

APS Update

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Angiography Add-On Code 75774

Code 75774 (Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation) is reported when an additional selective angiography study within the same anatomic area as the initial vessel is studied. Per CPT, code 75774 is an add-on code, which means it must be reported in addition to the S&I code for the service provided for the initial angiography. Therefore, the appropriate S&I code would always be reported first for the vessel studied. The code descriptor also specifies that the additional study must be selective. So, either the catheter would need to be manipulated through a fork in the arterial pathway while moving away from the aorta or, after entering the aorta, the catheter would be manipulated into a vascular family that is different from the one initially accessed. If a selective catheterization is done in a higher order branch after the basic study and a more specific code is available, do not report code 75774. Instead report the specific code for the procedure.

An example of the use of code 75574 would be: The catheter in the abdominal aorta is advanced down to the bifurcation for complete bilateral run-off. It is then manipulated into the bilateral external iliacs from a right common femoral puncture with injection and imaging at all catheter stops.

- The correct codes would be: 36245 (left external iliac), 75625 (aorta), 75716 (bilateral lower extremity run-off), 75774 (left external iliac) and 75774-59 (right external iliac).

Long Delays for Medicare Provider Numbers

If you've been waiting for your Medicare provider number for a new corporation or a new doctor for what seems like eons, at least there are a lot of people in that exact same place. There are plenty of examples of carriers taking up to six months after the submission of information to even pick up the application and give an initial response such as, "the application is complete."

This is not a local problem as a recent issue of [Medicare Part B News](#) featured the problem on the front page. The delays are substantial, often going up to 8 months.

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For new providers, this can be especially painful as most commercial plans, including the Blue Cross/Blue Shield plans and many Medicaid plans will not credential a provider until Medicare has granted a number. This means that a new provider may have virtually no revenue coming in for over half a year because no one at the Medicare carrier can get around to looking at the application.

Medicare does backdate the effective date to when they received the application and will pay at that time for any services provided during the delay. Commercial insurers, however, are not as kind. First, you can't even submit your application in many cases until you have your Medicare number and even then, many commercial plans will not accept claims for services provided prior to their decision.

Since this is so injurious to health care providers' finances, we contacted CMS to see if there were performance guidelines and sanctions to be placed on carriers for their performance on this critical issue. We were disappointed to find out that there are no guidelines and no sanctions whatsoever.

CMS, reacting to the rising level of dissatisfaction with the situation, has issued the usual comment on any such problem saying that;

1. The issue is really due to incomplete or inaccurate submissions by the providers and,
2. CMS is working on an electronic version of the submission which will speed the process.

Based on anecdotal evidence, in all cases where we have had such a circumstance, the issue is not confined to those applications which are incomplete or inaccurate as our applications have not been returned for such issues and still take 5-7 months to finish the process.

If you are looking at the creation of a new entity for the provision of any health service it is important to add this delay into your planning timeline as its impact on revenues can be significant.

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CT, CTA or Both

CTA codes (Computed tomographic angiography) in CPT are all defined as "without contrast material(s) followed by contrast material(s) and further sections, including image post-processing"). However, a preliminary non-contrast scan is not always performed and is not required in order to charge for CTA.

Three dimensional rendering (reported with CPT codes 76376 and 76377) is integral to CTA and should not be separately charged. The key distinction between a CTA and CT is that CTA includes reconstruction post-processing of angiographic images of the vessels, such as maximum intensity profile (MIP) or 3-D renderings an interpretation. If reconstruction post-processing is not done, it is not a CTA study. An example of a CTA would be a scan of the chest for pulmonary emboli with MIP'S. This would be coded 71275 (CTA, chest, non-coronary) rather than a plain CT scan.

In most cases it is not appropriate to charge for a CT in conjunction with a CTA. Reporting both a CT and a CTA on the same day of the same region would be very rare. For example, if the CT reveals abnormal findings it may be decided to perform a CTA for additional information. In order to charge for both a CT and CTA there must be an order from the treating physician for both exams. Both exams must be medically necessary and both must be separately and completely documented.

The CTA of the chest, code 71275, is the only code Medicare has specific diagnosis codes that must be present in the record to reflect medical necessity. Some examples follow:

- * chest pain
- * shortness of breath
- * abnormal findings on radiological and other exam of other intrathoracic organs
- * abnormal function study of cardiovascular system
- * abnormal ECG, EKG

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NPI Registry Download Until August 1, 2007

The original release date of the downloadable registry of National Provider Identification has been pushed from June 28 to August 1, 2007. The delay comes after some Social Security Numbers and Tax Identification Numbers were found in the document which will be publicly disclosed information.

All the information populated in the NPI registry is with data provided to the National Plan and Provider Enrollment System when an application was completed for individual and facility NPI's. CMS is creating the registry under the Freedom of Information Act.

To ensure your information is accurate and the information contained within the registry is not sensitive data, log into the NPPE website (<https://npes.cms.hhs.gov>). Here you will be able to make the necessary changes prior to the public release of the information.

Medicare Revision Proposal Likely to be Delayed

Based on the current political environment the actual Medicare Physician Payment System revisions are likely to be delayed into the fall. This was the conclusion of a presentation made by John Patti, MD of the ACR Commission on Economics.

The current House legislation has the revisions linked to the State Children's Insurance Plan (SCHIP) initiative. The Senate had no such revision plan introduced so the House bill is likely to be stripped of its Medicare revisions in order to permit the SCHIP to go forward. Medicare revisions which were published on July 24th pertaining to the House legislation will be reintroduced in some form in the fall session with action taken prior to the holidays.

The key provision of the legislation introduced by the House is that the conversion factor upon which all physician fees are based is proposed to be broken into six different categories, permitting the political process to favor one type of doctor over another (e.g. improving payment for primary care at the expense of specialists). The component for most hospital based physicians will be bundled with "minor procedures" and diagnostic support (e.g. pathology and radiology).

This is legislation that will bear monitoring throughout the fall.