Local Coverage Determination (LCD):
Independent Diagnostic Testing Facilities (IDTFs) (L31626)
Title XVIII of the Social Security Act (SSA or the Act), Section 1862(a) (1) (A), explains that payment may be allowed only for those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the SSA, Section 1833(e), prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the SSA, Section 1862(a)(7), states that Medicare will not cover any services or procedures associated with routine physical checkups.

Title XVIII of the SSA, Section 1834 (e) (1)(B) of the Act defines advanced diagnostic imaging. Suppliers, including physicians, non-physician practitioners and physician and non-physician organizations, of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) of the Act, must become accredited by a designated accreditation organization designated by the Secretary beginning January 1, 2012.

CMS Manual System, Pub. 100-02, Benefit Policy Manual, Chapter 15, Section 80, describes the requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests

CMS Manual System, Pub. 100-08, Program Integrity Manual, Chapter 3, describes and authorizes medical review documentation requests from the contractor to the referring provider and the financial liability of the billing provider.

CMS Manual System, Pub. 100-08, Program Integrity Manual, Chapter 15, Provider/Supplier Enrollment, Section 4, describes enrollment requirements for Independent Diagnostic Testing Facilities.

42 Code of Federal Regulations, 410.32, Diagnostic X-Rays, diagnostic laboratory tests, and other diagnostic tests: Conditions. This section describes regulations that apply to performing these tests.

42 Code of Federal Regulations, 410.33, Independent Diagnostic Testing Facilities includes requirements of the treating physician, the supervising physician, non-physician personnel, ordering of tests, state requirements for IDTFs. See also the regulatory preamble to this section (Federal Register, 10/31/1997).

42 Code of Federal Regulations, 410.33 Independent Diagnostic Testing Facilities Performance Standards, Supervision limitation of no more than three sites (12/01/2006) (Volume 71, Number 231)


Transmittal 1787, Change request 2410, January 24, 2003 ordering diagnostic tests (15021)

Pub 100-20 One-Time Notification Change Request 6912- Mailing To All Individual Practitioners, Medical Groups and Clinics and Independent Diagnostic Testing Facilities (IDTF) Who Are Billing or Have Billed For Advanced Diagnostic Imaging Services

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

An Independent Diagnostic Testing Facility (IDTF) is an entity independent of a hospital or physician’s office in which diagnostic tests are performed. It was created by regulation (42CFR§410.33) as published in the Federal Register, Vol. 62, number 211, October 31, 1997.

Effective for diagnostic procedures performed on or after March 15, 1999, carriers will pay for diagnostic procedures under the physician fee schedule only when performed by a physician, a group practice of physicians, an approved supplier of portable x-ray services, a nurse practitioner, or a clinical nurse specialist when he or she performs a test he or she is authorized by the State to perform, or an independent diagnostic testing facility (IDTF).

By definition, therapeutic procedures and interventions are not allowed to be performed by an IDTF (see Section A below).
This policy addresses the structure, approved services, licensure, certification requirements, and credentialing for an IDTF and the personnel who provide the service. Diagnostic testing performed in or by an IDTF must follow the supervision and certification guidelines set forth in this policy. IDTF’s must meet the technician licensing or credentialing requirements at the time of their enrollment.

Medicare will cover diagnostic tests performed by an IDTF when the procedures are medically necessary and the criteria in this policy are met. The procedures listed in the Appendix are also subject to the medical necessity criteria as outlined in the applicable Local Coverage Decisions (LCD’s).

IDTF Regulations in this policy do not apply to approved portable x-ray suppliers or to diagnostic tests furnished in physicians’ offices, group practices, or multi-specialty clinics.

A. An IDTF must have the following characteristics:

   a. It may be in a fixed location or be a mobile entity or supplied by an individual non-physician practitioner;
   b. Is independent of a physician’s office or hospital; however, these rules apply when an IDTF furnishes diagnostic procedures in a physician’s office.
   c. Performs only diagnostic tests by licensed, certified non-physician personnel under appropriate physician supervision;
   d. The sole purpose is to furnish diagnostic testing;
   e. Is not engaged in any form of patient treatment; and
   f. Is properly enrolled with Medicare as an IDTF and approved for the specific tests to be provided.

B. Ordering diagnostic tests

All procedures performed by the IDTF must be specifically ordered in writing by the physician who is treating the beneficiary, or 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 results of a diagnostic test in the management of the beneficiary’s specific medical problem.

The order must specify the diagnosis or other basis for the testing. The supervising physician for the IDTF may not order tests to be performed by the IDTF, unless the IDTF’s supervising physician is in fact the beneficiary’s treating physician with a prior relationship to the patient. The IDTF may not add any procedures based on internal protocols without an order from the treating physician/practitioner.

Although all procedures performed by the IDTF must be specifically ordered by the physician/practitioner treating the beneficiary as noted above, the mere fact that the test or tests were properly ordered does not reflect or imply Medicare coverage for these services. Medical necessity must be apparent and standard exclusions and medical policies apply.

As noted above, the results of any diagnostic test performed by the IDTF must actually be used in the management of the beneficiary’s specific medical problem.

Orders:

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.
   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.
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. Physician Supervision
This section describes the levels of physician supervision required for furnishing the technical component of diagnostic tests for a Medicare beneficiary who is not a hospital inpatient or outpatient. Diagnostic tests covered under the physician fee schedule, with certain exceptions listed in the regulation, have to be performed under the supervision of an individual meeting the definition of a physician. Nurse practitioners, clinical nurse specialists, and physician assistants are not defined as physicians under 1861(r) of the Act. Therefore they may not function as supervisory physicians under the diagnostic tests benefit.

Exceptions: The following diagnostic tests, payable under the Physician Fee Schedule, are not required to be furnished in accordance with the ordering and supervising requirements as outlined in this document.

a. Diagnostic mammography procedures, which are regulated by the Food and Drug Administration.
b. Diagnostic tests personally furnished by a qualified audiologist as defined in section 1861(ll)(3) of the Act.
c. Diagnostic psychological testing services personally furnished by a clinical psychologist or a qualified independent psychologist as defined in program instructions.
d. Diagnostic tests (as established through program instructions) personally performed by a physical therapist who is certified by the American Board of Physical Therapy Specialties as a qualified electrophysiologic clinical specialist and permitted to provide the service under State law.

General Supervision: An IDTF must have one or more supervising physicians who are responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of the equipment used to perform tests, and the qualifications of non-physician personnel who use the equipment.

Not every supervising physician has to be responsible for all these functions. These responsibilities may be divided among the supervising physicians. For example, one supervising physician may be responsible only for the operation and calibration of the equipment, while other supervising physicians are responsible for test supervision and/or the qualifications of the non-physician personnel. There is no physical distance limitation between where the test is performed and where the supervisory physician is located. When a remote supervisory physician is responsible for general supervision of the IDTF, written documentation indicating how he/she has fulfilled the requirements of general supervision must be made available to WPS upon request.

The supervising physician(s) must evidence proficiency in the performance and interpretation of each type of diagnostic procedure performed by the IDTF. In the case of a procedure requiring the direct or personal supervision of a physician, the IDTF’s supervising physician must personally furnish this level of supervision whether the procedure is performed in the IDTF or, in the case of mobile services, at the remote location.

It is required that the supervising physician demonstrate expertise by residency training and be board certified or board eligible from the appropriate specialty board of the American Board of Medical Specialties.

Direct supervision means that the physician must be present in the suite/facility and immediately available to furnish assistance and direction throughout the performance of the procedure.

In the case of procedures requiring direct supervision, the supervising physician may oversee concurrent procedures.

Personal supervision means the physician must be in attendance in the room during the performance of the procedure.

All diagnostic tests payable under the physician fee schedule must be performed under the supervision of a physician with the exception of certain procedures personally performed by qualified independent psychologists, clinical psychologists, qualified audiologists and physical therapists who are certified as qualified electrophysiologic clinical specialists.
The basic requirement is that all the supervising functions be properly met at each location, regardless of the number of physicians involved. This is particularly applicable to mobile IDTF units that are allowed to use different supervising physicians at different locations. A different physician may supervise the test at each location. The supervising physicians only have to meet the proficiency standards for the tests they are supervising. Supervising physicians do not have to be employees of the IDTF. They may be contracted physicians for each location served by the IDTF.

The level of physician supervision required for diagnostic procedures can be found in the Medicare Physician Fee Schedule Database (MPFSDB).

D. Non-physician personnel
All non-physician personnel used by the IDTF to perform tests must demonstrate the basic qualifications to perform the tests in question and have appropriate training and proficiency as evidenced by licensure or certification by the appropriate State health or education department. In the absence of a State licensing board, the technician must be certified by an appropriate national credentialing body. It is expected non-physician personnel must maintain an active status in order for the diagnostic tests to be covered.

The only exception to this is when a Medicare payable diagnostic test is not subject to state license or certification of the technician performing the test, and no generally accepted national credentialing body exists. In that instance, the technician should be listed and the IDTF should submit as an attachment any education/credentialing and/or experience that the person has. Documentation of training and proficiency must be verified by the supervising physician and provided to the carrier.

The contractor does not establish a credentialing service but the contractor is authorized to determine which organizations it recognizes. For example, the use of the word “national” in the organization’s name does not, in itself, meet Medicare standards for national credentialing.

1. The technicians do not have to be employees of the IDTF. They can be contracted by the IDTF.

2. Non-physician practitioners may not supervise diagnostic testing performed by others.

3. Audiologists, psychologists and physical therapists, may personally perform certain diagnostic tests without physician supervision and bill using their own provider number.

4. Physician supervision of any type is not required for diagnostic tests performed by nurse practitioners or clinical nurse specialists when they are authorized by the State to perform such tests and the testing is within the scope of their practice. (They must bill under their own number.)

5. Physician assistants require general physician supervision for the performance of diagnostic tests permitted within the scope of their practice authorized by their state.

The physician and non-physician personnel credentialing requirements are listed in Appendix A.

E. Multi-state entities
An IDTF that operates across State boundaries must maintain documentation that the supervising physicians and technicians are licensed and certified in each of the States in which it is furnishing services. The technicians must be licensed and/or nationally certified for each state in which they provide services. An IDTF must comply with applicable laws of any State in which it operates.

F. Accreditation for Advanced Diagnostic imaging
Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended section 1834(e) of the Social Security Act and required the Secretary to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and Independent Diagnostic Testing Facilities, that furnish the technical component (TC) of advanced diagnostic imaging services.

MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012.
The Centers for Medicare & Medicaid Services (CMS) approved three national accreditation organizations to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The accreditation will apply only to the suppliers of the images themselves, and not to the physician's interpretation of the image. All accreditation organizations have quality standards that address the safety of the equipment as well as the safety of the patients and staff.

The accreditation organizations are:

1. American College of Radiology (ACR)
2. Intersocietal Accreditation Commission (IAC)
3. The Joint Commission (TJC) Ambulatory Care Accreditation Program

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes

Group 1 Paragraph: See Appendix A

Group 1 Codes:
XX000  Not Applicable

ICD-9 Codes that Support Medical Necessity

Group 1 Paragraph: Note: ICD-9 codes must be coded to the highest level of specificity.
NA

Group 1 Codes:
XX000  Not Applicable

ICD-9 Codes that DO NOT Support Medical Necessity
N/A
**General Information**

**Associated Information**

**Documentation Requirements**

Medical record documentation maintained by the Independent Diagnostic Testing Facility must include the information listed below:

- Written, electronic (EMR), faxed, e-mailed order from the treating physician/practitioner
- Hard copy or electronic documentation of the test results and interpretation; and
- The medical necessity (reason) for performing the diagnostic test(s).

Although all procedures performed by the IDTF must be specifically ordered in writing by the practitioner treating the beneficiary, the mere fact that the test(s) were properly ordered does not reflect or imply Medicare coverage for these services. Medical necessity must be apparent and statutory exclusions, national and local coverage determinations (LCDs) apply.

Documentation may be requested from the ordering/treating provider or from the billing provider of the diagnostic test. Additional records may be requested from the ordering provider that is directly relevant to the medical necessity of the test.

Payment will be denied to the billing provider (IDTF) if the ordering provider does not respond to the documentation request or provides documentation which does not support the test.

In addition, documentation must be available upon request verifying that the technician performing the service(s) meet(s) the credentialing requirements as outlined in this policy.

The IDTF must maintain documentation to demonstrate the required physician supervision requirements were met. In the case of procedures requiring direct supervision, the supervising physician may oversee concurrent procedures.

Documentation must be maintained in the IDTF that the personnel performing the diagnostic test(s) have been adequately trained and demonstrate proficiency in the performance of the service(s). This documentation must contain verification by the supervising physician(s).

**Utilization Guidelines**

Data Analysis has shown over utilization of IDTF services in place of service (POS) 12 home. Including but not limited to CPT codes 93307, 93320, 93325, 93922, 93925, 93965, 93970, 93880, 93886, 93000.

Documentation may be requested to support the service being performed in the home. See the Documentation Requirements section of this policy.

**Sources of Information and Basis for Decision**

WPS-J 5 MAC –B and Legacy B LCD:
Other Carriers Local Coverage Decisions:
Palmetto GBA South Carolina
Blue Cross Blue Shield (BCBS) - Arkansas.
National Heritage Insurance Company (NHIC)-California
Georgia's IDTF Guide

**Advisory Committee Meeting Notes**

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wisconsin</td>
<td>01/28/2011</td>
</tr>
<tr>
<td>Illinois</td>
<td>01/26/2011</td>
</tr>
<tr>
<td>Michigan</td>
<td>02/02/2011</td>
</tr>
<tr>
<td>Minnesota</td>
<td>01/20/2011</td>
</tr>
<tr>
<td>Iowa, Kansas, Missouri, Nebraska</td>
<td>02/10/2011</td>
</tr>
</tbody>
</table>
Open Meeting:
01/06/2011

Any Carrier Advisory Committee (CAC) related information, including Start Date and End Date of Comment Period, reflects the last time this LCD passed through the Comment and Notice process. Formal comment is not required for LCDs being adopted as part of the MAC transition.

Start Date of Comment Period
02/10/2011

End Date of Comment Period
03/27/2011

Start Date of Notice Period
(Published)
08/01/2011

Revision History Information
Please note: The Revision History information included in this LCD prior to 1/24/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 1/24/2013 will display as a row in the Revision History section of the LCD and numbering will begin with "R2".

<table>
<thead>
<tr>
<th>Revision History Date</th>
<th>Revision History Number</th>
<th>Revision History Explanation</th>
<th>Reason(s) for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2014</td>
<td>R5</td>
<td>01/01/2014 - Code update. Removed deleted codes 77031, 77032 from the Appendix; updated manual references in the LCD and the billing and coding document; reformatted; added in documentation information that had been inadvertently dropped; Annual review.</td>
<td>Other</td>
</tr>
<tr>
<td>01/01/2014</td>
<td>R4</td>
<td>01/01/2014 - Code update. Removed deleted codes 77031, 77032 from the Appendix; updated manual references in the LCD and the billing and coding document; reformatted; added in documentation information that had been inadvertently dropped; Annual review.</td>
<td>Revisions Due To CPT/HCPCS Code Changes</td>
</tr>
<tr>
<td>09/07/2013</td>
<td>R3</td>
<td>09/07/2013 - This LCD policy was indicated to cover Part A contractors in error, during the J6/Legacy Contractor transition. This policy has never been effective for providers in states covered by contractor numbers 05101, 05201, 05301, 05401, 05901, 08101 or 08201.</td>
<td>Change in Assigned States or Affiliated Contract Numbers</td>
</tr>
<tr>
<td>09/07/2013</td>
<td>R2</td>
<td>The WPS Carrier Contract Numbers 00951(WI), 00952(IL), and 00954(MN) were removed from this LCD. Effective 09/07/2013, the Jurisdiction 6 Part B MAC contractor for Illinois, Wisconsin, and Minnesota is National Government Services (NGS).</td>
<td>Change in Assigned States or Affiliated Contract Numbers</td>
</tr>
<tr>
<td>08/20/2012</td>
<td>R1</td>
<td>08/20/2012: This LCD was revised to add the Jurisdiction 8 (J-8) Indiana Part B MAC Contract Number 08102. The CMS Statement of Work for the J8 Medicare Administrative Contract (MAC) requires that the contractor retain the most clinically appropriate LCD within the jurisdiction. This WPS policy is being promulgated to the J8 MAC as the most clinically appropriate LCD within this jurisdiction. No coverage changes were made to this LCD for this revision.</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Change in Assigned States or Affiliated Contract Numbers</td>
</tr>
</tbody>
</table>
07/16/2012: This LCD was revised to add the Jurisdiction 8 (J-8) Michigan Part B MAC Contract Number 08202 and remove the legacy Michigan Part B Carrier Contract Number 00953. The CMS Statement of Work for the J8 Medicare Administrative Contract (MAC) requires that the contractor retain the most clinically appropriate LCD within the jurisdiction. This WPS policy is being promulgated to the J8 MAC as the most clinically appropriate LCD within this jurisdiction. No coverage changes were made to this LCD for this revision.

08/01/2011 - Draft policy released to Final. No Revision History.

Associated Documents
Attachments
Billing & Coding Guidelines opens in new window (PDF - 215 KB )
Appendix A opens in new window (PDF - 478 KB )

Related Local Coverage Documents
N/A

Related National Coverage Documents
N/A

Public Version(s)
Updated on 01/10/2014 with effective dates 01/01/2014 - N/A
Updated on 12/18/2013 with effective dates 01/01/2014 - N/A
Updated on 09/13/2013 with effective dates 09/07/2013 - 12/31/2013
Updated on 08/26/2013 with effective dates 09/07/2013 - N/A
Updated on 08/03/2012 with effective dates 08/20/2012 - 09/06/2013
Some older versions have been archived. Please visit the MCD Archive Site opens in new window to retrieve them.

Keywords
N/A
Read the LCD Disclaimer opens in new window

Back to Top