Coding Guidelines for All Lab NCDs

1. On and after the implementation date for ICD-10-CM coding of Medicare billing claims, a claim for a clinical diagnostic laboratory service must include a valid ICD-10-CM diagnosis code. When a diagnosis has not been established by the physician, codes that describe symptoms and signs, as opposed to diagnoses, should be provided (see also bullet #5 below).

   Please note that ICD-10-CM codes for diagnoses are not required (and will not be effective) for Medicare billing transactions prior to October 1, 2015. Please use ICD-9-CM codes for diagnoses prior to that date.

   Please check the CMS website www.cms.gov/ICD10 for more information on the implementation of ICD-10-CM codes.

2. Medicare distinguishes 'screening' from 'diagnostic uses' of tests. 'Screening' is testing for disease or disease precursors so that early detection and treatment can be provided for those who test positive for the disease. Screening tests are performed when no specific sign, symptom, or diagnosis is present and the beneficiary has not been exposed to a disease.

   In contrast, 'diagnostic' testing is testing to rule out or to confirm a suspected diagnosis because of a sign and/or symptom in the beneficiary.   In these cases, the sign or symptom should be used to explain the reason for the test.

   Some laboratory tests are covered by the Medicare program for screening purposes (for example, NCD # 210.1, Prostate Cancer Screening Tests). However, this manual focuses only on coding policies for diagnostic uses of laboratory services (for example, the test for prostate specific antigen (PSA)).

3. When the reason for performing a test is because the beneficiary has had contact with, or exposure to, a communicable disease, the appropriate code from category Z20, 'Contact with or exposure to communicable diseases', should be assigned. However, on review, the test might still be considered screening and not covered by Medicare.

4. All digits required by ICD-10-CM coding conventions must be used. A code is invalid if it has not been coded with all digits/characters required for that code.

5. The beneficiary's condition(s) and/or diseases should be coded in ICD-10-CM to the highest degree of certainty for that encounter/visit, such as signs, symptoms, abnormal test results, or other reasons for the visit. When a non-specific ICD-10-CM code is submitted, the underlying sign, symptom, or condition must be related to the indications for the test.