Medicare Policies Regarding the Clinical Laboratory

The following is a list of frequently asked questions and their answers regarding Medicare's reimbursement policies affecting laboratory services. If you have any additional questions, please contact Gail Jomaoas, HealthCare Clinical Laboratories' Representative at (209) 467-6425.

Does Medicare pay for all lab testing?

No. Although Medicare pays for most lab tests, there are certain types of tests for which Medicare will not pay. The types of tests that are not covered by Medicare and must be billed to the patient or another guarantor include:

1- tests that are ordered for a diagnosis or condition that in Medicare's opinion are not medically necessary;

2- "screening" tests that are performed as part of a routine exam when the patient displays no evidence of disease;

3- tests that are performed more frequently than recommended by Medicare; or

4- tests that are considered experimental or investigational because they have not yet been approved by the FDA.

What is a limited coverage policy?

The term "limited coverage policy" means a policy established by an insurance carrier (including Medicare and other third party payors) to limit payment of certain laboratory tests to situations where the tests were ordered and performed for a set of pre-determined diagnoses. The limited coverage policy defines the medical conditions (diagnoses, symptoms, complaints) or ICD-9 codes under which payment will be made by the insurance carrier for certain tests.

What is a limited coverage test?

A test subject to a limited coverage as determined by a local medical review policy.

What is the Advance Beneficiary Notice (ABN)?

If a test subject to limited coverage policy is ordered for a condition that has not been deemed medically necessary by the Medicare carrier, the carrier will not pay the laboratory for performing the test. For the laboratory to bill the Medicare patient for such non-covered service, the patient must be informed prior to the service being rendered that the service may not be covered by Medicare and the patient must agree to be financially responsible for payment if the service is not covered. The ABN is used to inform the patient about the potential financial responsibility, and must be signed by the patient each time a non-covered service is ordered to confirm the patient's agreement to be financially responsible for payment.

I am concerned that my staff is too busy to explain these policies to patients and/or respond to phone calls requesting additional diagnosis information.

The limited coverage policies are a Medicare requirement, not a HCCL requirement. We appreciate the additional administrative work this requirement is placing on your practice. Unless and until the carrier chooses to change the published policies, HCCL must comply with such policies in order to get paid for services we perform at your request for your patients.

Must every Medicare patient sign an ABN?

If you do not order a limited coverage test, a signed ABN is generally not required. In addition, if you order a limited coverage test for a patient under a medical condition (ICD-9 code) that the Medicare carrier deems as medically necessary, Medicare will pay for the testing, and a signed ABN is not required.

If I order more than one limited coverage test, will the patient have to sign more than one ABN?

No. Only one ABN needs to be completed. However, all limited coverage tests that are ordered must be included on the ABN form.

Do repeat patients need to sign the ABN form each time they have limited coverage tests ordered?

Yes. An ABN form must be signed by a patient each time one of the limited coverage tests is ordered for a condition that has not been deemed medically necessary by the Medicare carrier.

Can the patient sign the ABN after HCCL has performed the ordered testing?

NO. By statute, for HCCL to bill the Medicare patient for non-covered services, the ABN form must be signed by the patient prior to services being rendered by HCCL.

If I order a limited coverage test as part of a profile do I still have to provide ICD-9 codes?

Yes. Regardless of whether a limited coverage test is ordered individually or as part of a profile, you need to provide ICD-9 codes. The Medicare carrier's limited coverage policy does not make any distinction regarding how a test is ordered.

If I order a panel that includes a limited coverage test under a non-covered medical condition and the patient signs an ABN, will the patient be billed for the entire profile or just the limited coverage test?

The patient will only be billed for the limited coverage test, as Medicare is likely to pay for the other tests in the panel. Tests not subject to limited coverage policies and otherwise paid for by Medicare will only be billed to Medicare.

What happens if I do not provide diagnosis information when I order limited coverage tests?

If we do not receive diagnosis information when you order one of the limited coverage tests for a Medicare patient for a non-covered condition, your office will contacted to supply the diagnosis information, creating needless rework for you and HCCL. In addition, if HCCL is not reimbursed by Medicare for such testing, we reserve the right to invoice such Medicare tests directly to you where permitted by law. Consistent failure to comply with these Medicare policies may result in HCCL discontinuing service to your account, as HCCL cannot continue to provide services without being paid.

May I bill my patient for the non-covered tests?

NO. Under the Medicare law, a physician can only bill for laboratory services performed by the physician. If the laboratory services are performed by HCCL, only HCCL can bill Medicare or the patient.

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Another doctor sends his lab work to a laboratory other than HCCL. We both order similar tests for our patients, but are subject to different diagnosis requirements. Why?

Different independent laboratories may submit claims to different local Medicare carriers, based on the laboratories' geographic location or special arrangements. Unfortunately, HCFA has not yet implemented national limited coverage policies that apply uniformly to all local Medicare carriers. Local Medicare carriers develop their own limited coverage policies, which apply to different limited coverage tests and define different covered conditions even for the same limited coverage test. Therefore, physicians are subject to various inconsistent policies based upon the location of the laboratory and the carrier which processes the lab's claims.

HCFA has informed us that the carrier medical directors are aware of this lack of uniformity and are exploring ways to minimize differences. A carrier medical director workgroup has been established to develop model policies. To date, several draft model limited coverage policies have been developed. Once finalized, HCFA will distribute and recommend the use of these policies.

However, Information has come to the carriers that some providers are telling their clinical labs that these requirements are too prohibitive and that they'll take their business to another clinical lab where they don't require ABNs or ICD-9 codes. Medicare must obviously take exception. If another clinical lab truly is not requiring diagnosis codes from the physician, then one of two things is occurring:

1- The laboratory is billing, taking the denials as a loss, and hoping to make a profit with the provider's other tests. This is referred to as "inducement" and could constitute fraud under Medicare law.

2- The laboratory is plugging in payable diagnosis codes from the carrier's published local medical review policies. This is fraudulent activity on the part of the lab.

If you know that a clinical laboratory is practicing either of these two fraudulent activities, please call the fraud and abuse hotline at (800) 952-8627 or (800) HHS-TIPS.

I have my own physician office laboratory. How do the limited coverage policies affect me and my billing protocols?

Because laboratory and physician billing requirements may differ, HCCL is unfortunately not able to advise you on your billing operations. You should contact your local Medicare carrier for issues specific to your billing practice.

I have ordered a test for a Medicare patient for a diagnosis that is not included on the Medicare carrier's list of medically necessary ICD-9 codes. What should I do?

1- Supply HCCL with the ICD-9 code(s) which represents the diagnosis, symptom, complaint, condition or problem of the patient for the date of service and which are consistent with the information found in the patient's medical records. NEVER GIVE HCCL AN ICD-9 CODE THAT YOU THINK DOES NOT ACCURATELY REFLECT THE PATIENT'S DIAGNOSIS. This issue of whether Medicare reimburses HCCL for any service is not relevant - and in no way should influence - your assigning the proper ICD-9 code(s) for the ordered testing.

2- Check the patient's medical records to see if there are any other reasons why you ordered the test. Although a non-covered ICD-9 code may be an appropriate code, it may not be the only medically appropriate code. As stated in the HCFA coding guidelines, you should include all ICD-9 codes for any coexisting conditions that affect the treatment of the patient for that visit or procedure.

3- If you order the test solely for a non-covered ICD-9 code, please notify the patient that we will obtain his/her signature on an ABN prior to collection of the specimen.

4- If you believe Medicare should pay for the test when you order it for the particular non-covered ICD-9 code, please contact the Medicare carrier to add the non-covered ICD-9 code(s) to the carrier's list of medically necessary ICD-9 codes. All such requests, or other concerns about the medical implications of this approach to test utilization control or the policies in general, should be directed to the medical director of HCCL's Medicare carrier. Please contact HCCL for the name and address.

Do I need to supply HCCL with ICD-9 codes if I order a test that is not one of the tests impacted by a limited coverage policy?

YES! To avoid the need for you or your staff to keep track of the ever increasing number of different limited coverage policies imposed by more and more third party payors, we request that you provide all medically appropriate ICD-9 code(s) for each service ordered.

What ICD-9 code(s) do you need?

Only those ICD-9 codes that are medically appropriate for the patient's condition and consistent with the information found in the patient's medical records for the date of service.

How can I supply a diagnosis or an ICD-9 code if I do not yet have the lab results?

According to HCFA, you should provide the ICD-9 code(s) based on your judgment of the patient's diagnosis, symptom, complaint, condition or problem at the time the tests are ordered. If you review the listing of covered diagnoses, you can see that they address a broad spectrum of symptoms for which the limited coverage tests may be ordered.

Shouldn't HCCL be responsible for identifying which diagnosis matches the tests ordered?

NO!! Medicare requires that only the ordering physician determine the medical necessity of each ordered test. The physician ordering the test - not the laboratory - knows the patient's medical condition and history and has the training to make determinations of medical necessity. Accordingly, HCCL must rely on the ordering physician to provide the evidence of such medical necessity in the form of ICD-9 codes.

Can HCCL accept diagnosis information from the patient?

NO!! According to the HCFA coding guidelines, you should not code diagnoses documented in the patient's records as "probable, questionable, or rule out" as if they are established diagnoses. On the requisition you should code the condition(s) to the highest degree of certainty, such as symptoms or signs.

Can I provide the diagnosis narrative instead of an ICD-9 code? My staff doesn't have time to look up ICD-9 codes.

It is not possible for the lab personnel to translate narrative diagnosis into ICD-9 codes because the coding system is very specific and open to significant interpretation. Moreover, limited coverage tests are covered for specific ICD-9 codes that may not include a common narrative which is not specific enough.

The automated Medicare claims processing system is designed to edit specific covered ICD-9 codes. A verbal diagnosis would cause delays and interpretation errors that would result in a rejection. The lab would then have to disturb your office at a date much later than when you saw the patient to obtain additional information. Our objective is to process your work with the least amount of intrusion.

How specific should the diagnosis be?

According to HCFA coding guidelines, you should always code to the highest degree of specificity. This means coding the numerical code to the 4th or 5th digit and using multiple ICD-9 codes when medically appropriate. Three- digit codes should be used only when there are no four or five digit codes within a category. Four digit codes should be used only when there are no five digit codes within a category.

What ICD-9 code(s) should I use when I order a service as part of a routine screen?

According to the HCFA coding guidelines, if you order a service solely for routine screening purposes and there is no sign, symptom, or diagnosis indicative of the medical necessity of the test, you should report the service using one of the ICD-9 V codes. Please consult your ICD-9 manual for a complete listing of the V codes.