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NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Spring 2025 Virtual Conference

Understanding Medicare Compliance for Part B Providers

Laboratory Part B Billing

6/4/2025

NGSMU
NGS Medicare University

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Provider Outreach and Education Consultants
  - Carleen Parker
  - Nathan L. Kennedy, Jr., CHC, CPC, CPPM, CPC-I, CPB, CPMA

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Objective

Our objective for today's laboratory billing is to review codes and policies around the codes so providers bill laboratory appropriately, improve revenue and decrease appeals administrative burden

Agenda

- Introduction and Overview
- Clinical Laboratory Improvement Act (CLIA)
- CPT/HCPCS Codes
- Modifiers
- National Coverage Determinations (NCD) via Medicare Coverage Database (MCD)
- Medically Unlikely Edits (MUEs)
- National Correct Coding Initiative (NCCI)
- Screening/Preventive Lab Services
- Specimen Collections
- Resources and References

Introduction and Overview

Introduction

- Clinical Laboratory Services
  - Involve examination of samples obtained from human body for interpretation of medical condition and to make decision for its prevention, diagnosis, and treatment
- Diagnostic Laboratory Services
  - Diagnostic lab services are different from simple clinical tests
  - Clinical tests require pathologist and lab technician to run and interpret samples whereas, diagnostic tests require physician or other certified professional to perform them
- Approved to provide specific type of test being performed
- Ordered promptly by physician/NPP treating patient
- Services are reasonable and necessary

Overview

- For laboratory services to be covered, services must be related to patient's illness or injury (or symptom or complaint) and ordered by physician/NPP
- Outpatient clinical laboratory services are
  - Paid on Clinical Laboratory Fee Schedule
  - Participating laboratory
  - Ordered by physician or qualified nonphysician practitioner
- Must accept assignment
- Neither annual deductible nor 20% coinsurance applies to
  - Clinical laboratory tests performed by a physician, laboratory, or other entity paid on an assigned basis
  - Specimen collection fees
  - Travel allowance related to laboratory tests (e.g., collecting specimen)

Laboratories

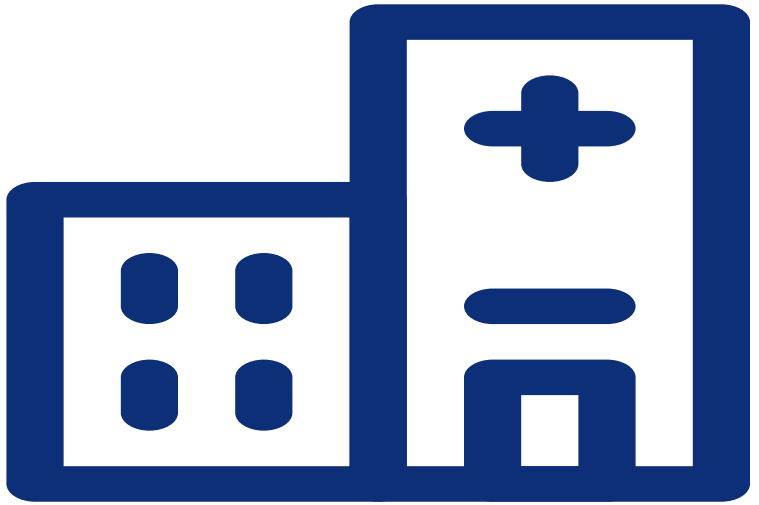
- When working with primary physician, there may be some amount of lab testing
- If physician's office has a certified lab, then providers may bill for significant number of lab procedures including E/M services
- Diagnostic laboratory test is considered laboratory service for billing purposes, regardless of whether it is performed in
  - Physician's office,
  - Independent laboratory
  - Hospital laboratory for inpatient or outpatient

Lab Written Orders

- All tests must have written order on file
- Physician/NPP should clearly indicate all tests to be performed
- Unsigned physician/NPP orders or unsigned requisitions alone don't support physician intent to order
- Authenticated medical record supporting intent to order specific tests
- Sign all orders for services to avoid potential denials
- MLN® Fact Sheet *Complying with Laboratory Services Documentation Requirements*

Place of Service

- POS designation identifies location where laboratory specimen was collected
  - Independent Laboratory or Reference Laboratory
    - POS 81
  - Office/clinic
    - POS 11
  - Facility setting
    - POS 21 or 22



Ordering and Referring Services

- To qualify as an ordering and certifying provider
  - Must have an individual National Provider Identifier
  - Be enrolled in Medicare either an “approved” or an “opt-out” status
  - Be of an eligible specialty type
- If currently enrolled as Medicare Part B provider, you can order and certify
- Referring/ordering must be in PECOS Ordering & Certifying

Clinical Laboratory Improvement Amendments (CLIA)

CLIA

- CLIA mandates and regulates laboratories that test patient specimens and ensures laboratories produce accurate and reliable test results
- When laboratory undergoes inspection and is found in compliance with all applicable CLIA requirements, it is typically issued a CLIA certificate
- Certificate verifies laboratory meets all federal standards for quality and safety in laboratory testing
- Type of CLIA certificate issued can vary based on the complexity of tests laboratory is authorized to perform, such as a Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation
- Certificates help ensure and validate the reliability, accuracy, and timeliness of patient test results

CLIA Types and Definitions

- Type 1- Certificate of Compliance
  - Issued to laboratory after an inspection that finds laboratory in compliance with all applicable CLIA requirements
- Type 2- Certificate of Waiver
  - Issued to laboratory to perform only waived tests
- Type 3- Certificate of Accreditation
  - Issued to laboratory on basis of laboratory's accreditation by accreditation organization approved by CMS
- Type 4- Certificate for Provider-Performed Microscopy Procedures
  - Issued to laboratory in which physician, midlevel practitioner or dentist performs no tests other than the microscopy procedures
  - Permits laboratory to also perform waived tests
- Type 9- Certificate of Registration
  - Issued to laboratory that enables entity to conduct moderate or high complexity laboratory testing or both until entity is determined by survey to be in compliance with CLIA regulations
- To obtain further information, you may contact your Clinical Laboratory Improvement Amendments (CLIA) State Agency Contacts

Laboratory Certification Responsibilities (not all inclusive)

- CMS via States
  - Issues laboratory certificates
  - Collects user fees
  - Conducts inspections and enforces regulatory compliance
  - Publishes CLIA rules, regulations, and guidance
- FDA
  - Categorized tests based on complexity
  - Reviews requests for CLIA Waiver by Application
  - Develop rules/guidance for CLIA complexity categorization
- CDC
  - Provides analysis, research, and technical assistance
  - Conducts laboratory quality improvement studies
  - Develops and distributes professional information and educational resources
  - Manages the Clinical Laboratory Improvement Advisory Committee

Clinical Lab Improvement Amendment Waived

- Waived laboratories must
  - Enroll in the CLIA program
  - Pay applicable certificate fees every two years
  - Follow manufacturer's test instructions
  - Enter CLIA in item 23
- Clinical Laboratory Improvement Amendments (CLIA)
- MLN Matters® *MM13959: HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: April 2025*

CPT/HCPCS Codes

Path and Lab Services 80047-84999

- 80047-80081 Organ or Disease Oriented Panels
- 80143-80299 Therapeutic Drug Assays
- 80305-80377 Drug Assay Procedures
- 80400-80439 Evocative/Suppression Testing Procedures
- 80503-80506 Clinical Pathology Consultations
- 81000-81099 Urinalysis Procedures
- 81105-81408, 81479 Molecular Pathology Procedures
- 81410-81471 Genomic Sequencing Procedures and Other Molecular Multi analyte Assays
- 81490-81599 Multi analyte Assays with Algorithmic Analyses
- 82009-84999 Chemistry Procedures

Path and Lab 85002-89398 and 0001U-0520U

- 85002-85999 Hematology and Coagulation
- 86000-86849 Immunology
- 85850-86999 Transfusion Medicine
- 87003-87999 Microbiology
- 88000-88099 Anatomic Pathology
- 88104-88199 Cytopathology
- 88230-88299 Cytogenetic Studies
- 88300-88399 Surgical Pathology
- 88720-88749 In Vivo (Transcutaneous) Lab Procedures
- 89049-89240 Other Procedures
- 89250-89398 Reproductive Medicine Procedures
- 0001U-0520U Proprietary laboratory Analyses

Modifiers

Modifier 90

- Modifier 90: outside lab
  - Diagnostic tests subject to anti-markup price limitations
  - Anti-markup rule price limitation for diagnostic services (technical and professional components) that are ordered by physician and provided by third party
  - Test(s) either purchased from an outside provider or conducted outside of physician's usual practice setting
  - Providers cannot mark up charge(s) over actual cost of test
- Anti-markup rule for claim submissions
  - Line item 19, 20, and 32 or electronic equivalent must reflect amount and place where test was performed
- Documentation
  - Shall show outside entity
- Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) *Medicare Claims Processing Manual, Publication* 100-04, Chapter 1, Section 30.2.9 and Chapter 13, Section 20.3

Modifier 91

- Modifier 91: repeated lab
  - If patient requires multiple blood glucose level checks throughout day to manage insulin dosing, each test after first would be reported using same CPT code but with modifier 91 appended
  - This ensures billing reflects medical necessity of each test as part of patient care
- Repeated lab procedures
  - Same day
  - Medically necessary
- Claim submissions
  - Line item 24D or electronic equivalent appended after code
- Documentation
  - Shall indicate how many done that day
- CMS IOM *Medicare Claims Processing Manual*, Publication 100-04, Chapter 23, Section 20.9.1.1 (C)

Modifiers 59, XE, XS, XP, XU

- Distinct Procedural Services
  - Used to indicate distinct laboratory services when reported by same physician/NPP
  - Indicates that two or more procedures performed on same day, but separate and distinct, and not part of same service
- Claim Submissions
  - Line item 24D or electronic equivalent appended after laboratory code
- Documentation
  - Shall show what made services distinct from other services
- CMS IOM *Medicare Claims Processing Manual*, Publication 100-04, Chapter 23, Section 20.9.1.1 (B)
- MLN® Booklet *Proper Use of Modifiers 59, XE, XP, XS & XU*
- Examples of Appropriate and Inappropriate Use

Distinct Procedural Modifiers XE

- CMS allows modifiers XE on Column 1 or Column 2
- We define these modifiers as follows
  - XE- Separate encounter, distinct because it occurred during **separate encounter**
    - Different organs
    - Different anatomic regions
    - Performed during **different patient encounters** on the same day that can't be described by more specific modifiers, RT, LT, E1–E4, FA, F1–F9, TA, T1–T9, LC, LD, RC, LM, RI, 24, 25, 27, 57, 58, 78, 79, or 91
- MLN® Booklet *Proper Use of Modifiers 59, XE, XP, XS & XU*
  - Examples of Appropriate and Inappropriate Use

Distinct Procedural Modifiers XS

- CMS allows modifiers XS on Column 1 or Column 2
- We define these modifiers as follows
  - XS- Separate structure, performed on a separate organ/structure, **same encounter**
    - Different organs
    - Different anatomic regions
    - Only use for different anatomic sites during **same encounter** only when procedures which aren't ordinarily performed or encountered on same day
    - Can't be described by modifiers, 24, 25, 27, 57, 58, 78, 79, or 91, RT, LT, E1–E4, FA, F1–F9, TA, T1–T9, LC, LD, RC, LM, or RI
- MLN® Booklet *Proper Use of Modifiers 59, XE, XP, XS & XU*
  - Examples of Appropriate and Inappropriate Use

Distinct Procedural Modifier XP

- CMS allows modifiers XP on Column 1 or Column 2
- We define these modifiers as follows
  - XP- Separate practitioner, service that is distinct because it was **performed by a different practitioner**
- Related CR 11168 *Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP and XU Involving the NCCI PTP Column One and Column Two Codes*
- MLN® Booklet *Proper Use of Modifiers 59, XE, XP, XS & XU*
  - Examples of Appropriate and Inappropriate Use

Distinct Procedural Modifier XU

- CMS allows modifiers XU on Column 1 or Column 2
- We define these modifiers as follows
  - XU- Unusual Non-Overlapping service, use of service that is distinct and **does not overlap usual components of main service**
    - Diagnostic procedure that occurs after completed therapeutic procedure only when diagnostic procedure isn't common, expected, or necessary follow-up to therapeutic procedure
- MLN® Booklet *Proper Use of Modifiers 59, XE, XP, XS & XU*
  - Examples of Appropriate and Inappropriate Use

Modifier LR

- Modifier LR- round trip
  - Laboratories submit HCPCS modifier LR as informational purposes only to indicate "Round Trip"
  - When using HCPCs code P9604; travel allowance, prorated trip charge
- Claim Submissions
  - Line item 24D or electronic equivalent appended after code
- CMS IOM *Medicare Claims Processing Manual,* Publication 100-04, Chapter 16 - Laboratory Services

Modifier QP

- Test ordered individually
  - QP modifier for single ordering of tests or when single code is available for groupings of tests
  - QP modifier indicates that documentation is on file showing laboratory test(s) was ordered individually or ordered as a CPT-recognized panel
  - Physician may order mix of panels and individual tests, but physician should review what tests are in each panel and not order individual tests that duplicate tests in panel
- Claim Submissions
  - Line item 24D or electronic equivalent appended after code
- CMS IOM *Medicare Claims Processing Manual*, Publication 100-04, Chapter 16 - Laboratory Services
  - Table of Chemistry Panels

Modifier QW

- CLIA waived
  - QW mandatory modifier
  - Not all CLIA-waived tests require modifier QW
  - Tests granted waived status under CLIA
  - CMS identifies CLIA waived tests by providing an updated list of waived tests on quarterly basis
  - All claims submitted for laboratory tests subject to CLIA are edited at CLIA certificate level
  - Always check CMS waived test list to ensure code requires QW
- Claim Submissions
  - Line item 23 or electronic equivalent
  - MLN Matters® *MM13546: New Waived Tests*
- Tests Granted Waived Status Under CLIA

National Coverage Determinations via Medicare Coverage Database

2025 Quarterly Releases

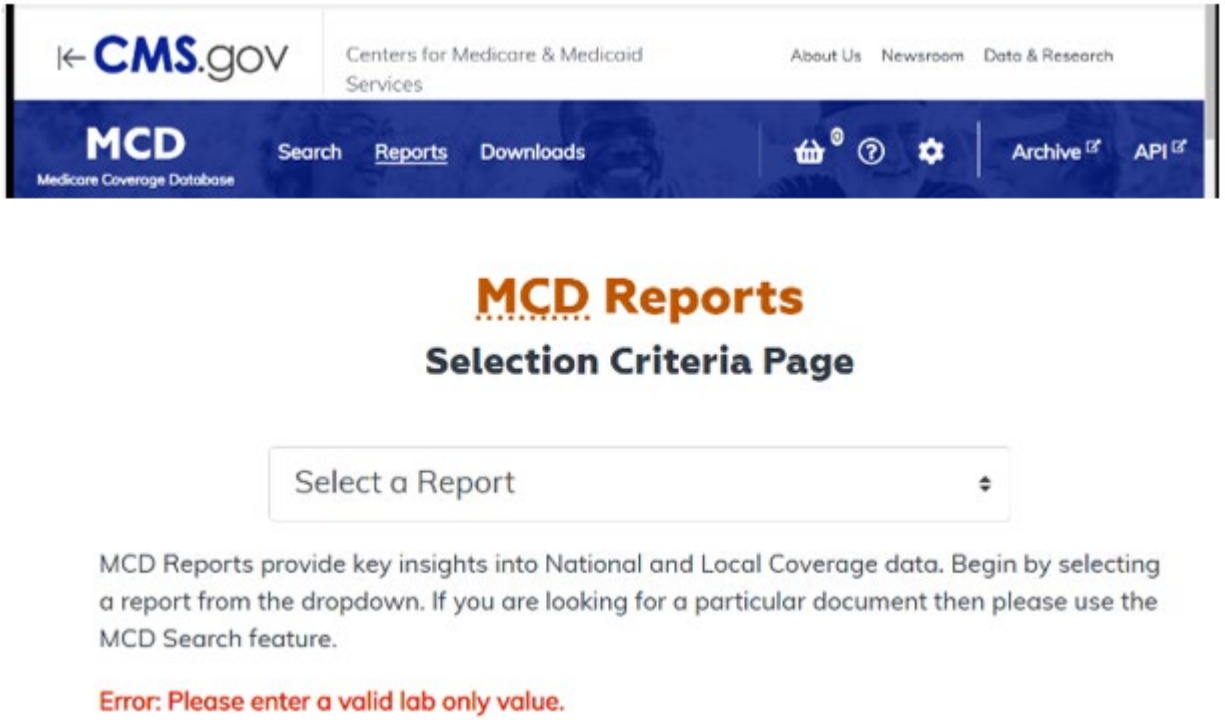
- National Coverage Determinations for clinical diagnostic laboratory services were developed by laboratory negotiated rulemaking committee
- Nationally uniform software was developed and incorporated in Medicare's shared systems, so laboratory claims subject to one of 25 NCDs
- CMS IOM, *Medicare National Coverage Determinations (NCD) Manual,* Publication 100-03, Chapter 1, Part 3, Sections 190.12 - 190.34
- Previous NCD ICD-10 coding changes and NCD spreadsheets for CR 13350 Enhancements to Home Health Consolidated Biling Edits are available

National Laboratory NCD Coding

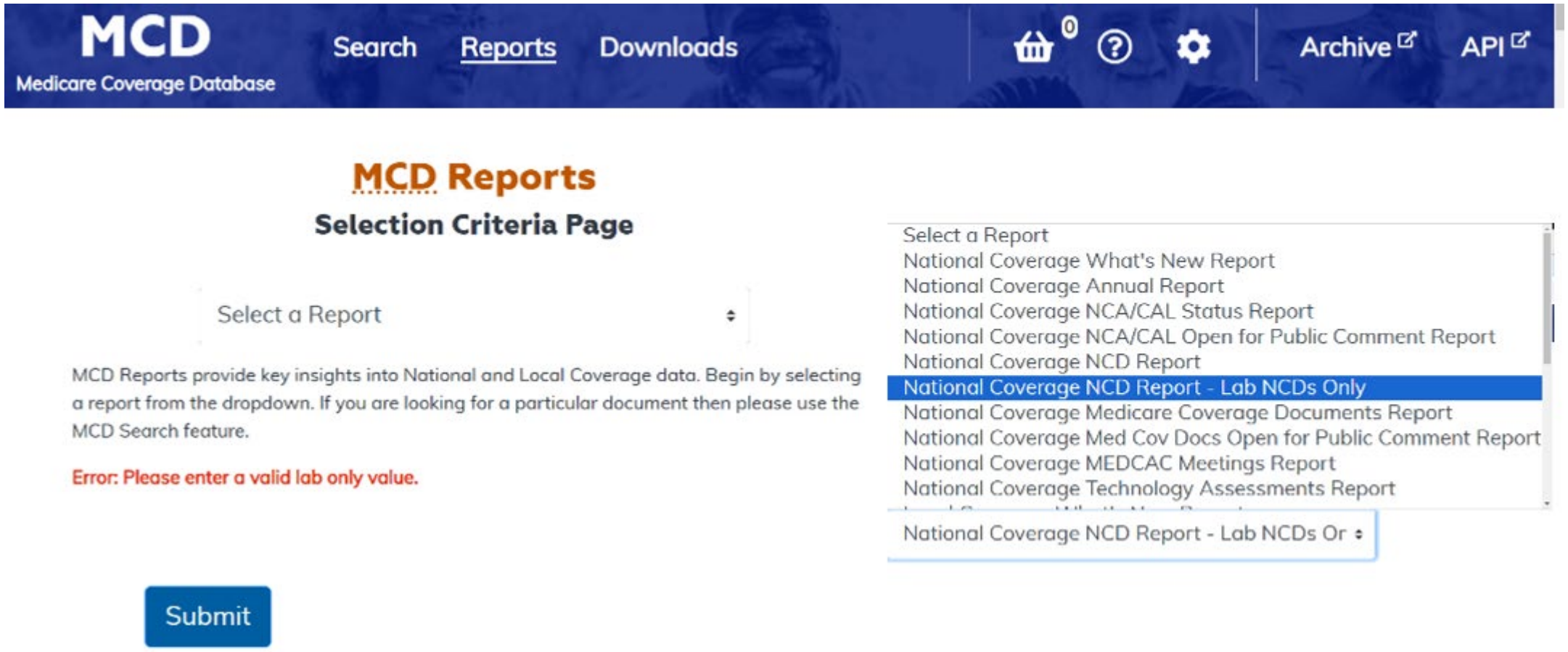
- NCD 190.12-Urine Culture, Bacterial
- NCD 190.13-Human Immunodeficiency Virus (HIV)Testing (Prognosis Including Monitoring)
- NCD 190.14–Human Immunodeficiency Virus (HIV) Testing (Diagnosis)
- NCD 190.15–Blood Counts
- NCD 190.16–Partial Thromboplastin Time (PTT)
- NCD 190.17–Prothrombin Time (PT)
- NCD 190.18–Serum Iron Studies
- NCD 190.19–Collagen Crosslinks, Any Method
- NCD 190.20A–Blood Glucose Testing
- NCD 190.20B–Blood Glucose Testing
- NCD 190.21–Glycated Hemoglobin/Glycated Protein
- NCD 190.22–Thyroid Testing
- NCD 190.23A–Lipids Testing
- NCD 190.23B-Lipids Testing
- NCD 190.24–Digoxin Therapeutic Drug Assay
- NCD 190.25–Alpha-fetoprotein
- NCD 190.26–Carcinoembryonic Antigen
- NCD 190.27–Human Chorionic Gonadotropin
- NCD 190.28–Tumor Antigen by Immunoassay CA 125
- NCD 190.29–Tumor Antigen by Immunoassay CA 15-3/CA 27.29
- NCD 190.30–Tumor Antigen by Immunoassay CA 19-9
- NCD 190.31–Prostate Specific Antigen
- NCD 190.32–Gamma Glutamyl Transferase
- NCD 190.33-Hepatitis Panel/Acute Hepatitis Panel
- NCD 190.34–Fecal Occult Blood Test

How to Use the Medicare Coverage Database

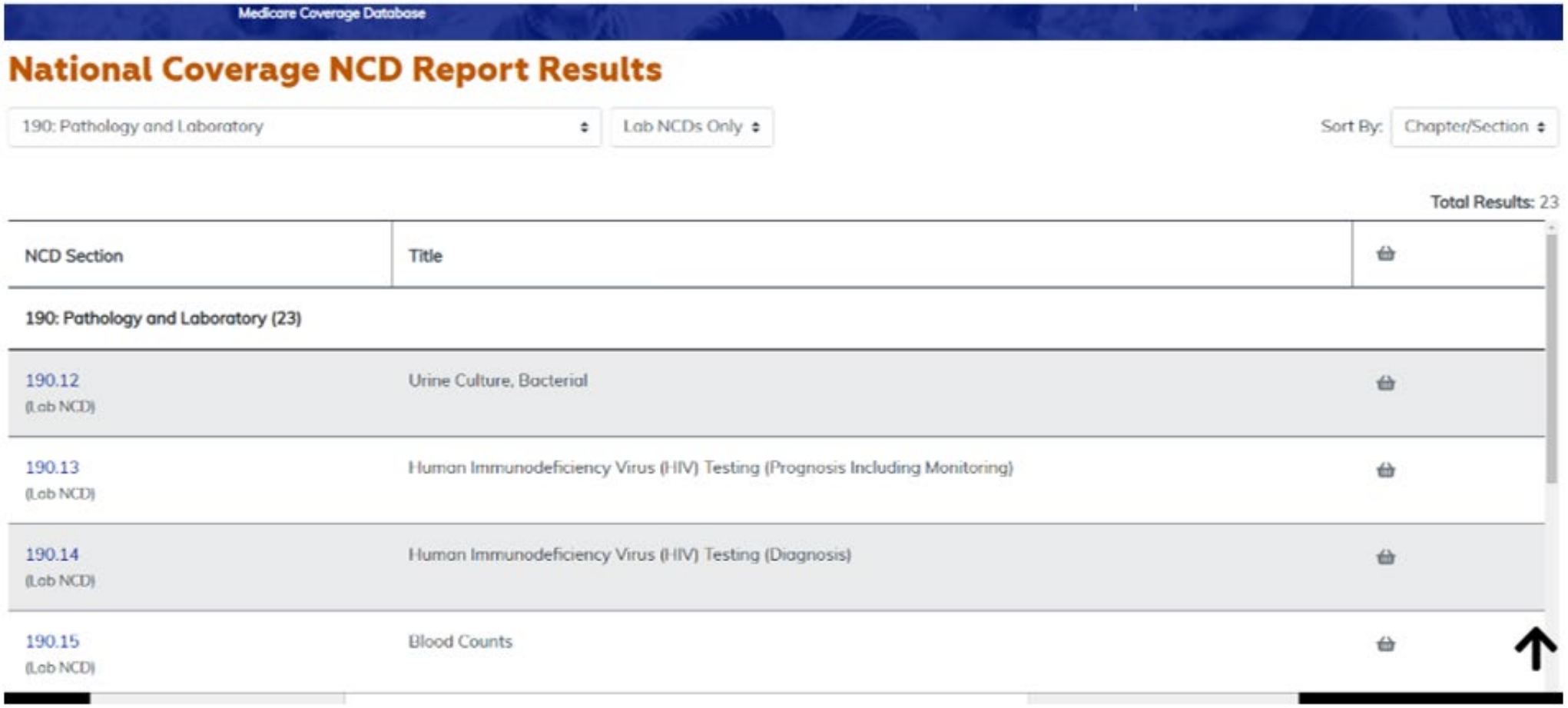
- MLN® Educational Tool: *How to Use the Medicare Coverage Database*
  - Table of Contents
    - Introduction
    - Using the MCD
    - Search
    - Search Results
    - Reports
    - Downloads
    - Resources



CMS Maintained MCD



NCD Pathology and Laboratory

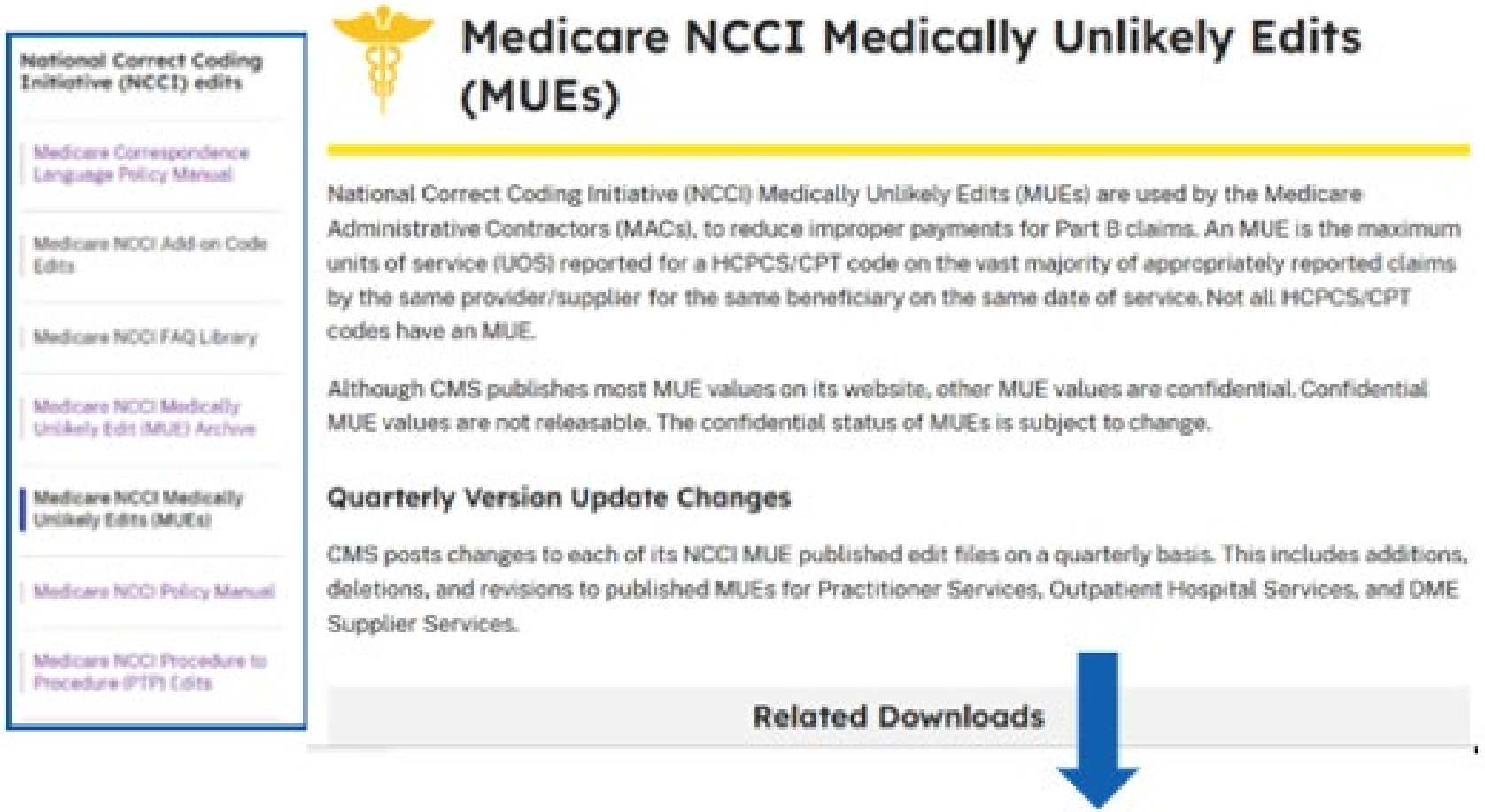


National Coverage Database

- Contains all national coverage documents, Medicare coverage and general information
- NCDs are nationwide determination of whether Medicare will pay for service
- Developed by CMS to describe circumstances when Medicare coverage for specific medical service or procedure
- NCDs outline conditions for which service is considered covered or not covered and issues program instruction
- Database also include LCDs mandated at contractor level and those guidelines are only applicable to certain jurisdiction

Medically Unlikely Edits

MUEs


National Correct Coding Initiative (NCCI) edits
Medicare Correspondence Language Policy Manual
Medicare NCCI Add-on Code Edits
Medicare NCCI FAQ Library
Medicare NCCI Medically Unlikely Edit (MUE) Archive
Medicare NCCI Medically Unlikely Edits (MUEs)
Medicare NCCI Policy Manual
Medicare NCCI Procedure to Procedure (PTP) Edits
Medicare NCCI Medically Unlikely Edits (MUEs)
National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs) are used by the Medicare Administrative Contractors (MACs), to reduce improper payments for Part B claims. An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service. Not all HCPCS/CPT codes have an MUE.
Although CMS publishes most MUE values on its website, other MUE values are confidential. Confidential MUE values are not releasable. The confidential status of MUEs is subject to change.
Quarterly Version Update Changes
CMS posts changes to each of its NCCI MUE published edit files on a quarterly basis. This includes additions, deletions, and revisions to published MUEs for Practitioner Services, Outpatient Hospital Services, and DME Supplier Services.
Related Downloads

MUE Table

HCPCS/CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
80048	2	3 Date of Service Edit: Clinical	Clinical: Data
81536	11	3 Date of Service Edit: Clinical	Clinical: Data
82024	4	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
82525	2	3 Date of Service Edit: Clinical	Nature of Analyte
82528	1	3 Date of Service Edit: Clinical	Nature of Analyte
82530	4	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
82533	5	3 Date of Service Edit: Clinical	Code Descriptor / CPT Instruction
82540	1	3 Date of Service Edit: Clinical	Nature of Analyte
82542	6	3 Date of Service Edit: Clinical	Clinical: Data
82550	3	3 Date of Service Edit: Clinical	Clinical: Data
83516	4	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup
83518	1	3 Date of Service Edit: Clinical	Clinical: Data
83519	5	3 Date of Service Edit: Clinical	Clinical: Data
83520	9	3 Date of Service Edit: Clinical	Clinical: Data
86001	20	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup
86005	2	3 Date of Service Edit: Clinical	Clinical: Data

- Practitioner Services MUE Table-R1 (ZIP) - Effective 4/1/2025; Posted 3/7/2025

MUE Adjudication Indicators

- MUE Adjudication Indicator of “1” indicates edit is claim line
- Appropriate use of NCCI modifiers (e.g., 59, 76, 77, 91, anatomic) may be used to report same code on separate lines of claim
- Medical records must support total units for date of service and use of modifiers

- MUE edits with MUE Adjudication Indicator of “2” (Date of Service Edit: Policy)
- MUE value is absolute date of service limit that may not be bypassed with modifier
- MUE edit limits with an MAI of “2” have been rigorously reviewed within CMS
- Units more than MUE value on date of service would be considered impossible because of code definition, anatomical consideration, CMS statute, regulation or sub-regulatory guidance

- MUE edits with MUE Adjudication Indicator “3” (Date of Service Edit: Clinical)
- Medically highly unlikely more units than MUE value would ever be performed on same date of service; same patient
- Quantity limits based on clinical benchmarks and criteria (e.g., nature of service, prescribing information) combined with data
- MUE limits will be applied during claim processing

National Correct Coding Initiative

CMS Official Website

CMS.gov Centers for Medicare & Medicaid Services

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Medicare Medicaid/CHIP Marketplace & Private Insurance Priorities Training & Education

National Correct Coding Initiative (NCCI) edits

- Medicare NCCI Policy Manual
- Medicare Correspondence Language Manual
- Medicare NCCI Add-on Code Edits
- Medicare NCCI FAQ Library
- Medicare NCCI Medically Unlikely Edit (MUE) Archive
- Medicare NCCI Medically Unlikely Edits (MUEs)

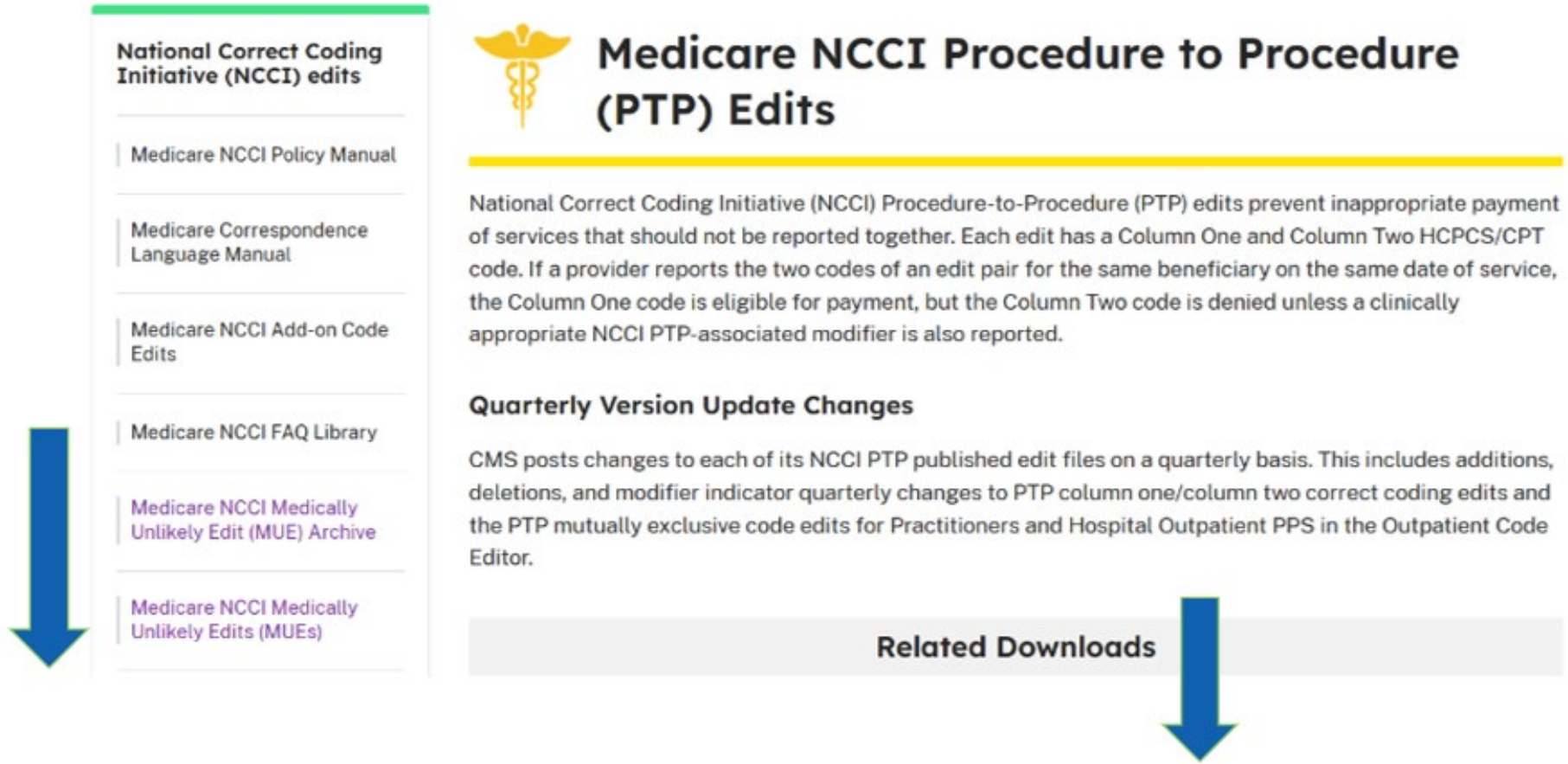
Medicare National Correct Coding Initiative (NCCI) Edits

NCCI Implementation | Replacement Files | Contact Information | Submitting an Appeal

CMS developed the NCCI program to promote national correct coding of Medicare Part B claims. CMS owns the NCCI program and is responsible for all decisions regarding its contents.

CMS develops its coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of

NCCI PTP Edits



Practitioner PTP Edits

- Medicare NCCI Procedure to Procedure (PTP) Edits
  - Related Downloads

Practitioner PTP Edits

Practitioner PTP Edits v311r0 (675,242 Records) 0001A/0591T --25680/G0471 (ZIP) - Effective April 1, 2025; Posted March 5, 2025

Practitioner PTP Edits v311r0 (674,813 Records) 25685/01810 --38760/G0471 (ZIP) - Effective April 1, 2025; Posted March 5, 2025

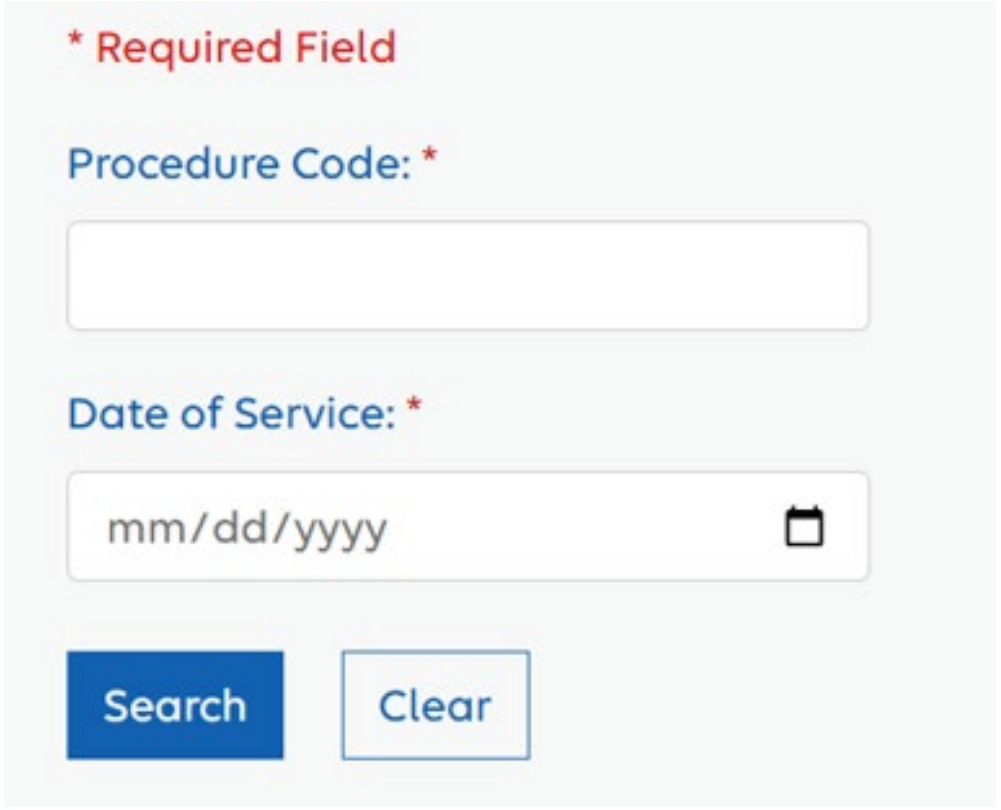
Practitioner PTP Edits v311r0 (675,103 Records) 38765/0213T --63277/G0471 (ZIP) - Effective April 1, 2025; Posted March 5, 2025

Practitioner PTP Edits v311r0 (571,248 Records) 63278/0213T--U0003/U0004 (ZIP) - Effective April 1, 2025; Posted March 5, 2025

NCCI Table

Column 1	Column 2	*=in existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
80048	80051		20000605	20060930	1	Mutually exclusive procedures
80048	80051		20061001	*	1	HCPCS/CPT procedure code definition
80048	82310		20000605	*	1	Laboratory panel
80048	82374		20000605	*	1	Laboratory panel
80048	82435		20000605	*	1	Laboratory panel
80048	82565		20000605	*	1	Laboratory panel
80048	82947		20000605	*	1	Laboratory panel
80048	84132		20000605	*	1	Laboratory panel
80048	84295		20000605	*	1	Laboratory panel
80048	84520		20000605	*	1	Laboratory panel
80048	96523		20190401	*	0	CPT Manual or CMS manual coding instruction

NGS NCCI Lookup Tool



- Search for coding pairs on our website by entering procedure code and performing date(s) of service
- Results display two coding pair lists; refer to comprehensive or major to component or minor
  - Column one contains comprehensive or major code
    - Primary service code that Medicare considers for reimbursement
  - Column two contains component or minor code
    - Represents service that is typically included in primary service (Column 1) and is generally not separately allowed when reported together
- National Government Services NCCI Lookup Tool

NGS NCCI Lookup Tool Results 80048

Major Code	Minor Code	Effective Date	Modifier/Policy Indicator
80048	80051	2006-10-01	1 - Allowed
80048	82310	2000-07-01	1 - Allowed
80048	82374	2000-07-01	1 - Allowed
80048	82435	2000-07-01	1 - Allowed
80048	82565	2000-07-01	1 - Allowed
80048	82947	2000-07-01	1 - Allowed
80048	84132	2000-07-01	1 - Allowed
80048	84295	2000-07-01	1 - Allowed
80048	84520	2000-07-01	1 - Allowed
80048	96523	2019-04-01	0 - Not allowed

Screening/Preventive Lab Services

Medicare Preventive Services

Diabetes Screening

- Patients with certain diabetes risk factors or who have been diagnosed with pre-diabetes
- Two screenings within 12-month period following date of patient's most recent diabetes screening test
  - 82947: Glucose; quantitative, blood (except reagent strip)
  - 82950: Glucose; post glucose dose (includes glucose)
  - 82951: Glucose; tolerance test (GTT), 3 specimens (includes glucose)
  - 83036: Hemoglobin; glycosylated (A1C)
  - ICD-10: Z13.1
- Patients previously diagnosed with diabetes aren't eligible for this benefit

Specimen Collections

Specimen Collection Date

- Date specimen was collected
- Specimens collected over span of dates, use date collection ended
- Exceptions
  - Date test performed on stored specimens
  - Date for chemotherapy sensitivity test performed on live tissue
  - Date for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests
- MLN Matters® *SE17023 Revised: Guidance on Coding and Billing Date of Service on Professional Claims*

Stored Specimens

- Stored less than or equal to 30 calendar days from collection, date of test must be date test was performed only if
  - Test is ordered by physician at least 14 days following date of patient's discharge from hospital
  - Specimen was collected while patient was undergoing hospital surgical procedure
  - It would be medically inappropriate to have collected sample other than during hospital procedure for which patient was admitted
  - Results of test do not guide treatment provided during hospital stay
  - Test was reasonable and medically necessary for treatment of an illness
- If the specimen was stored for more than 30 calendar days before testing, specimen is considered to have been archived, and DOS of test must be date specimen was obtained from storage

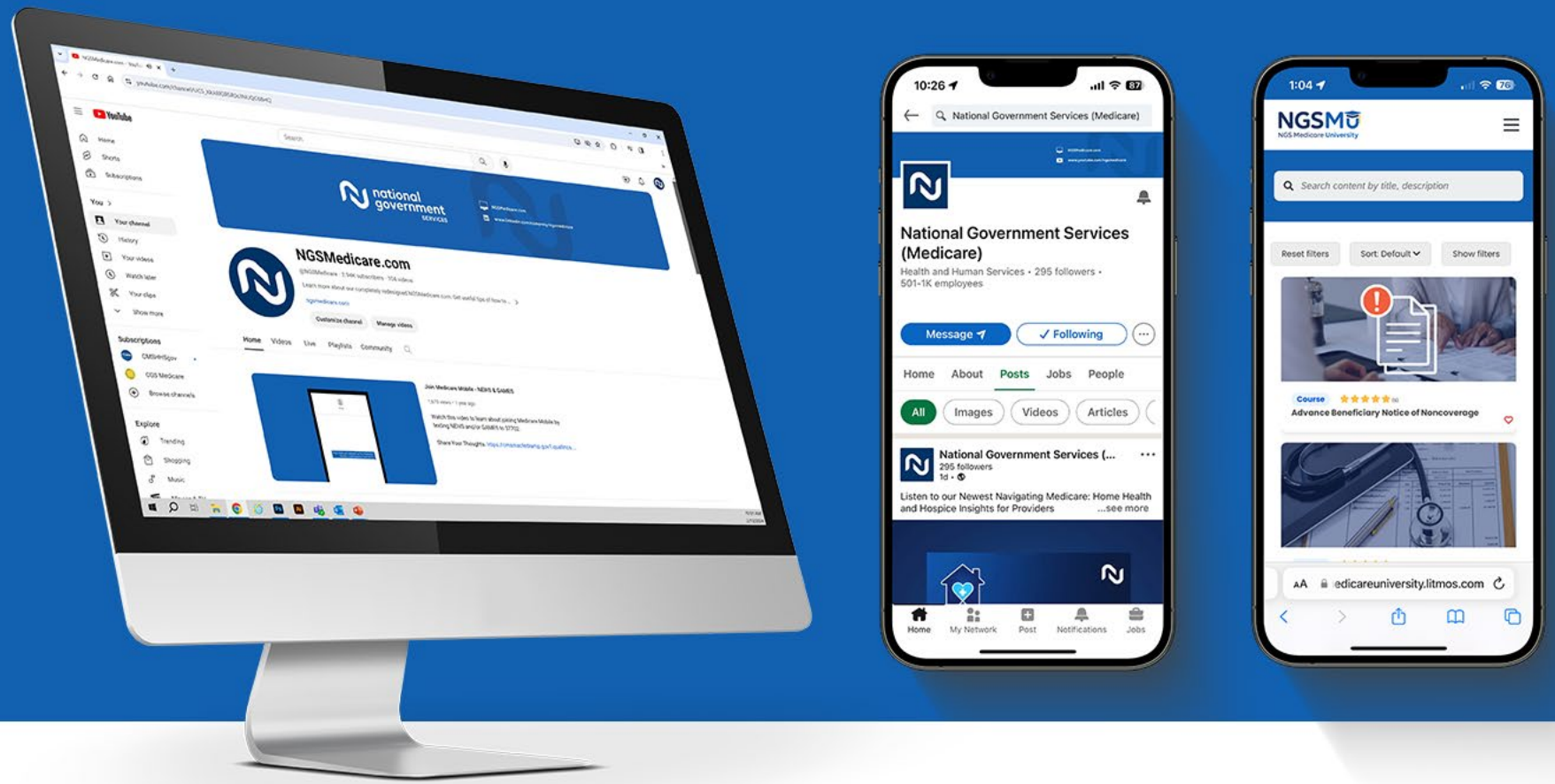
Resources and References

Resources

- MLN® Educational Tool: *Medicare Preventive Services*
- Medicare NCCI Medically Unlikely Edits (MUEs)
- Medicare NCCI Procedure to Procedure (PTP) Edits
- Clinical Laboratory Improvement Amendments (CLIA)
- CMS IOM *Medicare Claims Processing Manual*, Publication 100-04, Chapter 16 - Laboratory Services
- Coverage Determinations Process Lab NCDs - ICD-10
- MLN Matters® *SE17023 Revised: Guidance on Coding and Billing Date of Service on Professional Claim*
- MLN Matters® *MM14055: Clinical Laboratory Fee Schedule & Laboratory Services Subject to Reasonable Charge Payment: July 2025 Update*

Questions?

Thank you!



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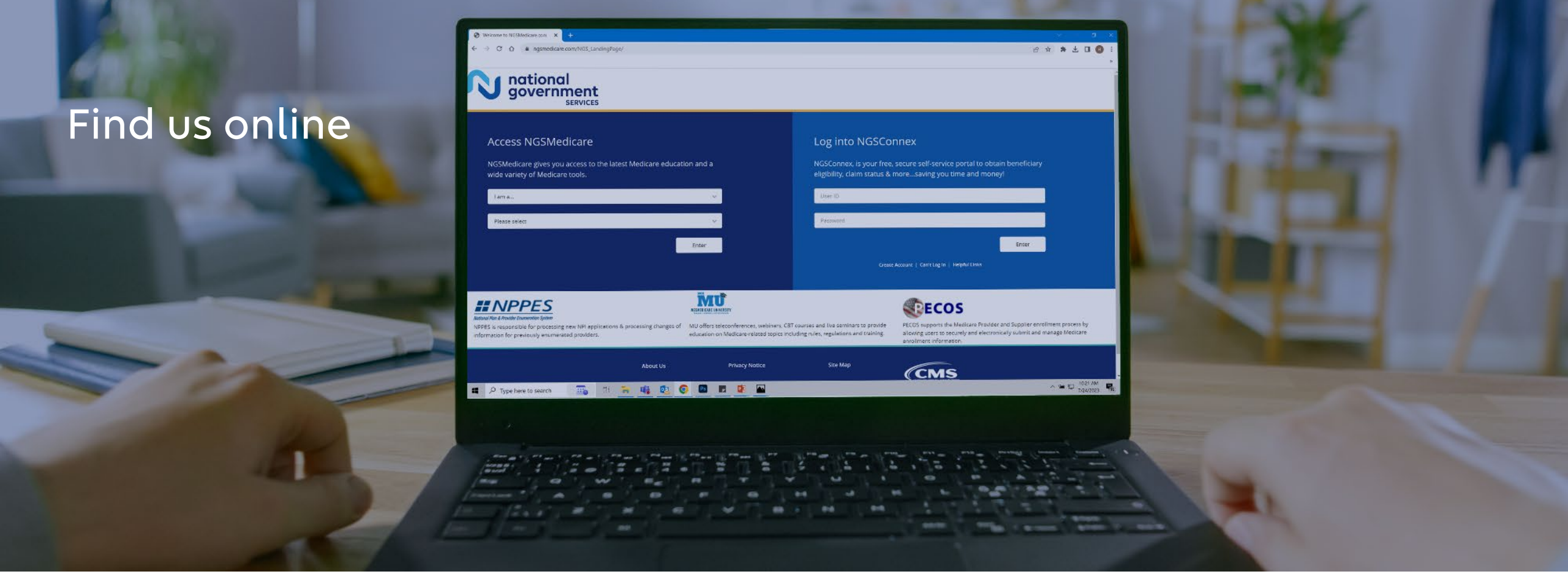

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