Documentation Requirements

1. Documentation supporting the medical necessity of lab tests, such as ICD-9-CM diagnosis codes must be submitted on the claim(s). Failure to do so may result in denial of claim(s). The OIG (Office of Inspector General) may seek sanctions against individuals who knowingly cause false claims to be filed.

2. The ordering physician should retain in the patient's medical record, history and physical, examination notes documenting evaluation and management of one of the Medicare covered conditions/diagnoses, with relevant clinical signs, symptoms or abnormal laboratory test results, appropriate to one of the covered conditions.

3. ICD-9 codes are preferred with each order and for each condition applicable to the test requested. If a narrative sign/symptom/diagnosis is received on the order the laboratory will assign the appropriate diagnosis code for the purpose of billing.

4. The patient's clinical record should further indicate changes/alterations in medications prescribed for the treatment of these conditions.

5. There must be an attending/treating physician's order for each test documented in the patient's medical/clinical record and signed by the physician or authorized person.

6. If the laboratory test requisition is the only document in the medical record that illustrates the physician’s intent, it must be signed.

7. Documentation requirements must be kept on-file in the patient's medical record and be available to the Laboratory and/or payer upon request.

8. If the provider of the service is other than the ordering /referring physician, that provider must maintain documentation of the test results and interpretation, along with copies of the physician's order for the test. The physician must document the clinical indication for the test on the order. Documentation requirements must be made available to the Laboratory and/or payer upon request.

9. When submitting a non-specific medication ICD-9-CM code, the name of the related medication should be documented in the medical record and preferably submitted with the order. This information, as well as supporting medical documentation is critical in CMS determining whether a service is medically reasonable and necessary.

10. ICD-9 codes must be used at their highest level of specificity.