



PARKVIEW HEALTH LABORATORIES

TRUSTED CARE

MEDICAL NECESSITY AND ADVANCE BENEFICIARY NOTICE GUIDE

This diagnosis code reference guide was compiled from the Federal Register NCD Final Ruling and the Indiana Medicare Part A Update Newsletters. This information is subject to change without notice. Parkview Health Laboratories *does not recommend any diagnosis codes and will only submit diagnosis information supplied to us by the ordering physician or his/her designated staff.*

Failure to list the correct diagnosis is one of the most frequent reasons for claim rejections. When submitting claims, the patient's diagnosis code must be reported to the *highest level of specificity* as listed in the latest edition of the ICD-9-CM.. Physicians frequently write in their patient's records a complete list of past diagnoses (post-cholecystectomy, post M.I., etc.) as a reminder and as a matter of thoroughness. Chronic diseases treated on an on-going basis should be coded and reported on the claim as many times as the patient received treatment and care for those conditions.

If the diagnosis is unknown, the physician should report the signs and symptoms related to the visit. For example, if a physician sees a patient who has symptoms of "dizziness and double vision" and starts a work-up to "rule out multiple sclerosis," the reason given for the visit should be "dizziness and double vision" an not "multiple sclerosis."

It is important to realize that one cannot use the results of a test to justify performance of a test. For example, if during an annual exam, the patient's blood sugar is reported elevated, the claim should not be submitted with the diagnosis of diabetes, but as a screening blood glucose. *Please contact your local Medicare Carrier for the latest guidelines concerning Medical Necessity.*

Medicare Limited Coverage Tests Covered Diagnosis Codes Reference Guide

Instructions

The lists of covered diagnosis codes for Medicare Limited Coverage Tests are provided as a guide for determining if the test is reimbursable by Medicare based on the patient's symptoms or medical condition (as indicated by the appropriate ICD code). Please note diagnosis codes are required for all Medicare orders to document medical necessity of the testing.

If the diagnoses you provide do not meet the reimbursement rules, or the frequency limit on test procedures has been exceeded, payment may be denied. In that case, Parkview Health Laboratories can only seek reimbursement from the patient. If they choose to have the test, the patient must sign and date an Advance Beneficiary Notice, confirming their understanding that they will be responsible for payment.

The lists and complete text of the National Coverage Decision and the Local Medical Review Policies are available in the Federal Register or the Medicare Part A Special Newsletters.

How to use this guide to comply with Medicare regulations:

1. Determine the diagnosis for the patient.
2. Write the diagnosis codes on the test requisition form.
3. Check the Table of Contents to determine if the test(s) ordered are on the list of Medicare Limited Coverage Tests. If the test is not listed no further action is required.
4. If the test is listed, turn to the appropriate page for the test and if the patient's diagnosis IS listed, no further action is required.
5. If the patient's diagnosis is not listed, inform the patient that payment for this service is likely to be denied and the reason for the denial (i.e.; medical necessity, Research Use Only Tests (RUO), or screening tests). *If the patient chooses to have the test, he/she must be asked to sign and date an Advance Beneficiary Notice (ABN). **This notice is provided on the second page of our Laboratory Requisition.***
6. Please note: if you do not know the ICD code for the patient's diagnosis, the Reference Guide lists the diagnoses in alphabetical order with corresponding ICD codes. If you do know the ICD code, there is a list of ICD codes in numerical order immediately following each list of narrative diagnosis for easy review.

Please provide all applicable ICD codes on the test requisition form (indicating the patient's symptoms or medical condition) with every Medicare, Medicaid, and Commercial insurance test order. Medical orders for Limited Coverage Tests with diagnosis not covered per the Medicare National Coverage Decision Policy or the carrier's Local Medical Review Policy must include a patient-signed Advance Beneficiary Notice (ABN) if the patient chooses to have the test.

Your cooperation in complying with the Medicare regulations and related test ordering procedures will eliminate the need for time-consuming follow-up contact to your office.



PARKVIEW HEALTH LABORATORIES

TRUSTED CARE

Preface

Provision of Diagnosis Information by Physicians and Non-Physician Practitioners

The Balanced Budget Act of 1997 requires that non-physician practitioners provide diagnostic codes for physician services they furnish on or after January 1, 1998. Currently, all physician specialties must use ICD-9-CM codes and must code to the highest level of specificity. Effective January 1, 1998, the same requirement was expanded to include non-physician practitioners. For purposes of this provision, non-physician practitioners include: physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, and clinical social workers.

In addition, effective for services furnished after January 1, 1998, this provision also requires that physicians and non-physician practitioners provide diagnostic information when ordering certain items or services furnished by another entity. Services affected by this provision include: equipment; prosthetic devices (other than dental); and leg, arm, back, and neck braces, and artificial legs, arms, and eyes.

Physicians and non-physician practitioners are required to provide diagnosis information (i.e., ICD-9-CM diagnosis codes) when ordering services that are furnished by another entity when there is a National Coverage Decision Policy or a Local Medical Review Policy in place requiring such diagnosis information from the entity performing the service. In the past, physicians ordering such services were not required by law to provide diagnosis information to the entity billing Medicare. Medicare took the position between suppliers/providers and their physician clientele. With the passing of the Balanced Budget Act, physicians and non-physician practitioners will now be required to provide this information to the entity furnishing the service at the time the service is ordered, if a policy exists requiring such diagnosis information from the entity performing the service.



PARKVIEW HEALTH LABORATORIES

TRUSTED CARE