Diagnostic Test Order: Who Needs It?

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In every profession, a certain amount of direction and instruction is required. For diagnostic radiologists, one critical piece of instruction comes in the form of an order for a study. Radiologists depend on patient referrals, expressed through orders, to exercise their imaging expertise. The smooth, effective continuum of patient care that we would want for our family members and ourselves requires clear, timely, and well-documented orders from those treating practitioners who request imaging. Without such orders, ACR members and their practices will struggle to contribute value to patients. They also may risk legal liability if they cannot justify the medical necessity of the studies they interpret.

The ACR legal office has fielded many calls from members asking to clarify the regulatory compliance landscape for ordering tests. Except for self-referred patients who seek a screening mammogram, federal and state laws prohibit radiologists and their practices from performing and interpreting tests unless they have a valid order from a physician or other authorized practitioner. But does that order have to be written? If not, how soon after a verbal order is issued must it be authenticated? May a medical professional who is not a physician, such as a nurse practitioner or a chiropractor, order a diagnostic study? These and other questions regarding diagnostic test orders need answers.

Let’s begin by defining fundamental terms.

WHAT IS AN “ORDER”?

The Centers for Medicare and Medicaid Services (CMS) define an order as “communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary.” An order may include any of the following:

- A written communication signed by the treating physician/practitioner (hand-delivered, mailed, or faxed to the testing facility)
- A telephone call
- An e-mail from the treating physician/practitioner or his/her office to the testing facility

Therefore, Medicare permits a treating physician to issue an oral or verbal order for a diagnostic study like a chest X-ray. In its 2001 clarification, CMS noted that if a physician or practitioner communicates an order via telephone, both the treating physician and the testing site must document the phone call in their respective copies of the patient’s medical record.

You should confirm with any private payer network to which you belong whether it follows Medicare reimbursement rules on orders for diagnostic tests. Regardless, more payers are requiring prior authorization for imaging studies. In that instance, a patient would have to present a written order from a treating physician or practitioner for the payer to approve your practice doing the study.

WHO IS A “TREATING PHYSICIAN”?

Federal law defines a “treating physician” as a “physician 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.” Historically, the ACR maintained that the radiologist “manages” the imaging/interventional components of the patient’s medical care and thus should be considered a “treating physician.”

CMS went halfway on that point. It clarified that a radiologist performing a therapeutic interventional procedure is considered a “treating physician” and thus can order tests related to the condition for which the intervention is being performed. However, a radiologist performing a diagnostic interventional procedure is not considered a treating physician. This continues to remain a point of discussion between the ACR and CMS.

WHO IS A “TREATING PRACTITIONER”?

A “treating practitioner” is a nurse practitioner, clinical nurse specialist, or physician assistant who furnishes, under state law, a consultation or treats a beneficiary for a specific medical problem. The practitioner uses the diagnostic test result to manage that problem. So a nurse practitioner or physician assistant may order a diagnostic test, if authorized under state law.
AUTHENTICATING VERBAL ORDERS

Under Medicare conditions of participation effective January 26, 2007, physicians or practitioners must authenticate any verbal order they issue for a hospital patient. They may do so in writing or electronically, such as through an electronic signature. Verbal orders must be authenticated either within a timeframe that state law prescribes or, if no timeframe exists, within 48 hours. Significantly, CMS requires hospitals to verify the identity of the practitioner who has authenticated a verbal order, including faxed or computer-based orders. Hospital-based radiologists should review and comply with author verification processes at their institution. Medicare similarly requires that treating physicians or practitioners based in offices document a verbal order in the patient’s medical record.

WHEN TO DOCUMENT VERBAL ORDERS

Radiology practices, especially in hospital settings, frequently receive verbal requests to conduct diagnostic studies. For example, the patient is in the radiology suite and the practice is ready to perform the test, but it has not received a written order from the treating practitioner. What to do? The practice may proceed with the study. However, the practice must document the order in the patient’s medical record as soon as possible. A radiologist must demonstrate in writing that the study performed was ordered by the treating physician or practitioner. Medicare will not deem a diagnostic test “reasonable and medically necessary” unless a practitioner who will use it to manage a patient’s care orders it.

Auditors will hone in on a pattern or practice of diagnostic tests occurring without orders. Without proper documentation, you could confront a potential false claim action. The Federal False Claims Act prohibits an individual or entity from submitting or causing to be submitted, a “false” claim to Medicare or any federally funded program. A prior RADLAW column commented on one radiology group that paid more than $2 million to settle a false claims lawsuit. Auditors will hone in on a pattern or practice of diagnostic tests occurring without orders. Without proper documentation, you could confront a potential false claim action. The Federal False Claims Act prohibits an individual or entity from submitting or causing to be submitted, a “false” claim to Medicare or any federally funded program. A prior RADLAW column commented on one radiology group that paid more than $2 million to settle a false claims lawsuit alleging that it inadequately documented verbal orders (September 2006 ACR Bulletin).

VALID TEST ORDERS

ACR members continually report problems with obtaining proper clinical indications for the studies they are to interpret. Physicians or practitioners ordering diagnostic tests need to provide radiologists with sufficient clinical information so that “testing entities” may submit accurate claims. That isn’t just responsible medical practice, it’s the law. At a minimum, the order must specify a valid clinical reason for the study, preferably at the time of patient registration.

For years, ACR staff urged CMS to recognize that as physicians, radiologists who lack such information should be able to talk — either themselves or through their staff — with the patient to determine why the study was ordered. This is critical because the ordering physician who failed to provide ICD-9 coding information does not have to deal with a denied claim; the radiologist does. CMS fortunately agreed, issuing a memorandum to its carriers and intermediaries in 2001. Radiologists may use ICD-9-clinical diagnoses based on information they glean from the patient or the patient’s medical record. However, CMS indicates that someone in the interpreting physician’s office should try to contact the treating physician/practitioner’s office to verify information from the patient.

CHANGING ORDERS

Depending on the site of service, orders can be changed, e.g., performing a study with contrast instead of without contrast. Hospital-based radiologists have wider latitude to modify test orders, if permitted by hospital policies, Joint Commission guidelines, and state law. Office-based radiologists fall under somewhat tighter rules. They may change an order only in certain conditions:

- Amending a clear and obvious error (i.e., X-ray on wrong foot)
- Setting test protocol (such as using or not using contrast) unless the order specifies the design
- Patient’s physical condition will not allow the test to occur

However, radiologists may not change the originally ordered study to a completely different one (e.g., CT to an MRI) without first contacting and obtaining a new order from the treating physician or practitioner.

ORDERS FROM CHIROPRACTORS

Should a radiologist accept an order from a chiropractor? Doesn’t that increase the radiologist’s liability? In legalese, it depends. As we discussed in the first RADLAW column (published in the June 2005 Bulletin), ACR policy states that a radiologist may choose whether or not to accept an order from a chiropractor. That decision carries reimbursement and potential liability consequences.

Chiropractors traditionally could only treat patients using X-rays that a medical or osteopathic doctor ordered. Yet a Medicare demonstration project launched from 2005 to 2007 in five states enabled a chiropractor to order and perform X-rays and bill Medicare for them. Additionally, a chiropractor could order CTs or MRIs, but a physician had to perform and interpret those studies. As with requests from physicians, radiologists had to evaluate the study and obtain the underlying reason for it, and document such data in their records.

On the liability front, courts may differ on whether a radiologist who interprets a study that a chiropractor requests meets the standard of care obligation. Some courts hold that radiologists only have to

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ensure proper delivery of their report to the chiropractor, noting any findings that merit follow-up treatment. Other courts have ruled, though, that a radiologist who is the sole physician of record has skill and expertise that warrant communicating results directly to a patient. If they fail to do so, they may be liable for negligence. Don’t jeopardize your own practice or your reputation. Be prudent and consult a qualified health care lawyer in your state for specific advice.

ENDNOTES

2. 42 U.S.C. section 1395x(r).
4. 42 C.F.R. section 1395x(r).
5. 42 C.F.R. section 410.32(a).

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The ACR Legal Department welcomes questions from members on general legal topics. We cannot provide specific legal advice but will answer questions that apply broadly to radiologists and their practices. Please submit questions in writing to:
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Connecting With Your Patients

“I have breast cancer.” That is the united thought of the thousands of women who impatiently wait for the results of their annual mammograms.

For a small percentage of those women, that statement becomes an unfortunate reality. At that point, you, as their doctor need to communicate in a way that is compassionate, respectful, and free of confusing medical jargon. Can they trust you to accomplish this?

“Many radiologists are excellent diagnosticians but not clinicians. Good patient contact is not taught in medical school,” says Michael Linver, M.D., FACR. Linver, a passionate advocate for communication between doctors and patients, demonstrated his passion in his presentation, “Talking With Patients: Ways to Gain Their Trust,” at the Society for Breast Imaging Conference last April.

Imagine this scenario: A patient is in the radiology waiting room waiting to be told she has breast cancer. Her doctor quickly reviews her file and heads into the busy room. Standing above the sitting patient, the doctor tells her that the results from the core needle biopsy are in. The doctor reminds her that she is positive for BRCA1 genetic mutation, possibly a contributing factor. It’s cancer, an adenocarcinoma, the doctor says hurriedly while clicking a pen. The doctor suggests discussing her options when there is more time. She can talk to the other radiologist on shift; otherwise, she should make another appointment.

At this point in this scenario, the patient is confused and unsure of her next steps. She’s not even sure what kind of breast cancer she has; was it adeno-something, or was it BRCA1? She couldn’t even listen to what the doctor was saying. All she heard was one word: “cancer.”

Exaggerated situations like the one described above are hopefully few and far between, but poor communication skills are more common. Exercise those skills and start with a simple gesture: extend your hand to the patient. Reinforce that physical bond with a positive attitude, which is essential whether it’s the physician’s first appointment of the day, or the 21st.