

APS Update

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Additional Selective Imaging

By Jan Toczynski, CPC, CCP

An Interventional Radiologist may perform multiple catheterizations in the same vascular family and report multiple catheterization codes. When additional, selective angiography studies are done within the same family vessel, in addition to the catheter codes, RS&I codes need to be reported.

What code(s) is the correct code to report?

Per CPT, always assign the appropriate code for the vessel **originally** studied. When further selective catheterization is done in a higher order branch after the basic study, the correct code to report is:

+75774 - Angiography, **selective**, each additional vessel studied after basic examination, radiological supervision and interpretation. (List separately in addition to code for primary procedure)

Code 75774 is designated as an "add-on" which means it must be reported in addition to the RS&I code for the service provided for the initial angiography. 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 important reminder also is code 75774 is not assigned for each injection of view but for each additional selective examination performed to supplement the basic examination with the recording of permanent images and interpretation.

Documentation should always support the reason why the additional selective exam was necessary.

An example of the use of code 75774:

Abdominal aortography with selective catheterization in the celiac axis, common hepatic and superior mesenteric. Injection and images were reviewed for each vessel and the catheter removed. Code: 36245 (superior mesenteric), 36246 (common hepatic), 75726 (celiac), 75726-59 (SMA), 75774 (common hepatic).

CBO Projects Cut in Physician Medicare Payment

By Tim Mousseau, Director of Revenue

In a report released the week of June 13th; the Congressional Budget Office confirmed that a 29.4 percent cut in physician Medicare payments is scheduled in January using Medicare's sustainable growth-rate mechanism (SGR).

The scheduled reduction in payments follows several years of legislative intervention to either maintain or increase physician payment rates under the Medicare program when the rates were scheduled to decrease under the SGR mechanism, the CBO said.

Two positive developments impacted physician reimbursement, according to the CBO. The removal from spending targets of the costs associated with physician-administered drugs and lower-than-expected growth in Medicare spending for physicians' services in 2010 resulted in "downward pressure on future updates to payment rates," the report said.

Although it is anticipated that Congress will act to avoid the steep cut, it is not clear where it will find the savings to fund that action.

Cholecystostomy Coding Changes for 2011

By Jan Toczyński, CPC, CCP

As part of the AMA RUC Five-Year Review Identification Workgroup analyses, the cholecystostomy codes have been editorially revised to instruct that code 47480 is intended to describe an open cholecystostomy procedure and 47490 is intended to include the bundled service of a percutaneous cholecystostomy with radiological supervision and interpretation, so it now represents a "complete" service.

2010: 47490 - Percutaneous cholecystostomy

2011: 47490 - Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation

Per CPT, a parenthetical note under code 47490 states "codes 47505, 74305, 75989, 76942, 77002, 77012 and 77021 cannot be reported in conjunction with 47490." Immediately under this parenthetical note is another parenthetical note saying "For radiological supervision and interpretation, use 75989." According to the AMA's published errata, the parenthetical note directing you to report 75989 for radiological supervision is incorrect and should be deleted as RS&I is included per the code descriptor.

CMS has assigned code 47490 a 10-day global period. Related Evaluation and Management services on the day of the procedure and for 10 days following the procedure are not separately payable. This also includes two post-procedure services.

APS Reporting Update

By Tim Mousseau, Director of Revenue

As APS continues to meet the demand for paperless, 24/7 reporting access for our clients; we urge you to visit our online reporting web site at <https://onlinereports.apsmmedbill.com> to see our latest reporting enhancements. Not signed up yet? Please contact your assigned Account Representative or Account Executive to get the latest paperless, 24/7 reporting access.

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Looming Deadline for ANSI 5010 Causes Concerns APS First in Nation to Pass Anthem Testing

By Matt Ward, Regional Director of Business Development

As of this coming January, all providers who submit electronic claims will have to conform to the version 5010 electronic administrative standard transaction format. There are several changes, none of which seem dramatic (e.g. the place of service cannot be a PO Box) but the effect on your cash flow of an inadequately planned transition can be tremendous. Take the example mentioned above; if you have changed the place of service to correctly identify the street address of the place of service and maintain your PO Box as the remittance address, but have not communicated the change to payers, your claims may not be honored as many use the place of service address as a confirming data element to identify your claims. In essence, in complying with ANSI 5010 requirements, you have changed your address and that requires a whole set of credentialing activity as well.

In recent meetings questions have been posed to providers as to whether they are ready for this change. Roughly 2% have indicated that they are ready with only 7 months before the mandated deadline. The January 1, 2012 deadline is merely the last day for the switch, many carriers and all Medicare carriers/MACs are ready to accept ANSI 5010 transaction format claims now.

As in any such change, many carriers may not be completely ready or may require additional activities, such as the credentialing mentioned above, on the part of providers to ensure that claims are able to be received and processed. APS has been actively addressing this transition for our clients and has completed all the necessary internal programming necessary. We have also been actively working with payers to ensure that our clients' claims can be submitted and will be honored to avoid any delays in payment due to programming issues on the payer side. As part of that effort we were pleased to hear from Anthem Blue Cross and Blue Shield that APS was the first organization to successfully test an ANSI 5010 claims submission with them.

This is just part of APS' determination to ensure that regulatory changes in the business of health care do not go unaddressed. With only 2% of providers actively addressing this change it is clear that there will be many who are unready for the change and experiencing cash flow shortages. Our clients will be ready. If you have questions about the ANSI 5010 transition please feel free to call your practice manager or client representative. If you are not an APS client and have concerns about this transition, please feel free to contact Tom Scheanwald at (800) 288-8325.

CMS Payment Trends for Radiology

By Matt Zaborski, Regional Account Executive

As if radiologists haven't felt enough of a pinch in 2011, decreases in reimbursement keep popping up on the radar. Read what follows carefully to be sure you're up to date on MedPAC's proposal of new reimbursement cuts and expanded bundling, proposed expansion of the Multiple Procedure Payment Reduction (MPPR) to the professional component, and 2011 bundles that have already negatively impacted cash flow of radiologists nationwide. Each of the following will have varying impacts on your practice depending on TC, PC and Global billing arrangements.

On May 20th 2011 Congressmen Joseph R. Pitts (R-PA), chairman of the Subcommittee on Health of the House Energy and Commerce Committee and Frank Pallone (D-NJ), ranking member of the Subcommittee sent a letter to Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC), questioning MedPAC's data on trends of imaging utilization. At MedPAC's April 2011 meeting they stated from its March Report that the volume of imaging increased by 2 percent from 2008 to 2009 and the volume of advanced imaging services (e.g., CT, MRI) per fee-for-service beneficiary increased by 0.1 percent in that same period. Upon completion of this hearing, the Commission approved additional payment cuts through expanded bundling and discounting the professional component of multiple imaging procedures, to be presented to Congress in its June Report.

The letter went on to cite a Moran Company analysis which showed Medicare spending for advanced imaging services was cut by 19.2% (13.3% for overall imaging) in 2007, as compared to 2006 due to the Deficit Reduction Act (DRA), as well as the countless other payment cuts experienced by imaging since the DRA. Additionally, the Congressmen urged MedPAC Commissioners to consider that previous scheduled reductions to payment levels for imaging services have yet to be implemented. Bob Still, RBMA President-Elect, was quoted as saying, "The tide against additional Medicare payment cuts to imaging may be turning in our favor in Congress. RBMA leaders and I met with Congressman Pitts recently and expressed our concerns about recent payment cuts and the impact they're having on radiology practices and their patients."

(cont.)

Bundles, Cuts (cont.)

Another revenue decreasing proposal by CMS is extending the MPPR to the professional component of MRI, CT and ultrasound procedures. CMS is also discussing applying the MPPR to all imaging services. These potential cuts will certainly have an effect on every radiology group's bottom line. The impact will be felt immediately in the Medicare portion of each practice, but will become even more staggering when commercial carriers follow suit and adopt these reimbursement models. The future financial impact of extending the MPPR to the PC is predicted to be anywhere from 5-14% amongst radiology practices. This latest revenue disruption comes just months after new CPT bundles have shown their effects.

As of January 1st 2011, CPTs 74176, 74177, and 74178 have been bundled and relinquish the ability to bill for CT of the abdomen and pelvis separately to commercial payers. The financial impact is being felt by practices nationwide and they are looking for ways to counteract this and enhance revenues. One suggestion we have that can offset some of this loss and help ensure financial stability through future cuts is to verify, claim by claim, that you are being paid at negotiated contracted rates. Sounds simple? But maybe not...

The AMA recently completed a study of carrier payment patterns (NHIRC 2010) and found that accuracy of claims processing by commercial carriers is a dismal 84%. This means that 1 out of 6 line items are paid incorrectly. With such a high frequency of incorrect payments, we feel it is imperative to our clients' financial health to verify every payment from all carriers.

APS' proprietary contract management system verifies correct payment for every claim in real time. Underpayments are flagged, a specialist is notified and action is taken to collect the money owed for each client. Please contact your account representative with any questions.