

Coding Tip – Ultrasound Storage of Images and Documentation Within Reports

Complete documentation of work performed is a central tenet of optimal care and communication between medical teams. The ultrasound report serves as an instrument of communication between providers and acts as documentation of findings for care and follow-up. Hence, it is imperative that the documentation of work is complete, and findings are promptly communicated.

Other organizations have detailed the information required for appropriate documentation of an ultrasound examination (1,2). Examinations should be recorded and stored to allow review of an exam for adequacy and accuracy. Images may be captured in a static format or may require video archiving or cineloop utilization. These archived images, per AIUM, should contain (2):

- Patient's name and other identifying information
- Facility's identifying information
- Date and time of the ultrasound examination
- Output display standard (thermal index and mechanical index)
- Label of the anatomic location and laterality, when appropriate
- Image orientation when appropriate

AIUM then states that the body of the report should contain the following components:

- A description of the studies and/or procedures performed
- Comments on the components of the examination as outlined in the relevant practice parameter(s)
- A description of any contrast media and/or pharmaceuticals used (including route of administration and dose, when applicable)
- Additional medications, catheters, or devices used should be indicated
- Any significant patient reaction or complication should be documented
- Anatomic measurements (e.g., fetal biometry), as appropriate, and measurement of abnormal structures or organs, if taken
- A description of examination findings, using appropriate anatomic and ultrasound terminology (use of acronyms and abbreviations should be avoided)

Additionally, the report summary should include:

- An impression, conclusion, or summary statement
- A specific diagnosis or differential diagnosis, if appropriate
- A recommendation for follow-up studies, if clinically applicable
- An accounting of any failure to include standard views or other necessary components (as listed in the appropriate practice parameter)
- If prior relevant imaging studies were reviewed, a statement of comparison should be included
- Details concerning any provider-to-provider communication in cases in which a delay in communication may have an adverse effect on the patient's outcome

The ACR practice parameter states that for documentation (1): "Adequate documentation is essential for high-quality patient care. There should be a permanent record of the ultrasound examination and its interpretation. Comparison with prior relevant imaging studies may prove helpful.



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Images of all appropriate areas, both normal and abnormal, should be recorded. Variations from normal size should generally be accompanied by measurements. The initials of the operator should be accessible on the images or electronically on PACS. Images should be labeled with the patient identification, facility identification, examination date, and image orientation. An official interpretation (final report) of the ultrasound examination should be included in the patient's medical record. "

Each imaging organization has statements regarding image storage (1,2). Per AIUM: "Archiving methods and communication of reports and images must comply with local, state, and federal regulation." Per ACR: "Retention of the ultrasound examination images should be based on clinical need and relevant legal and local health care facility requirements." Neither organization mentions the need to document this storage in the report summary.

CPT guidelines for ultrasound state: "All diagnostic ultrasound examinations require permanently recorded images with measurements, when such measurements are clinically indicated."

Based on the above requirements by ACR, AIUM and CPT, permanently stored images are implicit in the use of any ultrasound CPT code. The guidelines do not require a statement in the physician's professional interpretation to this effect.

It has come to the attention of the SMFM that some payers are requiring a statement within ultrasound reports confirming the digital storage of exam images as part of the patient's permanent record. In some cases, payers are demanding reimbursement for past examinations and/or denial of payment for services provided.

It should be noted that the SMFM disagrees with this payer strategy in ultrasound reimbursement. Furthermore, other major organizations also disagree with this interpretation of the need for a statement within reports discussing the storage of images. It should be noted that appropriate storage, per organization practice parameters, is a requirement for ultrasound exams. However, payers should not penalize providers who appropriately utilize archiving systems, but do not place a specific statement within their reports. The increased documentation is unnecessary, adds excess verbiage to reports which increases time in reading reports without clinical benefit, increases additional provider work without clinical value, and is an inappropriate strategy that adds to provider disenchantment and possible burnout.

The SMFM believes demanding additional statements beyond those required by a major imaging organization (AIUM, ACR) is gratuitous and counterproductive to collaborative relationships between clinical teams and payers. Nonetheless, if desired to stop this mode of non-payment, providers may want to include a statement within their reports until this payer tactic is nullified. If desired by a practice, we recommend a statement such as:

The associated images are stored on a PACS/EMR system either maintained or contracted by the practice/institution where the study was performed.

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References

1. <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/US-Perf-Interpret.pdf>
2. AIUM Practice Parameter for Documentation of an Ultrasound Examination. *J Ultrasound Med.* 2020;39(1):E1-E4. doi:10.1002/jum.15187

