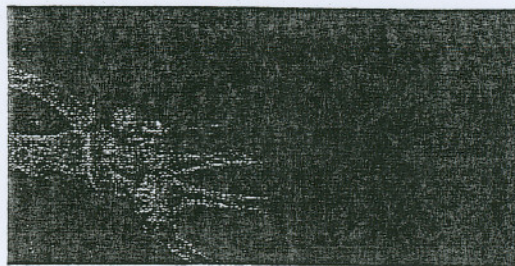


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ACR Receives Final Instruction on X-Ray in the Emergency Room

The ACR has received the final Medicare instruction on emergency radiology from the Health Care Financing Administration (HCFA). The language of the instruction, a result of several years of ACR work, is positive for both radiology and quality patient care.

The ACR has met with HCFA about x-rays done in the emergency room and communicated with them extensively in letters and conversations. As a result HCFA has adopted language in the instruction that benefits radiology. Such language includes both a distinction between an "interpretation and report" and a "review" of an x-ray, and the elements necessary in a written report. These are two important examples of language in the instruction that promotes appropriate and quality patient care.

Other points of interest in the instruction are outlined in the remainder of this report.

Interpretation and Report

The instruction first addresses an interpretation and report as follows:

"Under the revised policy, physicians should 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 because the review is already included in the emergency department 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)."

HCFA distinguishes clearly between an "interpretation and report" and a "review" of an x-ray procedure and gives an appropriate example showing what does not constitute an interpretation. HCFA also lists the necessary elements of a report, which is in direct response to the ACR's discussions with HCFA and submission of the ACR's Standard on Communication.

One Claim Filed

HCFA's language in the instruction specifically addresses how to reimburse the physician when only one claim is filed:

"When you receive only one claim for an interpretation, presume that the one service billed was a service to the individual beneficiary rather than a quality control measure and pay the

claim if it otherwise meets any applicable reasonable and necessary test."

In other words, if the radiologist is the only physician filing a claim, he or she is to be paid for the services provided with no further conditions to be met outside of standard medical practice.

Multiple Claims

HCFA's language regarding multiple claims is critical and needs to be read carefully:

"When you receive multiple claims for the same interpretation, generally pay for the first bill received. Pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. Cease consideration of physician specialty as the primary factor in deciding which interpretation and report to pay regardless of when the service is performed. Do not consider designation as the hospital's 'official interpretation' a factor in determining which claim to pay. Pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary. (This interpretation may be an oral report to the treating physician that will be written at a later time.)"

It is important to remember that the elements of this paragraph only apply

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when there are multiple claims. If the radiologist is the only physician filing a claim, his or her claim submissions will be processed as instructed under the "one claim filed" language.

It is to the benefit of the radiologist to have his or her claim submitted first for an x-ray when the emergency physician is also filing a claim. However, even if the radiologist's claim is not the first claim, the last two sentences in the "multiple claims" paragraph still allow payment to the radiologist when the radiologist's interpretation was performed at the same time as the diagnosis of the patient. It is important to note that this can be an oral report that will be written later. The last two sentences are:

"Pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary. (This interpretation may be an oral report to the treating physician that will be written at a later time.)"


One carrier has misinterpreted this "multiple claims" paragraph. That carrier placed the following statement in its newsletter: "Documentation on claims submitted for interpretation for

EKGs or x-ray performed in the emergency room must contain a statement that this interpretation contributed directly to the diagnosis and treatment of the patient. In the absence of this documentation, the claim will be denied."

This statement is incorrect because:

1. The instruction does not state that there must be a statement on the claim about the interpretation contributing to the diagnosis and treatment of the patient.
2. Whether the interpretation contributed directly to the diagnosis and treatment of the patient is only an issue when multiple claims are filed.

The ACR has mailed the MCM instructions to its Carrier Advisory Committee members and asked that they discuss this issue with their Carrier Medical Directors. It is important that the CMDs understand the various points of this instruction to further minimize misinterpretations as shown in the example above.

Any ACR members who would like a copy of HCFA's instruction on x-rays and EKGs furnished to emergency room patients may call the Economics Department at 800-227-5463, ext. 4923, or e-mail their fax numbers to economics@acr.org. 


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other clinical activity, reducing the neurology residency from 48 months to 32, and decreasing the radiology training (including a standard one-year neuro fellowship) from 60 months to 52. This is accomplished by focusing the goals of training on neuroradiology.

The first year's recruitment has been positive. The candidates for the hybrid program have been excellent, and they were attracted to it because it is perceived as providing a level of training that enables them to become better neuroradiologists.

It is difficult to argue that this hybrid seven-year program will produce less-qualified neuroradiologists than our standard six-year program in neuroradiology.

Dr. Bramwit has taken the position that board certification in neurology somehow renders an individual less of a neuroradiologist. This is not tenable. Neuroradiology should benefit from incorporating these individuals into its ranks. These are fully qualified radiologists by definition.

It is likely that the hybrid neuroradiologists will be better trained to perform the responsibilities of neuro-radiology as a dynamic, relevant specialty that is participating fully as an integral part of the neurosciences. 

William J. Casarella, MD, is the vice president of the American Board of Radiology

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