

APS Update

RADIOLOGY NEWSLETTER

November 2011

Coding for Multiple Views

By Jan Toczynski, CPC, CCP

When CPT coding for x-rays with multiple views, tracking the number of views, when and why they are taken, is key in selecting the correct code(s). There can be times when all views taken would be added together and a single code reported or times you can report multiple codes or selecting a single code when there are more than the “minimum” number of views per the code descriptor.

The CPT Manual does provide various combinations of codes to address the number and type of radiograph views and the radiographic series that most accurately describes. The number of views needed to obtain medically useful information will vary and it is important to assure accurate coding to report the most comprehensive code to describe the service.

Here are guidelines for reporting various scenarios with multiple views:

When multiple views are performed on the same day from the same location, all the views should be added and the CPT code describing the total service reported. This applies to any x-rays that have to be repeated throughout the day due to substandard quality or if the radiologists elect to obtain additional views to render an interpretation. There is an exception to this rule. Per NCCI, “if additional films are necessary due to a change in the patient's condition, separate reporting of CPT codes may be appropriate.”

There are times when reporting two codes instead of one is the correct way to go. For example: a single-view chest and single-view abdomen. Your first thought would be to report code 74022 (Radiographic exam, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest) but code 74022 requires the complete abdomen series which was not performed. So, for this scenario the correct coding would be code 74000 (radiographic exam, abdomen; single AP view) **and** code 71010 (Radiographic exam, chest; single view).

(cont.)

“The Views” (cont.)

Minimum Number of Views. There are some CPT codes that include a minimum number of views and all views taken at or above that number for that code should be included. For example, if the patient had 4 views of the hand, the correct code would be 73130 (Hand; minimum of 3 views) one unit of service only, rather than 73120 x 2 (Hand; 2 views) to cover all views. Again, per NCCI “CPT code descriptors that specify a minimum number of views include additional views if there is no more comprehensive code specially including the additional views.”

Obviously, documentation is important for these types of x-rays to support the CPT code reported. Always include positions, type of views and above all, number of views. Keywords such as anteroposterior, posteroanterior, decubitus, oblique, etc. are also key in supporting the CPT code chosen.

Medicare Provider Enrollment Revalidation

By Nikki Dawson, Credentialing Specialist

The Affordable Care Act established requirements for all enrolled Medicare providers to revalidate their enrollment under new screening criteria. All providers enrolled with Medicare prior to March 25, 2011 will be required to revalidate their enrollment information with their Part B Medicare Carrier. CMS will send out letters between now and March 23, 2013 to each provider when it is time for revalidation. CMS is requesting revalidation applications not be sent in prior to receiving this letter. Once you receive the letter there is a 60-day window to submit the revalidation application along with supporting documents (ex: NPI confirmation, License, Drivers License, etc). When APS receives the letter for revalidation, a Credentialing specialist will send that provider an application to sign and return to APS for processing to their Medicare carrier.

If you have any questions, please contact your assigned Credentialing Representative at APS at (800)288-8325 with questions.

CPT Coding Changes For 2012

By Jan Toczyński, CPC, CCP

The American Medical Association via the CPT text has announced its coding updates and changes for 2012. The bundling of CPT codes for radiology services that began with the release of the 2010 text continues into 2012 with further bundling of the CT's of abdomen and pelvis codes (CPT codes 74176, 74177 and 74178).

The bundling of CPT codes is due to CMS' initiative to combine multiple codes into a single code for procedures that have been performed together. Obviously, the goal of such bundling efforts is to reduce Medicare payments.

What's in store for 2012? The CPT text identifies bundling of the CTA of the abdomen and pelvis and the IVC filter placement, repositioning and retrieval codes. These will now be reported using a single code. In addition, changes will be made to the renal angiography codes. As with the CTA's, the renal angiography codes will include all catheter placement and imaging.

In Nuclear Medicine, changes were made to the lung and hepatobillay codes. Currently, there are 9 CPT codes for lung imaging. This has been reduced to 4 CPT codes and the 2 hepatobillay codes have been replaced by two new codes. These coding changes were made at the request of the ACR and Society of Nuclear Medicine to provide clarification with focus on simplifying the descriptors.

Additionally, a change that will affect many radiology providers is the deletion of the paracentesis codes (49080 and 49081) with the addition of the following codes:

- 49082 - abdominal paracentesis diagnostic or therapeutic; without imaging guidance
- 49083 - abdominal paracentesis diagnostic or therapeutic; with imaging guidance
- 49084 - Peritoneal lavage, including imaging guidance when performed

Once the Medicare Physician Fee Schedule Final Rule has been released and published by CMS in the Federal Register, APS will know the RVU values that have been assigned for these codes. A complete list of all revised, deleted and new codes will be provided to APS clients within the next 4 weeks. If you have any questions regarding these new codes, feel free to contact our Coding Department at (800) 288-8325.

APS Stays Out Front with ANSI 5010 Implementation

By Matt Ward, Regional Director of Business Dvlpmnt

In our last newsletter we indicated that APS was leading the industry in the preparation for ANSI 5010 implementation, required for January, 2012. As we have continued our efforts to work with payers we have found that many of the commercial carriers are not currently ready for the mandated switch over.

Most Medicare programs are in testing with their business partners, including billing companies and clearinghouses, and for all carriers that are ready APS has completed testing and has entered actual production status, meaning that we are already sending and receiving ANSI 5010 files for current business. As stated above, the switch over is mandatory for January 1, 2012 but the entities can begin using the new format immediately, if ready.

The record with commercial insurers and clearinghouses is somewhat spottier. As APS has reached out to carriers and intermediaries we have found several who are not ready to test and few that are willing to move into a production status with us. This follows a typical pattern for any mandated change in file format. Commercial plans which must absorb the cost of the change are typically slow in moving into the new format for testing and even slower for adoption. In this case, however, many of our requests to enter testing have been met by the carriers with comments that we are the first claim submitting organization to ask to do so. While heartening from a readiness standpoint, this may point to an industry lack of readiness for the switch over that could cause cash flow shortages for the unprepared come January.

APS is currently able to produce files in both the new and old format and remains as one of the early adopters of the ANSI 5010 format. Regardless of the readiness of an individual carrier, APS is prepared to submit claims in either format and can switch between the two formats quite easily. We do however want to continue to push for the adoption of the ANSI 5010 format as soon as possible. The key is that the new format gives insurers less leeway to have carrier specific denial codes, etc. enabling APS to more efficiently sort such items as denials for swift action in appeals or requests for reconsideration or to submit corrected claims if necessary.

While we expect all such changes to be attempted on time, the late availability of testing on the part of the commercial carriers may indicate that there could be some difficulties in the first quarter of 2012 as they transition their systems to the new format. APS will continue to push for implementation of the format with our carriers and will alert our clients to specific issues which may impact them.

Update: Illinois Out of Network Billing (HB 5085)

By Matt Zaborski, Regional Account Executive

Effective June 1st 2011 the Illinois State Insurance Code was amended by adding Section 356z.3a. This amendment creates a very important shift in reimbursement rules that will affect all hospital based specialties. Previous law had required the insurer to reimburse an out-of-network provider in full for services provided when a patient had made a good faith effort to use an in-network provider. As outlined in the new legislation, insurers shall provide non-participating providers with a written EOB that specifies "proposed" reimbursement and the applicable patient responsibility. If the parties fail to agree on a rate, then arbitration may be initiated by either party through the state's Department of Insurance. The costs associated with arbitration are then paid as determined in the decision.

I recently contacted Anne Owings-Ford of McDonald Hopkins, LLC and was given an update on both Federal and State cases. Her firm is engaged with healthcare providers in fighting this new law. She explained:

"In the federal court case, although the defendants' motion to dismiss the action was granted, Plaintiffs' requested and were granted permission to file an amended complaint. Plaintiffs' new complaint is due in court November 10, 2011, and a status conference with the court has been set for one week later (November 17, 2011).

In the meantime, having filed a complaint in state court regarding Plaintiffs' Illinois state constitutional claims, we are nearly finished with briefing the preliminary injunction and Defendants' motion to dismiss. Depending on the court's ruling on those motions, the case will take shape from there."

APS will continue to stay on top of this issue and update you as information becomes available. If you have any immediate questions, please contact your Account Manager.

2012 Proposed Radiology Quality Measures

By Matt Zaborski, Regional Account Executive

The 2012 Medicare Physician Fee Schedule Proposed Rule includes 10 new PQRS measures under the "Radiology Measures Group." The Measures included fall under the following titles:

- ⇒ Reporting to a Radiation Dose Index Registry
- ⇒ Cumulative Count of Potential High Dose Radiation Imaging Studies: CT Scans and Cardiac Nuclear Medicine Scans
- ⇒ Utilization of a Standardized Nomenclature for CT Imaging Description
- ⇒ Appropriateness: Follow-up CT Imaging for Incidental Pulmonary Nodules According to Recommended Guidelines
- ⇒ Overuse: Abdomen, Pelvis or Combined Abdomen/Pelvis CT Studies
- ⇒ Equipment Evaluation for Pediatric CT Imaging Protocols
- ⇒ Utilization of Pediatric CT Imaging Protocols
- ⇒ Search for Prior Imaging Studies through a Secure, Authorized Media-Free Shared Archive
- ⇒ Images Available for Patient Follow-up and Comparison Purposes
- ⇒ Exposure Time Reported for Procedures Using Fluoroscopy

The incentive payment for 2012 PQRS is set to be reduced from 1.0% to 0.5%. Participation in the Maintenance of Certification (MOC) program allows for an additional incentive payment of 0.5%, as authorized through 2014. In order to meet CMS requirements for the additional 0.5% incentive, MOC participants must:

- ⇒ Satisfactorily submit data on quality measures under PQRS, for a 12-month reporting period, either as an individual physician (i.e., claims-based, registries, or EHRs) or as a part of a group practice under one of the PQRS Group Practice Reporting Options (GPROs). Physicians must continue to report to CMS as usual in order to receive the baseline 0.5% (2012) incentive payment and to qualify for the additional 0.5% incentive payment; AND
- ⇒ Participate in a MOC Program during reporting period "more frequently" than is required to maintain certification, including documentation activity in a qualified MOC practice quality improvement (PQI) project; AND
- ⇒ Complete a patient-experience-of-care survey.

APS will continue to update you on the never-ending changes and challenges affecting the business of radiology. Should you have any questions about this program or other revenue enhancement provided, please contact your Account Representative at (800) 288-8325.

Medicare Issues Calendar Year 2012

Physician Payment Rates Changes

By Matt Ward, Regional Director of Business Development

CMS has issued proposed 2012 payment regulations as required by law. The regulations as issued contain several factors which will impact physician payment next year.

- ⇒ Heading the list is the imposition of a 27.4% reduction in physician payment levels resulting from the application of the SGR formula. CMS indicates that the Obama administration is “committed to fixing the SGR and ensuring these payment cuts do not take effect.” In ten of the past eleven years, legislation has been passed to avert the reductions called for by the SGR formula. Dr. Berwick, the CMS administrator, says that the imposition of the SGR formula would have “dire consequences that should not be allowed to happen.” CMS will find few disagreements amongst physicians. The concern is that legislation will need to be passed well before the holidays in order to avoid the cuts. Even if the legislation is passed prior to the beginning of the year cuts may have to be entered into the Medicare fee schedule and removed later due to the need for MACs to be ready to administer the program under current law on 1/1/12. Final regulations will be posted in the Federal Register by 11/28/11. Given the current political gridlock, such action is certainly not guaranteed to occur in a timely fashion, if at all.
- ⇒ Continued review of geographical cost factors will result in adjustment of rates as well. It is expected that these changes are technical in nature and will not affect payment rates significantly.
- ⇒ 2012 will see the third year of four, phasing in adjustments in the practice expense RVUs used to calculate payment rates.
- ⇒ Additional PQRS case types and measures will be introduced in 2012 along with updates as to the reporting of the cases.
- ⇒ Changes to the e-prescribing system and the electronic health records initiative are also included in the rule.
- ⇒ The multiple procedure payment reduction policy (MPPR) will be extended to cover physician professional payments in advanced imaging (CT, MR and ultrasound). After a great deal of comment as to this extension, CMS has tempered the reduction in payment for second and subsequent procedures in the same session on the same day to 25%, from the originally proposed 50%. CMS admits that application of this methodology will be especially difficult for providers who work in groups as the payment reduction will be imposed on the entire group, not just individual physicians. Use of modifier -59 will be accepted to identify those procedures which are truly in a separate session, but CMS expects such use to be infrequent. The impact of these changes will vary but have been estimated to be most significant at trauma centers at 1.5% and declining as the percentage of advanced imaging performed in the emergency room declines.

(cont.)

Medicare Payment Changes (cont.)

While many of the rules are continuations of previous initiatives, the expansion of the MPPR to include professional payments for imaging is significant. Future expansion of the policy is being reviewed for professional and technical components of all imaging and the technical component of all diagnostic testing.

APS will continue to monitor these regulations and their impact on our client's practices. Additional information will be forwarded as it becomes available. If you have questions please feel free to contact your Account Manager.

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