



COMPLYING WITH LABORATORY SERVICES DOCUMENTATION REQUIREMENTS

Updates

Note: We revised this product with the following content updates:

- Clarified documentation requirements to add language acceptable to Medical Review Contractors auditing records for regulatory guidance compliance
- Added clarification to the term “standing orders”

Introduction

The majority of improper laboratory services payments identified by the [Comprehensive Error Rate Testing \(CERT\) Program](#) are due to insufficient documentation. Insufficient documentation means something is missing from the medical records. Examples include:

- Documentation to support intent to order, such as a signed progress note, signed office visit note, or signed physician order
- Documentation to support the medical necessity of ordered services

Remember the following tips to help you avoid errors.

Documentation Requirements

- The physician who treats a patient must order all diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests for a specific medical problem. The physician uses test results to manage the patient's specific medical problem and may provide a consultation. Tests not ordered by the physician aren't considered reasonable and necessary.
- The physician should clearly indicate all tests to be performed (for example, "run labs" or "check blood" **by itself** doesn't support intent to order) when completing progress notes. **Medical review contractors will consider diagnostic test order requirements met if there's:**
 - A signed order or requisition listing the specific test
 - An unsigned order or requisition listing the specific test(s) **and** an authenticated medical record supporting the physician's intent to order the tests (for example, "order labs", "check blood", "repeat urine")
 - An authenticated medical record supporting the physician intent to order specific tests
- Documentation in the patient's medical record must support the medical necessity for ordering the service(s) per Medicare regulations and applicable Local Coverage Determinations (LCDs). Submit these medical records if they're requested.
- These records need to be available to submit upon request:
 - Progress notes or office notes
 - Physician order or intent to order
 - Laboratory results
 - Attestation or signature log for illegible signatures

For more information about **signature requirements and attestation statements**, refer to the Medicare [Simplifying Documentation Requirements](#) webpage or the [Complying with Medicare Signature Requirements](#) fact sheet.

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 the signature is missing on a progress note, which supports intent, the ordering physician must complete an attestation statement and submit it with the response. For an example of a signature attestation statement, visit the [CERT Provider website](#). If the signature is illegible, an attestation statement or signature log is acceptable.
- Attestation statements are unacceptable for unsigned physician orders or requisitions.

Ordering or Referring Services

If you bill laboratory services to Medicare, you must get the treating physician's signed order (or progress note to support intent to order) and documentation to support medical necessity for 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 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 delivered to a population of patients. Only medically necessary services ordered and rendered, including those based on treatment protocols, are considered for reimbursement when documentation supports the orders and/or protocols are individualized to each patient.

If you order diagnostic services for Medicare patients, you must also maintain documentation of the 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, along with the test results, upon request for a Medicare claim review. For information on "access to documentation," refer to [42 CFR Section 424.516\(f\)](#).

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

The Medicare Learning Network® (MLN) along with the CERT Part A and Part B (A/B) MAC Outreach & Education Task Forces, developed this fact sheet to offer nationally consistent education on topics of interest to health care professionals. Visit the [CMS CERT](#) webpage to learn about the CERT Program and review CERT Improper Payments Reports. CMS started the CERT Program to measure improper payments in the Medicare Fee-for-Service (FFS) Program. Under the CERT Program, a random sample of all Medicare FFS claims are reviewed to determine if they were paid properly under Medicare coverage, coding, and billing rules. Two contractors manage the CERT Program: the CERT Statistical Contractor (CERT SC) and the CERT Review Contractor (CERT RC). The CERT SC determines Medicare claims sampling and calculates the improper payment.

Key Takeaways

- A **signed** order, a **signed** requisition, or a **signed** medical record supporting the physician's intent to order tests (for example, "order labs", "check blood", "repeat urine") satisfies the order requirement for laboratory tests.
- Ensure all diagnostic laboratory services documentation includes the order (including standing orders) or intent to order and medical necessity of the services.
- An unsigned order or requisition listing of specific tests is only acceptable if it's accompanied by an authenticated medical record supporting the physician's intent to order the tests.

Resources

- [42 CFR Section 410.32 Diagnostic X-Ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions](#)
- [Medicare Benefit Policy Manual, Chapter 15, Section 80.6](#)
- [Medicare Claims Processing Manual, Chapter 16](#)
- [Medicare National Coverage Determinations Manual, Chapter 1, Part 3, Section 190](#)
- [Medicare Program Integrity Manual, Chapter 3, Sections, 3.2.3.3 and 3.2.3.7](#)
- [Provider Compliance Webpage](#)

The Comprehensive Error Rate Testing (CERT) Part A and Part B (A/B) Medicare Administrative Contractor (MAC) Outreach & Education Task Force is independent from the Centers for Medicare & Medicaid Services (CMS) CERT team and CERT contractors, which are responsible for calculation of the Medicare Fee-for-Service improper payment rate.

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