Reimbursement Policy

Effective Date .............................................. 11/15/2018
Reimbursement Policy Number ............................ R26

Physician Interpretation and Report (I&R) Services

Table of Contents

Overview ....................................................... 1
Reimbursement Policy ..................................... 1
General Background ....................................... 1
References .................................................... 3
Policy History/Update ..................................... 3

Related Policies

M26 Professional Component

INSTRUCTIONS FOR USE
Reimbursement policies are intended to supplement certain standard benefit plans. Please note, the terms of an individual’s particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual’s benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual’s benefit plan document always supersedes the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersedes the information in a reimbursement policy. Proprietary information of Cigna. Copyright ©2019 Cigna

Overview

This policy pertains to the reimbursement of interpretation and report codes (I&R) with evaluation and management (E&M) codes. This policy applies to claims submitted on a CMS1500 claim form.

Reimbursement Policy

Cigna will provide separate reimbursement for physician’s interpretation and report (I&R) services in addition to an Evaluation & Management (E&M) service when the following criteria is met:

- The I&R must be a separate, distinct and retrievable report, not contained within the E&M report.
- The written report must contain the required detail, comparable to a report provided by a specialist (e.g.: Radiologist, Cardiologist) in that field. See documentation requirements below.

Cigna will not provide separate reimbursement for an I&R if any of the following apply:

- More than one claim for an I&R is received for the same service.
- I&R services performed solely for the purpose of quality control.
- The report is generated by a machine and is unconfirmed by a physician.

Modifiers will not override the denial of the I&R when billed with an E&M code.

General Background

Cigna is aligned with the American Medical Association (AMA) for the reimbursement of physician’s interpretation and report (I&R) services. Per the 2018 Professional Edition Current Procedural Terminology (CPT®) Manual- Evaluation and Management (E/M) Services Guidelines: “the actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the E/M code. The physician’s interpretation of the results of diagnostic
tests/studies (i.e.: professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately using the appropriate CPT code with modifier 26 appended.”

Note: treating physicians (including but not limited to emergency room physicians, orthopedic surgeons, trauma specialists, surgeons, internists, family physicians and podiatrists) who routinely review radiographs or EKG tracings as an integral part of the reimbursed E&M service are typically not entitled to reimbursement for the professional component of the radiographic review. This service, like other diagnostic data evaluations, is included in the reimbursement for the E&M service. Clinical code edits will be applied to I&R services billed in addition to an E&M on the same date of service by the same physician.

Exception: CPT Codes 76604 (Ultrasound, chest (includes mediastinum), real time with image documentation) and 76705 (Ultrasound, abdominal, real time with image documentation; limited will be allowed separately in addition to an Emergency Room E&M. This exception is based on the practice of emergency room physicians performing this imaging service themselves in the setting of Focused Assessment with Sonography for Trauma (FAST) examinations. FAST is a rapid bedside ultrasound examination performed by surgeons, emergency physicians and certain paramedics as a screening test for blood around the heart or abdominal organs following trauma. In this situation, a complete imaging report is being performed by the physician and thus, warrants separate reimbursement.

**Documentation Requirements-Radiology**

In order to receive separate reimbursement for an interpretation and report in addition to the E&M service, the following must be documented and available:

- Recipient’s name and hospital identification number (if applicable)
- Name or type of examination
- Date of examination
- Appropriate anatomic and sonographic terminology must be used. The use of acronyms and abbreviations should be avoided. Variations from normal size should be accompanied by measurements when appropriate (e.g.: organomegaly and masses)
- Pertinent commonly used anatomic measurements should be listed (e.g.: fetal biometry)
- Limitations that compromise the quality of the examination should be noted (e.g.: increased body mass index)
- Comparison with prior relevant imaging studies if available
- A specific diagnosis or differential diagnosis
- An impression or conclusion
- A recommendation for follow-up studies should be provided if clinically appropriate
- The final report must be generated, signed and dated by the interpreting physician

**Documentation Requirements-Electrocardiogram (EKG/ECG)**

In order to receive separate reimbursement for an interpretation and report in addition to the E&M service, the following must be documented and available:

- Recipient's name and hospital identification number (if applicable)
- Name or type of examination
- Date of examination
- Measurement of intervals
- Measurement of axis, rhythm and heart rate
- Interpretation of the tracing by the physician
- Summary of the findings/review
- Comparison with prior relevant EKG studies
- Recommendation for follow-up studies should be provided is clinically appropriate
- The final report must be generated, signed and dated by the interpreting physician
References


5. The American College of Emergency Physicians, Resources, Reimbursement, Diagnostic Interpretations. Available at URL address: http://www.acep.org/content.aspx?id=30322

Policy History/Update

<table>
<thead>
<tr>
<th>Date</th>
<th>Change/Update</th>
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<tbody>
<tr>
<td>02/18/2019</td>
<td>Effective date for the removal of the allowance of modifiers to override the denial of the I&amp;R code when billed with an E&amp;M code.</td>
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<tr>
<td>11/15/2018</td>
<td>Policy template updated and notification for the removal of the allowance for modifiers to override the denial of the I&amp;R code when billed with an E&amp;M code effective 02/18/2019.</td>
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<tr>
<td>06/06/2017</td>
<td>Policy template updated.</td>
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<tr>
<td>02/25/2016</td>
<td>Added CPT code 76604 to the exception which allows separate reimbursement in addition to the Emergency room E&amp;M.</td>
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<tr>
<td>12/07/2015</td>
<td>Policy published to indicate documentation requirements for separate reimbursement for an interpretation and Report in addition to an E&amp;M service. No change to code edit.</td>
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