BlueCross BlueShield of Illinois

Documentation Guidelines for Urine Drug Testing

Blue Cross and Blue Shield of Illinois (BCBSIL) processes and reimburses claims for urine drug testing in accordance with BCBSIL Medical Policy MED207.154, Drug Testing in Pain Management and Substance Use Disorder Monitoring. BCBSIL only reimburses claims for urine drug testing that are medically necessary under that medical policy. BCBSIL requires that urine drug testing claims be properly documented and that the documentation reflect the medical necessity of the testing. The provider that submits the claim is responsible for submitting such documentation upon request. Incomplete or insufficient records can result in a denial of payment for services.

This guidelines document is intended to assist providers in understanding BCBSIL's documentation and medical necessity requirements for urine drug testing claims.

Medical Necessity of Quantitative or Definitive Drug Testing
Generally, whether quantitative (or definitive) urine drug testing for a particular drug is medically necessary depends on (1) the patient's qualitative (or presumptive) testing results for that drug and (2) whether the drug has been prescribed for the patient. Specifically, Medical Policy MED207.154 explains that quantitative testing for a particular drug is considered medically necessary if one of the four following criteria is met:

- Qualitative testing was positive for a prescription drug that is not prescribed to the patient;
- Qualitative testing was negative for a prescription drug that is prescribed to the patient;
- Qualitative testing was positive for an illicit drug; or
- A qualitative test for the relevant drug is not commercially available.

Urine drug testing for pain management or substance abuse monitoring is not medically necessary if none of the above criteria is met. Similarly, routine screenings (performed as part of a clinician's protocol for treatment, without documented individual patient assessment) and tests given pursuant to standing orders (non-individualized, routine orders that are not used in the management of the patient's specific medical condition and are given to a population of patients) are not medically necessary.

Medical necessity must be met for each drug or drug class for which a quantitative test is ordered.

Providers that order or perform drug testing should carefully review BCBSIL Medical Policy MED207.154. Medical policies are updated regularly, so it is important to visit BCBSIL's website, *bcbsil.com/provider*, often for the most up-to-date medical policy information. Medical policies can be found by visiting the Medical Policy page in the Standards and Requirement section of our Provider website.

Documentation Requirements
For a urine drug testing claim to be properly reimbursable, the documentation must meet BCBSIL's requirements. In particular, the documentation must be patient-specific and must accurately reflect the need for each test ordered; each drug or drug class being tested for must be indicated by the ordering clinician in a written order and documented in the patient's medical record; and the laboratory's or ordering provider's medical records or other documentation must be sufficient to show that the testing performed was medically necessary.

BCBSIL does not require billing laboratories to recover and submit medical records from ordering providers. Nevertheless, if BCBSIL conducts an audit or review of a urine drug testing claim and finds that there is insufficient documentation, that claim will be denied. The provider that submits the claim is responsible for providing, upon request, documentation sufficient to support all services submitted on the claim form.

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Laboratories that submit urine drug testing claims should possess, at a minimum, (1) a signed, valid requisition form from the ordering provider that specifies the tests being ordered, and (2) complete results of the tests performed. The requisition form must include the following:

- A list of the specific drugs or drug classes being tested. Reference to a standard order or a "custom panel" is not acceptable;
- The identity of the patient;
- The identity of the ordering provider, including full name, credentials, and National Provider Identifier (NPI);
- A legible signature from the ordering physician (not a stamp or photocopy, and it is not acceptable to state that the physician's signature is on file);
- The facility and location where the sample was collected (e.g., office, home, hospital, residential treatment center);
- The type of sample (i.e., urine);
- The date and time the sample was collected;
- The identity of the individual who collected the sample; and
- The date and time the sample was received in the laboratory.

For claims submitted by laboratories, if the laboratory's requisition form (and/or any other supporting documentation) is insufficient to show the medical necessity of the testing, it will be necessary for the laboratory to submit additional records or documentation upon request (or upon appeal of the claim denial). To avoid this need for additional documentation, the laboratory should include the following additional information in its requisition form or other supporting documentation. This information is necessary for BCBSIL to assess the medical necessity of the quantitative testing performed. Without the following information, reimbursement of the claim may be denied:

- Information about any relevant qualitative point-of-care or screening testing performed, including the date of the testing, what drugs or drug classes were tested, and the results; and
- A list of medications prescribed to the patient, to the extent the medications are relevant to the tests ordered.

A laboratory's documentation of the results of the testing performed must include:

- The complete identification of the entity performing the testing, including name, address, and Clinical Laboratory Improvement Amendments (CLIA) number;
- The patient's name and date of birth;
- The ordering provider's name and NPI;
- Facility name, if applicable;
- The date the sample was collected;
- The date the sample was received in the laboratory;
- The date the test results were reported; and
- Complete test results, including validity testing if performed.

Of course, beyond the documentation of the services performed, other factors can affect whether a claim is reimbursable by BCBSIL, including but not limited to the member's benefits and eligibility.

In the event an ordering physician's medical records do not support the laboratory's records, the ordering physician's patient medical record shall prevail. For example, if an ordering physician's medical records contradict the laboratory's requisition or are silent as to any testing, the medical record will determine the review/audit findings.

Laboratories should be mindful of requests for testing they receive from inpatient and intensive outpatient behavioral health facilities or residential treatment centers. Laboratory services are included in rates paid to such entities, so laboratory services should not be unbundled and submitted separately for reimbursement. In those instances, separate reimbursement for laboratory services may be denied.

Finally, independent laboratory claims should be submitted to the Blue Cross Blue Shield plan in the state where the referring/ordering provider is located, regardless of where the testing laboratory is located. Failure to abide by this requirement may similarly result in a denial of payment for a claim.

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