



**Date:** 05/19/2023

**To:** Pacific Pathology Associates Client

**From:** Compliance Department

**Re:** 2023 Annual Notice to Physicians

Pacific Pathology Associates is providing annual notification to our clients of the Medicare policies governing the ordering and reimbursement of laboratory tests. Pacific Pathology Associates is committed to promoting awareness of and adherence to these policies. In accordance with the Office of the Inspector General's (OIG) Compliance Program Guide for Clinical Laboratories, we are providing the following information about Medicare requirements:

**CMS Medical Necessity Policy**

Medicare will only pay for tests that meet the Medicare definition of "medical necessity". Medicare may deny payment for a test that the physician believes is appropriate, such as a screening test, which does not meet the Medicare definition of medical necessity. All diagnosis and clinical relevance for patient treatment should be noted in the patient's chart.

The OIG takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal and administrative law.

Individuals who knowingly cause a false claim to be submitted to Medicare may be subject to sanctions or remedies available under civil, criminal and administrative law.

**CMS Signature Requirements**

According to CMS' guidance on laboratory services documentation requirements, unsigned requisitions alone do not support physician intent to order. Physicians should sign all orders for diagnostic services to avoid potential denials. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/LabServices-ICN909221-Text-Only.pdf>

**Medicare Laboratory National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)**

Coverage determination policies define medical conditions through the inclusion on a list of ICD (diagnosis) codes for which these tests are covered or reimbursed by Medicare. HIPAA regulations require ICD codes to be present on each claim filed. These codes must also be documented in the patient's medical record.

NCDs: <https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html>



LCDs: <https://med.noridianmedicare.com/web/jeb>

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### **Frequency Limitations for Laboratory Tests**

Certain laboratory tests have specific frequency limitation requirements. The limitations may apply to tests that are included in NCDs and LCDs.

### **Medicare Preventive Screening Laboratory Tests**

Certain preventive screening laboratory tests are covered services for Medicare beneficiaries. Benefit coverage is specific for each service, diagnosis codes, coverage requirements, and frequency limitations. <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html>

### **American Medical Association (AMA) Organ or Disease-Oriented Panels**

The AMA panels were developed for coding purposes only and should not be interpreted as clinical parameters. Organ and disease-oriented panels will only be paid by Medicare when all tests within the panel are deemed medically necessary by Medicare.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c16.pdf>

Section 90.2 – Organ or Disease Oriented Panels

In the case of custom test panels, all individual tests must meet medical necessity guidelines.

### **Reflex Testing**

Reflex testing occurs when initial test results indicate that a second related test is medically appropriate or required by state, regulatory, or accreditation standards. Most tests can be ordered without a reflex. Find details at <https://www.sonichealthcareusa.com/ap/testing-solutions/test-menu/>.

### **Advance Beneficiary Notice of Non-Coverage (ABN)**

- **Limited Coverage** -- An ABN is required if the diagnosis is not covered
- **Frequency Limit** -- An ABN is required at each encounter for frequency limited tests
- **Non-Coverage** -- An ABN is required for experimental or research use tests or tests designated by Medicare as non-covered

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>

Manual 100-04 Medicare Claims Processing Manual

Chapter 30 Financial Liability Protections

Section 50 Form CMS-R-131 Advance Beneficiary Notice of Non-Coverage (ABN)

### **Medicare Clinical Laboratory Fee Schedule (CLFS)**

Medicare reimbursement for laboratory CPT/HCPCS codes is located at.

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Laboratory-Fee-Schedule-Files>



Additional details can be found at PAMA regulations.  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/PAMA-Regulations.html>

*Medicaid reimbursement amount will be equal to, or less than, the amount of Medicare reimbursement.*

**Medicare Part B National Correct Coding Initiative (NCCI) Edits**

The Medicare NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment.

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

**Contact Information**

The Medical Directors and other pathologists are available to discuss appropriate testing and test ordering. Please call 503-561-5350 for assistance. You may also contact our Compliance Department at [APCompliance@sonichealthcareusa.com](mailto:APCompliance@sonichealthcareusa.com).

Please review this notice with all appropriate staff.

*Thank you for supporting **Pacific Pathology Associates**.*