# APS Update

## RADIOLOGY NEWSLETTER

*Volume 5* *May 2008* *Issue 5*


## Non-Selective Catheterization for Arterial and Venous

In certain Interventional Radiology studies a catheter must be inserted to administer the contrast agent for imaging. The most extensive catheter placement is what will determine which procedure code to assign. There are two selections: non-selective and selective. It is considered a non-selective code when:

* the catheter or needle is placed directly into an artery and is not manipulated or moved into another branch
* the catheter or needle into the aorta from any approach and is not manipulated any further

Therefore, if the catheter remains in the same vessel that was accessed or is manipulated into the main trunk of either vascular system, it is considered nonselective.

Arterial non-selective catheterization codes are:

* 36200-Aorta
* 36100-Carotid/vertebral artery
* 36120-Retrograde brachial artery
* 36140-Extremity artery
* 36145-AV shunt created for dialysis
* 36160-Aortic, translumber

Venous non-selective catheterization codes are:

* 36005-Injection procedure for extremity venography
* 36010-Introduction of catheter, superior or inferior vena cava

If the catheter is moved outside the vessel that was entered or outside the main trunk of either system, the catheterization becomes selective. Document the branch artery and, depending on the final placement, report either 36215-36218 (head, neck, arms & thorax) or 36245-36248 (abdomen, pelvic & legs). If a venous catheterization, 36011 (first order) or 36012 (second or more selective).

## NPI Change Is Finally Here

May 23rd is the final due date to make the change in all transactions to the National Provider Identifier (NPI). Since the carriers will be implementing new processes to handle these claims, the Centers for Medicare & Medicaid Services (CMS) suggests the following:

1. Initially send claims with both the legacy system ID (e.g UPIN) and the NPI.

2. Assuming that those claims are processed, begin with a small batch of claims with just the NPI and monitor those claims' processing.

3. Once those are processing correctly, move to including only the NPI.

While carriers are supposed to be ready for the switch over, the many delays in this process is the result of carrier's inability to accept the NPI.

APS has pretested our clients' NPIs with carriers and have found the most common issues to be ones in which the precise names of corporations were different between the legacy systems and the NPI filings. Those issues have been worked through prior to the required change date.

**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
RSNA

## Choosing the Correct OB/Non-Gyn Ultrasound CPT Code

OB patients can have ultrasounds for any number of reasons. One, most likely during the course of a normal global ob care, or one may be ordered for a non-ob patient if presenting with a gynecological complaint. Per CPT, there are only a few codes to choose from and choosing successfully will depend on the diagnosis and documentation.

The most commonly used ob ultrasound codes:

- **76801** - Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester, transabdominal approach; single or first gestation
- **76805** - Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester, transabdominal approach, single or first gestation
- Codes **76811-76816** are generally reserved for high-risk or problem pregnancies
- **76817** - Ultrasound, pregnant uterus, real time with image documentation, transvaginal

Three commonly used non-ob ultrasound codes:

- **76830** - Ultrasound, transvaginal
- **76856** - Ultrasound, pelvic (non-obstetric), real time with image documentation; complete
- **76857** - Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up

Per an October 2001 CPT Assistant, published by the AMA, it states "for a patient with an established pregnancy diagnosis with signs and symptoms that are possibly pregnancy-related and require an ultrasound, ob ultrasound codes 76801-76817 should be reported, even if the outcome of the procedure is that the patient is now not pregnant or has an ultrasonic diagnosis that might be construed as being independent of the pregnancy."

If a patient presents with pelvic pain, but without a confirmed diagnosis of pregnancy, base your CPT choice on the reason for the exam (pelvic pain) even if the ultrasound shows her to be pregnant and report code 76830 or 76856-76857 depending on the test ordered.

## Medicare Fix for 7/1/08 Still Not Clear

The Senate has outlined its approach to a Medicare physician pay fix to avert the scheduled July 1, 2008 reduction in payment rates of 10.6%. It is looking at an 18 month fix to provide the time necessary to come up with a more permanent solution to the issue. Even with such a temporary fix, the cost in comparison to the amounts to be paid under the current regulations are significant. Under current legislative rules, the monies to pay for any such "increase" in expenditures have to be specifically accounted for through either new revenues (taxes or fees not already collected) or through cost reductions. It is not felt that there could be any revenue increases associated with such a fix so the focus will be on finding acceptable cost reductions.

Certainly some of the savings necessary to meet the requirements of a temporary fix will come from changes to the Medicare Advantage program which has been targeted by the Democratic leadership as requiring adjustments in the payment formula. The Administration has fought such changes but has not been able to put forward an argument to avoid the cuts to the managed care programs. Given the size of the savings necessary, however, it may not be possible to get all of the savings necessary from the Medicare managed care payments.

There is currently no consensus as to the other sources of cost savings necessary to avert the payment reductions. Unless sufficient savings are found by the Congress it may not prove possible to avert all of the planned reduction in fees.

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