APS Update

RADIOLOGY NEWSLETTER

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Reporting for Breast Biopsies

There are many options for various breast biopsies and imaging. Knowing what they are and the proper documentation can be key in receiving the appropriate reimbursement for the procedure performed.

- 19100-Biopsy of breast, percutaneous, needle core, not using imaging guidance
- 19101-.....open, incisional
- 19102-.....percutaneous, needle core, using imaging guidance
- 19103-.....percutaneous, automated, vacuum assisted or rotating biopsy device, using imaging guidance
- 19290-Preoperative placement of needle localization wire, breast
- 19291-.....each additional lesion (List separately in addition to code for primary procedure)
- 19295-Image guided placement, metallic localization clip, percutaneous, during breast biopsy (List separately in addition to code for primary procedure)

Documentation of keywords is what will help determine the choice of the appropriate code. When performing a stereotactic needle core biopsy the choice can be either code 19100, 19102 or 19103. Code 19100 is reported when not using imaging guidance, whereas 19102 and 19103 require imaging guidance. In addition to the imaging guidance for codes 19102 and 19103, code 19102 is reported for a device inserted and extracting the "core" of tissue. Code 19103 is similar but the device is not. It has a suction or rotating motion to obtain the tissue. Be sure to document specific words such as "mammotome device," "vacuum" or "rotating device." Code 19295 can also be reported if a clip is placed. Be sure to document this service as well.

If performing an ultrasound-guided needle localization into a breast lesion prior to surgery, the appropriate code would be 19290 for the first lesion. When more than one lesion is done, document appropriately, and code 19291 can be reported for each additional lesion. Code 76098 is reported for the radiographic exam, surgical specimen when performed.

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When performing either of these procedures, the imaging guidance is reported by using one of the following codes: 77031, 77032, 77012, 77021 or 76942.

Medicare does cover for percutaneous image-guided breast biopsy using stereotactic or ultrasound imaging for a radiographic abnormality that is nonpalpable and is graded as a BIRADS III [probably benign], IV [suspicious abnormality], or V [highly suggestive of malignant neoplasm], per Medicare's national coverage determination (NCD). It also states it may cover percutaneous image-guided breast biopsies for palpable lesions that may be difficult to biopsy using palpation alone.

CT Colonography Update

On February, 11 2009, CMS announced a proposed decision memo that states, "The evidence is inadequate to conclude that CT colonography is an appropriate colorectal cancer screening test under the Social Security Act. CT colonography for colorectal cancer screening remains noncovered."

The final decision has yet to be posted but many comments have been sent by physicians, specialty groups as well as patients supporting coverage of this less invasive choice.

Private carriers may still cover CTCs, so when reporting this service report CAT III code 0066T (Computed tomographic colonography [i.e., virtual colonoscopy]; screening) or 0066T (....diagnostic). Add additional requirements such as documentation of a patient's failed traditional colonoscopy.

2009 EDUCATION CALENDAR

Hope to see you there!

Aug 8: Williamsburg, VA
Virginia ACR

Nov 29-Dec 4: Chicago, IL
RSNA

Physician Payment Fix Included in Budget

Well at least it's something. In the budget approved by Congress, an amount totaling $311 billion covering a ten year period was included to support physician payment reform. The exact amount which will be targeted for the upcoming year has been left to Congress. The $311 billion is based on the adjustments Congress has made in the past to the physician payment rates and does not reflect a specific future policy. As a result, it remains unclear exactly what form Physician Payment Reform will take and whether the gains are likely to be felt evenly or whether specific specialties will benefit more than others.

Congress on the other hand, has signaled that they are unlikely to address Physician Payment Reform for at least two or more years. The proposed item for the budget resolution for 2010 includes blocking the 21 percent pay decrease, granting a two year payment increase with the involved committees to hammer out exactly how the unspecified increase will be allotted.

Of course all of this activity must be viewed within the context of the warning, which came out the week after the Budget, that the Medicare hospital trust fund is expected to become insolvent by 2017, two years earlier than previously expected. Such news is not likely to create an atmosphere conducive to solving issues like Physician Payment Reform which will require additional funds.

Currently the administration is counting on savings in a wide variety of non-physician related payments to help balance the healthcare component of the budget.

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These include a Hospital Quality Incentive Program, the reduction of hospital readmissions, bundled Medicare payments (including post-acute care), physician-owned hospital conflict of interest denials, reductions in home health payments and continued prosecution of fraud and abuse cases specifically targeted at Medicare Advantage programs and the prescription drug coverage.

It is likely to be a very busy year in Congress and the Physician Payment correction will be one of the items that will be up in the air. We don't expect to know the exact changes for 2010 until very late in the year.

Electronic Payments Gain Ground

Blue Cross Blue Shield of Michigan has just joined a long list of carriers mandating that physicians accept electronic payment and remittances. The advantage to physicians includes quicker deposits of payments. The advantages to carriers include the elimination of paper generation and mailing costs. This change, however, creates a new task, that of verifying payments. Traditionally, electronic payments also indicate electronic remittance data. Payments and remittances must be matched or credit is given for payments when no payment has been received.

We have found significant differences between the payments indicated on the remittances and the payments received in bank accounts. By relying on electronic remittances as proof of payment, practices can be making substantial mistakes in posting payments resulting in lost revenue and poor relations with patients. Always verify that the payments that are claimed to have been made actually have been received before posting.

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