New Medicare Policies for Clinical Diagnostic Laboratory Services

*On Friday, November 23, 2001 the "**FINAL RULE**" was published in the Federal Registry (Vol. 66, No 226), regarding a national payment policy for diagnostic laboratory services performed on outpatients. These rules and regulations are the result of almost two years of negotiated rulemaking between a committee on clinical diagnostic laboratory tests and the Center for Medicare and Medicaid (CMS). Some of these rules went into effect on February 21, 2002. The 23 National Medical Review Policies on test coverage are scheduled to go into effect on November 25, 2002. Local Medical Review Policies (LMRP) will apply only to tests not on the national list of tests, and may very well be non-existent for the state of Indiana.*

Purpose of the National Policy:

- Establish national coverage and administrative policies for services payable under Medicare Pt. B
  - Uniform procedures for handling claims (all Medicare Carriers/Intermediaries)
- Promote program integrity and national uniformity for medical review coverage:
  - Uniform frequency "limitations" for tests and services
  - No "Local Medical Review Policy" may conflict with national coverage policy
  - Establishes 23 national - test coverage decision determinations
  - Standard/uniform denial of claims
- Simplify administrative requirement for payment
  - Medicare may contact the physician directly regarding missing medical necessity documentation, even when the claim is submitted by another entity
  - Uniform definition of date of service (requires *collection date* on all specimens)
  - Appropriate use of procedure codes and modifiers
  - Uniform documentation and record keeping requirements

Medical Conditions for which a Test may be Reasonable and Necessary:

- Indiana University Health's Pathology Laboratory has provided a summary of the 23 National test coverage decision policies (includes all tests, acceptable ICD-9 codes/diagnosis, and the frequency limitations - copied from the Federal Register -Final Rule)
- It is estimated by American Clinical Lab Association (ACLA) that these *23 tests represent 43% of Medicare laboratory services and 51% of carrier laboratory payments*, so *it is imperative* that *ALL* necessary diagnosis codes, or diagnosis, condition/reason be supplied with all requests for any of the tests listed in the National Review policy. [*the 23 test policies represent more than 65 actual tests*]

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