



## IN OFFICE IMAGING – SEPARATE REPORT OR NOT?

In-office diagnostic radiology services are a combination of a professional component and a technical component. Payment for radiology services includes both components and is referred to as “global billing”. Most orthopedic offices perform both the technical and professional components of this service. The payment for this “global” service includes the physician’s work, practice expense and malpractice expense.

API risk managers have done practice assessments for many orthopedic groups. During these assessments we often find no separate report in the patient encounters where radiology services were also performed. This is problematic not only from a billing standpoint but also a malpractice standpoint. For example, many physicians document statements such as “x-ray looks fine”. This is inadequate not only from a billing standpoint but also from a malpractice defense standpoint if the medical record is called into question.

According to Medicare’s Claims Processing Manual (Chapter 13 , Section 100.1) *“carriers generally distinguish between an “interpretation and report” of an x-ray or an EKG procedure and a ‘review’ of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the ...evaluation and management (E/M) payment. For example, a notation in the medical records saying “fx-tibia” or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An “interpretation and report” should address the findings, relevant clinical issues, and comparative data (when available).”*

The November 2009 Part B Diagnostic Radiology Manual addresses the written interpretation and documentation requirements if interpretation is included in the body of the E/M note. The policy states:

### ***Written Interpretation and Report Documentation***

*“Based on increased number of provider questions regarding written interpretation and report of diagnostic X-rays, Medicare expects the separate and distinct report (may be on separate paper or within the body of the patient’s record) for the interpretations to follow the American College of Radiology (ACR) guidelines and include a minimum of the following:*

*The name of the patient and other identification such as birth date and social security number.*

- *The name of the referring physician, if any.*
- *The name or type of examination performed.*
- *The date on which the X-ray was performed.*
- *The name of the interpreting physician.*
- *Authentication of non-handwritten note (i.e., legible*

*initials, legible signature, electronic signature, etc.).*

- *The body of the report:*
  - *Procedures and materials.*
  - *Findings.*
  - *Limitations.*
  - *Clinical issues.*
  - *Comparative date, if indicated.*
- *The diagnosis*
  - *A prescribing diagnosis should be provided when possible.*
  - *A differential diagnosis should be provided when appropriate.”*

CPT guidelines also address the need for a separate written report. The following instructions are found in the 2009 and 2010 AMA CPT Manual:

- *Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of the test results. Certain procedures or services described in the CPT codebook involve a technical component (e.g. tests), which produce results (e.g. data, images, slides). For clinical use, some of these results require interpretation. Some CPT descriptors specifically require interpretation and reporting to report that code. (2009 AMA CPT, p. xvi, 2010 AMA CPT, p. xvi)*
- *The physicians interpretation of the results of diagnostic tests with preparation of a separate distinctly identifiable signed written report may also be reported separately from the technical component of that service, using the appropriate CPT code with modifier “26” appended. (2009 AMA CPT p.3, 2010 AMA CPT p.3)*
- *A written report, signed by the interpreting physician, should be considered an integral part of a radiology procedure or interpretation. (2009 AMA CPT p. 236, 2010 AMA CPT p.240)*

In summary, CPT rules and Medicare billing rules address the importance of a separate written report. As noted above, Medicare also requires the report to mimic the ACR guidelines.

#### Risk Reduction Strategies:

1. Your practice should determine on the best method for achieving documentation compliance.
2. Remember to include views, anatomic location, diagnosis, reason for x-ray, and interpretation.
3. If you use an electronic health record, many vendors can create a section that will hyperlink information from the body of the E/M note to a separate radiology report.
4. Sign or electronically verify all reports.

The Centers for Medicare and Medicaid Services (CMS) enacted the Recovery Audit Contractor (RAC) program in 2005 to recoup improper payments to healthcare providers. The goal of the recovery audit program is to identify improper payments made on claims of services provided to Medicare beneficiaries. Providers, compliance officers and billing staff must continue to educate themselves on coding and documentation requirements as part of the expanding compliance focus of CMS.

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