FACT SHEET

ADVANCED IMAGING SERVICES

No Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

DOCUMENATION

MUST support the service was rendered and/or supervised as required:

- Ordered service is same as billed service
- Signed interpretation of the service
- Notation on report that the supervision requirements of the service were met – if required
- Utilization of the results in the patient's treatment planning and/or care as needed to establish Medical Necessity
- Must support the treating physician's use of the diagnostic test in the patient's care
- Must support the completion and interpretation of the test

Orders

An order is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary.

Documents that may serve as an order or intent to order:

- Written/signed document from the treating physician, hand-delivered, faxed or mailed
- Signed progress note indicating reason and test desired
- E-mail from treating physician to testing facility requesting test and reason for such. The treating physician must sign the emailed order.
- Telephone call documented by the treating physician and testing facility in the patient's medical record. The treating physician must sign off on the phoned in order during his next visit to the facility.
- An order may conditionally request additional or sequential tests if the results of the initial test yields a certain value predetermined by the treating physician

"There are some circumstances for which an order does not need to be signed. For example, orders for clinical diagnostic tests are not required to be signed. The rules in 42 CFR 410 (http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/Downloads/lab1.pdf) and Pub 100-02, chapter 15, section 80.6.1 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf), state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician (i.e. a progress note) that he/she intended the clinical diagnostic test be performed. **This documentation showing the intent that the test be performed MUST be authenticated by the author** via a handwritten or electronic signature." CMS Publication 100-08, Chapter 3, sec 3.3.2.4 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf).

Repeat Testing

- If subsequent or repeat testing is required, documentation must support the reasons why the initial tests were insufficient or why the serial progression of test was required. (i.e. CT first then MRI).
- Imaging services that are repeated or advanced based on conditional orders from the treating physician; those conditions must be documented and supported by the interpretation of the initial test report.
- If an interpreting physician determines that an ordered diagnostic radiology test is clinically inappropriate or suboptimal and a different diagnostic test should be performed a new order MUST be obtained from the treating physician/practitioner.
- If the result of an ordered diagnostic test is normal and the interpreting physician believes that another diagnostic test should be performed a new order MUST be obtained from the treating physician/practitioner.

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services billed to Medicare must meet Medical Necessity. The definition of "medically necessary" for Medicare purposes is located in Section 1862(a)(1)(A) of the Social Security Act – Medical necessity (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

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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:

- 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
- Delaying the performance of the additional diagnostic test would have an adverse effect of the care of the beneficiary
- The result of the test is communicated to and is used by the treating physician/practitioner in the treatment of the beneficiary; and
- The interpreting physician at the testing facility documents in his/her report why additional testing was done.

Medical Necessity

- Must be evidenced not only by the correct ICD-9 coding but also by documentation in the patient's medical record supporting the diagnosis and need for the test
- Frequency of services must be medically necessary based on initial inconclusive results, need for further diagnostic testing, measurement of efficacy of treatment (tumor growth/recession), or superiority of imaging techniques.

Additional Information

- Advanced imaging must be used in accordance with standard of medical practice
- All Medicare providers, including outpatient facilities, independent diagnostic treatment facilities (IDTF), may be required to submit a copy of the ordering provider's clinical notes to allow a determination of medical necessity. An order with an ICD-9 code or only a written diagnosis is insufficient if clinical notes are requested for review.
- Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf). You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters article MM6698 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf). A sample attestation statement (http://www.cgsmedicare.com/kyb/claims/cert/Attestation_form.pdf) is available on the CGS website. Guidelines regarding signature requirements are located in CMS Publication 100-8, chapter 3, section 3.3.2.4 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf).

References:

- Covered Medical & Other Health Services: CMS Publication 100-02, Chapter 15, sec 80.6: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
- Radiology Services: CMS Publication 100-04, Chapter 13, sec 20.1, 20.3, 30.1, 40.1, 100: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c13.pdf
- Coverage of Diagnostic Testing: Section 1861(s)(2)(A) of the Social Security Act: http://www.ssa.gov/OP_Home/ssact/title18/1861.htm#s2A
- National Coverage Determination, Radiology: CMS Publication 100-03, Chapter 1, Part 4, section 220: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf

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