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*)

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* ABN = Advanced Beneficiary Notice

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