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FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

Complying with Documentation Requirements for Lab Services

What's Changed?

Note: No substantive content updates.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network
CERT A/B MAC Outreach & Education Task Force for Error-Free Medicare Claims

CMS uses the Comprehensive Error Rate Testing (CERT) program to measure improper payments in the Medicare Fee-for-Service (FFS) Program. Under CERT, we review a random sample of all Medicare FFS claims to determine if we paid them correctly under Medicare coverage, coding, and billing rules.

The majority of improper lab services payments identified by CERT come from insufficient documentation. Insufficient documentation means the patient medical records are missing something. Sufficient documentation supports:

- Intent to order (for example, a signed progress note, signed office visit note, or signed physician order)
- The medical necessity of ordered services

Documentation Requirements

The physician who treats a patient must order all diagnostic X-rays, diagnostic lab tests, and other diagnostic tests for a specific medical problem. They use the results to manage the patient's specific medical problem and may provide a consultation. We don't consider tests not ordered by the physician to be reasonable and necessary.

When completing progress notes, the physician should clearly indicate all tests to be performed (for example, "run labs" or "check blood" alone doesn't support intent to order). Medical review contractors consider diagnostic test order requirements are met if there's:

- A signed order or requisition listing the specific tests
- An unsigned order or requisition listing the specific tests **and** an authenticated medical record supporting the physician's intent to order the tests (for example, "order labs," "check blood," and "repeat urine" aren't acceptable)
- An authenticated medical record supporting the physician's intent to order specific tests

Documentation in the patient's medical record must support the medical necessity for ordering each test per Medicare regulations and applicable Local Coverage Determinations. Submit these medical records if we request them:

- Signed progress notes or office notes
- Signed physician order or intent to order
- Lab results
- Signature attestation (when applicable) or signature log for illegible signatures

Simplifying Documentation Requirements has more information.

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Medicare Signature Requirements

Unsigned physician orders or unsigned requisitions alone don't support physician intent to order. Physicians should sign all orders for diagnostic services to avoid potential denials.

If a signature is missing on a progress note, which supports intent, the ordering physician must complete an attestation statement and submit it with the response:

- The CERT C3HUB has a sample signature attestation statement
- If the signature is illegible, we'll accept an attestation statement or signature log
- We don't accept attestation statements for unsigned physician orders or requisitions

The Complying with Medicare Signature Requirements fact sheet has more information.

Ordering or Referring Services

If you bill lab services to Medicare, the treating physician must sign the order (or progress note to support intent to order) and document the medical necessity of ordered services. These records may be housed at another location (for example, a nursing facility, hospital, or referring physician's office).

While a signature isn't required on the physician order, the physician must clearly document in the patient's medical record their intent to perform the test.

Providers should be aware of the various meanings of the term "standing orders." Some understand this to mean recurring orders specific to the care of an individual patient. Others interpret this as routine orders for services to a population of patients. Only medically necessary services ordered and provided, including those based on treatment protocols, are considered for payment when documentation supports the orders, and protocols are tailored to each patient.

If you order diagnostic services for Medicare patients, you must also keep the documented order (including standing orders and protocols) or intent to order and medical necessity of the services in the patient's medical record. Keep this information available and submit it with the test results, upon request for a Medicare claim review. 42 CFR 424.516(f) explains "access to documentation."

Cooperation among ordering and referring providers and facilities that perform diagnostic tests is important to reducing errors and avoiding claim denials.

Resources

- 42 CFR 410.32
- Medicare Claims Processing Manual, Chapter 16
- Provider Compliance
- Section 80.6 of the Medicare Benefit Policy Manual, Chapter 15
- Section 190 of the Medicare National Coverage Determinations Manual, Chapter 1, Part 3
- Sections 3.2.3.3 and 3.2.3.7 of the Medicare Program Integrity Manual, Chapter 3

The Medicare Learning Network® (MLN) and the Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Medicare Administrative Contractor (MAC) Outreach & Education Task Force developed this content together to provide nationally consistent education to health care providers.

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