Medicare National Coverage Determinations and Local Coverage Determinations for Clinical Diagnostic Laboratory Services

While Medicare recognizes that physicians or other qualified treating non-physician practitioner must be able to order any test that they believe is appropriate for the treatment of their patients, Medicare will only cover testing that is medically necessary, i.e., reasonable and necessary to diagnose or treat a patient. As a result, Medicare may deny payment for a test that the physician believes is appropriate, but which (1) does not meet the Medicare coverage criteria or (2) where documentation in the patient's record does not substantiate that the tests were reasonable and necessary. Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied.

Medicare regulations state that it is the responsibility of the physician or an authorized representative to select the diagnosis based on the patient's medical record and not reimbursement conditions. **The Medicare Coverage Determinations are not meant to suggest or in any way influence the selection of an ICD Code; it is not the intention of Mission Health to suggest or imply that physicians or their representatives should select only the ICD codes listed on these documents.**

The Medicare Coverage Determinations are also available on the Centers for Medicare and Medicaid Services (CMS) website. Mission will update the policies as the NCDs or LCDs are modified or new ones issued.

If you have any questions about this information or its use, contact Myra Fields, Laboratory Compliance Officer, at (828) 213-5155 or myra.fields@msj.org.

Selecting and Documenting ICD Codes

When ordering tests from a Mission Health Laboratory, the requesting physician or other qualified treating non-physician practitioner must document the reason that the test is being performed. When a diagnosis has not been established, codes that describe symptoms and signs should be provided. The code must be clinically relevant and coded to the highest degree of specificity.

Mission Health includes the ICD code(s) provided by the physician or other qualified treating non-physician practitioner on the insurance claim. This ICD code is used when billing Medicare regardless of the test results. If the test is being performed for screening purposes only, Mission Health cannot change the screening code to a diagnosis code after test results are available, even if the test results support another diagnosis.

Mission Health requires that you provide relevant ICD codes, **not descriptions or narratives**, on the laboratory requisition or order. This is due to the difficulty in accurately translating a narrative diagnosis to the appropriate ICD code, particularly without access to the patient's medical record. It is critical that the diagnosis or sign/symptom code provided on the laboratory requisition or order is consistent with the documentation in your patient's medical record on that date of service.

Finally, the diagnosis or sign/symptom code on the laboratory requisition or order must document the reason the test is being performed. Organ or disease related panels will only be paid when all components are medically necessary. **Note that the General Health Panel is not covered by Medicare**. In many cases, a final diagnosis will not be available at the time the laboratory test is being ordered; in these instances, sign/symptom ICD codes are appropriate.

In summary, when providing ICD codes:

- Document the reason the test is being performed.
- Provide all applicable codes and not a narrative.
- Assign the code to the highest degree of specificity.
- The code(s) provided by the patient's physician or other qualified treating non-physician practitioner must be consistent with information in the patient's medical record for that date of service.
- All components of an organ / disease related panel must be medically necessary.

How to Use the Laboratory Coverage Policies

Medicare's NCDs, or National Coverage Decisions, provide a narrative description of the test, clinical indications for its use, coverage limitations and related ICD codes. Mission's Medicare Administrative Contractor, PalmettoGBA, has established local coverage decisions for other laboratory tests based on Medicare national policy. These tests also require specific medical necessity documentation. The reason the test is being performed for that patient must be listed on the LCD or coverage will be denied.

How to use the NCD or LCD:

- Using documentation in the patient's medical record, determine the diagnosis or sign/symptom ICD code(s) that describes why each test is being performed.
- If the test has a specific coverage policy, determine if the patient's ICD code is included in the policy.
- If the patient's ICD code **IS** listed, medical necessity is met and no ABN form is required.
- If the patient's ICD code **IS NOT** listed, medical necessity is not met and a signed ABN form is required before the test can be performed. Complete the ABN form and present to the patient for signature. Send the original copy to the laboratory with the requisition or order and give a copy to the patient.

Note: The Blood Counts coverage policy, which includes CBC, lists ICD codes that do NOT support medical necessity. If the patient's ICD code not listed, medical necessity is met.