Local Coverage Determination
Coding Guidelines

Contractor Name
Wisconsin Physicians Service (WPS)

Contractor Number
00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302, 05402, 52280

LCD Title
Vitamin D Assay Testing

LCD Database ID Number

Contractor's Determination Number
PATH- 032

CMS Regulations

A. **Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services**
80.6 - Requirements for Ordering and Following Orders for Diagnostic Tests

B. **Limitation of Liability**

1. Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.
Notice to beneficiaries related to discharge and coverage notification, as described in CMS Publication 100-04, **Medicare Claims Processing Manual, Chapter 1, Sections 60 – 60.1.1,** applies.
Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:
- not medically necessary;
- not delivered in the most appropriate setting; or
- custodial in nature.

2. Advance Beneficiary Notice of Non coverage (ABN) Modifier Guidelines (for outpatient services):
An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons. Refer to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, revised 09/05/2008, for complete instructions.

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.

The –GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a specific service as not reasonable and necessary and they **do have** an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary or Part A MAC, occurrence code 32 and the date of the ABN is required.
The –GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an ABN signed by the beneficiary.
If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

Coding Guidelines

A. General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC:

1. Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

2. For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

3. A claim submitted without a valid ICD-9-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act. The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.

4. For outpatient settings other than CORFs, references to "physicians" throughout this policy include nonphysicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care for Vitamin D Assay Testing services as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

B. **For claims submitted to the fiscal intermediary or Part A MAC:**

Bill type codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Hospital Inpatient Claims:

1. The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. *The principal diagnosis is the condition established after study to be chiefly responsible for this admission.*
2. *The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they coexisted at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.*
3. For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 25, Section 75 for additional instructions.)

Hospital Outpatient Claims:

1. *The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67.* If no definitive diagnosis is made during the outpatient evaluation, the patient's symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider *should report an ICD-9-CM code for Persons Without Reported DiagnosisEncountered During Examination and Investigation of Individuals and Populations (V70-V82).*

2. *The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that coexisted in addition to the diagnosis reported in FL 67.*

C. **For claims submitted to the carrier or Part B MAC:**

1. All services/procedures performed on the same day for the same beneficiary by the physician/provider should be billed on the same claim.

2. Claims for Vitamin D Assay Testing services are payable under Medicare Part B in the following places of service: office (11), independent clinic (49), Federally Qualified health Center (50) and independent lab (81).

Original Determination Effective Date
12/15/2010

Revision History Number/Explanation