (NPI).

Participant: A term used to identify an individual receiving coverage under one of the Department's medical programs. It is interchangeable with the term "recipient".

Practitioner: For purposes of this handbook, a practitioner is a health care professional or entity who is rendering medical services and is enrolled with HFS as one of the following provider types (physician, advanced practice nurse, imaging center, portable X-ray company, school-based linked health center, local health Department, independent laboratory, fee-for-service hospital or optometrist or dentist providing medical services).

Procedure Code: The appropriate codes from the American Medical Association Current Procedural Terminology (CPT) or appropriate HCPCS Codes.

Provider Enrollment Services (PES): The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

Recipient Identification Number (RIN): The nine-digit identification number unique to the individual receiving coverage under one of the Department's Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

Remittance Advice: A document issued by the Department which reports the status of claims (invoices) and adjustments processed. May also be referred to as a voucher.

Chapter L-200

Laboratory Services

L-200 Basic Provisions

For consideration for payment by the Department for laboratory services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs via the web-based system known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Services provided must be in full compliance with applicable federal and state laws, the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the Department's paper forms and apply to patients enrolled in traditional fee-for-service, Accountable Care Entities (ACEs), and Care Coordination Entities (CCEs) and **do not apply to patients** enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Further information can be found at the HFS Care Coordination website.

Providers wishing to submit X12 electronic transactions must refer to Chapter 300, Handbook for Electronic Processing. Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

L-201 Provider Enrollment

An independent laboratory is one that is independent both of the attending or consulting physician, and of a hospital.

Participation requirements for medical providers that do not meet the definition of an independent laboratory, but are providing laboratory services in their own offices or in a hospital, can be found in Chapter 200 for the specific provider type.

CLIA requirements described in Topic L-201.5 apply regardless of provider type.

L-201.1 Enrollment Requirements

An independent laboratory holding a valid license issued by the Illinois Department of Public Health (or meeting the requirements of the state in which the laboratory is located), a valid current Clinical Laboratory Improvement Act (CLIA) Certificate and a certification by the Social Security Administration for participation in the Medicare Program (Title XVIII) is eligible to be considered for enrollment to participate in the Department's Medical Programs.

To comply with the Federal Regulations at 42 CFR Part 455 Subpart E - Provider Screening and Enrollment, Illinois has implemented a new electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

Under the IMPACT system, category of service(s) (COS) is replaced with Specialties and Subspecialties. When enrolling in IMPACT, a Provider Type Specialty must be selected. A provider type subspecialty may or may not be required.

Refer to IMPACT Provider Types, Specialties and Subspecialties for additional information.

L-201.2 Enrollment Approval

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix L-3.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic L-201.4.

L-201.3 Enrollment Denial

When enrollment is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten (10) calendar days, or is received~~,~~ but later withdrawn, the Department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of enrollment are in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are in 89 Ill. Adm. Code 104 Subpart C.

L-201.4 Provider File Maintenance

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims. Any inaccuracies found are to be corrected and the Department notified immediately via IMPACT.

Failure of a provider to properly update IMPACT with corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

L-201.5 Clinical Laboratory Improvement Amendments (CLIA) Certification

The Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, apply to laboratories that examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of, the health of human beings. No person may solicit or accept materials derived from the human body for laboratory examination or other procedure unless there is in effect

for the laboratory a CLIA certificate issued by the Department of Health and Human Services that is applicable to the specialty or subspecialties of laboratory services offered by the provider. The provider may obtain one of four types of CLIA certificates:

A. Certificate of Waiver
B. Physician Performed Microscopic Procedure
C. Certificate of Accreditation
D. Certificate of Compliance

To receive reimbursement for laboratory services, all providers, regardless of type of business or professional licensure, must have a current CLIA certificate on file with the Department. Payment will not be made for laboratory services performed by a provider if the Department does not have the required CLIA certification as described below.

- A CLIA certificate issued to an independent laboratory is effective only for that laboratory and no other entity. A physician or hospital cannot submit the CLIA certification of an independent laboratory and attempt to bill the Department for laboratory services using that certification.

- The certificate must be issued in the specific name and address of the enrolled provider who will be billing for the laboratory services. Exceptions to this are:

  - A clinic may enroll with the Department as an independent laboratory or may place its CLIA certificate in each of the clinic's physician files. However, the clinic cannot do both.
  - A pathologist contracted by a hospital may submit a CLIA certificate for the contracting hospital.

For additional information on the CLIA certification process please contact:

Illinois Department of Public Health
Laboratory Regulation
525 West Jefferson Street
Springfield, IL 62761
217-782-7412

L-202 Laboratory Reimbursement

A claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payer applicable to the provision of services must be reflected as a credit on any claim submitted to the Department for those services or items.

Many laboratory tests have both a technical and professional component. Refer to Topic L-210 for an explanation of the circumstances under which each is billed to the Department.

Please note it is the provider's responsibility to verify claims are received by the Department, whether submitted electronically or on paper, and to check claim status.

L-202.1 Charges

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department after the service has been provided.

A provider may only charge for services he or she personally provides. Providers may not charge for services provided by another provider, even though one may be in the employ of the other.

Charges for services provided to participants enrolled in a Managed Care Organization (MCO) or Managed Care Community Network (MCCN) must be billed to that entity according to the contractual agreement with the MCO or MCCN. Information regarding these plans can be found on the HFS Care Coordination web page.

L-202.2 Electronic Claim Submittal

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100 or Chapter 300.

Providers may also submit claims directly to the Department via the Internet through the MEDI IEC system. Further information regarding MEDI IEC can be found on the Department's website.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that claims were not received into processing due to electronic file compliance errors, or service rejections were caused by the submission of incorrect or invalid data.

L-202.3 Claim Preparation and Submittal

The Department will not accept paper claim forms hand-delivered to HFS office buildings by providers or their billing entities. HFS will return hand-delivered claims to the provider identified on the claim form. All services for which charges are made must be coded on the appropriate claim form.

For general information on billing Medicare covered services provided and submittal of claims for participants eligible for Medicare Part B, refer to the Chapter 100 handbook.

Form HFS 3797 (Medicare Crossover Form) is to be used to submit Medicare allowable crossover charges. Detailed instructions for completion are included in Appendix L-2.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix L-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability/imaging evaluation. Turnaround on a claim scannability/imaging evaluation is approximately 7-10 working days and providers are notified of the evaluation results in writing. Please send sample claims with a request for evaluation to the following address:

Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

L-202.3.1 Preparation of Claims – Independent Laboratories

Form HFS 2211 (Laboratory/Portable X-Ray Invoice) is to be used by independent laboratories to submit charges for covered services. Detailed instructions for its completion are included in Appendix L-1 and a facsimile of the HFS 2211 is on the Medical Forms page of the website. Current Procedural Terminology (CPT) or Common Procedure Coding System (HCPCS) codes must be used when billing for test procedures.

L-202.3.2 Preparation of Claims – Other Providers

Form HFS 2360 (Health Insurance Claim Form) is to be used by all providers except independent laboratories to submit charges for covered services. Refer to the Handbook for Practitioners Rendering Medical Services, Chapter A-200, Appendix A-1 for detailed instructions on completing Form HFS 2360. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes must be used when billing for test procedures.

L-202.3.3 Claims Submittal

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, Form HFS 2245 (Laboratory/Portable X-Ray Invoice Envelope). Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use Form HFS 2248 (NIPS Special Handling Envelope). A non-routine claim is a claim to which any other document is attached.

For electronic claims submittal, refer to Topic L-202.2 above. Non-routine claims may not be electronically submitted.

L-202.4 Payment

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Refer to Chapter 100 for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

Payment for allowable laboratory services includes collection and handling of specimens by laboratory personnel; use of laboratory equipment and supplies and the written report of test results to the referring practitioner.

L-202.5 Fee Schedule

The Department’s maximum reimbursement rates for the allowable procedures are listed in the Practitioner Fee Schedule on the Department’s website.

Providers will be advised of changes via an electronic notification. Providers should sign up to receive electronic notification of new releases on the Department’s website. Please mark “All Medical Assistance Providers” as well as each specific provider type for which notification is requested.

L-203 Covered Services

A covered service is a service for which payment can be made by the Department in accordance with 89 Ill. Adm. Code 140.3.

Payment for services will be made only when the following conditions have been met:

- The test for which charges are made is within the specialties or subspecialties the laboratory is CLIA certified by Medicare to provide, and

- The patient's referring practitioner has provided the laboratory with a written order for the test(s). (Refer to Topic L-205 for a description of acceptable documentation.)

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

Any questions a provider may have about coverage of a particular service should be directed to the Department prior to provision of the service. Providers may call the Bureau of Professional and Ancillary Services at 1-877-782-5565.

If services are to be provided to a participant enrolled in Care Coordination prior authorization and payment must be obtained from the Care Coordination entity.

L-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 Ill. Adm. Code 140.6 for a general list of non-covered services.

In addition, the following laboratory services are excluded from coverage in the Department's Medical Programs and payment will not be made for the provision of these services:

- Laboratory services when not specifically required by the condition for which the patient is being treated such as blanket "rule out" or open-ended tests
- Laboratory services provided to patients eligible for Medicare Part B benefits when the Medicare intermediary determines that the services are not medically necessary
- Laboratory tests that are available without charge from other sources including, but not limited to, private and governmental agencies
- Blood lead tests performed by laboratories other than the Illinois Department of Public Health, unless the results are reported to the Illinois Department of Public Health (refer to L-212.5)
- Tests and study of specimens as a result of an autopsy examination
- Tests which have not been performed on the laboratory's premises, by the laboratory's staff, using the laboratory's equipment and supplies
- The collection and handling of specimens obtained for referral to another laboratory
- Sensitivity studies when a culture shows no growth or when a growth is identified as beta hemolytic streptococcus

L-205 Record Requirements

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100 for record requirements applicable to all providers.

Additionally, Illinois laboratories must comply with State regulations governing the maintenance of medical records, as issued by the Illinois Department of Public Health (IDPH) and contained in IDPH rules at 77 Ill. Admin. Code Section 450. Out-of-state laboratories must comply with applicable regulations in their state.

In addition to record requirements discussed in the Chapter 100 handbook, the basic records that must be retained include:

- All written or electronic orders from practitioners for laboratory services for Medical Programs participants. The written documentation may include, but not be limited to:

  - An original order
  - A copy of an original order faxed from the ordering practitioner's office
  - An electronic order e-mailed from the ordering practitioner's office

  The order, regardless of medium, must clearly identify its source, including the name of the ordering practitioner. It must also include the exact test(s) to be performed (amount, frequency, and duration) and the diagnosis or condition of the patient pertinent to the order.

- Copies of all reports to referring practitioners
- A method of verification of usual and customary charges to the general public
- For non-emergency blood lead tests performed, documentation showing that the results were reported to the Illinois Department of Public Health

The practitioner's written or electronic order must be contained in the laboratory's medical records. It must specify the test(s) ordered. The order must contain the patient's diagnosis or presenting symptoms which indicate the need for the specific test(s) ordered. The practitioner's state license number must be available to each lab to which referrals are made.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

L-210 General Limitations and Considerations on Covered Services

L-210.1 Technical and Professional Components

For any given lab test, no more than one provider may be reimbursed for the technical component of a service and no more than one provider may be reimbursed for the professional component.

Practitioners billing the technical component only must use modifier “TC”. Practitioners billing the professional component only must use modifier “26”. Both technical and professional components are implied when no modifier is entered.

L-210.1.1 HFS 2211 Claim Form

Payment to an independent laboratory includes both the technical and professional components. Payment will not be made to a practitioner for the interpretation of any tests performed and billed by an independent laboratory.

Independent laboratories may not bill the Department for lab tests done during an inpatient stay. The all-inclusive rate that the hospital receives is considered to cover all services provided during the inpatient stay.

L-210.1.2 HFS 2360 Claim Form

A practitioner may charge for tests performed in the practitioner’s office by the practitioner’s staff. Payment made by the Department for laboratory tests performed in the practitioner’s office includes both the professional and technical component fees. A practitioner may not charge for laboratory tests when a specimen is obtained but sent out of the office, e.g., skin lesions, pap smears, etc.

A central laboratory, serving practitioners in group practice is considered a practitioner’s office laboratory.

Hospitals may bill global (both professional and technical components) for laboratory services in the outpatient setting when the hospital obtains tests the specimen, completes the test and issues the report.

Hospitals may bill for the technical component only when the hospital obtains the specimen and completes the test. The pathologist may bill for the professional component if the pathologist is not salaried by the hospital. Hospitals should never bill only for the professional component of any laboratory service.

Hospitals frequently utilize reference laboratories (an off-site laboratory that completes the procedure on the specimen provided to them). If the hospital has a financial agreement with the reference laboratory that the laboratory provides the

services for the hospital and the hospital reimburses the laboratory for those services, the hospital is entitled to bill the Department for the services rendered at the laboratory for outpatient services. If no such agreement exists, the laboratory may submit charges to the Department. The hospital cannot bill for laboratory services done by an outside laboratory during an inpatient stay or when there is a billable APL Service.

The Department will only pay an individual service one time. If the hospital bills global and a pathologist bills the professional component, the claim received first will pay. All subsequent claims will be rejected. This also holds true if both the hospital and the reference laboratory bill the same service.

L-210.2 Multiples of the Same Test on the Same Day

L-210.2.1 Independent Laboratories

In order for an independent laboratory to bill for multiples of the same test performed on the same date of service, the laboratory must use both the CPT code for the test being performed and the appropriate unlisted code. The CPT code for the test being performed is placed in the procedure code portion of the service section for test #1 and the name of the test or a description is placed in the procedure description field. The charge for the first test is placed in the provider charge field. The appropriate unlisted procedure (example 87999) is placed in the procedure code field of the next service section. The name(s) and number of the additional test(s) must be shown in the procedure description field and one charge, which includes all the additional tests billed under the unlisted code, is to be entered in the charge field. If there is not adequate space on the billing form to describe the additional service(s), either a narrative description of the test(s) or test results must be attached to the claim.

L-210.2.2 Hematology Tests for All Other Providers

A practitioner may bill for multiples of hematology services by using the days/unit field. When multiples of a hematology service are performed, the practitioner enters a 4 digit code in the days/unit field (example: 0004 for 4 tests within a 24 hour time period). If a quantity greater than 5 is placed in the Days/Units field, either the test results or a narrative explanation of the services must be attached to the claim.

A hospital billing fee for service for multiple hematology services is to use the same procedure as that described for a practitioner.

L-210.2.3 Pathology Services for All Other Providers

A practitioner may bill for multiples of pathology services by using the Days/Units field. When multiples of a pathology service are performed, the practitioner enters a 4 digit code in the Days/Units field (example: 0004 for 4 tests within a 24 hour time period). If a quantity greater than 5 is placed in the Days/Units field, either the test results or a narrative explanation of the services must be attached to the claim.

Certain laboratory tests which are not reasonably performed more than once on the same service date, for the same participant, are limited to a quantity of one, e.g., Pap smears, DNA testing. If more than one of these services is repeated on the same day, the unlisted code is to be shown for the additional test(s) and tests results attached to the claim.

A hospital billing fee for service for multiple pathology services is to use the same procedure as that described for a practitioner.

L-212 Limitations and Considerations on Specific Services

L-212.1 Vitamin B12 Testing

Payment is allowable for Vitamin B12 and Folic Acid testing only when the possibility of macrocytic anemia is detected by a complete blood count (CBC). CBC test results performed within the past 30 days must be attached to the claim when charges are submitted for Vitamin B12 or Folic Acid testing.

L-212.2 Multi Phasic Tests

Routine, multi phasic (battery) tests are covered only in those instances where the tests performed are consistent with the patient's diagnosis or condition.

L-212.3 Organ or Disease Oriented Panels

Appropriate CPT or Level II or III HCPCS codes for specific panels are to be used in lieu of individual codes to report organ panels or profiles that combine tests under a problem oriented classification. Organ or Disease Oriented Panel codes should be used only when all of the tests listed in the panel definition are performed. When all of the tests listed are not performed, individual test codes are to be used and a separate charge shown for each code. Individual codes are also to be used for automated tests that are not included in a panel code.

Providers may not submit charges for individual or profile codes for tests included in the panel(s) billed, and vice versa.

L-212.4 Therapeutic Drug Monitoring

Measurement of one or more drugs in body fluids or excreta may be billed under the specific procedure code for the drug(s) test. If no specific drug code exists, the unlisted Drug Assay code is to be used. When the unlisted code is used, the specific drug(s) tested for must be entered in the description field of the invoice. A copy of the test reports or a narrative listing of the drug(s) included in the charge must be attached. The unlisted code can only be used once for the same date, same patient, with one charge that includes all drugs which have no specific code.

L-212.5 Blood Lead Draws

Payment will be made to a laboratory for a "draw fee" if the laboratory obtains a specimen for delivery to the Illinois Department of Public Health lab for a blood lead test. HFS strongly encourages providers to use the IDPH (State) laboratory for blood analysis.

The Illinois Lead Poisoning Prevention Act requires reporting of all blood lead test results to the IDPH Illinois Lead Program. For testing not performed by the IDPH lab, reporting requirements are identified in Illinois Department of Public Health rules at 77 Ill. Admin. Code Section 845.60.

The IDPH Illinois Lead Program may be contacted by calling or emailing:

Illinois Department of Public Health
Illinois Lead Program
Phone: 1-217-782-3517 or 1-866-909-3572
TTY: 1-800-547-0466
Email: DPH.Lead@illinois.gov

Additional information regarding blood lead testing may be found in Chapter HK-200, Handbook for Providers of Healthy Kids Services.

L-270 Home and Long Term Care Facility Services

Payment for travel to a patient's place of residence will be allowed only when:

- The patient's attending physician indicates on the order that the patient is physically unable to travel to a laboratory; and
- When it is the custom of the laboratory to charge the general public a travel fee in addition to the fee for the laboratory service.

If the laboratory travels to the patient's place of residence, the laboratory should bill the appropriate HCPCS code for travel. Covered procedures are identified in the Practitioner Fee Schedule.