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Radiology Trends

Medical Billing and Management Services

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Did You Know?

In fiscal year 2011 the federal government recovered $5.6 billion in fraudulent payments. This represents a 167% increase over recoveries made in 2008.

CMS announced that it will NOT apply the 25% reduction for multiple procedures for group practices in 2012. The reduction will still apply to studies done by the same physician on the same day.

SGR relief was only passed until March 1st to allow Congress more time to debate the issue.

ACR Seeks to Educate Lawmakers

The American College of Radiology (ACR) has launched a new website in efforts to educate lawmakers of the importance of accessible and affordable medical imaging in the health of Americans. The site, RadiologySavesLives.org, tries to show the value of early diagnosis, among other issues.

The ACR contends that reductions in reimbursements for imaging have already had an affect on accessibility of healthcare, citing the fact that following the 2007 imaging cuts there are now 223 fewer mammography facilities and 1,331 fewer mammography scanners.

RadiologySavesLives.org lists the results of a national poll of voters showing:

- 70% oppose further cuts to medical imaging
- 90% think further cuts would affect early detection of disease
- 81% who had an imaging exam in the past five years believe the study was “absolutely essential” to the proper diagnosis and treatment

The site also lists members of the House who have signed on to sponsor or co-sponsor the Diagnostic Imaging Services Protection Act of 2011, HR-3269.

Medicaid Prompt Payment Bill Proposed

The Fair Pay to Medicaid Providers Act was introduced by bipartisan lawmakers from California. The bill would require Medicaid to reimburse 90% of the claims they receive within 30 days and the remaining 10% within 90 days. According to Anna Eshoo (D-CA), “Our healthcare professionals and facilities deserve to be reimbursed in a predictable and consistent timeframe in order to provide optimal care to those in need.” The bill has been referred to the House committee on Energy and Commerce.

ICD-10 Corner

Happy 2012! This new year not only brings us the usual new beginnings but also brings us closer to the implementation of ICD-10-CM on October 1st of *next year*. While many of the coding guidelines are similar, the documentation necessary to code correctly will change dramatically, as well as the coding structure itself. The new coding system will increase the number of codes to approximately 68,000, more than doubling the current number of code selections.

Specificity is the buzz word for ICD-10. Coding will be based on specifics such as laterality and specific bones and vessels involved in disease processes. Past medical history will also play a role in code selection as well as previous visits, as some codes will be encounter based. With up to seven digits in each alpha numeric code, the possibilities are seemingly endless.

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Coding and Compliance Tips by Lori Shore

Each year we anxiously await the new, revised and deleted CPT codes, but just as important as the code changes are the narrative instruction changes. For 2012 CPT has added a lengthy clarification for billing AV fistulas (grafts, shunts). The shunt itself is now defined as "beginning with the arterial anastomosis and extending to the right atrium." CPT code 36147, which was bundled in 2010, includes, "all manipulation of the catheter for diagnostic imaging of the AV shunt". What is not included is ultrasound guidance for the puncture of the shunt. This can be reported using CPT code 76937, provided that selected vessel patency, real-time visualization of the needle entry and notation that permanent images were stored in PACS are documented. Additional selective catheter work outside the peri-anastomotic segment into the inflow artery is also separately reportable.

Interventions required for AV shunts are only reportable once per segment. The shunt is divided into peripheral and central segments. Peripheral is defined as extending from "the peri-arterial anastomosis through the axillary vein (or the entire cephalic vein in the case of cephalic venous outflow.). The central segment "includes the veins central to the axillary and cephalic veins through the vena cava."

The AV shunt is coded with venous intervention codes with the exception of the peri-anastomotic segment which is coded using arterial intervention codes. Please see the 2012 CPT book for a more detailed explanation.

Wishing you a Happy and Healthy 2012!