Establishing Medical Necessity for Laboratory Tests and Services

- Medicare will reimburse providers only for services that are “medically necessary” for the diagnosis and/or treatment of existing disease and injuries.

- Medicare requires laboratories to provide a diagnosis code to support the medical necessity for all test(s) and service(s) that are submitted for payment. Medical necessity for laboratory service is determined by the diagnosis code(s) [ICD-9-CM code] and whether it is a match to the service code(s) [CPT, HCPCS codes].

- The Center for Medicare and Medicaid Services (CMS) has established the physician as responsible for determining, keeping and providing medical necessity information for a patient’s medical record. The patient’s physician should determine the correct diagnosis code(s) or narrative(s) and provide the information as part of the order.

- Submitting the information needed for establishing Medical Necessity:
  - Determine the reason for ordering "each & every" test or service requested:
    - If all the tests ordered are related to a single reason then only one Diagnosis is required
    - If there are different reasons for the tests ordered, then submit all the supporting diagnosis(s) as part of the order
  - If Panels or Profiles are ordered:
    - look at each test within the panel to see if they are supported by the diagnosis submitted.
    - most of the "Organ Specific" panels/profiles will be supported by a single diagnosis
    - most of the "large screening - multi-test panels" will not be supported by a single diagnosis. Consider ordering specific test(s) separately - or - obtain an *ABN
  - Medicare/Medicaid allows multiple diagnosis codes to be submitted in support of Medical Necessity when multiple diagnostic services are ordered.

- Medicare generally recognizes three types of treatment:
  - Medically Necessary treatment - which triggers reimbursement
  - Medically Appropriate treatment - which generally reflects good medical practice, such as, screening of patients with no signs or symptoms, or preventative services. These types of service would require an "Advanced Beneficiary Notice (ABN)" be obtained from the patient, before reimbursement would be considered by Medicare. (see Laboratory Compliance Bulletin on ABNs)
  - Medically Unnecessary treatment - refers to treatment that may not be appropriate, overutilization of a treatment, or inappropriate treatment. Results in denial of reimbursement (requires an ABN)

- Indiana University Health Pathology Laboratory (IUHPL) provides condensed versions of the Local Medical Review Policies (LMRP / LCD), and the National Medicare Coverage Policies (NCD) for Clinical Lab Services (effective 11/25/2002). These policies may help you determine what tests and services may or may not be covered by a specific Diagnosis code. (available at www.iuhealth.org/pathologylab)

* ABN = Advanced Beneficiary Notice