# REQUIRED DOCUMENTATION UPON SUBMISSION OF A URINE DRUG TEST SAMPLE

## OVERVIEW

1. Medication/ drugs of interest list (individualized for the patient)
2. If your clinic performed a screen onsite please provide the results
3. Encounter notes/visit notes/SOAP notes
4. Medical record documentation (e.g., history and physical, progress notes) maintained by the ordering physician/ treating physician must indicate the medical necessity for performing a qualitative drug test. All tests must be ordered in writing by the treating provider and all drugs/drug classes to be tested must be indicated in the order.
5. When a definitive/quantitative test is performed, the record must show that an inconsistent positive finding was noted on the presumptive testing or that there was no available, commercially or otherwise, presumptive test except when not medically necessary to perform presumptive testing in the COT patient subset.
6. If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of the lab results, along with copies of the ordering/referring physician's order for the test. The physician must include the clinical indication/medical necessity in the order for the test.
7. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
8. The submitted medical record must support the rationale for ordering the test.
9. The submitted medical record must support the use of the selected ICD-10-CM code(s).
10. The submitted medical record must support the frequency of testing.

NOTE: You must provide missing documentation within 72 hours if requested by the lab or the payor requirements