SUBJECT: Physician Signature Requirements for Diagnostic Tests

I. SUMMARY OF CHANGES: The information in this Change Request updates the manual to incorporate language that was previously contained in Section 15021 of the Medicare Carriers Manual.

New / Revised Material
Effective Date: January 1, 2003
Implementation Date: September 30, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

<table>
<thead>
<tr>
<th>R/N/D</th>
<th>CHAPTER/SECTION/SUBSECTION/TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>15/80.6.1/Definitions</td>
</tr>
</tbody>
</table>

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

*Unless otherwise specified, the effective date is the date of service.*
SUBJECT: Physician Signature Requirements for Diagnostic Tests

Effective Date: January 1, 2003

Implementation Date: September 30, 2008

I. GENERAL INFORMATION

A. Background: The information in this Change Request (CR) updates the manual to incorporate language that was previously contained in Section 15021 of the Medicare Carriers Manual. This language was inadvertently omitted when the Internet Only Manual was published. Also, some further clarifying language has been added to the end of the manual section to reflect the fact that, while a physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed.

B. Policy: In order that payment can be made for diagnostic tests, there are certain ordering requirements which must be met. The requirements related to a physician’s signature are specified in this CR.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility (place an “X” in each applicable column)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A / B D M E M A C F I C A R R I E R R E D C E M A C D</td>
</tr>
<tr>
<td>6100.1</td>
<td>Contractors shall be aware of Pub. 100-02, chapter 15, section 80.6.1 of the Internet Only Manual, as revised.</td>
<td>X X X</td>
</tr>
</tbody>
</table>

III. PROVIDER EDUCATION TABLE

<table>
<thead>
<tr>
<th>Number</th>
<th>Requirement</th>
<th>Responsibility (place an “X” in each applicable column)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>A / B D M E M A C F I C A R R I E R R E D C E M A C D</td>
</tr>
<tr>
<td>6100.2</td>
<td>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLN">http://www.cms.hhs.gov/MLN</a> Matters Articles/ shortly after the CR is released. You will receive notification of the article release via the established &quot;MLN Matters&quot; listserv.</td>
<td>X X X</td>
</tr>
</tbody>
</table>
Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A

*Use "Should" to denote a recommendation.*

<table>
<thead>
<tr>
<th>X-Ref Requirement Number</th>
<th>Recommendations or other supporting information:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Glenn McGuirk – glenn.mcguirk@cms.hhs.gov

Post-Implementation Contact(s): Glenn McGuirk – glenn.mcguirk@cms.hhs.gov

VI. FUNDING

A. For Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. For Medicare Administrative Contractors (MACs):

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.
80.6.1 - Definitions  
(Rev.94, Issued: 08-29-08, Effective: 01-01-03, Implementation: 09-30-08)

Diagnostic Test

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

Treating Physician

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.

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.

Treating Practitioner

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.

Testing Facility

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).

Order

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 be delivered via the following forms of communication:

- 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 clinical**
laboratory fee schedule, the physician fee schedule, or for physician pathology services;.

- A telephone call by the treating physician/practitioner or his/her office to the testing facility; and

- An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

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. *While a physician order is not required to be signed, the physician must clearly document, in the medical record, his or her intent that the test be performed.*