The Radiology Report:

Essential to the Business of Radiology

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The radiology report is considered a critical component of radiology—to the point the American College of Radiology addresses it with specific guidelines, and the Joint Commission identifies the communication of critical test results as a compliance element essential for accreditation. Few could argue with the fact that without the reporting of the radiologist's interpretation, our job isn't done and physicians are pressed to dictate a specific and complete report, containing valuable diagnostic information and delivered in a timely manner. However, the role of the radiology report extends much further, with its documentation impacting practice reimbursement, regulatory compliance, and risk management.

Technology has improved the efficiency of communication between the radiologist and referring physician, with results (including key images) often made available online. In addition, voice recognition has improved turnaround time and overall efficiency, although it has added new challenges as well. Specifically, certain phrases can be misinterpreted by the technology, and errors missed by radiologists during the review/signature process. Errors range from amusing to shockingly incorrect, especially when "no evidence of mass" becomes "evidence of mass."

On the other hand, a report considered adequate for the purpose of communicating diagnostic information may be underpaid, denied (not paid at all), or determined "unbillable" unless appropriate information is included. Each time a radiologist interprets a procedure, he/she assumes the medical malpractice risk. Doesn't it also make sense to ensure appropriate payment is made? Or that malpractice risk is not compounded by incomplete or error-prone reporting?

Regulatory Implications

The first assumption is the dictated radiology report serves as the source document for coding. While this seems like an obvious conclusion and a recognized

industry standard, there are still instances of procedures billed from a hospital charge ticket or imaging center superbill alone.

Common problems if the radiology report is not used as the source document include:

1. Patient cancellations and/or changes made by radiologist
2. Errors in report headers and/or charge documentation (failure to match with what is dictated in the report)

Risk management also extends to the increased medical malpractice risks inherent in incomplete dictation. For example, the time of the study can be especially critical supporting documentation for an emergency case, multiple studies on the same day, or a sequence of studies monitoring a medical condition. Another essential piece of documentation notes the radiologist communicated results (or discussed indications for the study) by phone with the ordering physician. In a legal proceeding, it is usually the person with the best documentation who wins and radiologists increase their liability by not making sure seemingly unimportant details are included in their dictation.

A good basic internal compliance audit involves the following:

What was ordered was what was done.
What was done was what was billed.
What was billed was what was paid.

The radiology report serves as the primary source document for this type of audit and should contain the appropriate indications for the study as well as details of the procedure performed (what was done—and why). If sufficient information is provided for the coders, such as the number of views, details of a complete ultrasound study, use of contrast, etc., the "what was done" will match the "what was billed—and paid."

Problems occur when there is a failure to match all the way through the audit process, and documentation lapses potentially impact more than payment. There are significant penalties for filing a false claim (billing for something that was not done) and they can include exclusion from Federal programs, fines, and incarceration. Errors will occur from time to time, but every effort should be made to ensure there are not operational failures that put the practice at risk.

Coding and Reimbursement

In underperforming radiology practices, coding is often front and center as a source of payment problems. In addition, denials for medical necessity can result from inadequate radiology report documentation if the reason for the study is not included. What does this mean specifically?

If the radiologist does not provide sufficient specificity, the coder (who uses the radiology report to determine appropriate procedure and diagnosis codes) will usually tend to be conservative and under-code the procedure. For example, if the radiologist states "chest x-ray" but does not specify if the procedure involves one view or two, the coder would probably select the code for a one-view study. If there is no indication for the study in the report and the results are normal, the procedure becomes virtually unpayable in many cases. In the end then, the chest x-ray procedure would be paid at a lower rate—or not paid at all. And while it's easier to justify documentation omissions because the reimbursement for a chest study is low, the volume in a hospital-based practice is high, so the financial impact can be considerable over the course of a year.

Failure to reference the number of views is relatively common in physician dictation but there is also a tendency to neglect information regarding the use of contrast—or to dictate details regarding complete versus limited studies. Frequently the failure to provide sufficient information to support accurate coding is not limited to a particular procedure or type of omission—but more often reflects the overall philosophy of the group regarding radiology report dictation. The objection to correcting dictation issues initially lies with the feeling it will "take too much time" to gather and/or dictate the additional information when it's the coders job to identify the necessary details. However, even the most adamantly opposed physicians have become converts when revenue improves and denials decrease after a "dictation intervention," admitting the few seconds involved in doing the job right the first time were worth it.

Another reimbursement example arises when payors reject multiple procedures on the same day as duplicate studies. Including the time of the study on the radiology report enables the coder to attach the appropriate modifier to document additional studies were performed on the same day. While claims denied for this reason can often be successfully appealed, the lost time, increased costs, and cash flow delays should provide sufficient incentive to do the job correctly the first time.

Problems in hospital-based practices frequently occur when billing information from the hospital includes the

admitting diagnosis code, rather than one related to the radiology order. Groups relying strictly on hospital information for coding will experience a higher level of denials due to the ICD-9 (diagnosis code) and CPT (procedure code) not matching appropriately.

Where to Begin

Correcting reimbursement problems related to dictation and accurate coding involves a team effort. The billing/collections department (or outside billing service) can help quantify coding and reimbursement issues, provide resources and guidance—and then serve as a feedback source as specific problems are addressed. The collective effort should improve reimbursement and reduce compliance risk and can do so fairly quickly. The steps can include:

1. **Quantify the problem.** Staff coders should be able to identify examples of procedures that are difficult to code and/or denied for a coding reason. Are certain procedures, sites, or radiologists involved? Information from the practice management system should be able to assist in determining how frequently coding denials occur, especially those related to coding or medical necessity which often involve higher-dollar procedures such as MRI and CT. In the event the computer system cannot provide a categorized denials report, baseline information can be hand counted from Medicare explanation of benefits forms. (Medicare denial codes are standardized and this approach assumes a problem with Medicare claims will extend to other payors.) This is a "brute force" method that can be more time consuming but will still yield the desired results.
2. **Involve practice leadership.** The leaders of the practice will usually respond favorably when presented with the financial and/or regulatory risks. How often do coding denials occur? How much time is spent when the coder must look up information on the hospital system because it is not dictated in the report? What does this potentially add to office overhead? Quantifying the scope of the issue and providing examples should get the practice leaders behind the wisdom of improving the situation.
3. **Present the information.** Since the goal of the improvement program is to enhance practice effectiveness, it is valuable to present information to the group in a "blinded" format so the dictating physician remains anonymous. It is helpful to provide samples of actual reports that have been denied, under-coded, or were exceptionally difficult to code, with notations regarding the limitations of each dictated report. In addition, a separate confidential section can be provided to each radiologist containing his/her specific denied reports. Expect pushback from several members in the practice and again, the effectiveness of your effort will benefit from the support of practice leadership.
4. **Provide educational information regarding the Medicare Local Coverage Determination (LCD) guidelines.** If physicians are provided with specific information regarding how Medicare assesses appropriate ordering of studies, they can assist with the gathering of additional information. It would not be unusual to find the radiologists already had the technologist ask additional questions of the patient—but then did not dictate this information into the report. The few seconds taken to appropriately document can mean the difference between being paid or doing the study for free. In other cases, scheduling protocols can be changed to ensure all information is captured regarding indications for the study.
5. **Adopt a standardized reporting format.** This will represent a difficult transition for some members of the group, so billing/collections "reasons why" will also need to be supported by those related to compliance and malpractice. Obtaining buy-in from physician leaders in the group will make this process easier—and it must be physician-driven to have the desired level of success. The use of templates in voice recognition systems can help ensure appropriate information is included. An excellent example of this involves the elements required to document a complete ultrasound study versus a limited procedure. If all elements automatically appear on the dictation system, the physician will be prompted to provide complete information.
6. **Provide feedback.** Continue to monitor denied claims and report improvement to the physician group as it is noted. This will include positive feedback regarding changes made in dictation and should be supported by decreases in coding denials and hopefully, in medical necessity denials. There will also be members of the group who will lag behind in terms of changing dictation patterns and these problems

must also be noted, with appropriate encouragement coming from physician leadership. It isn't uncommon to find the greatest percentage of problems will lie with only a few physicians in the group—and they are consistent. On the other hand, peer pressure works wonders and they do not like being identified as the problem children by the group's physician leaders.

7. **Continue to monitor and refine.** Denials management is an ongoing process, but becomes easier to monitor once established. Patterns in coding denials will vary at times and it will be important to recognize and react to these new trends as they occur.

In Conclusion

Highly proficient coders can compensate for marginal radiology reports, but ethically will not "assume" a protocol or invent an indication for the study. On the other hand, who is more qualified than the radiologist to document what was done and why? Assuming they are too busy to do the job correctly is costly in terms of increased administrative overhead, decreased revenue, and heightened levels of regulatory and/or malpractice risk.

The American College of Radiology (ACR) "Guideline for Communications: Diagnostic Radiology" provides a standardized, objective protocol not only for radiology report documentation but for the communication of that information between and among physicians. Rather than assume the burden of attempting to develop an internal standard, groups can take advantage of the considerable efforts and insight behind the ACR guideline to establish a starting point for the development of sound business practices.

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