Annual Provider Notice

Date: 2025

From: Dominion Diagnostics Compliance Department

The Office of the Inspector General ("OIG") recommends that all laboratories should provide all of their Providers with annual written notices that set forth: (1) the Medicare medical necessity policy; (2) the CPT or HCPCS codes that the laboratory uses to bill the Medicare program for each such profile; (3) the Medicare National Limitation Amount for each CPT or HCPCS code used to bill Medicare for each profile and its components; (4) a description of how the laboratory will bill Medicare for each profile, and (5) other relevant information regarding the laws and regulations that govern the ordering of laboratory testing.

MEDICAL NECESSITY

The Medicare Program, through its Local Contractors, has developed Local Coverage Determinations (LCDs) for urine drug testing and blood testing. These policies outline requirements for among other things medical necessity, the creation of physician created test profiles, appropriate indications for urine drug testing and test frequency. Copies of these policies are available through the Medicare website at: https://www.cms.gov/medicare/coverage/determination-process/local

Providers should only order those tests that he/she determines are medically necessary for each patient. According to Medicare the determination of what testing is medically necessary should be based upon a clinical assessment of the individual patient. If all the tests that are contained in a provider's Custom Profile are not medically necessary for a patient, then the provider should only order tests on an individual basis.

PAYER POLICY

Most Commercial, Medicare Advantage, and Managed Medicaid plans issue policies that outline medical necessity requirements for both presumptive and definitive drug testing. In some instances, payer policies will include annual or monthly frequency limits per patient that may include prior authorization requirements to order beyond the limitation.

Drug testing for routine job-related screening or monitoring purposes, unrelated to treatment of an individual patient's condition is not covered by Medicare, Medicaid, and Commercial Plans.

Commercial, Medicare Advantage, and Managed Medicaid policies may bundle reimbursement for laboratory testing initiated from inpatient, intensive outpatient, and partial hospitalization facilities. In these instances, laboratory services cannot be unbundled and submitted separately for reimbursement. If your facility is aware that any of the services provided are included in a bundled rate, please notify Dominion to ensure that the services are appropriately billed.

PROVIDER CREATED PROFILES

There are many policy changes and guidance documents from both governmental and commercial payors that discourage, if not prohibit the use of provider-created custom profiles or standing orders. Dominion permits a provider, under the appropriate circumstances outlined below, to create a custom profile for his/her patients.

The Office of Inspector General recommends that if a Provider creates a custom profile for his/her patients, the laboratory performing the testing should send to the Provider an annual Provider Acknowledgment. Dominion Diagnostics follows this recommendation and issues Provider Acknowledgments annually to our Ordering Providers. Provider Acknowledgments disclose Dominion's Medicare reimbursements for the tests that are part of the Custom Profiles that providers have selected for their patients.

Because utilizing a custom profile may result in the ordering of tests for which Medicare or other federally funded payers may deny payment, providers should make sure that any profiles created and ordered are medically necessary for the patient being tested. Any custom profiles created and ordered by providers for their patients should be specifically tailored to the diagnosis of the patients being tested.

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TEST ORDERING

Dominion Diagnostics receives test orders both electronically and on paper. Dominion's electronic ordering system, Dominion Connect™, permits Providers to individually order tests for their patients. Likewise, Dominion's paper requisitions permit Providers to select either their Custom Profile or write in individual tests. In order to comply with applicable regulations, test orders should contain the following:

1. Date
2. Patient name
3. Patient Date of birth
4. Test(s) to be performed
5. Ordering providers name and signature
6. Indications as to why the test is being performed, such as a diagnosis code
7. Additional information necessary to properly perform the test and report the results

ORDERING PROVIDER REQUIREMENTS

In order to be reimbursable, laboratory testing must be ordered by an ordering provider. In accordance with 42 CFR 410.32 (a), All diagnostics tests must be ordered by the provider who is treating the beneficiary, that is, the provider who furnishes a consultation or treats a beneficiary for a specific medical problem. Tests not ordered by the provider who is treating the Beneficiary are not reasonable and necessary.

MEDICAL RECORD DOCUMENTATION REQUIREMENTS

The patient's medical record must contain documentation to support the medical necessity of the tests being ordered and the frequency of testing. In the event that Dominion Diagnostics receives from a payor an audit inquiry or request for the medical necessity documentation that supports the tests ordered and/or the frequency of testing, the provider agrees to provide to Dominion Diagnostics a copy of the medical necessity documentation. The following list includes common recommendations from Medicare, Medicaid, and Commercial payers.

- Written or electronic documentation of the order for the date of service billed
- Current treatment plan
- List of patients prescribed medications
- List of illicit medications
- Risk assessment plan
- Medical record documentation indicating the medical necessity for performing each drug test (history and progress notes)
- Test order forms and test result reports

PROVIDER SIGNATURES

All requisitions, both electronic and paper must be signed by the ordering provider. If a provider is ordering tests electronically, the provider acknowledges and agrees that Dominion will include on a printed copy of the electronic test requisition either an electronic version of the provider's signature or a notation that the test(s) ordered were electronically signed by that provider. In the case of paper test requisitions, the provider agrees that each requisition will be signed with an original signature.

CLINICAL SERVICES – PHARMACIST TEAM

Drug Testing results can be complex, and quality patient care depends on accurate interpretation. Physicians and clinicians authorized to order lab tests have access to Dominion Diagnostics clinical team of pharmacists to review individual patient results at their convenience.

PATIENT BILLING

Dominion Diagnostics is a Medicare and Medicaid provider for laboratory services and an in-network provider with most commercial plans. Dominion Diagnostics accepts reimbursement as determined by the patient's coverage plan. After the insurance carrier has been billed for services, the patient may receive an Explanation of Benefits (EOB). Although the EOB details the cost of the laboratory services performed, it is not a bill. Dominion Diagnostics will, as required by law, attempt to collect any co-pays, co-insurance, deductibles, or other fees for which insurance deems the patient's responsibility. To assist in offsetting patient bills and the cost of laboratory services Dominion Diagnostics offers a Financial Assistance program. Patients interested in completing a Reduced Rate Form can find one online here: https://bit.ly/domdiag-pt-billing

Dominion Diagnostics uses third party services to search for insurance for patients who are listed as uninsured or as a financial hardship patient. If insurance is discovered Dominion Diagnostics reserves the right to submit claims to the insurance payor.

COMPLIANCE

Dominion Diagnostics adheres to all applicable state and federal laws and regulations including but not limited to the STARK LAW, ANTI KICKBACK STATUTE, ELIMINATING KICKBACKS in RECOVERY ACT ("EKRA"), FALSE CLAIMS ACT, and HIPAA.

CUSTOMER SUPPORT

Clinical Services Pharmacists Team	800.511.8492
Client Services & Supply Center	800.511.8427
Billing Support	800.511.8427, Option 4

Definitive Drug Testing Codes

CMS HCPCS CODE	CODE DESCRIPTION	2025 MEDICARE FEE SCHEDULE
80307	Presumptive drug test - any number of drug classes, any number of devices or procedures by instrumented chemistry analyzers, includes sample validation when performed, per date of service	$ 62.14
G0480	Definitive drug tests, 1 - 7 drug classes*	$ 114.43
G0481	Definitive drug tests, 8-14 drug classes*	$ 156.59
G0482	Definitive drug tests, 15 - 21 drug classes*	$ 198.74
G0483	Definitive drug tests, 22+ drug classes*	$ 246.92

*Drug class includes any of the classes listed below. The list below is taken from the CMS 2016 Final Payment Determination.

List of drug classes that may be included in definitive drug testing codes listed above:

DRUG	DRUG CLASS
Amphetamines & Methamphetamines	Amphetamines & Methylenedioxyamphetamines
Antipsychotics	Antipsychotics, not specific
Barbiturates	Barbiturates
Bath Salts	Stimulants, Synthetics
Benzodiazepines	Benzodiazepines
Buprenorphine & Norbuprenorphine	Buprenorphine
Cannabinoids	Cannabinoids, natural
Cocaine & Metabolite	Cocaine
Dextromethorphan	Opiates & Opiates Analogs
ETG & ETS	Alcohol Biomarkers
Gabapentin	Gabapentin
Mitragynine/Kratom	Alkaloids
Meprobamate/Carisoprodol	Skeletal Muscle Relaxants
Methadone/Methadone Metabolite	Methadone
Methylphenidate/Ritalinic Acid	Methylphenidate
Naloxone	Opiates & Opiates Analogs
Norfentanyl	Fentanyl
Norpropoxyphene	Propoxyphene
Opiates	Opiates
Oxycodone & Oxymorphone	Oxycodone
Pregabalin	Pregabalin
PCP	Phencyclidine
Synthetic Cannabinoids	Cannabinoids, Synthetic
Tapentadol	Tapentadol
Tricyclic Antidepressants (TCA's)	Antidepressants, Tricyclics & Other Cyclics
Tramadol	Tramadol
Xylazine	Sedative Hypnotics
Z-Drugs	Sedative Hypnotics

Blood Testing Codes

CMS CPT CODES	CODE DESCRIPTION	2025 MEDICARE FEE SCHEDULE
85025	Complete CBC w/Automated Differential WBC	$ 7.77
80053	Comprehensive Metabolic Panel	$ 10.56
80061	Lipid Panel	$ 13.39
83036	Glycosylated Hemoglobin Test	$ 9.71
81003	Urinalysis Auto w/o Scope	$ 2.25
80076	Hepatic Function Panel	$ 8.17
84436	Assay of Total Thyroxine	$ 6.87
84439	Assay of Free Thyroxine	$ 9.02
84443	Assay Thyroid Stimulating Hormone	$ 16.8
84480	Assay Triiodothyronine (T3)	$ 14.18
80074	Acute Hepatitis Panel	$ 47.63
81015	Microscopic Exam of Urine	$ 3.05
82746	Assay of Folic Acid Serum	$ 14.7
85027	Complete CBC, Automated	$ 6.47
86709	Hepatitis A IGM Antibody	$ 11.26
87522	Hepatitis C Viral Quantitative	$ 42.84
87070	Culture, Other Specimen Aerobic	$ 8.62
87205	Smear, Gram Stain	$ 4.27
82977	Assay of GGT	$ 7.20
80048	Metabolic Panel	$ 8.46
84153	Assay of PSA Total	$ 18.39
84270	Assay of Sex Hormone Binding Globulin	$ 21.73
84402	Assay of Free Testosterone	$ 25.47
84403	Assay of Total Testosterone	$ 25.81
87340	Hepatitis B Surface Antigen IA	$ 10.33
83540	Assay of Iron	$ 6.47
83550	Iron Binding Test	$ 8.74
87086	Urine Culture/Colony Count	$ 8.07
86317	Immunoassay Infectious Agent	$ 14.99
85651	RBC Sed Rate, Non Automated	$ 4.27
86038	Antinuclear Antibodies	$ 12.09
86705	Hepatitis B Core Antibody IGM	$ 11.77
G0480	Methadone, Confirmation by GCMS, Serum	$ 114.43
81001	Urinalysis, Auto w/Scope	$ 3.17

STI Testing Codes

CMS CPT CODES	CODE DESCRIPTION	2025 MEDICARE FEE SCHEDULE
87491	Chlamydia trachomatis by DNA or RNA probe, amplified probe technique	$ 35.09
87563	Mycoplasma genitalium by DNA or RNA probe, amplified probe technique	$ 35.09
87591	Neisseria gonorrhoeae by DNA or RNA probe, amplified probe technique	$ 35.09
87661	Trichomonas vaginalis by DNA or RNA, amplified probe technique	$ 35.09