

APS Update

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Myocardial Perfusion 2010

As of January 1, 2010 one of the many CPT code changes will be to the myocardial perfusion codes. Some codes will be deleted and new codes added. This is due to the AMA-RUC five year analysis of potentially misvalued codes.

Codes 78460-78465, 78478 and 78480 will no longer be valid. They will be replaced with four new codes:

- * **78451** - Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification when performed); single study, at rest or stress (exercise or pharmacologic)
- * **78452** -.....multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
- * **78453** - Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
- * **78454** -.....multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection

Since CMS found that providers had reported wall motion and ejection fraction more than 90% of the time a myocardial perfusion imaging was performed, add-on codes 78478 (wall motion) and 78480 (ejection fraction) have been deleted for 2010. This service will be part of the new myocardial perfusion codes and will include any method to determine the left ventricular ejection fraction and wall motion when performing services as described in codes 78451-78454. This can be from the gated SPECT data or from first pass data upon injection of the radiopharmaceutical for the myocardial perfusion study.

Remember, when reporting for services after January 1st, report 2010 CPT codes. Reporting inactive codes can result in denials.

Radiology to Take Another Medicare Hit

Radiologists will absorb an additional 5% reduction in payment rates under Medicare for services in 2010. This is the final year of the adjustments in rates designed to fund increases in payment to primary care physicians. Specific components of the adjustments include malpractice expense, practice expense RVUs and work RVUs. The primary factor impacting radiologists are the practice expense RVUs and the malpractice expense adjustments.

Of those Part B provider specialties or types who provide services comprising over \$100 million in charges to the Medicare program, only cardiology and diagnostic testing facilities (which are heavily weighted towards imaging services) have greater reductions in their payment levels than radiologists (at 8% and 12%, respectively). Interestingly, nuclear medicine, which often falls under radiologist management, is expected to absorb an 18% reduction in payment rates

This reduction is independent of the ultimate treatment of the Sustainable Growth Rate discussions which, if unresolved, will result in an additional 21.2% cut. There is reason to believe that the SGR will at least be delayed if not eliminated entirely as a threat to reimbursement as part of the ongoing health care reform discussions, but if action does not occur in a timely fashion the rates may be reduced for the beginning of 2010 even if they are ultimately restored through Congressional action as has happened in previous years. The impact on cash flow in the short term, especially for those practices that are highly dependent on Medicare payments, can be substantial and practices are best served by considering this a very real possibility and preparing for such a drop.

Ultrasound Coding

CPT has specific ultrasound codes for many areas of the anatomy but there are times an ultrasound is performed on an area not specifically listed in an ultrasound CPT code, such as the groin, axilla or lower back. Per CPT Assistant May 2009, they have clarified these areas of anatomy along with additional areas and assigned a CPT code.

Lower back or abdominal wall soft tissue mass:

- * Code 76705 (ultrasound, abdominal, real time with image documentation; limited [single organ, quadrant, follow-up])

Upper extremity, axilla, groin, lower extremity:

- * Code 76880 (ultrasound, extremity, nonvascular; real time with image documentation)

Chest wall, upper back:

- * Code 76604 (ultrasound chest [includes mediastinum], real time with image documentation)

Pelvic wall, buttock, perineum

- * Code 76857 (ultrasound pelvic [nonobstetric], real time with image documentation; limited or follow-up [e.g. for follicles])

A Breach To Be Aware Of

Recently, APS has been made aware by various Blue Cross Blue Shield programs around the country that the Blue Cross and Blue Shield Association (the licensure of the Blue Cross and Blue Shield brands across the United States) experienced an unauthorized transfer of provider network data. Apparently, a BCBSA employee transferred provider data onto a personal laptop and that laptop was stolen. BCBSA has indicated that there is no evidence at this time that the information has been misused, however they are taking steps to notify various providers around the country of this breach. The data that was on the laptop includes, provider name, address, provider tax ID number/social security number and NPI number. As APS receives notification from the various Blue Cross Blue Shield plans they will forward these letters to our clients as quickly as possible. BCBSA is recommending that any affected providers activate a credit monitoring program that will monitor your personal credit report for a one year period of time free of charge. This is recommended to establish an on-going monitoring of your personal credit report.

Comparative Effectiveness Research and Imaging

The provision of \$1.1 billion in funding for Comparative Effectiveness Research (CER) in the American Recovery and Reinvestment Act (the Stimulus) has created a two edged sword for imaging. By reviewing the results of such programs in other countries which have used them to a much greater degree than has been pursued in the US, we can gain an idea of the potential impact of the program on coverage decisions here.

The experience in Europe has been that CER has focused more expensive technology on specific diseases and processes (e.g. PET should be used in the event of an inconclusive CT for detection of lung cancer, but should not be used prior to the inconclusive CT, according to an Italian study). While providing clear guidelines for treatment and payment, the CER also limits the use of these modalities in ways which may preclude sufficient volume to make purchase of the hardware possible. As a result, while it removes some of the "medical necessity" fog surrounding high end technology purchases it also shrinks the potential market in ways which may restrict access to the technology.

Of particular interest is that, in Europe the CER studies have coalesced around the concept of the worth of an additional year of life. By and large if a treatment can result in an additional year of life, it has been deemed to be worth 33,500 euros, around \$50,000. Thus if a diagnostic procedure combined with the following treatment will generate an additional year of life, in Europe that is worth \$50,000. By putting this statistic in place the comparison to non-treatment can be made, something that has not been as rigorously used in the US.

The example noted above is only one of many which can occur in imaging. Of the 100 priority CER projects identified by the Institutes of Medicine, 11 include questions concerning the use of diagnostic imaging. Clearly there will be a lot of interest in the results of such studies. Given the uproar over the recent suggested changes in the mammogram guidelines we should expect interest beyond the economic and clinical communities as well.