APS Update

RADIOLOGY NEWSLETTER

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What is an NPI?

An NPI or National Provider Identifier, is an outcome from the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA) and establishes unique identifiers for healthcare providers, health plans, and employers involved in HIPAA standard transactions. The purpose of the NPI, which is a 10-digit number that contains no embedded intelligence, is to improve the efficiency and effectiveness of the electronic transmission of health information. To comply with this mandate, all health care providers must obtain a National Provider Identifier number or NPI by May 23, 2007.

APS Medical Billing has taken the steps to enroll all of their physicians and have made the necessary computer systems changes to accommodate this change. In fact, APS started using NPI numbers for electronic claims in October 2006.

In addition to utilization of the NPI to identify the healthcare provider rendering services, HIPAA mandates the use of this number in claims submission to identify the referring provider. To date, a national database of NPI numbers has not yet been created. NPI will become one of the mandatory data elements clients are required to provide enabling APS to submit a claim for our providers. APS is working closely with all business partners, both carriers and facilities in which our clients provide services, to obtain NPI numbers for referring providers on behalf of our clients.

Any information you may have about efforts of others creating a database for sharing of NPI numbers, can be passed onto your Practice Manager or Client Representative.

New Guidance Codes for 2007

Percutaneous biopsies, drainages, aspirations and needle placements are some of the more common services performed using imaging guidance, such as fluoroscopy, computed tomography, magnetic resonance, ultra-sound or other methods. Some of the guidance codes used in 2006 have been deleted and replaced with new codes for 2007.

Unchanged for 2007

75989 Radiological guidance (fluoroscopy, ultrasound or computed tomography) for percutaneous drainage (abscess, specimen collection) with placement of catheter, RS&I
76942 Ultrasound guidance for needle placement (biopsy, aspiration, injection, localization device) imaging S&I
76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access
sites, with permanent recording
76000 Fluoroscopy, up to 1 hour physician time

Changed for 2007

77001 (previously 75998) Fluoroscopic guidance for central venous access device placement, replacement or removal
77002 (previously 76003) Fluoroscopic guidance for needle placements
77003 (previously 76005) Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures
77012 (previously 76360) Computed tomography guidance for needle placements, RS&I
77021 (previously 76393) Magnetic resonance guidance for needle placement, RS&I

Codes 77002, 77012, 77021, and 76942 are used to report the imaging guidance for numerous procedures, based on the method used. Code 75989 is not reported with the codes 77002, 77012, 77021 and 76942 unless two separate lesions or areas of interest are involved. For example, drainage of abdominal fluid and a percutaneous needle core biopsy of the liver during the same encounter.

Process New NPI for Revised 1550 Health Insurance Claim Form

It began on October 1, 2006, health plans, clearinghouses and other information support vendors were required to be ready to handle and accept the revised (8/05) 1500 Claim Form. From now until March 31, 2007, providers can use either the current (12/90) version or the revised (8/05) version of the 1500 Claim Form. The newly revised form includes the splitting of box 17a to provide for reporting of the NPI number or other identifying number with similar changes made to box 241 and box 33. Additional minor changes include the removal of the bar code on the top of the form and the addition of Tricare above Champus.

The revised 1500 Claim Form (8/05) was approved by OMB and can now be recognized for use within the federal government and other various federal health care programs. Private health payers will utilize the revised 1550 Claim Form (8/05) due to the administrative simplification for standardized claims processing.

On April 1, 2007 the current (12/90) version of the 1500 Claim Form will be discontinued and only the revised (8/05) version will be allowed for usage. The instructions clearly state all resubmissions/rebilling of claims should use the revised (8/05) form from this date forward, even if earlier submissions have been on the current (12/90) 1500 Claim Form.

Additional instructions on how to use the new 1500 (8/05) Claim Form can be found on the National Uniform Claims Committee website, it provides general guidance on the use of the new 1500 Claim Form. www.nucc.org/images/stories/PDF/instruction_manual.pdf

Uterine Fibroid Embolization

FYI for 2007--- If you are performing a uterine fibroid embolization, new code for 2007 is 37210. This code **includes** all vascular access, vessel selection, the injection of the material for embolization, all radiological supervision and interpretation, intraprocedural roadmapping and imaging guidance necessary to complete the procedure.

Ohio Law for Copies Medical Records

The State of Ohio has established a maximum fee that may be charged by a healthcare facility or medical records company when requested a copy of a patient's medical record. Additionally, the law provides limitations for situations in which medical records may be obtained free of charge.

Effective January 1, 2007, there are two instances in which maximum fees may be charged (maximum amounts will be adjusted on an annual basis).

Maximum fee applies below when the request comes from a patient or patient's representative:

⇒ No records search fee is allowed;

For data recorded on paper

⇒ Maximum fee is $2.67 per page for the first 10 pages; $0.55 per page for pages 11-50; $0.22 per page for pages 51 and higher

For data recorded other than on paper

⇒ Maximum fee is $1.82 per page; the actual cost of postage may also be charged.

Maximum fee applies when the request comes from a person or entity other than a patient or a patient's representative:

⇒ $16.38 records search fee

For data recorded on paper

⇒ Maximum fee is $1.08 per page for the first 10 pages; $0.55 per page for pages 11-50; $0.22 per page for pages 51 and higher

For data recorded other than on paper

⇒ Maximum fee is $1.82 per page; the actual cost of postage may also be charged.

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