National Coverage Provision

Subject:
Ordering Diagnostic Tests and Interpretation of Test Results

Policy Number:
PHYS-002

Indications and limitations of Coverage

A. Ordering Diagnostic Tests

1. *The treating physician/practitioner must order all diagnostic tests furnished to a beneficiary who is not an institutional inpatient or outpatient. A testing facility that furnishes a diagnostic test ordered by the treating physician/practitioner may not change the diagnostic test or perform an additional diagnostic test without a new order. This policy is intended to prevent the practice of some testing facilities to routinely apply protocols which require performance of sequential tests.*

2. A "diagnostic test" includes all diagnostic x-ray tests, all diagnostic laboratory tests, and other diagnostic test furnished to a beneficiary.

*3. *A "treating physician" is a physician, as defined in §1861(r) of the Social Security Act (the Act), who furnishes a consultation or treats a beneficiary for a specific medical problem, and who uses the results of a diagnostic test in the management of the beneficiary's specific medical problem.*
Note: A radiologist performing a therapeutic interventional procedure is considered a treating physician. A radiologist performing a diagnostic interventional or diagnostic procedure is not considered a treating physician.

*4. *A "treating practitioner" is a nurse practitioner, clinical nurse specialist, or physician assistant, as defined in §1861(s)(2)(K) of the Act, who furnishes, pursuant to State law, a consultation or treats a beneficiary for a specific medical problem, and who uses the result of a diagnostic test in the management of the beneficiary's specific medical problem.*

*5. *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).*

*6. *An "order" is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y). An order may include the following forms of communication:*
   a. *A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility; NOTE: No signature is required on orders for clinical diagnostic test paid on the basis of the physician fee schedule for physician pathology services.*

b. *A telephone call by the treating physician/practitioner or his/her office to the testing facility; and*

c. *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.

*7. *When an interpreting physician, e.g., radiologist, cardiologist, family practitioner, general internist, neurologist, obstetrician, gynecologist, ophthalmologist, thoracic surgeon, vascular surgeon, at a testing facility determines that an ordered diagnostic radiology test is clinically inappropriate or suboptimal, and that a different diagnostic test should be performed (e.g., an MRI should be performed instead of a CT scan because of the clinical indication), the interpreting physician/testing facility may not perform the unordered test until a new order from the treating physician/practitioner has been received. Similarly, if the result of an ordered diagnostic test is normal and the interpreting physician radiologist believes that another diagnostic test should be performed (e.g., a renal sonogram was normal and based on the clinical indication, the interpreting physician believes an MRI will reveal the diagnosis), an order from the treating physician must be received prior to performing the unordered diagnostic test.*

*8. *Additional Diagnostic Radiology Test Exception. --If the testing facility cannot reach the treating physician/practitioner to change the order or obtain a new order and documents this in the medical record, then the testing facility may furnish the additional diagnostic test if all of the following criteria apply:*

a. *The testing center performs the diagnostic test ordered by the treating physician/practitioner;*

b. *The interpreting physician at the testing facility determines and documents that, because of the abnormal result of the diagnostic test performed, an additional diagnostic test is medically necessary;*

c. *Delaying the performance of the additional diagnostic test would have an adverse effect on the care of the beneficiary;*

d. *The result of the test is communicated to and is used by the treating physician/practitioner in the treatment of the beneficiary; and*

e. *The radiologist at the testing facility documents in his/her report why additional testing was done.*

EXAMPLE: (a) the last cut of an abdominal CT scan with contrast shows a mass requiring a pelvic CT scan to further delineate the mass; (b) a bone scan reveals a lesion on the femur requiring plain films to make a diagnosis.

*9. *Interpreting Physician Exception--This exception applies to an interpreting physician of a testing facility who furnishes a diagnostic test to a beneficiary who is not a hospital inpatient or outpatient. The interpreting physician must document accordingly in his/her report to the treating physician/practitioner.*

a. Test Design--Unless specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).

b. *Clear Error-The interpreting physician may modify, without notifying the treating physician/practitioner, an order with clear and obvious errors that*

would be apparent to a reasonable layperson, such as the patient receiving the test (e.g., x-ray of wrong foot ordered).

c. Patient Condition. --The interpreting physician may cancel, without notifying the treating physician/practitioner, an order because the beneficiary's physical condition at the time of diagnostic testing will not permit performance of the test (e.g., a barium enema cannot be performed because of residual stool in colon on scout KUB; PA/LAT of the chest cannot be performed because the patient is unable to stand). When an ordered diagnostic test is cancelled, any medically necessary preliminary or scout testing performed is payable.

10. *Surgical/Cytopathology Exception. --This exception applies to an independent laboratory's pathologist or a hospital pathologist who furnishes a pathology service to a beneficiary who is not a hospital inpatient or outpatient, and where the treating physician/practitioner does not specifically request additional tests the pathologist may need to perform. When a surgical or cytopathology specimen is sent to the pathology laboratory, it typically comes in a labeled container with a requisition form that reveals the patient demographics, the name of the physician/practitioner, and a clinical impression and/or brief history. There is no specific order from the surgeon or the treating physician/practitioner for a certain type of pathology service. While the pathologist will generally perform some type of examination or interpretation on the cells or tissue, there may be additional tests, such as special stains, that the pathologist may need to perform, even though they have not been specifically requested by the treating physician/practitioner. The pathologist may perform such additional tests under the following circumstances:*

    a. These services are medically necessary so that a complete and accurate diagnosis can be reported to the treating physician/practitioner;

    b. *The results of the tests are communicated to and are used by the treating physician/practitioner in the treatment of the beneficiary; and*

    c. *The pathologist documents in his/her report why additional testing was done.*

    EXAMPLE: A lung biopsy is sent by the surgeon to the pathology department, and the pathologist finds a granuloma which is suspicious for tuberculosis. The pathologist cultures the granuloma, sends it to bacteriology, and requests smears for acid fast bacilli (tuberculosis). The pathologist is expected to determine the need for these studies so that the surgical pathology examination and interpretation can be completed and the definitive diagnosis reported to the treating physician for use in treating the beneficiary.

B. <u>X-rays and EKGs furnished to Emergency Room Patients</u>

1. *The carrier pays for radiology services furnished by a physician to a beneficiary on a fee schedule basis only if the following requirements are met:*

    a. The services are personally furnished for an individual beneficiary by a physician.

    b. The services contribute directly to the diagnosis or treatment of an individual beneficiary

    c. The services ordinarily require performance by a physician.

    d. Are indentifiable, direct, and discrete diagnostic or therapeutic services furnished to an individual beneficiary, such as interpretation of x-ray plates, angiograms, myelograms, pyelograms, or ultrasound procedures. Payment for a professional component of a diagnostic procedure furnished to beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medial record maintained by the hospital.

2. *A professional component billing based on a review of the finding of an X ray or an EKG procedure, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service since the review is already included in the emergency department evaluation and management (E/M) payment. For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available).*

3. Generally, payment is made for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. The second interpretation is generally a quality control service to be taken into account by intermediaries in determining hospital reasonable costs. Hospitals are encouraged to work with their medical staffs to ensure that only one claim per interpretation is submitted. Payment may be made for a second interpretation (which may be identified through the use of modifier-77) only under **unusual** circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.
    a. When only one claim for an interpretation is received, presumption is that the one service billed was a service to the individual beneficiary rather than a quality control measure and payment will be made if it otherwise meets any applicable reasonable and necessary test.
    b. *When multiple claims for the same interpretation are received, generally payment is made for the first bill received. Payment is made for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. We will consider the second interpretation to be a quality control service. The physician specialty is not the primary factor in deciding which interpretation and report to pay regardless of when the service is performed. Payment for the interpretation billed by the cardiologist or radiologist may be made, if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary. (This interpretation may be an oral report to the treating physician that will be written at a later time.)*

Covered ICD-9 Codes
NA

Coding Guidelines

When submitting a claim for a 2nd Interpretation of an Xray or EKG in the Emergency room

1. Submit POS 23 in item 24b on the CMS 1500 claim form
2. Use modifier 77 in item 24e on the CMS 1500 claim form
3. Documentation should be available upon request.

History:

*MCM-3-Rev 1787, MCM 15021, MCM 15023, 42 CFR § 415.120, Formerly IL, MI and WI policy PHYS002, Merge Quad State 10/01/02

Dates:
Effective Date: 10/01/2002
Date Published: 10/01/2002, *03/01/2003 Article
Revision Date and Number: *03/01/2003 One: Defined Interpreting Physician, Defined Testing Facility

Comments
Italicized text is wording of Centers for Medicare and Medicaid Service (CMS). This text is published from CMS documentation and is subject to the CMS implementation date.

The CPT codes, descriptions and two-digit modifiers used in this policy are copyright by the American Medical Association. All rights reserved.