DEPARTMENT: Regulatory Compliance Support	**POLICY DESCRIPTION:** Billing Guidelines for Orders for Outpatient Tests and Services for Non-Hospital Entities
PAGE: 1 of 6	**REPLACES POLICY DATED:** 11/15/06, 7/1/09, 10/15/10, 10/1/15
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APPROVED BY: Ethics and Compliance Policy Committee	

SCOPE: All personnel responsible for ordering, registering, performing, charging, coding or billing for testing performed in Non-Hospital entities. This includes, but is not limited to:

- Administration
- Advanced Practice Professionals (APPs)
- Ambulatory Surgery Division (ASD)
- Coding/Billing
- Employed and Managed Physicians
- Ethics and Compliance Officers (ECOs)
- Freestanding Imaging Centers
- Freestanding Radiation Oncology Centers
- Independent Diagnostic Testing Facilities (IDTFs)
- Ordering/Referring/Rendering Physicians
- Parallon
- Physician Service Center (PSC)
- Physician Services Group (PSG)
- Practice Management
- Shared Service Center (SSC)

PURPOSE: To establish billing guidelines outlining the documentation required for complete non-hospital outpatient test and service orders in order to bill in accordance with Medicare, Medicaid and other federally-funded payer guidelines.

POLICY: Orders for outpatient tests and services are valid for billing purposes provided they are documented and include the data elements as defined in this policy. Absent specific exceptions and consistent with Federal and State law, tests and services must be provided based on the order of physicians or Advanced Practice Professional (APP) acting within the scope of any license, certificate, or other legal credential authorizing practice in the state in which the entity is located. The physician or APP who orders the service must maintain documentation of the reason for the test or diagnosis in the patient's medical record.

PROCEDURE:

A. Non-Hospital entity staff must review outpatient orders for tests and services to verify required data elements exist as outlined below. Each category listed below (Documentation Elements for Tests and Services Orders, Requirements for Orders for Diagnostic Tests and Services, Coding Documentation for Orders for Tests and Services, Billing Documentation for Tests and Services) is mutually exclusive.

1. **Test and Service Orders – General Documentation Requirements**
   The following elements are needed to support the performance and charging of a test or service. Please note all elements need not be in the same document, but may be found in many areas, including the patient's medical record in the referring provider's office.
   a. Reason for ordering test or service (i.e., diagnosis, sign, symptom, ICD-10-CM diagnosis code)
   b. Test or service requested (i.e., CPT, HCPCS code or description of service)
   c. Orders must be reduced to writing
   d. Ordered only by the treating Physician/APP
   e. Name of Physician or APP ordering test or service
   f. Address of Physician or APP ordering test or service

g. Phone Number of Physician or APP ordering test or service
h. Physician or APP authentication ordering test or service
i. Patient name
j. Current dates for verbal orders- date order given, date/time order entered into patient record and date/time of authentication by responsible practitioner

2. **Orders for Diagnostic Tests and Services – Formats, ASC, Exceptions, and Preventive**
   a. Orders for diagnostic tests or services, absent a test specific exception, for example screening mammography, must be obtained from the treating physician/practitioner and can be any of the following:
      i. A written document signed or generated by the treating physician/practitioner that is hand delivered, mailed or faxed to the testing facility.
      ii. A telephone call by the physician/APP or their office to the testing facility. If the order is communicated via telephone, both the treating physician/APP or their office, and the testing facility must document the telephone call in their respective copies of the patient's medical records.
      iii. An electronic mail communication by the treating physician/APP or their office to the testing facility.
      iv. Some Medicare contractors may issue specific instructions on how orders for diagnostic tests need to be documented in an IDTF. When a contractor has issued such instructions, their requirements must be followed.
   b. Freestanding Ambulatory Surgery Centers
      Many ASCs perform diagnostic tests prior to surgery that are generally included in the facility charges, such as urinalysis, blood hemoglobin, hematocrit levels, etc. The medical record documentation (e.g., operative report, history and physical, anesthesia evaluation) should support the performance of the diagnostic test as integral to the surgical procedure.
   c. Additional requirements for IDTFs**:**
      i. All procedures performed by the IDTF must be specifically ordered in writing by the physician/APP that is treating the patient with the exception of screening mammography services.
      ii. IDTFs may not add any procedures based on internal protocols without a written order from the treating physician/APP (e.g., every screening mammography performed is followed by a diagnostic mammography regardless of findings).
      iii. A testing facility that furnishes a diagnostic test ordered by the treating physician/APP may not change the diagnostic test or perform an additional diagnostic test without a new order.
      iv. When an interpreting physician 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, the interpreting physician/testing facility may not perform the unordered test until a new order from the treating

physician/APP 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, an order from the treating physician/APP must be received prior to performing the unordered diagnostic test.

d. Exceptions for Orders for IDTFs:
   i. If the testing facility cannot reach the treating physician/APP 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/APP;
      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 patient;
      d) The result of the test is communicated to and is used by the treating physician/APP in the treatment of the patient; and
      e) The interpreting physician at the testing facility documents in his/her report why the additional testing was done.
   ii. Interpreting physicians in a freestanding testing facility may do the following provided the report of the findings to the treating physician/APP includes the following information:
      a) Unless specified in the order, an interpreting physician of a freestanding testing facility may determine the parameters of the diagnostic test without notifying the treating physician/APP (e.g., number of radiographic views obtained, use or non-use of contrast media).
      b) The interpreting physician may modify, without notifying the treating physician/APP, an order with clear and obvious errors that would be apparent to a reasonable layperson, such as the person receiving the test (e.g., x-ray of the wrong foot ordered).
      c) The interpreting physician may cancel, without notifying the treating physician/APP, an order because the patient's physical condition at the time of diagnostic testing will not permit performance of the test.

e. Orders for Preventive Diagnostic Imaging Services
   CMS allows for a patient to self-refer for a screening mammogram which means an order is not required from the patient's treating physician/APP.

f. Diagnostic Mammogram Following a Screening Mammogram
   CMS has established an exception to the ordering rules that enables the testing facility to immediately perform a diagnostic mammogram if the results of the patient's screening mammogram are abnormal. This exception permits the interpreting radiologist to order only a diagnostic mammogram. Performance of a breast

ultrasound or other diagnostic tests requires an order from the treating physician. [Medicare Claims Processing Manual Chapter 18, Section 20.6]

Providers submitting a claim for a screening mammography and a diagnostic mammography for the same patient on the same day, attach modifier "-GG" to the diagnostic mammography. A modifier "-GG" is appended to the claim for the diagnostic mammogram for tracking and data collection purposes.

3. **Coding Documentation for Diagnostic Tests and Services**
   The following list represents those minimum elements required to code tests or services.
   a. Reason for ordering test or service including symptom, sign or rationale for visit, ICD-10-CM code, or diagnosis Test or service requested (i.e., CPT, HCPCS code or description of service)
   b. Written orders/communication from the referring provider/office
   c. Name of Physician or APP ordering test or service
   d. Patient name
   e. Date of service

4. **Billing Documentation for Diagnostic Tests and Services**
   The following list represents those minimum elements required to submit a bill for payment of a test or service.
   a. ICD-10-CM diagnosis code
   b. Tests or services ordered and performed
   c. Date of Service
   d. Name of Physician or APP ordering test or service
   e. NPI, State License, or Payer Specific Number of Physician or APP
   f. Patient name
   g. Patient date of birth
   h. Patient sex
   i. Patient Social Security Number
   j. Patient demographics/insurance information

5. **Unique Payer Requirements: Unique Payer Requirements are defined as a specific requirement(s) described by the payer as being a situation in which the payer will be responsible for payment of a bill or invoice.**
   a. Generally, Unique Payer Requirements will meet some or all of the following criteria:
      - Specific coding and/or billing instruction or requirements described by the payer (e.g., Medicare, Medicaid, Blue Cross) for claims submitted by the provider.
      - Variation(s) from official coding and/or billing guidance (e.g., Coding Clinic, CPT Assistant, CMS Rules).
      - Description of certain conditions in which the payer states a claim will be paid or considered for payment.
      - Explanation of various coverage conditions (e.g., medical necessity evidence and services excluded from coverage).

- Specific information may be found in the following documents:
  - Local Coverage Determination (LCD)
  - Local Coverage Article (LCA)
  - Medicare National Coverage Determination (NCD)
  - Medicare Administrator Contractor (MAC), or Payer newsletters
  - Contract agreement between provider and payer

NOTE: Unique payer requirements are not intended to be coding guidelines. However, the payer may provide guidance that it requires codes to be reported in a certain manner.

b. Medicare billing guidelines may vary by MAC and other payers may have different billing guidelines. Therefore, verbal guidelines must be obtained in writing. It is important to document all conversations held with the payer as an audit trail (this should include the date, the name of the person spoken with, and the subject discussed). It may be helpful to send a certified letter to the payer seeking confirmation of the understanding of the Unique Payer Requirement and request that the letter be signed and returned.

6. **Obtaining Missing Information Related to Orders for Tests and Services**
If information from the order is missing, the testing center staff members receiving the outpatient order must attempt to obtain the required information from the treating physician/office. Every effort should be made to obtain all information prior to tests being performed or services being rendered. However, if patient care is at risk, perform the test(s) or the service(s) and subsequently obtain required elements. Refer to the attached Written Verification of Verbal and Incomplete Orders which can be used as a mechanism to obtain any required information that may be missing from the order or to document a verbal order.

B. All staff responsible for ordering, registering, performing, charging, coding or billing outpatient tests or services must be educated on the contents of this policy.

DEFINITIONS:

ASC Radiology Services: Freestanding ASC radiology services are only separately paid when they are provided integral to the performance of covered surgical procedures (72 FR42498). Physician documentation to support the performance and separate charging of these radiology services should be included in the medical record documentation.

Authentication: An author's validation of his or her own entry in a document. Methods may include but are not limited to written signatures, faxed signatures or electronic "signatures" depending on state law. Only the physician or APP ordering the test or service may perform authentication. State regulations and entity rules and regulations specify whether APP orders

require countersignature by a physician. Signature stamps are not valid for medical record documentation purposes.

Independent Diagnostic Testing Facility (IDTF): A facility that performs only diagnostic testing and may be a fixed location or a mobile unit. Consistent with 42 CFR 410.33(a)(1), an IDTF is one that is independent both of an attending or consulting physician's office and of a hospital. However, IDTF general coverage and payment policy rules apply when an IDTF furnishes diagnostic procedures in a physician's office.

Advanced Practice Professional (APP): Individuals such as clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners and physician assistants who furnish services that would be physician services if furnished by a physician and who are operating within the scope of their authority under State law and within the scope of their Medicare statutory benefit.

Treating Physician: A physician who furnishes a consultation or treats a patient for a specific medical problem, and who uses the results of a diagnostic test in the management of the patient's specific medical problem. A radiologist performing a therapeutic interventional procedure is considered a treating physician. A radiologist performing a diagnostic interventional or diagnostic procedure who is not assuming the care for the patient is not considered a treating physician.

Treating APP: An APP who furnishes, pursuant to State law, a consultation or treats a patient for a specific medical problem, and who uses the result of a diagnostic test in the management of the patient's specific medical problem.

REFERENCES:

1. Federal Register 42 CFR 410.32, 410.33(d), 410.34
2. Records Management Policy, EC.014
3. Licensure and Certification Policy, COG.PPA.002
4. Medicare Claims Processing Manual (Pub 100-4), Chapter 18, Sections 10 and 20
5. Medicare Claims Processing Manual (Pub 100-04), Chapter 35
6. Medicare Benefit Policy Manual (Pub 100-2), Chapter 15, Section 50
7. Attachment A: Written Verification of Verbal and Incomplete Orders