100.1 - X-RAYS AND EKGs FURNISHED TO EMERGENCY ROOM PATIENTS
(Claims Processing Manual, Rev. 1, 10-01-03)

The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital. (See 42 CFR 415.120(a).)

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 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).

Generally, carriers must pay for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier "-77") only under unusual circumstances (for which documentation is provided), such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.

When carriers receive only one claim for an interpretation, they must 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.

When carriers receive multiple claims for the same interpretation, they must generally pay for the first bill received. Carriers must pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. Consideration is not given to physician specialty as the primary factor in deciding which interpretation and report to pay, regardless of when the service is performed. Consideration is not given to designation as the hospital's "official interpretation" as a factor in determining which claim to pay. Carriers 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.)

If the first claim received is from a radiologist, carriers generally pay the claim because they would not know in advance that a second claim would be forthcoming. When carriers receive the claim from the emergency room (ER) physician and can identify that the two claims are for the same interpretation, they must determine whether the claim from the ER physician was the interpretation that contributed to the diagnosis and treatment of the patient and, if so, they pay that claim. In such cases, carriers must determine that the radiologist's claim was actually quality control and institute recovery action.