



Guidelines for Ordering Medical Imaging Examinations

Screening tests

With rare exceptions (e.g., mammography) Medicare does not cover preventive or screening services. If ordered incorrectly, a fully justified procedure or test could easily seem to fall into the “screening” category to a Medicare auditor. Please avoid use of terms indicating uncertainty, such as “rule out,” “possible,” “question,” “working diagnosis,” or “lesion” when ordering imaging tests, unless these speculative terms are supported by information regarding *your reason* for desiring the examination. An example of an appropriate order for CT scan of the pelvis is: “Left lower quadrant abdominal pain, fever, R/O diverticulitis.” Even though “R/O” appears in the order, supporting symptoms are present to justify the CT scan.

If you wish to obtain an examination that you know to be for screening purposes (e.g., “chest X-ray for annual physical”), please label it as such on your written order. This simple step will help us greatly. Bear in mind that such services are likely to be considered non-reimbursable by Medicare, and that your patient will assume financial responsibility for the screening examination.

Some physicians do not wish to subject their patients to anxiety by giving them prescriptions that have “R/O cancer” or other potentially serious diagnoses. Once again, listing the symptoms leading up to your decision to order the test will usually suffice. Alternatively, please send a confidential FAX requisition with the appropriate history directly to us.

Frequently linked examinations

Please remember to list *all* desired imaging examinations on the patient’s written order form. Medicare rules specifically prohibit us from adding additional imaging studies beyond those requested by the treating physician/practitioner, except in cases of true medical emergency. Anatomically sequential CT scans are probably the most frequently encountered linked examinations. For example, if only an abdominal CT scan is ordered for “Right lower quadrant pain, appendicitis,” we are technically not allowed to add a CT pelvis without obtaining a new written order. Similarly, if your patient needs both a standard MRI of the brain as well as an MR angiogram of the intracranial arteries, written orders for both of these tests are necessary. We are not allowed to substantially change or add to your written order unilaterally, even if we feel we know exactly what you meant to say.

Conditional orders

At times, the decision to proceed with further testing will depend on the results of a first-line imaging examination. For example, a physician treating a patient with abdominal pain might order an abdominal ultrasound, but would be interested in an abdominal CT if the ultrasound proved to be normal. It is appropriate to order the abdomen CT at the same time as the abdominal ultrasound, but on a conditional basis. The written order would state: “Abdominal ultrasound for abdominal pain. If negative, abdominal CT scan.”

Conditional orders must not be routine, but used selectively on a case-by-case basis. Due to the clear potential for abuse, any policy of *always* adding on additional examinations is frowned upon by the federal government. Clifton Park Advanced Imaging neither encourages nor discourages use of conditional orders – they are simply a time-saver when used appropriately.

Patient History and Diagnosis Documentation

Medicare documentation rules require that any imaging test or procedure billed to Medicare must be:

- 1) Ordered by the patient's treating physician or other approved health care provider,
- 2) Medically necessary for the treatment of the patient, and
- 3) Properly documented with sufficient patient history or diagnoses to establish medical necessity as defined by Medicare.

The recent Centers for Medicare & Medicaid (CMS) Program Memorandum Transmittal B-01-61, "ICD-9-CM Coding for Diagnostic Tests," sets out certain important ground rules. First, **CMS requires "referring physicians ... to provide diagnostic information to the testing entity at the time the test is ordered."** Second, the interpreting physician (in our case, radiologist) "should code the ICD-9-CM code that provides the highest degree of accuracy and completeness for the diagnosis resulting from the test, or for the sign(s)/symptom(s) that prompted the ordering of the test." Third, an order may include "a written document signed by the treating physician/practitioner," "a telephone call [or] an electronic mail by the treating physician/practitioner or his/her office to the testing facility." CMS goes on to state: "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 record." Fourth, "... 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. However, an attempt should be made to confirm ... by contacting the referring physician."

Clifton Park Advanced Imaging is required by law to retain the treating physician's order for any examination that we perform, and to produce this order in case of an audit. Our staff may from time to time find it necessary to telephone your office for additional supporting historical or diagnostic information during the scheduling or registration of your patients. We apologize in advance for any inconvenience that this may cause you and your office staff, but we are obliged to follow the law. In order to head off most of these potential calls, please:

- 1) Provide a diagnosis at the highest level of specificity that has been attained for the patient's condition. For example, "Pancreatic adenocarcinoma" is preferable to "Tumor" when requesting a CT scan of the abdomen (providing that a definitive diagnosis of pancreatic cancer has been made). "Tumor" is considered more specific than "mass."
- 2) Avoid using a coexisting, but unrelated, condition as the reason for the test. If a patient with reflux esophagitis also has frequent headaches, please list "headaches" rather than "history of reflux disease" as the indication for the CT scan of the brain.
- 3) List symptoms or signs as the reason for a test, if that is your highest level of certainty. It is helpful to then state a "rule out" or "possible" diagnosis to guide us as to your thinking.
- 4) Feel free to specify diagnoses by using actual ICD-9 codes, if they are available and appropriate.

Determination of Medical Necessity

Medicare publishes its standards of medical necessity as Local Medical Review Policies, or LMRP's. These policies cover a variety of services of interest to CMS, and list the approved range of ICD-9-CM codes for substantiating the medical necessity of each service, grouped under each CPT code. If you would like to refer to any of these LMRP's, they may be found on the Internet at <http://www.umd.nycpic.com/lmrp.html>.

Summaries of these policies are available on our website, <http://www.cliftonparkimaging.com>, by clicking the Provider Information tab on the left side of the home page.

Relevant LMRP's for our services at CPAI include:

- 1) Abdominal retroperitoneal ultrasound
- 2) Abdominal ultrasound procedures
- 3) Computerized axial tomography (CT/CAT scans)
- 4) Magnetic resonance angiography (MRA)
- 5) Measurement of post-void residual urine and/or bladder capacity by ultrasound
- 6) Noninvasive vascular diagnostic studies
- 7) Nonvascular extremity ultrasound
- 8) Pelvic ultrasound procedures
- 9) Radiologic examination of the chest

At the time of scheduling or registration, CPAI's receptionists will consult the LMRP appropriate for the examination you have ordered, if one has been published. If the patient's stated history or diagnosis does not support medical necessity, as defined by Medicare, we will make every attempt to contact your office for additional historical information which might further clarify your diagnostic concerns. **Please do not give us, or allow your staff to give us, incorrect or inaccurate information intended solely to establish medical necessity. We prohibit our staff from coaching or directing any provider to supply inaccurate diagnosis or historical data for the purpose of inappropriately justifying medical necessity.** Once again, we have adopted this policy to remain in compliance with the law.

Advance Beneficiary Notices

Medicare does not prohibit us from performing services it deems "not medically necessary." However, in these instances, the patient is responsible for payment, either out-of-pocket or via a secondary insurer. In order to establish that the patient has been informed of his or her financial obligation *prior to* receiving the service, we are required to obtain the patient's signature on an Advance Beneficiary Notice (ABN). This Medicare-approved form explains the process to the patient, and our staff is required to give the estimated cost up front and in writing. Advance Beneficiary Notices may not be obtained after the service is rendered.

The act of signing an ABN does not inevitably mean that your patient will have to pay for the examination. If, when we contact your office, you provide us in good faith with further historical information that allows the legitimate addition of an approved ICD-9 code, then the patient's bill will be submitted to, and payable by, Medicare in the usual fashion. Some patients have secondary, or MediGap, insurance that may pay most or all of our charges. Finally, Medicare regulations now permit retrospective coding, meaning that ICD-9 coding may reflect diagnoses made as a result of the test itself. For example, the only information available for a chest X-ray might be "rule out pneumonia," but the chest film may demonstrate that, in fact, pneumonia is present. The ABN, having been obtained because "rule out pneumonia" would be considered a screening indication, becomes unnecessary once a firm diagnosis of "pneumonia" is made.

If we have exhausted all reasonable possibilities to obtain insurance payment, we are required by law to make good faith efforts to collect our charges directly from the patient. We recognize that many seniors live on fixed incomes, and may simply be unable to pay our stated fee. Clifton Park Advanced Imaging will be happy to work with your patients to arrive at a fee adjustment in cases of genuine financial hardship.

By asking the patient to sign an ABN, our only goal is compliance with the law. We are sensitive to referring physicians' concerns that patients might understandably draw the wrong conclusions from an implied doubt on our part about the necessity of the service you have ordered. Questioning your clinical judgment is not our intent, and we will do everything possible to explain the situation to your patient.

Confirmation of additional history

At any time that it becomes necessary to modify or substantially add to the original diagnosis or clinical history given to us, we will record this new information and FAX it to you for your review. Please review this form for accuracy and let us know if there are any errors. Since the law requires that both you and we enter this information into the patient's clinical record, we encourage you to incorporate our FAX (or at least the information that it conveys) into your office chart. We will also utilize this form to record information received directly from the patient. We are not seeking to conduct our own separate history-taking, but will ask the patient to relate his or her impression of what led *you* to request this particular imaging evaluation.

Alternatives

In short, there are no alternatives. As providers of services under Medicare, both the referring physician and the radiologist have a legal obligation to furnish accurate diagnostic information in connection with any Medicare claim. The Social Security Act and subsequent legislation allows for imposition of stiff civil penalties, including fines and possible exclusion from Medicare and Medicaid, for violations of regulations. Even criminal penalties may apply in egregious cases of willful misconduct. Our practice takes these legal responsibilities seriously. We encourage you to do the same, both for your own protection and your peace of mind. Please view with skepticism any representations that may be made to you by others indicating that these Federal regulations are in any way optional, overly restrictive, or unlikely to be enforced. We *all* have to live with these laws.

Further information

We have found the following web sites to be of value:

Office of Inspector General, Health and Human Services <http://oig.hhs.gov/>

Upstate NY Medicare <http://www.umd.nycpic.com/provinfo.html>

Centers for Medicare and Medicaid Services <http://cms.hhs.gov/professionals/default.asp>

Please contact us

If you have any questions, complaints, or suggestions, please feel free to call us at 688-1177. Our practice administrator, Michael Whalen, will be glad to speak with you or your staff concerning our compliance responsibilities and procedures. We also employ a Certified Medical Coder, Ms. Deborah Kazukenus, who is available to speak directly with your office staff.

Once again, thank you for your continued support of Clifton Park Advanced Imaging.