Medicare Local Coverage Determination Policy

Frequency of Laboratory Tests

CPT: 80061, 82465, 82948, 82962, 82985, 83036, 83718, 83721, 84436, 84439, 84443, 84478, 84479

THE HEALTH ALLIANCE

CMS Policy for Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas

Local policies are determined by the performing test location. This is determined by the state in which your performing laboratory resides and where your testing is commonly performed.

Medically Supportive ICD Codes are listed on subsequent page(s) of this document.

Coverage Indications, Limitations, and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier. Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

Sections 42 CFR 410.32 and 411.15 specify that for a laboratory service to be reasonable and necessary, it must not only be ordered by the physician, but the ordering physician must also use the result in the management of the beneficiary's specific medical problem. Implicitly, the laboratory result must be reported to the physician promptly for the physician to use the result and instruct continuation or modification of patient care; this includes the physician's order for another laboratory service. Compliance program guidance for laboratory services sets forth conditions under which a physician's order for a repeat laboratory service can qualify as an order for another covered laboratory service. A standing order is not acceptable documentation for a covered laboratory service. A glucose monitoring laboratory service must be performed in accordance with laboratory service coverage criteria including the order and clear use of a laboratory result prior to a similar subsequent laboratory order to qualify for separate payment under the Medicare laboratory benefit.

Please note there are some specific relevant Medicare requirements with respect to glucose monitoring. Medicare Part B may pay for a glucose monitoring device and related disposable supplies under its durable medical equipment benefit if the equipment is used in the home or in an institution that is used as a home. A hospital or Skilled Nursing Facility (SNF) is not considered a home under this benefit (Section 1861(h) of the Social Security Act, 42 CFR 410.38). Routine glucose monitoring of diabetics is never covered in an SNF, whether the beneficiary is in a covered Part A stay or not. Glucose monitoring may only be covered when it meets all the conditions of a covered laboratory service, including use by the physician in modifying the patient's treatment.

Limitations

The following are the pertinent laboratory tests for which frequency limitations will be specified, noting that lipid, thyroid, glycated hemoglobin/glycated protein, and glucose testing frequencies apply to analytes from the laboratory National Coverage Determination (NCD) via negotiated rulemaking:

- Lipids
- Thyroid testing
- Glucose testing
- Glycated hemoglobin/glycated protein

This LCD imposes frequency limitations. For frequency limitations please refer to the Utilization Guidelines section below.

Notice: Services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules. Refer to Billing and Coding: Frequency of Laboratory Tests, A56420, for applicable CPT codes and diagnosis codes.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements of this LCD.

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There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

Code	Description
XX000	Not Applicable

Visit MAKOMedical.com/coverageguidance to view current limited coverage tests, reference guides, and policy information.

To view the complete policy and the full list of medically supportive codes, please refer to the CMS website reference

https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=35099 Last Updated: 3/18/25