APS Update

RADIOLOGY NEWSLETTER

Volume 6 *August 2009* *Issue 8*

The OIG Focused on Ultrasounds

With the growth in ultrasound imaging covered under Medicare Part B over the years, concerns were raised regarding the appropriateness of this service. In 2007 Medicare Part B covered about 17 million ultrasound services in ambulatory settings at a cost of over $2 billion dollars. The OIG (Office of Inspector General) conducted an audit on this service using claims from 2007. The results of the audit found 20 counties that were in the top 1% of counties for both average allowed charges for ultrasound per Medicare beneficiary and percentage of beneficiaries who received ultrasound services. The claims data was to analyze the use of ultrasound in the high-use counties to that in all other counties. They did not assess the medical necessity of the service.

It was found that one in five claims "had characteristics that raise concerns about whether the claims are appropriate," with the most common error being the claims lacked prior service claims by the ordering physician, which means physician ordered ultrasounds for patients that they hadn't treated within the last year. Other less common issues were: more than five ultrasound services provided to the same patient on the same day by the same provider, ultrasound services billed for patients for them by more than five providers in a year, missing or invalid data identifying the ordering physician, the questionable use of the procedure codes and claims involving more than one ultrasound for the same patient on the same date. The following code pairs were noted:

* 76700 - Ultrasound abdominal, complete
* 76705 - .....limited

* 76830 - Ultrasound, transvaginal
* 76856 - Ultrasound, pelvic

* 93925 - Duplex scan of lower extremities arteries or arterial bypass grafts; complete
* 93978 - Duplex scan of aorta, inferior vena cava, iliac vasculature or bypass grafts; complete

(cont.)

(cont.)

Regarding the billing of any of the code pairs listed above on the same claim for the same patient, the documentation should support both exams including medical necessity, test results and physician orders for both exams.

Going forward, the OIG will forward questionable claims identified by the report to RACS (Recovery Audit Contractors) to consider in prioritizing areas for post-payment review.

Implications of MIPAA

The Medicare Improvements for Patients and Providers Act of 2008 contains some key provisions which relate specifically to radiologists and imaging services. At this point, the provisions of MIPAA relate to reimbursement for the technical component of some imaging services (CT, MRI and nuclear medicine). In order to comply with MIPAA and be eligible for Medicare payment, each imaging center offering any of the covered services must be accredited by an accrediting body to be chosen by Medicare no later than January 1, 2010. It is expected that the American College of Radiology or the Intersocietal Accreditation Commission will be selected for this task.

The focus of the accreditation reviews will be individual pieces of equipment, technologist proficiency and medical direction from supervising physicians, with the goal of ensuring patients safety. It is expected that the accreditation will be initiated with an application. These applications must be prepared carefully as they must be prepared for each piece of equipment and the processing time could take up to 6 months. It seems that the inclusion of a radiologist in the selection of images for the application will have a positive impact on the application process and the ultimate pass rate for the applications.

2009 EDUCATION CALENDAR

Hope to see you there!

Nov 29-Dec 4: Chicago, IL
RSNA

ICD-10 Coding Update

As previously reported, the Department of Health and Human Services (HHS), finalized October 1, 2013 for the implementation for ICD-10-CM. ICD-9-CM codes will not be accepted after this date. Whereas ICD-9 contained over 17,000 codes, ICD-10 will be over 168,000 codes. For a period of up to two years, systems will need to access both ICD-9 and ICD-10 as we go through this transition. Before we can think about guidelines and the codes, there are many, many other areas to focus on. For example, a communication plan, the significant gathering of information on technology, IT systems, finance, clinical areas, payers and outcomes. The first thing to do is to read the ICD-10 Final Rule.

Next:

* Organize an Implementation Plan
* Create a timeline for each step
* Assign a project team or key person to organize and manage each step
* Include a physician and coding staff person in the implementation process
* Complete one step at a time

Every practice should begin this process immediately as preparing for this change will take a great deal of time and effort. Some items to start with could be:

1) Complete analysis of system impact. Internal/ external vendor information systems, hardware requirements for new software or any updates to existing hardware.
2) Conduct an analysis to identify resources needed for systems, educational expectations, budget for this project, etc.
3) Identify all areas that will impact the practice and speak to them about ICD-10-CM
4) Brief providers and staff on the scope of the work that needs to be done
5) Obtain support from all involved
6) Develop a regular schedule for communication (meetings, e-mails, newsletters, etc.)

In the coming months there will be information provided on additional steps to proceed with, certain topics that will help with crosswalking with general equivalence mapping (GEM), mapping for educational training (which can take up to two years) and documentation training. The Centers for Disease Control and CMS has also provided websites to help guide you through this process:

- http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm
- www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp

CMS Clarifies Billing Start Dates

In a new regulation incorporated in the 2009 Physician Fee Schedule, CMS has laid out the process whereby new provider applicants can bill for services. The new rules call for an application to be submitted, as previously, but establish a window surrounding the date the application is submitted within which billing will be permitted. The "effective date" is the later of, the date the application was received by the credentialing organization, or the day that the practice begins. Assuming approval of the application, billing will be permitted for dates of service up to 30 days prior to that date. Therefore, if a provider begins practice on September 1 and submits their application on the 15th, upon approval of the application Medicare will permit billing back to the beginning of the practice since it was within 30 days of the receipt of the application by the contractor. If, on the other hand, the provider began practice on August 1, the services provided during the first 16 days would not be billable to Medicare.

It is still important to realize that most commercial plans require the completion of the Medicare process prior to considering an application from a provider. Since the Medicare process generally takes more than a month to complete (and often well beyond that) the start date for commercial billings is often delayed as those insurances typically do not permit retrospective billing, as in the Medicare policy above. Careful planning of the credentialing for new providers is critical to establishing a steady cash flow.

APS Medical Billing
5700 Southwyck Blvd.
Toledo, OH 43614
419-866-1804 / 800-288-8325
www.apsmedbill.com