Medical Necessity

The Medicare and Medicaid programs, as well as some commercial insurance plans, cover only tests necessary for the diagnosis and treatment of the patient. Medicare and Medicaid generally do not cover routine screening tests, experimental or research tests, or tests that exceed Medicare's frequency guidelines.

Physicians should order only those tests that are medically necessary. Components of organ and disease panels developed by the American Medical Association (AMA) for coding purposes are listed in this reference manual as well as on the back of the TriHealth Laboratory requisitions. Any test may be ordered individually at any time.

- **Providing Diagnosis (ICD-9) Codes for Laboratory Tests**

  A diagnosis code (ICD-9) for each test ordered must be provided by the physician based on the patient's medical record. Each code should reflect the medical necessity of the test ordered. The laboratory cannot assign ICD-9 codes.

- **Advance Beneficiary Notice (ABN)**

  Medicare will pay only for services that it determines are reasonable and necessary for the diagnosis or treatment of an illness or injury. See section 1862(a)(1)(A) of the Social Security Act of 1965. Each test or panel should be medically necessary and must be accompanied by an appropriate ICD-9 code.

  It is the provider's responsibility to inform the patient of any test for which Medicare is likely to deny payment. The patient should be informed before the specimen is collected.

  Before the laboratory can perform the test, the patient must sign the Advance Beneficiary Notice (ABN) indicating that he/she has been informed

  1. that Medicare is likely to deny payment,
  2. the reason payment is likely to be denied, and
  3. that he/she will be fully and personally responsible for payment if Medicare denies payment.