
THE PATHOLOGY CENTER NEWSLETTER

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MEDICARE PART B WHAT'S NEW

This issue of The Pathology Center Newsletter will review the National Coverage Decisions (NCD's) for laboratory services and the New Advanced Beneficiary Notice.

MEDICARE COVERAGE CRITERIA

The federally funded Medicare Programs will only pay 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 states, "no payment may be made under Medicare Part A or B for any expenses incurred for items or services which are not reasonable

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ADVANCED BENEFICIARY NOTICE

The Advanced Beneficiary Notice (ABN) will alert the patient that they are responsible for any Part B laboratory service in the event that Medicare denies payment. The Medicare program will only allow the laboratory to bill the patient for denied services if an ABN has been completed and signed by the patient before laboratory testing. Effective October 2002 there are two standardized forms CMS-R-131-G for general use and CMS-R-131-L for laboratory testing. The use of these forms is mandatory for submitting claims for Medicare reimbursement. Your customized or modified ABN's will probably not protect you from financial liability. The new forms can be downloaded from the CMS website at <http://cms.hhs.gov/medicare/bni>

At least two copies of the ABN are required. The original is retained by the provider and a copy given to the patient. We ask that you have patients sign an ABN if it is likely that

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Medicare Coverage Criteria

and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.” Twenty three new National Coverage Decisions (NCD’s) for common lab tests become effective November 25th. The NCD’s will apply to all Medicare carriers including the fiscal intermediaries. The Local Medical Review Polices (LMRP’s) will be in effect if there is an item that conflicts with the NCD. The NCD’s will limit and define the diagnosis (ICD-9) codes that will support medical necessity for a laboratory test. You can access the NCD’s through our fiscal intermediary (Mutual of Omaha) on the website at www.mutualmedicare.com/medicare/lmrp. A claim submitted without a diagnosis code that indicates medical necessity based upon the NCD criteria will result in denial of payment for those services. The diagnosis may be an ICD-9 code or a comparable narrative. If the diagnosis has not been established, descriptive codes for signs and symptoms may be reported.

Medicare does not cover tests for routine examination with no specific signs, symptoms or diagnosis present. Medicare does not cover general screening tests. However, there are some screening tests that Medicare will pay for within a specific timeframe. Frequency limits are published in Medicare bulletins, and this newsletter explains some of the testing limitations.

Medicare does not cover tests ordered because of family history if there are not signs or symptoms to suspect a diagnosis. Diagnoses documented as “probable”, “suspected”, “questionable”, or “rule out” are not adequate for reimbursement under Medicare. Medicare is likely to deny tests that are not FDA approved (experimental or investigational).☼☼

FREQUENCY LIMITS

There are a number of frequency limits in the NCD’s that define how often a test can be ordered. They apply to lipid panel, CA-125, collagen crosslink, GGT, glucose, hemoglobin A1C, hCG, iron studies, PSA, PT and thyroid tests.

LIPID TESTING

The lipid testing frequency has several different limits depending on the patients condition. The following is allowed:

- ◆ For monitoring long term anti-lipid dietary or pharmacologic therapy or following patients with borderline high total or LDL cholesterol levels: lipid panel every 12 months.
- ◆ For interim visits if a patient does not have elevated triglycerides: total cholesterol as medically necessary.
- ◆ For monitoring dietary or pharmacologic therapy during the first year: total cholesterol OR triglycerides, OR HDL cholesterol, OR direct measured LDL cholesterol every 2 months.
- ◆ For marked elevations or changes to anti-lipid therapy due to inadequate initial patient response to dietary or pharmacologic therapy: total cholesterol, OR triglycerides, OR HDL cholesterol, OR direct LDL more frequently than every 2 months

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- ◆ After treatment goals have been achieved: total cholesterol OR direct measured LDL cholesterol every 4 months.
- ◆ For evaluating non-specific chronic liver abnormalities: lipid panel every 6 months
- ◆ No dietary or pharmacological therapy: monitoring is not necessary.

As you will notice in the outline of limits, the use of the direct LDL measurement has replaced the lipid panel to follow patients on lipid lowering regimens. The Pathology Center does not perform direct measured LDL in-house. If the direct LDL is the choice for monitoring lipid therapy, the test will be sent to our reference laboratory. ☼☼

SCREENING PSA

Total PSA for prostate cancer screening: frequency limits are:

- ◆ Once a year for males over age 50 in the absence of signs and symptoms.
- ◆ For patients with lower urinary tract signs or symptoms, the test is performed only once per year unless there is a change in the patient's medical condition.

Please indicate on the requisition if you are sending a screening PSA. This requires a specific HCPS code (G0103). ☼☼

For Your Information

The average overall turn-around-time for Pap Smears and surgical biopsies at The Pathology Center for the month of October was 2 days.

Medicare will not cover the laboratory test(s). You may attach a copy of the ABN to the requisition or you may write "GA" after the ICD-9 code or narrative diagnosis.

If Medicare denies the service and an ABN has not been completed, we will be unable to recoup our costs and at some point may have to consider billing these services back to your facility.

Once the beneficiary signs the ABN, we may bill the beneficiary directly if Medicare denies the service. ☼☼

TIPS ON COMPLETING AN ABN

- ◆ Do not have all Medicare Beneficiaries sign an ABN. Only have an ABN signed if there is likelihood that Medicare will deny the laboratory tests. (ABN's may be routinely given in certain circumstances such as services that are always denied for Medical Necessity, tests that are for research and investigational use only, and certain frequency limited tests.)
- ◆ Make sure the beneficiary understands the language of the ABN and receives a copy of the signed ABN.
- ◆ Do not have the beneficiary sign a blank ABN. Complete all boxes and signatures before testing is begun.
- ◆ If a beneficiary refuses to sign the ABN but demands the service, the provider should annotate the ABN and have the annotation witnessed, indicating the circumstances and persons involved. ☼☼

PLEASE NOTE

Cell Surface Markers/Chromosome Analysis, Leukemia or Lymphoma Panels should only be drawn and sent to The Pathology Center Monday – Thursday. The tests are not normally performed on the weekend and can not be held more than 24 hours. If the test has to be drawn on Friday, please call Client Services to arrange testing.

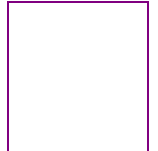
ODDS AND ENDS

- ❖ In an announcement issued June 12, the Occupational Safety and Health Administration (OSHA) prohibits the reuse of blood tube holders.



- ❖ Please change the specimen requirements for IgE in The Pathology Center Test Directory. The new requirements are : FROZEN SERUM. Refrigerated or room temperature specimens are not acceptable.

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ADDRESS CORRECTION REQUESTED

