

The Radiology Report

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ADVOCATE
Radiology Billing Specialists

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Agenda

- Introduction
- The Radiology Report-Legal Source Document
- Report Format
- “Standard” Reports

Disclaimer

The information presented is based on the experience and interpretation of the presenters. Though all of the information has been carefully researched and checked for accuracy and completeness, ADVOCATE does not accept any responsibility or liability with regard to errors, omissions, misuse or misinterpretation.

CPT codes are trademark and copyright of the American Medical Association.

Resources

- AMA
- CMS
- ACR



The Radiology Report

- Used for patient care, coding & billing, and legal purposes
- Serves as communication of interpretations and conclusion
- Legal Source Document
- Consider the audience

The Radiology Report

- Patient Care
 - Requires a pertinent medical history to provide informed care
 - Definite interpretation and opinion of the results of imaging exam or procedure
 - Contributes to continuity of care and establishing the entire clinical picture for the patient
 - Should answer a clinical question

The Radiology Report

- Coding & Billing
 - Key components of the report, and specific exam criteria, are required for proper CPT code selection and appropriate reimbursement
 - Documentation of complete and pertinent history as well as key findings correlate to accurate ICD-10 coding, which contributes to supporting the medical necessity of a study
 - Quality Payment Program

The Radiology Report

- Malpractice/Legal Considerations
 - Never alter the report with information that is not deemed accurate at the time of service
 - Authentication of reports
 - “Hedging”



Elements of the Report

- Demographics
- Clinical History
- Report/Exam Title
- Technique
- Findings
- Impression

<https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CommunicationDiag.pdf>

Demographics

- Not typically part of dictation
- Should Include:
 - The facility or location where the study was performed
 - Name of patient and another identifier
 - Name(s) of ordering physician(s) or other health care provider(s). If the patient is self-referred (a patient who seeks medical care without referral from a physician/health care provider), that should be stated.
 - Name or type of examination
 - Date of the examination
 - Time of the examination, if relevant (eg, for patients who are likely to have more than one of a given examination per day)
 - Inclusion of the following additional items is encouraged:
 - Date of dictation
 - Date and time of transcription
 - Patient's date of birth or age
 - Patient's gender

Clinical History-Why is the Patient Here?

- “REASON FOR EXAM”
- Signs/symptoms
- Any pertinent medical history, including chronic conditions and/or previously established DX
- Key factor for medical necessity/ICD-10

Report/Exam Title-What was Done?

- Should include:
 - Body site
 - Type of modality
 - Specific exam performed
 - Modality specific information:
 - W/WO/W&WO Contrast
 - 3D/SPECT when applicable
 - Screening/Diagnostic
 - Limited/Complete

Technique-How was the Exam Done?

- Contrast administration
- Medications and/or radiopharmaceuticals utilized
- Special additional procedures or variations
- Catheters/devices

Report Body/Findings-What was Seen?

- Any patient complications or reactions
- Potential Limitations
- Diagnostic findings
- Any comparison studies
- Clinical Issues
- Incidental findings

Impression-What is the Conclusion?

- Final conclusion/diagnoses
- Any recommended follow-up
- Any significant patient reaction

“Standard” Reports

- Templates
- Macros
- “Structured Reports”
- Note Cloning



Q&A



Thank you!

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