

## TALLAHASSEE MEMORIAL HEALTHCARE LABORATORY SERVICES

### **Annual Notice to Physician: Medical Necessity Guidelines**

**Date: January 1, 2017**

The Office of the Inspector General (OIG) of the Department of Health and Human Services has issued a Compliance Plan for Hospitals setting forth certain operational guidelines. Included in the OIG Compliance Plans are recommendations that hospital laboratories should provide annual notification to their clients on pertinent topics.

Please review the information being provided to you. Additional information can be obtained by contacting Janis Nall, Laboratory Director at 850-431-5818. The following Pathologists are also available at 850-431-5888 to assist you with laboratory testing including ordering and interpretation:

Dr. Kenneth Whithaus - Medical Director  
Dr. Nicole Balmer  
Dr. Jerry Harris  
Dr. Stephen Sarbeck  
Dr. David Stewart  
Dr. Stephen Sgan  
Dr. Marcus Fisher  
Dr. Christopher Price  
Dr. Ashton B. Byington  
Dr. Ronald P. Mageau

#### **Medical Necessity**

Medicare will pay only for tests that meet the Medicare coverage criteria and are “reasonable and necessary to treat or diagnose an individual patient”. Section 1862 (a) (1) (A) of the Social Security Act. Tests submitted for Medicare reimbursement must meet program medical necessity requirements or the claim will be denied. The list of tests that Medicare has developed specific National Coverage Determinations (NCD) can be accessed at: <http://www.cms.hhs.gov/mcd>.

The physician is responsible for ordering only those tests that is medically necessary for patient diagnosis and treatment. This includes any and all tests that are components of ordered panels. The physician is responsible to:

- document medical necessity for each test in the permanent patient medical record
- provide appropriate diagnostic information in the form of ICD-10 code(s) or narrative, with any test(s) for which you instruct us to seek Medicare reimbursement.
- assure the completion of an Advance Beneficiary Notice (ABN) in the circumstances outlined below:

## **ADVANCE BENEFICIARY NOTICES (ABN)**

Medicare can deny reimbursement for tests based upon absence of medical necessity, routine health screening, investigational use only tests and frequency limitations. An ABN signed by the patient prior to service is necessary to document that the patient is aware that Medicare might not pay for a test and that the patient has agreed to pay for the testing in the event that Medicare payment is denied.

- Medicare frequently denies claims for laboratory tests for the following reasons:
  - Medicare does not usually pay for this service for the diagnosis provided.
  - Medicare will not pay for research or investigational use tests.
  - Medicare does not pay for this service based on frequency limitations.
  - Medicare does not pay for most routine screening tests.
  - Medicare does not pay for annual physical exams.
- Any tests ordered that Medicare is likely to deny payment on, must be accompanied by an appropriately completed ABN. ABN's must be obtained **prior** to service being performed. If an ABN is necessary, a copy of the completed ABN must be sent to the laboratory with the test requisition and the specimen. Patient's presenting directly to outpatient collecting sites will be screened for the necessity of an ABN prior to phlebotomy.
- Each ABN must be specific to each laboratory test ordered. Each test must be accompanied by the specific reason that Medicare might not pay for the test.

### **Organ or Disease Oriented Panels**

Organ or Disease Oriented Panels (CPT codes 80048 – 80076) should only be ordered when all components in the panel are medically necessary.

### **Medicare Secondary Payer (MSP) Screening**

Medicare requires that all healthcare providers make a good faith effort and have procedures in place to ensure that Medicare is the primary payer.