APS Update

RADIOLOGY NEWSLETTER

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Reminders on Bone Density Studies

Bone density CPT codes changed in 2007. They, along with many other radiology codes, were relocated and reassigned new codes in the CPT manual although their descriptors stayed the same:

⇒ 77080 Dual-energy x-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hip, pelvis, spine)
⇒ 77081 appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
⇒ 77082 vertebral fracture assessment

To report one of the above DXA codes, the documentation must reflect an order from a physician or a qualified non-physician practitioner, interpretation of the test results and a complete diagnosis. Per Medicare's National Guidelines, an individual who qualifies for coverage must meet one of the following conditions:

⇒ is estrogen-deficient and at risk for osteoporosis (female only)
⇒ has been diagnosed by x-ray with osteoporosis, osteopenia, or vertebral fracture
⇒ is receiving glucocorticoid therapy greater than or equal to 7.5 mg of prednisone per day for more than three weeks
⇒ has primary hyperparathyroidism
⇒ is being monitored for FDA-approved osteoporosis drug efficacy

Ohio and Michigan both provide LCDs (Local Coverage Determination) for specific ICD-9 codes that support medical necessity. This list is limited for both states. Michigan will reimburse for the screening studies; if a screening exam is converted to a diagnostic exam due to positive findings, the screening diagnosis should be reported. If the patient presents with symptoms that indicate a condition, the exam could then be ordered as a diagnostic study and reported with the appropriate diagnosis code(s).

Medicare will reimburse for Bone Mass Measurement every two years but will consider more frequent DXA scans medically necessary in the following circumstances:

⇒ monitoring a patient on glucocorticoid therapy for more than three months
⇒ the need for a baseline measurement for monitoring a patient who had an initial test using a different technique (such as sonometry) than the one that will be used to monitor the patient (such as densitometry)

RACs and MUEs

The Recovery Audit Contractor (RAC) program is set to be expanded from its current three state pilot. In this program, contractor reviews Medicare paid claims records over a three year period to identify overpayments and recover those monies for the Medicare Trust Fund. Based on the experience in California, Florida and New York, the program will be expanded to include three new states in 2008 (Arizona, Massachusetts and South Carolina).

The primary focus of the recovered overpayments has been hospital claims. Only six percent of the total recovered for a four year period reviewed in the pilot was for physician claims and in most cases these were reductions in surgeon payments for multiple procedures on the same date of service. In the three states mentioned, total recoveries from physicians and ambulance services were roughly $4 million.

Despite the small recovery from such providers the RAC program is likely to continue to have purview over such claims as an attempt to exempt physicians from the program in the future was denied.

On the MUE front there is motion to "remove the veil" from the MUEs and inform providers as to the "logic" behind the edits. While not a set policy, it appears as though CMS will consider making the MUEs public in order to gain comment and discussion around what really can be used to identify inadvertent claims (e.g. typos, etc.).

Diagnosis Coding News

Congress last year failed to enact a provision mandating a quick switch from the current ICD-9 diagnosis coding system to the next version, ICD-10, but the Centers for Medicare & Medicaid Services is moving ahead to prepare for an eventual transition. Medicare currently requires ICD-9 codes on lab claims in order for the claims to be paid.

CMS this month signed a contract (one year, plus four option years) with the American Health Information Management Association to assess ICD-10 implementation and related training consultation. Three subcontractors will work with AHIMA on the project: Symphony Corp., Vangent Inc., and The Rand Corp.

**Information provided by National Intelligence Report*

Ultrasound Guidance for Vascular Access (CPT Code 76937)

Ultrasound guidance for vascular access is reported with CPT code 76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting [list separately in addition to code for primary procedure]). As the descriptor states that a permanent record is required it is important to emphasize that documentation should clearly reflect that this is being done. This code should not be reported if image archiving is not being accomplished.

Since its addition to CPT in 2004, code 76937 is reported for all ultrasound guidance for vascular access. Therefore, it is no longer appropriate to report CPT code 76942 for this service (Ultrasound guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]).

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Medicare Fix Still in the Wings

The 2008 Medicare fee fix has been held hostage to the SCHIP negotiations. Originally CHAMP (the Children's Health and Medicare Protection Act) included many of the corrections to the 2008 fee schedule that were put in place by the SGR (sustainable growth rate) formula. As a result of the political struggle over the SCHIP program the Medicare provisions were stripped from the bill and remain pending.

The original legislation had included a reprieve from the looming 10% cut and additional cuts to the technical component of imaging services. The ACR has indicated that it will use the additional time to work with the House to improve the language of the bill, especially in relation to the imaging facility cuts.

A likely scenario is that the corrections will be put into an omnibus package as usually is introduced during the end of the Congressional session which includes other required corrections to permit the government to continue services. The concern, this year as in past years, is that the timing of the correction may not be such as to avoid the reductions, but rather may attempt to correct the reductions after the year begins. Importantly, many of the funds required for these corrections are targeted to be freed by reductions in payments to Medicare Advantage plans which will bring into play the insurance industry lobby. As such, the outcome of the "fix" cannot be clearly projected.

Earlier versions of the fix envisioned breaking the current single conversion factor into six separate conversion factors which would permit Congress to begin tinkering with the distribution of funds between specialties in a much more direct way than by changing the RBRVS RVU scales. The final form of this fix may be very different from those in past years and will bear careful scrutiny.