Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2410

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
15021 - 15021.1	15-31 - 15-32.2 (4 pp.)	15-32 - 15.32.2 (4 pp.)
15022 (Cont.) - 15022 (Cont.)	15-33 - 15-34 (2 pp.)	15-33 - 15-34 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* January 1, 2003
***IMPLEMENTATION DATE:* February 24, 2003**

Section 15021, Ordering Diagnostic Tests, is revised to broaden the instructions to include additional physicians as interpreting physicians.

Section 15022, Payment Conditions for Radiology Services, is revised to remove weekly radiation therapy management codes 77419-77430 that were deleted and replaced by code 77427.

Carriers must provide necessary information regarding this topic on their Web sites within two weeks and in their next scheduled bulletin.

MANUALIZATION—*EFFECTIVE DATE:* Not Applicable

Section 15021, Ordering Diagnostic Tests, manualizes Transmittal AB-02-030, dated March 5, 2002. In accordance with negotiated rulemaking for outpatient clinical diagnostic laboratory services, no signature is required for the ordering of such services or for physician pathology services.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All material was previously published in the manual and is only being reprinted.

87164 Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection
87207 Smear, primary source, with interpretation; special stain for inclusion bodies or intracellular parasites (e.g., malaria, kala azar, herpes)
88371 Protein analysis of tissue by Western Blot, with interpretation and report.
88372 Protein analysis of tissue by Western Blot, immunological robe for band identification, each
89060 Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)

15021. ORDERING DIAGNOSTIC TESTS

A. Definitions.--

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

2. 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.

3. 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.

4. 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).

5. 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 tests paid on the basis of the physician fee schedule or 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.

B. Treating Physician/Practitioner Ordering of Diagnostic Tests.--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.

C. Different Diagnostic Test.--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 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.

D. Additional Diagnostic 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:

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

2. 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;

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

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

5. The interpreting physician 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.

E. 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.

1. 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).

2. 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).

3. 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.

F. 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:

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

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

3. 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.

15021.1 ICD-9-CM Coding for Diagnostic Tests.--

As required by the Health Insurance Portability and Accountability Act (HIPAA), the Secretary published a rule designating the ICD-9-CM and its *Official ICD-9-CM Guidelines for Coding and Reporting* as one of the approved code sets for use in reporting diagnoses and inpatient procedures. This final rule requires the use of ICD-9-CM and its official coding and reporting guidelines by most health plans (including Medicare) by October 16, 2002. The Administrative Simplification Act of 2001, however, permits plans and providers to apply for an extension until October 16, 2003. HHS anticipates that most plans and providers will obtain this extension.

The *Official ICD-9-CM Guidelines for Coding and Reporting* provides guidance on coding. The ICD-9-CM Coding Guidelines for Outpatient Services, which is part of the *Official ICD-9-CM Guidelines for Coding and Reporting,* provides guidance on diagnosis coding specific to outpatient facilities and physician offices.

The ICD-9-CM Coding Guidelines for Outpatient Services (hospital-based and physician office) have instructed physicians to report diagnoses based on test results. The Coding Clinic for ICD-9-CM confirms this longstanding coding guideline. CMS conforms with these longstanding official coding and reporting guidelines.

The following are instructions and examples for coding specialists, contractors, physicians, hospitals, and other health care providers to use in determining the use of ICD-9-CM codes for coding diagnostic test results. The instructions below provide guidance on the appropriate assignment of ICD-9-CM diagnosis codes to simplify coding for diagnostic tests consistent with the ICD-9-CM Guidelines for Outpatient Services (hospital-based and physician office). Note that physicians are responsible for the accuracy of the information submitted on a bill.

Additional examples of using ICD-9-CM codes consistently with ICD-9-CM Coding Guidelines for Outpatient Services are provided at the end of this section.

A. Determining the Appropriate Primary ICD-9-CM Diagnosis Code For Diagnostic Tests Ordered Due to Signs and/or Symptoms.--

1. If the physician has confirmed a diagnosis based on the results of the diagnostic test, the physician interpreting the test should code that diagnosis. The signs and/or symptoms that prompted ordering the test may be reported as additional diagnoses if they are not fully explained or related to the confirmed diagnosis.

EXAMPLE 1: A surgical specimen is sent to a pathologist with a diagnosis of "mole." The pathologist personally reviews the slides made from the specimen and makes a diagnosis of "malignant melanoma". The pathologist should report a diagnosis of "malignant melanoma" as the primary diagnosis.

EXAMPLE 2: A patient is referred to a radiologist for an abdominal CT scan with a diagnosis of abdominal pain. The CT scan reveals the presence of an abscess. The radiologist should report a diagnosis of "intra-abdominal abscess."

EXAMPLE 3: A patient is referred to a radiologist for a chest x-ray with a diagnosis of "cough". The chest x-ray reveals a 3 cm peripheral pulmonary nodule. The radiologist should report a diagnosis of "pulmonary nodule" and may sequence "cough" as an additional diagnosis.

2. If the diagnostic test did not provide a definitive diagnosis or was normal, the testing facility or the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.

EXAMPLE 1: A patient is referred to a radiologist for a spine x-ray due to complaints of "back pain". The radiologist performs the x-ray, and the results are normal. The radiologist should report a diagnosis of "back pain" since this was the reason for performing the spine x-ray.

EXAMPLE 2: A patient is seen in the ER for chest pain. An EKG is normal, and the final diagnosis is chest pain due to suspected gastroesophageal reflux disease (GERD). The patient was told to follow-up with his primary care physician for further evaluation of the suspected GERD. The primary diagnosis code for the EKG should be chest pain. Although the EKG was normal, a definitive cause for the chest pain was not determined.

4. Positron Emission Tomography (PET) Scans (HCPCS Codes G0030 -G0047).--For procedures furnished on or after March 14, 1995, pay for PET procedure of the heart under the limited coverage policy set forth in §50-36 of the Coverage Issues Manual (CMS Pub. 6) using the billing instructions in §4173 of the Medicare Carriers Manual.

D. Radiation Oncology (Therapeutic Radiology) (CPT 77261-77799).--

1. Weekly Radiation Therapy Management (CPT 77427).--Pay for a physician's weekly treatment management services under code 77427. Instruct billing entities to indicate on each claim the number of fractions for which payment is sought.

A weekly unit of treatment management is equal to five fractions or treatment sessions. A week for the purpose of making payments under these codes is comprised of five fractions regardless of the actual time period in which the services are furnished. It is not necessary that the radiation therapist personally examine the patient during each fraction for the weekly treatment management code to be payable. Multiple fractions representing two or more treatment sessions furnished on the same day may be counted as long as there has been a distinct break in therapy sessions, and the fractions are of the character usually furnished on different days. Code 77427 is also reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately. The professional services furnished during treatment management typically consist of : Review of port films; review of dosimetry, dose delivery, and treatment parameters; review of patient treatment set-ups; examination of patient for medical evaluation and management, (e.g., assessment of the patient's response to treatment, coordination of care and treatment, review of imaging and/or lab test results).

EXAMPLE: 18 fractions = 4 weekly services
62 fractions = 12 weekly services
8 fractions = 2 weekly services
6 fractions = 1 weekly service

If billings have occurred which indicate that the treatment course has ended (and, therefore, the number of residual fractions has been determined), but treatments resume, adjust your payments for the additional services consistent with the above policy.

EXAMPLE: 8 fractions = payment for 2 weeks
2 additional fractions are furnished by the same physician. No additional Medicare payment is made for the 2 additional fractions.

There are situations in which beneficiaries receive a mixture of simple (code 77420), intermediate (code 77425), and complex (code 77430) treatment management services during a course of treatment. In such cases, pay under the weekly treatment management code that represents the more frequent of the fractions furnished during the five-fraction week. For example, an intermediate weekly treatment management service is payable when, in a grouping of five fractions, a beneficiary receives three intermediate and two simple fractions.

2. Services Bundled Into Treatment Management Codes.--Make no separate payment for any of the following services rendered by the radiation oncologists or in conjunction with radiation therapy:

11920 Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; 6.0 sq. cm or less
11921 6.1 to 20.0 sq. cm

11922	each additional 20.0 sq. cm
16000	Initial treatment, first degree burn, when no more than local treatment is required
16010	Dressings and/or debridement, initial or subsequent; under anesthesia, small
16015	under anesthesia, medium or large, or with major debridement
16020	without anesthesia, office or hospital, small
16025	without anesthesia, medium (e.g., whole face or whole extremity)
16030	without anesthesia, large (e.g., more than one extremity)
36425	Venipuncture, cut down age 1 or over
53670	Catheterization, urethra; simple
53675	complicated (may include difficult removal of balloon catheter)
99211	Office or other outpatient visit, established patient; Level I
99212	Level II
99213	Level III
99214	Level IV
99215	Level V
99238	Hospital discharge day management
99281	Emergency department visit, new or established patient; Level I
99282	Level II
99283	Level III
99284	Level IV
99285	Level V
90780	IV infusion therapy, administered by physician or under direct supervision of physician; up to one hour
90781	each additional hour, up to eight (8) hours
90841	Individual medical psychotherapy by a physician, with continuing medical diagnostic evaluation, and drug management when indicated, including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy; time unspecified
90843	approximately 20 to 30 minutes
90844	approximately 45 to 50 minutes
90847	Family medical psychotherapy (conjoint psychotherapy) by a physician, with continuing medical diagnostic evaluation, and drug management when indicated
99050	Services requested after office hours in addition to basic service
99052	Services requested between 10:00 PM and 8:00 AM in addition to basic service
99054	Services requested on Sundays and holidays in addition to basic service
99058	Office services provided on an emergency basis
99071	Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician
99090	Analysis of information data stored in computers (e.g., ECG, blood pressures, hematologic data)
99150	Prolonged physician attendance requiring physician detention beyond usual service (e.g., operative standby, monitoring ECG, EEG, intrathoracic pressures, intravascular pressures, blood gases during surgery, standby for newborn care following caesarean section); 30 minutes to one hour