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Southeast Radiology Management e-Alert

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Volume 1, Issue 1

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Greetings!

We are excited to bring to you the first of many e-Alerts to assist you with your day to day radiology coding and compliance challenges.

The "Official" Word on Diagnostic Test Orders

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For our first issue, I have chosen to focus on diagnostic test orders, an issue that affects each of us regardless of the setting in which we may work. Often I am asked for the "official word" on diagnostic test order requirements, so I have compiled a summary of all of those official sources for you as well as links to each of them.

The following information is taken directly from the *Medicare Claims Processing Manual, Chapter 23, Section 10.1.2:*

Instructions to Determine the Reason for the Test

The Balanced Budget Act (BBA) §4317(b) requires referring physicians to provide diagnostic information to the testing entity at the time the test is ordered. As further indicated in 42 CFR 410.32 all diagnostic tests "must be ordered by the physician who is treating the beneficiary. An "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. An order may include the following forms of communication:

- *A written document signed by the treating physician/practitioner, which is hand delivered, mailed, or faxed to the testing facility;*
- *A telephone call by the treating physician/practitioner or his/her office to the testing facility; or*
- *An electronic mail by the treating physician/practitioner or his/her office to the testing facility.*

NOTE: *If the order is communicated via telephone, both the treating physician/practitioner or his/her office and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.*

A. On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test and the referring physician is unavailable to provide such information, it is appropriate to obtain the information directly from the patient or the patient's

medical record if it is available. However, an attempt should be made to confirm any information obtained from the patient by contacting the referring physician.

It is important to note that the conditions specified in Chapter 23 of the Medicare Claims Processing Manual, do not apply to hospital patients, but do apply to independent diagnostic testing facilities and office-based imaging services. This guidance can be found in *Chapter 15, Section 80.6 of the Medicare Benefit Policy Manual.* This section starts out by stating the following:

"The following sections provide instructions about ordering diagnostic tests and for complying with such orders for Medicare payment.

NOTE: *Unless specified, these sections are not applicable in a hospital setting."*

It is also important to note that this same section goes on to say the following concerning the definition of a testing facility:

"A "testing facility" is a Medicare provider or supplier that furnishes diagnostic tests. A testing facility may include a physician or a group of physicians (e.g., radiologist, pathologist), a laboratory, or an independent diagnostic testing facility (IDTF)."

The CMS Hospital Conditions of Participation govern test orders in the hospital setting. 42 CFR 482.26 states the following:

"Radiologic services must be provided only on the order of practitioners with clinical privileges or, consistent with State law, of other practitioners authorized by the medical staff and the governing body to order the services."

If you work in the hospital setting, this information should be part of your Medical Staff Bylaws.

In summary, although hospitals are not governed by the same rules as IDTFs, independent laboratories or office based practices, it is important that medical necessity is documented for all tests ordered and performed in the hospital setting. Although hospital radiologists are permitted to request additional tests or modify test orders, it may be prudent to request additional orders and/or modifier orders in writing from the ordering physician. Furthermore, facilities should take care when establishing "routine" testing protocols.

Here is a list of the official sources for diagnostic test order requirements:

- CMS Transmittal 80:
  http://www.cms.hhs.gov/transmittals/downloads/R80BP.pdf
- Medicare Claims Processing Manual, Chapter 23:
  http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf

- Medicare benefit Policy Manual, Chapter 15:
  http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

- Code of Federal Regulations:
  42 CFR 410.32 -Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions
  42 CFR 410.33 - Independent diagnostic testing facility.
  http://www.access.gpo.gov/nara/cfr/waisidx_07/42cfr410_07.html
  42 CFR 482.26. Condition of participation: Radiologic services.
  http://www.access.gpo.gov/nara/cfr/waisidx_07/42cfr482_07.html

- Balanced Budget Act of 1997, Section 4317:
  http://hippo.findlaw.com/SubtitleD.html#Anchor11

Question & Answer

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The following question was submitted by one of our subscribers:

Question: Is a CTA considered a prior diagnostic exam when performed prior to a therapeutic interventional procedure?

Answer:

Chapter 9 of the NCCI Manual CMS states:

"Diagnostic angiography (arteriogram/venogram) performed on the same date of service by the same provider as a percutaneous intravascular interventional procedure should be reported with modifier -59. If a diagnostic angiogram ***(fluoroscopic or computed tomographic)****was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier -59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier -52 to the angiogram CPT code. If the prior diagnostic angiogram* ***(fluoroscopic or computed tomographic)****was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure."*

Our interpretation of the above citation is that a CTA is considered a prior diagnostic angiography study.

Note that this differs from CPT guidelines which state that diagnostic angiography performed at the time of an interventional procedure is separately reportable if no prior catheter based study angiographic study is available.

The NCCI Manual is located at:
http://www.cms.hhs.gov/NationalCorrectCodInitEd/01_overview.asp

Do you have a question that you would like to see featured in an upcoming issue? Email your question to: stacie@southeastrad.com
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CMS News & Resources

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Upcoming Critical Dates for Medicare's Fee-for-Service (FFS) Implementation of the National Provider Identifier (NPI)

http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0802.pdf

Quick Links...

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Seminar Schedule

Tips & Tools

Let Us Know What You Think!

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We want to make sure that the information that we provide to you is relevant and timely. Please feel free to share comments and suggestions with us about our e-Alerts.

Contact Information

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