

# APS Update

## RADIOLOGY NEWSLETTER

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### Cerebrovascular Ultrasound Coding

There are various codes to select from in non-invasive vascular studies. They include patient care required to perform the study, supervision of the study and interpretation of the study results. Also, copies of the patient's medical record including a hard copy image with analysis of all data, including bidirectional vascular flow or imaging when provided. For the Cerebrovascular Arterial Studies, the codes are:

- \* 93880 - Duplex scan of extracranial arteries; complete bilateral study
- \* 93882 - unilateral or limited study
- \* 93886 - Transcranial Doppler study of the intracranial arteries; complete study
- \* 93888 - limited study

The ultrasound study defined in code 93880 focuses on vessels positioned on the outside of the skull (extracranial). It covers the clavicle to the foramen where the vessels enter the skull. Code 93880 is typically ordered when a full and complete study of both carotid arteries is requested. Once the suspected issues are found and treated, a limited study will likely be ordered for that specific site. If it is necessary to identify arterial blockage or vascular spasms within the skull, an intracranial scan may be performed and is reported with code 93886. Just as the extracranial study, report code 93886 for the complete study and code 93888 is most often used to evaluate post procedure blood flow or the effect of various medical treatments for spasm.

Even though both studies may be medically necessary and performed on the same day, some carriers may require a modifier -59 (distinct procedural service) and documentation to indicate the clinical reasons for conducting both studies.

### Independent Diagnostic Treatment Facility Revisions

The first indications of the broadening of CMS' regulation of Independent Diagnostic Treatment (IDTF) facility regulations came during last year's overhaul of the Stark provisions. It became clear that CMS viewed the explosion of services being provided by practices through the in-office ancillary provisions was of concern to CMS and that further regulations would be forthcoming. During July of this year CMS produced a draft regulation which would result in a substantial increase in the oversight of such services.

*cont on pg. 2*

### CMS Plans to Expand PQRI Program for 2008

The Centers for Medicare & Medicaid Services will offer new reporting options to encourage physicians to submit quality data. The Physician Quality Reporting Initiative allows the use of 119 measures, including two "structural measures" focusing on the use of electronic health records and electronic prescribing technology. The other 117 measures are clinical performance measures, developed by leading physician organizations. These measures include factors such as percentage of patients who are receiving cancer screenings and flu shots.

*\*Information provided by  
Healthcare Finance News*

#### 2008 EDUCATION CALENDAR Hope to see you there!

Aug 16: Virginia Beach, VA  
Virginia ACR

Nov 1: Troy, MI  
Michigan Radiological Society

Nov 30-Dec 5: Chicago, IL  
Radiological Society of  
North America

## **Coding Tip Through Better Documentation for X-Rays**

Selecting the appropriate code for x-rays will depend on the documentation provided by the radiologist. There are two steps to follow to ensure the claim submitted is compliant. First, document the formal name of the x-ray and number of views. Many reports are submitted with headers that may show what was ordered and may not reflect what was actually done. If using the header, be sure what is documented is what was actually done. Secondly, document the number of views taken and in some cases it may be important to document the type(s) of views. For example, if four views of the abdomen are taken, the code will depend on whether the views were anteroposterior, oblique, cone, decubitus, erect, or supine to accurately select a CPT code. Another example would be cervical spine views. Documentation needs to specify whether the views are obliques and flexion, obliques and extension or all three types. These steps will help to ensure that you receive full reimbursement for these cases.

## **CT Colonography Under Review**

The Center for Medicare and Medicaid Services (CMS) is currently pursuing a study of CT Colonography to determine the impact of Medicare coverage of such services for colorectal cancer screening. The use of such "virtual colonoscopy" could have large ramifications for the services provided to Medicare beneficiaries nationwide. Such services have been technically feasible for over two years and are just now being reviewed for possible inclusion in Medicare benefits. The analysis, which should be complete early in 2009, could lead to a coverage decision which typically is used by other payers as a basis for benefit decisions as well.

Medicare reimbursement for colorectal cancer screening currently includes only some modalities, including traditional fiber optic colonoscopy, flexible sigmoidoscopy, barium enema and fecal occult blood testing. It would be reasonable to expect that the introduction of CT colonography would cause a significant change in the usage rates for those services. That calculation is likely to play a large part in the analysis being pursued by CMS.

### *Independent Diagnostic Treatment cont.*

Clearly the IDTF regulations impose a level of oversight and cost which are not required of the normal physician practice. CMS has indicated its concern that services such as those provided through IDTFs require a level of nonphysician services commensurate with the services provided, which may not be available within the practice. Indeed, CMS claims that practices may be providing such services as physician office services specifically to avoid the need to comply with IDTF regulations.

In the July proposed rulemaking, CMS has suggested that all such services (excluding diagnostic mammography, only) would become subject to IDTF regulations, regardless of previous enrollment as an office based service. CMS has softened some of the required standards, however, in recognition of the many legitimate services provided through these types of organizations. Office based services would not be required to be separately enrolled for each place of service and will not require separate comprehensive liability insurance for each location. In addition, several additional notice requirements of traditional IDTFs will not be required (posting hours, posting IDTF requirements, etc.).

Failure to comply with the new standards may result in a denial of payment or, in extreme cases revocation of billing rights for the sponsoring organization. In the case of a revocation of billing rights the organization will have only 30 days to file all remaining claims before CMS will no longer take claims in.

The current proposal is a large extension of the expansion of IDTF regulations included in last fall's rulemaking and may have far reaching impact for those practices which have been providing such services directly or through a shared arrangement. If you are involved in such types of service, either as the billing entity or as a provider of services, it will be important to review the impact on these proposed regulations to your business.

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