Ordering Diagnostic Tests—Are You Providing Accurate Information?

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Radiation and medical oncologists count on other providers for patient referrals—sometimes it is the surgeon, occasionally it is the internal medicine specialist or it may be the medical oncologist referring to the radiation oncologist (or vice versa). With the advent of ICD-10-CM, providers on the receiving end of referrals are expecting complete and accurate clinical information that may ultimately be used for diagnosis code assignment to be part of the referral process. But what if the oncologist is the physician referring a patient for a diagnostic imaging study? Will the test request have the correct patient diagnosis information with the highest degree of specificity? Unfortunately, complete and accurate orders for advanced imaging services, including CT, MRI, and PET scans, continue to challenge many healthcare organizations, regardless of which physician specialty placed the order.

The Department of Health and Human Services (HHS) recently announced goals of transferring 30 percent of Medicare payments into alternative payment models by the end of 2016 and 50 percent by the end of 2018, shifting 85 percent of Medicare payments to a model tied to quality or value by 2016 and 90 percent by 2018.[1] For any patient encounter, the CPT® procedure code(s) determines how much a provider is paid, but it is the diagnosis code(s) that determines if the service is reimbursed. The smooth, effective continuum of patient care that we want for our family members and ourselves requires clear, timely, and well-documented orders from the treating practitioners who request imaging.[2]

Medicare

It is important to remember that the Centers for Medicare & Medicaid Services (CMS) guidelines for Independent Diagnostic Testing Facilities (IDTFs) and physician offices are different from hospital ordering guidelines. In addition, commercial payer requirements for orders can also differ significantly, which means each payer policy must be obtained and reviewed. CMS has published specific rules for the ordering of diagnostic tests in the Medicare Benefit Policy Manual, Chapter 15, Section 80.6.[3] This section defines an order as a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. For a test to be reasonable and necessary it must be ordered by the attending physician or practitioner and the ordering physician must use the result in the management of the beneficiary's specific medical problem.

The requirements for any services ordered in the hospital are detailed in the Medicare Hospital Conditions of Participation (CoP). These can be found in the Code of Federal Regulations [42 CFR §482.26(b)(4)], which states that services must be provided only on the order of practitioners with clinical privileges or, consistent with State law, of other practitioners authorized by the medical staff and the governing body to order the services.[4] And of course, all orders for diagnostic tests must be medically necessary, which means that the reason for the order (the patient's diagnosis, disease surveillance, staging, etc.) must be both documented in the medical record and accurately represented by ICD-10-CM diagnosis codes.

Non-Medicare

Most commercial payers require that advanced diagnostic imaging studies, such as CT, MRI, and PET, be pre-certified (sometimes referred to as a pre-authorization) prior to their performance. It is the referring physician's responsibility to obtain this pre-certification by contacting the payer and providing the medical reason for the exam. Upon approval, the payer issues a pre-approval number, which must be submitted by both the facility and the interpreting physician. If the payer refuses to approve the exam, neither the facility nor the physician will be paid for their services—regardless of the exam findings. Referring physicians bear the responsibility to obtain the approval because they control the patient's medical record and should have all relevant documentation to support the reason for the diagnostic test.

Required Elements for a Valid Order

For a diagnostic testing order to be valid, it must contain the following elements:

- ***Specific test to be performed.*** The referring provider may request a test with specific views or protocols (such as, chest X-ray PA and Lat, MRI T-Spine without contrast) or may request a general test (such as, CT abdomen and pelvis, ankle X-ray). Both types of requests represent valid orders.
- ***Clinical Indications.*** The referring provider must supply the diagnostic

information, signs, and symptoms or diagnosis code on the order for it to be valid. Orders received without any clinical indications or with "rule out" conditions are not valid orders for Medicare and most other payers.

- ***Referring physician/practitioner name.*** The referring provider name can be in the header of the order like on a prescription form, typed under a signature, or handwritten. If multiple provider names are on the order, it is acceptable for the name of the referring provider to be circled.
- ***Referring physician/practitioner signature.*** If the referring provider name is not typed or handwritten anywhere on the order, the provider's signature must be legible.

Clinical Indications

The challenge for referring oncologists is to provide a complete and accurate diagnosis, signs, and symptoms or other reason for the diagnostic study. The need for detailed clinical information is always driven by patient care and medical necessity. Remember that the order for the test is why the study is needed by the treating physician, not just what condition the patient has. For example, the patient may have lung cancer, but the test may be ordered for intermittent and persistent headaches. Radiology examinations are performed and interpreted in a manner that addresses the clinical reason for the test.

And remember, a "payable" diagnosis or covered medical condition cannot be listed if it is not documented in the patient chart, and there are some scenarios where an imaging study may be ordered but not reimbursed by the patient's insurance. Some policies only allow a limited number of advanced imaging studies, such as PET scans, during a single course of therapy or over the patient's lifetime. As a result, oncologists should ensure that the clinical indications for the test are thoroughly and accurately reported. Table 1, page 14, lists some problem scenarios that radiologists encounter when oncologists order diagnostic tests.

The radiology department requires details regarding the patient's condition from the referring providers, including medical and radiation oncologists. Specifically, providers must document the location, severity, and the reason for the diagnostic test as it applies to a designated medical condition or presenting patient symptoms. Although it may appear that the referring provider is being asked for a lot more information, in reality the details required for the radiology order are the same details required for the clinical assessment and patient progress note. In other words, the referring oncologist is only required to provide ordering information that should already have been documented.

Choosing Wisely®

First announced in Dec. 2011, Choosing Wisely (ChoosingWisely.org) is part of a multi-year effort led by the ABIM Foundation to support and engage physicians in being better stewards of healthcare resources. The overall goal is to help physicians and patients engage in conversations to reduce overuse of tests and procedures and help patients make smart and effective care choices. Participating specialty societies are working with the ABIM Foundation and Consumer Reports to share the lists widely with their members and convene discussions about the physician's role in helping patients make wise choices.

The mission of the ABIM Foundation: to advance medical professionalism to improve the healthcare system. The Foundation achieves this by collaborating with physicians and physician leaders, medical trainees, healthcare delivery systems, payers, policy makers, consumer organizations, and patients to foster a shared understanding of professionalism and how the tenets of professionalism can be adopted into practice. Both the American Society of Clinical Oncology (ASCO) and the American Society of Radiation Oncology (ASTRO) participate in this endeavor and below are some of the items related to testing procedures:

1. Don't perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.
2. Don't perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
3. Don't perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.
4. Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.
5. Don't perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.
6. Don't routinely recommend follow-up mammograms more often than annually for women who have had radiotherapy following breast conserving surgery.

Remember that while these are specialty society recommendations, they do not constitute regulatory guidance, although some payers may reference these guidelines in policies or other publications. In addition to this specialty society information, other publications provide information on ordering diagnostic tests. For example, a large prospective trial indicates that an interim PET/CT scan following two cycles of rituximab plus cyclophosphamide, doxorubicin, vincristine and prednisone given every 14 days (R-CHOP-14) does not help guide treatment decisions in patients with diffuse large B-cell lymphoma who go on to receive six cycles of R-CHOP-14.[5]

Clinical Decision Support

The Protecting Access to Medicare Act of 2014 mandated the use of a clinical decision support tool in the ordering of every

Table 1. Problem Scenarios Radiologists Can Encounter When Oncologists Order Diagnostic Tests

ORDERING CONCERN	CORRECTION REQUIRED
VAGUE MALIGNANCY DESCRIPTION: "Breast cancer" "Bladder cancer" "Metastatic lung cancer" OR non-specific diagnosis codes	• Specific location of malignancy • Staging, including all known sites of disease • Quadrant, section, organ-specific area • Primary or secondary malignancy • Active malignancy, history of malignancy
It is essential that the imaging study be pre-authorized and/or performed for the correct diagnosis. If the patient has a history of lung cancer and an MRI of the brain is requested to determine if there are brain metastases, the correct diagnosis on the order is "personal history of lung cancer."	
SURVEILLANCE OR STAGING	• Personal history of malignancy • Prior treatment (chemotherapy, radiation therapy, surgery) • If no current conditions, report surveillance or aftercare code
There are no unique ICD-10-CM diagnosis codes for "staging." In this scenario, only those medical conditions known to be a fact about the patient can be coded and reported. For example, if the patient has no current symptoms and is post-treatment to breast cancer with no evidence of any malignancy, the diagnosis codes would include personal history of breast cancer and personal history of radiation and/or chemotherapy.	
RECURRENCE	• New presenting signs or symptoms • Active malignancy, same site as prior malignancy • Staging, including all known sites of disease
If the patient is symptomatic, then a description of the symptoms provides the reason for the study. However, if the imaging study is performed in order to determine if there is a recurrence or a new site of disease in the absence of patient symptoms, this may not be a payable imaging procedure.	
"RULE OUT"	• Patient signs, symptoms • If no conditions, report observation for suspected malignancy
Some patients present for an initial evaluation without a diagnosis of malignancy. An advanced imaging study performed to determine if there is a potential area of interest can be ordered based on the patient's current symptoms. If there are no symptoms, a screening diagnosis code can be reported, which *may not* be a payable imaging service.	
FOLLOW-UP	• Report code for follow-up care • Personal history of malignancy • Prior treatment (chemotherapy, radiation therapy, surgery) • Existing secondary sites of malignancy
Once the treatment has been fully completed, the primary diagnosis code will be the follow-up code, which also may not be reimbursed. Keep in mind that some payers will not pay for additional imaging to a known area of malignancy once treatment has been completed, unless the patient has symptoms of disease spread or new sites of disease.	

Medicare outpatient CT, MRI, nuclear medicine, and PET study performed in the U.S. Clinical decision support (CDS) is scheduled to be implemented Jan. 1, 2017, for all higher modality services (e.g., CT, MRI) reimbursed by CMS in an effort to reduce duplicate and/or unnecessary scanning and associated costs.[6] According to the 2016 Medicare Physician Fee Schedule (PFS) proposed rule, this means that oncologists ordering advanced imaging studies, such as CT, MRI, and/or PET scans, on or after Jan. 1, 2017, must consult with a listed, qualified clinical decision support mechanism and the furnishing radiologist must include specific information on the Medicare claim to identify the use of CDS by the ordering physician. When fully implemented, physicians who provide imaging services will only receive reimbursement for claims that include information about the specific CDS tool used.

The goal of CDS is to determine the range of potentially appropriate imaging procedures based on indications, such as patient symptoms, information from prior exams, the patient or family medical history, and risk factors or presenting circumstances. CDS looks to drive up the quality of care while keeping costs down. Additional benefits of CDS implementation:

- Offering real-time decision support
- Reducing patient exposure to unnecessary radiation
- Documenting appropriate medical care
- Reducing rescheduling of exams.

By Nov. 2015, the Department of Health and Human Services (HHS) must specify the applicable appropriate use criteria (AUC) for imaging services. The 2016 Medicare PFS proposed rule clarifies that only AUC developed, modified, or endorsed by organizations meeting the definition of a provider-led entity (such as national provider-led specialty societies, hospitals, or healthcare systems) would be considered applicable. According to an article by the Radiological Society of North America (RSNA):[7]

"Using the CDS tools embedded with appropriateness criteria is designed to improve the accuracy of ordering advanced diagnostic studies and ensure the appropriate studies are done for the right reason on the right patient."

During the 1990s, the American College of Radiology (ACR) recognized the need to define national guidelines for appropriate use of imaging technologies. Subsequently, the ACR Task Force on Appropriateness Criteria was created to develop nationally accepted, scientifically-based guidelines. According to the ACR:[8]

"The ACR Appropriateness Criteria® are evidence-based guidelines to assist referring physicians and other providers in making the most appropriate imaging or treatment decision for a specific clinical condition. Employing these guidelines helps providers enhance quality of care and contribute to the most efficacious use of radiology."

CMS recognizes that the number of clinicians impacted by the scope of the AUC program is massive; it will apply to every physician and practitioner who orders advanced diagnostic imaging studies. The final component of the Medicare AUC program is the Identification of Outlier Ordering Professionals, including the ability to implement a prior authorization requirement for outlier professionals beginning Jan. 1, 2020.

Although imaging has significantly improved the quality of healthcare and increased value, it is an expensive tool. Orders and medical necessity will continue to be a key factor in patient care and ultimately appropriate reimbursement. However, predictability in the determination of medically appropriate studies will promote compliance, help mitigate burdensome administrative costs, and promote the delivery of a uniformly high quality of patient care. Because these new provisions place the CDS completion burden on the referring physician, oncologists may require additional time to order diagnostic imaging studies. The investment of a little extra time will be worth it, however, to ensure performing the right study, at the right time, in the right way for each individual patient. OI

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