

Clinical Laboratory Improvement Amendments (CLIA) ID Requirement Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication. (CPT® is a registered trademark of the American Medical Association)

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid product.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Table of Contents

[Application](#)

[Policy](#)

[Overview](#)

[Reimbursement Guidelines](#)

[Definitions](#)

[Questions and Answers](#)

[Attachments](#)

[Resources](#)

[History](#)

Policy

Overview

This policy describes the information that is required on certain claims that are reported for laboratory services under the Clinical Laboratory Improvement Amendment (CLIA) 1988 statute and regulations.

All services described in this policy may be subject to additional UnitedHealthcare Community Plan reimbursement policies including, but not limited to, CCI Editing Policy, the Laboratory Services Policy, and the Professional/Technical Component Policy.

Reimbursement Guidelines

Background

CLIA was established to strengthen federal oversight of clinical laboratories to ensure the accuracy and reliability of patient test results. CLIA applies to all laboratories that examine “materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.” This applies if even one test is to be performed. CLIA regulatory requirements vary according to the kind of test(s) each laboratory conducts. All entities that meet the definition of a “Laboratory” under the CLIA statutes and regulations must obtain an appropriate CLIA certificate prior to conducting patient testing.

Purpose

For purposes of this policy, a valid CLIA Certificate Identification number will be required for reimbursement of clinical laboratory services reported on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent.

Claims Submission Process

Laboratory service providers must ensure that the required CLIA information is submitted using the correct loops, segments, and associated line level qualifiers (X4 and F4). Please refer to the ANSI X12N 837 Professional Claim guidelines and the Medicare Claims Processing Manual Chapters 1, 16, 26 and 35 for more information.

Additional information regarding CLIA, applying for or renewing a certificate, or regarding assigned test complexity levels can be found at the following website.

[Clinical Laboratory Amendments \(CLIA\) Website](#)

Modifier QW

Inclusion of this modifier when any applicable laboratory service is reported on a CMS 1500 claim form will be necessary to evaluate the claim to determine eligibility for benefit coverage of the laboratory services performed based upon the CLIA certification. Additional information regarding the categorization of laboratory tests by CLIA may be found at the website below.

[CLIA Categorization of Laboratory Tests](#)

Summary

Any claim that does not contain the CLIA ID, invalid ID, and/or the complete servicing provider demographic information will be considered incomplete and may be rejected or denied. Claim line edits may also be applied if the lab certification level does not support the billed service code. Laboratory service providers who do not meet the reporting requirements and/or do not have the appropriate level of CLIA certification for the services reported may not be reimbursed.

Definitions

Clinical Laboratory Improvement Amendments (CLIA)

The Centers for Medicare & Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total, CLIA covers approximately 251,000 laboratory entities. The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Clinical Standards and Quality (CCSQ) has the responsibility for implementing the CLIA Program. More information is available at: [Clinical Laboratory Amendments \(CLIA\) Website](#)

CLIA Waived Test	As defined by CLIA, waived tests are categorized as “simple laboratory examinations and procedures that have an insignificant risk of an erroneous result.” https://www.cms.gov/regulations-and-guidance/guidance/transmittals/transmittals/R11547CP
Laboratory	The CLIA regulations define a laboratory to be “a facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body”
Modifier QW	CLIA Waived Test.
Referred Laboratory Test	A billed laboratory service will be considered referred when the testing is performed by a servicing location other than the billing location. The appropriate claim line qualifier should be applied to indicate which location (billing or servicing) on the electronic claim applies to the submitted CLIA ID for the billed service code.
Referring Laboratory	A credentialed laboratory that receives a specimen to be tested and that refers the specimen to another credentialed laboratory for performance of the laboratory test.
Reference Laboratory	A credentialed laboratory that receives a specimen from another, referring laboratory for testing and that actually performs the test.

Questions and Answers

1	<p>Q: How do the Centers for Medicare & Medicaid Services (CMS) determine CLIA applicability?</p> <p>A: CLIA applicability is determined using the regulatory definition of “laboratory” quoted above. United Healthcare is acknowledging the CDC, FDA, and CMS CLIA regulations.</p> <p>Specifically, CLIA applies when:</p> <p>(1) patient-specific results are reported from the laboratory to another entity; AND</p> <p>(2) the results are made available “for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.” As stated above, whether a test service is billed to Medicare has no bearing on CLIA applicability. Therefore, if a facility performs tests for the above-stated purposes, it is considered a laboratory under CLIA and must obtain a certificate that corresponds to the complexity of testing performed.</p>
2	<p>Q: Where is there more information about the ANSI X12N implementation guidelines?</p> <p>A: More information can be found at www.x12.org or www.wpc-edi.com.</p>
3	<p>Q: Will a billed lab service be considered referred even if both labs are wholly or in part owned/operated by the same entity?</p> <p>A: Yes, the unique CLIA ID and servicing location information is required for every location where testing was performed. (See Referred Laboratory Test and Referring Laboratory definitions for additional information)</p>

4	<p>Q: Should modifier 90 be applied to all line level service codes for testing referred to another laboratory?</p> <p>A: Provider should continue to follow the defined coding and billing guidelines for the use of all applicable modifiers.</p>
5	<p>Q: For the purpose of claim line level submission, how should the X4 and F4 qualifiers be applied:</p> <p>A: For all billed laboratory services subject to CLIA the as submitted CLIA ID and servicing location will be verified utilizing the CLIA source validation files. The decision to validate using the billing or servicing location submitted on the claim is determined by the qualifier applied to the claim line as follows:</p> <p>Testing performed at billing location (test not referred)</p> <ul style="list-style-type: none"> • Report the billing laboratory’s CLIA ID number in: Loop 2300, REF02, REF01=X4 for all CLIA-covered laboratory tests submitted on the claim, <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • Report the billing laboratory’s CLIA ID number in: Loop 2400, REF02, REF01=X4 for each specific CLIA-covered laboratory tests submitted on the claim, <p>Testing performed at a location other than the billing location as submitted on the claim (test referred):</p> <ul style="list-style-type: none"> • Report the referral laboratory’s CLIA number in: Loop 2400, REF02, REF01=F4 for CLIA-covered laboratory tests referred to another (referral/rendered) laboratory. <p>(See Referred Laboratory Test and Referring Laboratory definition for additional information)</p>
6	<p>Q: Do I need to have CLIA certificate even if I am just performing simple laboratory tests?</p> <p>A: Yes, the CLIA regulations apply to all laboratories that examine “materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings.” This applies if even one test is to be performed.</p>

Attachments

List of CLIA Waived Tests	https://www.cms.gov/regulations-and-guidance/guidance/transmittals/transmittals/R11547CP
----------------------------------	---

Resources

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA)
US Food and Drug Administration (FDA)
Centers for Disease Control and Prevention (CDC)
Individual state Medicaid regulations, manuals & fee schedules
ANSI X12N 837 Professional Claim Guidelines

History

9/25/2022	Policy Version Change Definitions: Updated Attachments: Updated
------------------	---

6/29/2022	Policy Version Change Definitions: Updated link Attachments: Updated link History Section: Entries prior to 6/29/2020 archived
4/1/2022	Annual Policy Version Change Definitions Section: Updated formatting and link Attachments Section: Updated link Questions and Answers Section: Updated formatting History Section: Entries prior to 4/1/2020 archived
9/26/2021	Policy Version Change Definitions Section: Updated Attachments Section: Updated History Section: Entries prior to 9/26/2019 archived
8/1/2016	Policy implemented by UnitedHealthcare Community & State
4/13/2016	Policy approved by the Payment Policy Oversight Committee