DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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Provider Compliance Tips for Laboratory Tests – Other - Urine Drug Screening

Provider Types Affected:

- Physicians and other eligible professionals who write requisitions or orders for urine drug screening laboratory tests

Background

Based on the Supplementary Appendices for the Medicare Fee-For-Service 2015 Improper Payments Report, Laboratory Tests – Other, which includes urine drug screenings, had an improper payment rate of 39 percent and accounted for a projected $1.2 billion in Medicare FFS improper payments. The vast majority of these improper payments were due to insufficient documentation.

Reasons for Denials

1. Insufficient or no documentation to support the intent to order the test
2. Insufficient or no documentation to support the medical necessity for the test of the individual patient
3. Unsigned medical record documentation by the treating physician or non-physician practitioner

To Prevent Denials

The following conditions must be met:

- Urine drug screenings must be ordered by the physician who is treating the beneficiary, that is, the physician and other eligible professionals who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary.
- All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered for the treatment of the individual patient. Criteria to establish medical necessity for drug testing must be based on patient-specific elements identified during the clinical assessment and documented by the clinician in the patient's medical record. Tests used for routine screening of patients without regard to their individual need are not usually covered by the Medicare Program, and therefore are not reimbursed.
- The physician or other eligible professionals who ordered the test must maintain documentation of medical necessity in the beneficiary's medical record.
- Entities submitting a claim must maintain documentation received from the ordering physician or non-physician practitioner. (See **42 Code of Federal Regulations 410.32**.)

Examples of documentation that may be requested for medical review of claims for laboratory tests, including urine drug screenings are:

- Clinical evaluations, physician evaluations, consultations, progress notes, physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation is maintained by the physician and/or provider.
- Supplier/laboratory notes include all documents that are submitted by suppliers and laboratories in support of the claim.
- Other documents include any records needed from a biller in order to conduct a review and reach a conclusion about the claim.

Orders

An order may be delivered via the following forms of communication:

- A written document signed by the treating physician/eligible professionals, which is hand-delivered, mailed, or faxed to the testing facility. Although no signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services, documentation in the medical record must show intent to order and medical necessity for the testing.
- A telephone call by the treating physician/eligible professional or his/her office to the testing facility.
- An electronic mail by the treating physician/eligible professional or his/her office to the testing facility (See **"Medicare Benefit Policy Manual," Chapter 15**, Section 80.6 - Requirements for Ordering and Following Orders for Diagnostic Tests.)

If the order is communicated via telephone, both the treating physician/eligible professional or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records. While a physician/eligible professional order is not required to be signed, the physician/eligible professional must clearly document, in the medical record, his or her intent that the test be performed.

Resources

Laboratories may find the following resources helpful in avoiding improper payments for their services:

For More Information About…	Resource
The Supplementary Appendices for the Medicare Fee-For-Service 2015 Improper Payments Report	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2015ImproperPaymentsReport.pdf
42 CFR 410.32	http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/xml/CFR-2011-title42-vol2-sec410-32.xml
"Medicare Benefit Policy Manual," Chapter 15, Section 80.6 - Requirements for Ordering and Following Orders for Diagnostic Tests	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Hyperlink Table

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Supplementary Appendices for the Medicare Fee-For-Service 2015 Improper Payments Report	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2015ImproperPaymentsReport.pdf
42 Code of Federal Regulations 410.32	http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/xml/CFR-2011-title42-vol2-sec410-32.xml
"Medicare Benefit Policy Manual," Chapter 15	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

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