TRICORE REFERENCE LABORATORIES

PREAUTHORIZATION AND MEDICAL NECESSITY

Delivering high quality patient care can include testing for which insurance plans require preauthorization and proof of medical necessity. Most insurances follow the medical necessity guidelines from The Centers for Medicare & Medicaid Services (CMS) for their commercial plans. As healthcare reimbursement becomes more complex, it is hoped that the following information and accompanying *Annual Provider Notice* will assist with the process.

- Preauthorization paperwork must be completed by the ordering provider's office prior to submission of lab orders.
- The medical necessity of each test ordered must be documented in the patient's chart/medical record, signed by the ordering provider, and reflect any/all coding submitted on the lab order. Payers are reviewing provider's chart notes to ensure documentation and diagnosis before payment is provided to the lab.
- The ordering provider is responsible for obtaining a properly completed Advance Beneficiary Notice (ABN) if collecting specimens for testing from the Medicare beneficiary.
- The CMS Medicare ABNs may not be presented to Medicare Advantage Plan patients. Providers may see these tests on their client bill when supplied codes do not meet medical necessity or they do not provide additional information for the patient's Medicare insurance to pay for the ordered tests.
- If the laboratory receives an order without diagnosis information, or is unable to bill for testing performed because the coding supplied does not meet medical necessity requirements, we will attempt to contact the ordering provider to gather additional coding information that may have been documented in the patient's chart but was not noted on the original lab order. The laboratory will not assign diagnosis codes. If a response is not received, or medical necessity requirements are not met, claims may be billed back to the provider account.
- In the event the provider determines that a patient needs to be removed from the provider's invoice and billed to a third party insurance, the provider will provide valid diagnosis (ICD-10) codes to support medical necessity of the laboratory tests ordered, medical records to support the diagnosis codes provided, and a prior authorization number when appropriate. *The account will only be billed to the insurance if it is within the patient's insurance Timely Filing.*
- Effective January 6, 2014, CMS instructed the Medicare Administrative Contractors to turn on edits to deny claims for services ordered by providers who have not enrolled their National Provider Identifier (NPI) in the CMS internet based Provider Enrollment Chain and Ownership System (PECOS).
- If the ordering provider is not registered with PECOS, charges are billed to the provider. The provider must furnish TriCore a copy of the PECOS approval letter to have accounts removed from the provider's statement before we can resubmit a claim to the Medicare insurance. *The account will only be billed to the insurance if it is within the patient's insurance Timely Filing.*
- To order testing for a Medicaid recipient, CMS and the State of New Mexico require a provider to be enrolled in Medicaid (Section G of State of New Mexico Medical Assistance Program Manual Supplement 17-08). Claims will be denied for testing ordered by a non-registered provider and will be billed back to the ordering provider.