

MEDICARE COMPLIANCE/COVERAGE LIMITATIONS

What will Medicare cover?

Background

Medicare, like private insurers, makes decisions about what services will be covered under their program. While both Medicare Part A & Part B cover clinical laboratory testing, not every test in every clinical situation is covered. Services that are generally excluded from coverage include or treatment of an illness or injury. Some specific types of screening services are specifically covered by statute, but may be subject to frequency limitations.

Medical Necessity Documentation

Documentation of medical necessity is of the utmost importance. Under the Balanced Budget Act of 1997, *physicians are required to supply a diagnosis to the laboratory* for services provided so the laboratory can be paid. Medicare requires hospital laboratories to submit all the diagnosis information, in the form of ICD-10 codes, provided by the referring physician on claims. Medicare will only pay for testing that meets Medicare's definition of "medical necessity". Therefore, a physician may order a laboratory test that they believe is appropriate for the patient, however, Medicare will deny payment unless it meets Medicare's definition of medical necessity.

To determine the correct ICD-10 code to use, please refer to the current version of the International Classification of Diseases, Clinical Modification (commonly referred to as the Physician's ICD-10 CM manual). Please submit the specific diagnosis that describes the patient's signs and symptoms pertaining to why the laboratory testing was ordered. An ICD-10 code is preferable to a narrative diagnosis. We are happy to help you with ICD-10 coding if needed.

Statutorily Excluded Services

Medicare has published a list of ICD-10 diagnosis codes that are statutorily excluded from coverage regardless of the service. This means that services (including laboratory testing) submitted to Medicare with only a statutorily excluded diagnosis code will not be covered. A statutorily excluded ICD-10 code may be an appropriate diagnosis code to use in some cases, however, if a more specific sign/symptom is relevant to the requested testing then it too should be added as diagnosis information on the laboratory requisition. If a statutorily excluded ICD-10 code is the only appropriate ICD-10 diagnosis code, Medicare requires that we, as the billing entity, indicate to Medicare on the claim that it is a non-covered service.

Advance Beneficiary Notices of Non-coverage (ABN's) may be used for services that are statutorily excluded. Option #2 on the ABN form is appropriate in this circumstance. Please remind patients that Medicare will not pay and that the beneficiary is ultimately responsible for the charges.

Medicare Coverage Limitations

Types of Limitations

Laboratory testing is subject to the following limitations:

1. Medicare does not cover lab testing considered to be investigational or experimental.
2. Medicare generally does not pay for any tests ordered for screening purposes. There are exceptions noted below which are specifically covered by statute, however, the coverage is subject to frequency limits:
 - Sexually Transmitted Infections (STIs) Screening(includes Chlamydia, Gonorrhea, Syphilis and Hepatitis B)
 - Pap Smear screening for cervical or vaginal cancer
 - PSA for prostate cancer screening
 - Fecal Occult Bloods for Colorectal Cancer screening
 - Glucose testing as a screen for Diabetes Mellitus
 - Lipid testing as screen for Cardiovascular Disease
 - Hepatitis C Antibody Screening
 - Hepatitis B Virus Screening
 - Human Immunodeficiency Virus (HIV) Screening
 - HPV Screening

Please see “Lab Preventative Screening: Quick Reference” under Compliance Information for additional information on Medicare’s Preventative Services benefits.

3. Coverage Decisions are predicated on what is considered “medically necessary”. Medicare believes some tests may be over utilized (ex. Urine cultures, CBCs, Glucose, TSH). Their response to the perceived over utilization was to create the coverage decisions which define & limit the circumstances under which the test(s) will be covered. Medicare’s coverage decisions can be at a national or local level.
 - **National Coverage Decisions (NCD’s)**
An NCD is a policy developed at the national level that establishes the diagnoses (ICD-10 codes) under which a particular procedure/test will be considered medically necessary and thus reimbursable by Medicare.
 - **Local Coverage Decision (LCD’s)**
A local coverage decision is similar in purpose to an NCD except that it is developed at the local level. A local Medicare contractor may issue an LCD if there is no national policy or if they wish to supplement an NCD when it doesn’t address a specific issue, such as frequency.

Please see individual Medicare Coverage Decisions to determine if medical necessity will be met in the patient’s particular circumstances.

If a lab test is ordered and will not be considered medically necessary based on one of the coverage limitations, please obtain an Advance Beneficiary Notice (ABN).