

Documenting a Complete Interpretation Report for Diagnostic Radiology Services

The American College of Radiology's *ACR Practice Parameter for Communication of Diagnostic Imaging Findings* (<https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CommunicationDiag.pdf?la=en>) describes recommended guidelines for dictating an effective and complete interpretation report. The suggested format that starts with the patient's demographics followed by relevant clinical information; the body of the report; impression (ie, diagnosis); and standardized computer-generated templates works to ensure the appropriate details are included to thoroughly communicate the study and findings to the clinicians responsible for the patient's care.

Of course, these reports serve for coding and billing purposes as well, with much of the same information needed to determine the CPT and ICD-10-CM codes that will be billed to the insurance carriers. For example, when billing for the professional component, radiology coders are trained to apply the ICD-10-CM code(s) based on the radiologist's final diagnosis(es). But what if the result of a study is 'normal'? In that case, the coder will assign the diagnosis code(s) for the signs and symptoms that required the study in the first place as this establishes the base medical necessity required for the service. If the report did not contain this clinical information, coding would be defaulted to a generic diagnosis code equivalent to 'routine radiologic study' that is unlikely to be reimbursed by carriers.

Today's article will focus on how the documentation in the body of the report impacts the coding and billing process. Providers are often surprised to learn that, when coding for the professional component, radiology coders determine the applicable CPT codes from this part of the report, not the header of the report. This is because in most cases, the header reflects the ordered study which may or may not be the actual service ultimately rendered. Therefore, it is critical that the body of the report contain all details of the service, including the findings, etc., to guarantee accurate charge capture for the extent of the service rendered.

This coincides with the ACR's guidelines that state the body of the report should contain the following elements:

- a. Procedures and materials
 - Description of the studies and/or procedures performed and any contrast media and/or radiopharmaceuticals (including specific administered activities, concentrations, volume and route of administration when applicable)
 - Medications, catheters or devices used, if not recorded elsewhere
 - Any known significant patient reaction or complications
- b. Findings
 - Use appropriate anatomic, pathologic, and radiologic terminology to describe the findings
- c. Potential limitations
 - When appropriate, identify factors that may compromise the sensitivity and specificity of the exam
- d. Clinical issues
 - Address or answer any specific clinical questions; if there are factors that prevent answering the clinical question, it should be stated explicitly

e. Comparison studies and reports

- Comparison with relevant examinations and reports when appropriate and available

So, how does this clinical information drive CPT code selection? Consider the following examples where the coding process is dependent on the detail provided in the body of the report:

Applying a CPT code for CT imaging ‘with contrast’ requires that the contrast material be administered intravascularly, intra-articularly, or intrathecally.

- ✓ TIP: Oral and/or rectal contrast administration alone does not qualify as a study ‘with contrast’

Billing for a complete abdominal ultrasound requires documentation that the following organs were visualized:

- Liver
- Gallbladder
- Common bile duct
- Pancreas
- Spleen
- Kidneys
- Upper abdominal aorta
- IVC
- ✓ TIP: Documentation must state the reason an organ was not viewed/evaluated (ie, gallbladder is surgically absent)

The CPT code for OB ultrasound < 14 weeks requires documentation of the following elements:

- Number of gestational sacs/fetuses
- Gestational sac/fetal measurements appropriate for gestation
- Examination of maternal uterus and adnexa
- Survey of visible fetal and placental anatomic structure
- ✓ TIP: Documentation must state why it was not evaluated (ie, gestational age is too early)
- Qualitative assessment of amniotic fluid volume (adequate or inadequate) and gestational sac shape
- ✓ TIP: Documentation must state if it’s too early to evaluate fluid volume

Regardless of its function – clinical, compliance, legal and reimbursement – the formal interpretation report is the final comprehensive record of the provider’s professional service and related decision-making. The detail needed to satisfy one of its functions is essentially valuable for all of its uses so care should be taken to develop and maintain thorough documentation practices.

The APS Coding staff regularly reviews our client’s documentation practices to limit audit liability and promote optimal charge capture. They are always available to help our clients with documentation improvements, developing macros and other coding/billing-related questions.

Please contact your APS Practice Manager with additional questions or to schedule a call with a member of our radiology coding team.