Provider Compliance Tips For Laboratory Tests-Other (Non-Medicare Fee Schedule)

What’s Changed?
- Replaced the earlier year’s data with 2020

You’ll find substantive content updates in dark red font.

Introduction
This publication is meant to educate providers on coverage and proper billing of laboratory services.

Provider Types Affected
Physicians and Non Physician Practitioners (NPPs) who write requisitions or orders for laboratory tests
Background

Laboratory Tests – Other (non-Medicare fee schedule) is a very broad category of Part B services, which includes Healthcare Common Procedure Coding System (HCPCS) codes for pathology and laboratory services. The category is Berenson-Eggers Type of Service (BETOS) Code category T1H Lab tests - other (non-Medicare fee schedule). Examples of these services are urine drug screening, medication assays, genetic tests, tissue examination, blood tests, and others.

Reasons for Denials

The Medicare Fee-for-Service (FFS) improper payment rate for lab tests - other (non-Medicare fee schedule) for the 2020 reporting period is 18.9%, representing a projected improper payment amount of $732 million. The vast majority of these improper payments are for insufficient documentation.

How to Prevent Denials

You must meet the following conditions:

- You, the physician or NPP who’s treating the beneficiary, must order laboratory tests that is, the physician who provides 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 you haven’t ordered for treating the beneficiary aren’t reasonable and necessary.

- You must keep documentation of medical necessity in the beneficiary’s medical record when ordering the service.

- The entity submitting the claim must keep the documentation that it receives from you, documentation showing accurate processing of the order and submission of the claim, and diagnostic or other medical information you supplied to the laboratory, including any ICD-10-CM code or narrative description supplied.

Orders

Order requirements for diagnostic laboratory tests are met if there’s:

- A signed order or signed requisition listing the specific test

- An unsigned order or unsigned laboratory requisition listing the specific tests you will perform AND an authenticated medical record that supports your intent to order the tests (for example, order labs, check blood, repeat urine)

- An authenticated medical record that supports your intent to order the specific tests

Note: Please reference the Medicare Program Integrity Manual, Chapter 6, Section 6.9.1, for more information about order requirements.

You can deliver an order via the following forms of communication:

- Your written and signed document which is hand delivered, mailed, or faxed to the testing facility. Medicare doesn’t require signature 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.
● A telephone call by you or your office to the testing facility.
● An email by you or your office to the testing facility.

**Note:** If you communicate the order via telephone, you or your office, and the testing facility must document the telephone call in your respective copies of the beneficiary’s medical records. While Medicare doesn’t require a signed physician order, you must clearly document in the medical record your intent that the test are performed.

**Resources**

- [2020 Medicare Fee-for-Service Supplemental Improper Payment Data](#)
- [Code of Federal Regulations 42 CFR 410.32](#)
- [Medicare Benefit Policy Manual - Chapter 15 (Section 80.6 – Requirements for Ordering and Following Orders for Diagnostic Tests)](#)
- [Medicare Program Integrity Manual, Chapter 6, Section 6.9.1](#)

Contact your MAC for any updates or changes to policy and general documentation requirements.