American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2018

Interpretation of Diagnostic Imaging Tests

Revised June 2018 with current title, February 2013, June 2006 titled "Interpretation of Imaging Diagnostic Studies"

Reaffirmed October 2000

Revised September 1996

Originally approved titled, "Interpretation of Diagnostic Studies" March 1990

The American College of Emergency Physicians (ACEP) believes that the communication of diagnostic study results is critical to the evaluation and management of emergency department (ED) patients. Such communication should be performed contemporaneously with the ED visit to guide ongoing treatment decisions and promote effective provider and patient communication. Organizations should create service standards and operating procedures that clarify testing availability, timeliness, interpretation responsibility (including the role of residents), communication methods for preliminary and final results, as well as quality assurance, discrepancy follow-up, and incidental finding communication.

Interpretation of critical testing must be available 24 hours per day, 7 days per week. Interpretation should be completed by a provider who meets or exceeds the requirements of the institution in which the patient is receiving care. Off-site interpretation may be utilized, provided the process follows institutional and American College of Radiology (ACR) guidelines.[1] It is preferred that off-site radiologists be credentialed by the hospital medical staff where the studies are performed. Contemporaneous interpretation may be done by the emergency medicine providers or by another specialist within the limits of the training, experience, and competence of that physician. Quality assurance of non-radiology interpretations should follow institutional guidelines.

Per U.S. Centers for Medicare & Medicaid Services (CMS) guidance,[2,3] the provider performing contemporaneous interpretations of diagnostic studies is entitled to reimbursement for such interpretations.

Interpretations should be available immediately to the ordering provider or their designee in accordance with institutional guidelines. Organizations utilizing electronic medical records (EMR) and picture archiving and communication systems (PACS) should consider full integration, allowing for bidirectional communication, full versioning of results reporting, and full access to digital images.

Organizations should make allowances for the importation, interpretation, and storage of outside images and/or results when critical or beneficial to patient care or safety. Reinterpretation of outside images should be available when

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dictated by patient care needs or at the request of the treating provider.

Organizations should assure that results are communicated in a method commensurate with their criticality. Results suggesting the need for immediate or urgent interventions, or otherwise considered critical, must be readily identifiable in the radiologist's report and verbally communicated in real-time via closed loop communication to the ordering provider or their designee. Non-routine communications should follow ACR practice parameters.[4]

When patient needs dictate, preliminary reports may be required. Organizations must assure that all radiologist preliminary reports are readily identifiable, time stamped and permanently archived in the versioning of the final report accompanying the study. The radiologist must report any changes from the preliminary report in a timely, reliable, time stamped fashion to the ordering provider or their designee and document this in their report. Findings that may be seriously adverse to the patient's health but do not require immediate attention must be communicated in a reliable, time stamped fashion to the ordering provider or their designee and documented in their report. Organizations should provide clear guidance and support for the management of patient communication as it pertains to changes in findings, diagnosis, or need for further intervention, including the communication of incidental findings that were not available when the patient was in the ED.

If the emergency physician believes that an urgent consultation with a radiologist is needed for the interpretation of a diagnostic study, that consultant must be immediately available for discussion and/or consultation with the treating physician.

Whether the consultation is provided from a hospital staff physician or by an external contracted consultant, this physician should be board certified in radiology and licensed in the state where the images are obtained and should meet or exceed the credentialing requirements for physicians credentialed by the local health care facility.

References:

1. American College of Radiology. Radiologist Coverage of Imaging Performed in Hospital Emergency Departments, ACR Practice Parameter. Adopted 2000 (Resolution 32), Revised 2003 (Resolution 6), Amended 2006 (Resolution 36), Amended 2007 (Resolution 13), Revised 2008 (Resolution 34), Revised 2013 (Resolution 24) Amended 2014 (Resolution 39). Accessed April 2, 2018.
2. Chapter 13: Medicare Claims Processing Manual. U.S. Centers for Medicare & Medicaid Services web site. http://www.cms.gov/RegulationsandGuidance/Guidance/Manuals/downloads/clm104c13.pdf. Revised July 28, 2017. Accessed April 2, 2018.
3. Diagnostic X-ray Tests, Diagnostic Laboratory Tests, and Other Diagnostic Tests: Conditions, 42 C.F.R. § 410.32 (2017).
4. American College of Radiology. Communication of Diagnostic Imaging Findings, ACR Practice Parameter. Adopted 1991 (Resolution 5), Revised 1995 (Resolution 10), Revised 1999 (Resolution 27), Revised 2001 (Resolution 50), Revised 2005, 2010, 2014 (Resolution 11). Accessed April 2, 2018.

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