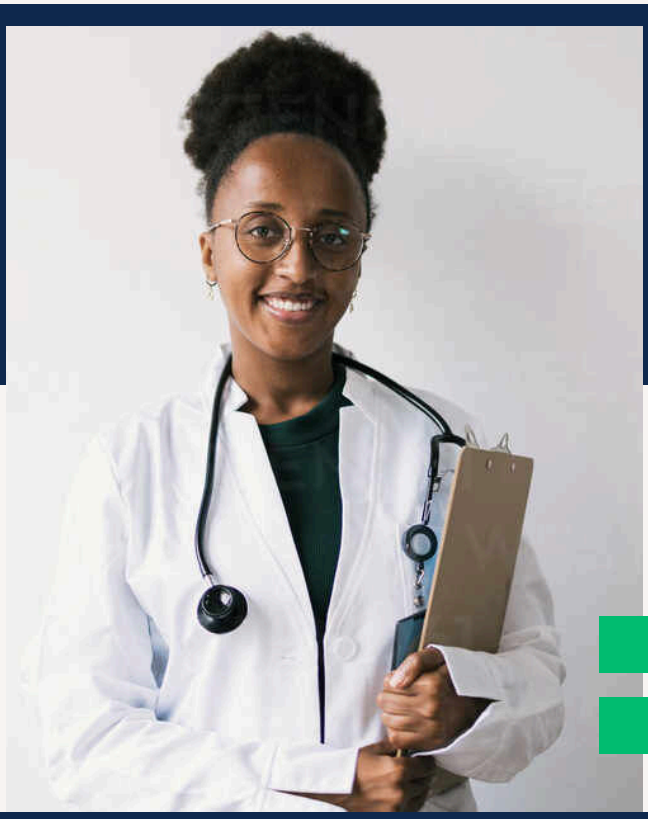
MED-LAKE LABORATORY NEWSLETTER

Quarter 2
Spring 2024

Medical Necessity

Section 1862(a)(1)(A) of the Social Security Act states that Medicare will not cover services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” Claims submitted to Medicare and private payers must meet the medical necessity requirements defined by each payer. Though the definition of medical necessity may have differences from payer to payer, the main idea is the same.

Payment for testing may be denied, even if a provider deems it necessary, if documentation and coding does not deem the test medically necessary. The responsibility of the provider is to ensure that submitted claims have proper documentation for medical necessity. A provider should only order laboratory tests that are reasonable and medically necessary for the diagnosis and treatment of the patient.



Individualized Testing

Physicians are responsible for individualizing drug test orders to each patient and the clinical laboratory must do its part to facilitate physician choice and individualized test orders. Most payors “non-cover” the physician’s use of a single custom test panel/profile for all patients. Such orders are often defined as “blanket orders” or “routine standing orders”. Many payors take the position that a physician’s use of a single custom profile does not reflect proper individualization of testing needs based on individual patient history and past drug test results.

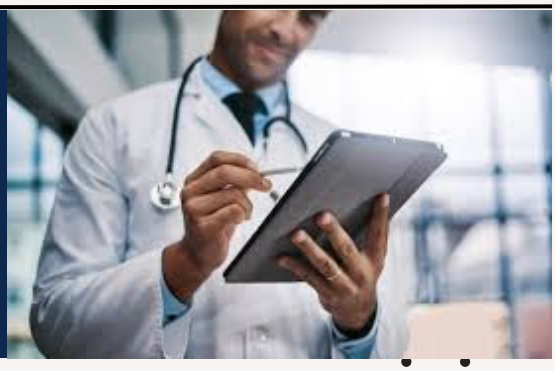
Test Ordering Documentation

Patient Specific Requirements:

- First and Last Name
- Date of Birth
- Address and Phone Number
- Current Insurance Provider and ID Number
- Provider Signature/Order Date

Test Specific Requirements:

- Clearly Marked Test
- Proper ICD10 Codes
- Collection Date
- Fasting Indicated (Blood)
- Medications Checked or Listed (Tox)



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