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Radiology Trends

Did You Know?

Cincinnati Children's Hospital in Ohio has implemented Standardized Radiology Reports.

A radiology jobs survey showed a small net gain in 2013.

Changes to PQRS for 2014

As Medicare moves away from fee for service and searches for a quality based payment model, so evolves the Physician Quality Reporting System (PQRS). The biggest change for 2014 is the increased reporting requirement from three measures to nine measures, when available. There is also an obvious shift away from claims-based reporting to registry-based reporting. The new measure group for

radiology, Optimizing Patient Exposure to Ionizing Radiation Measures Group, is only reportable through a registry. The threshold for successful reporting for registry-based measures has also been decreased from 80% to 50%.

What is the difference in claims and registry-based reporting?

Claims-based reporting is done by simply adding a category II code to a claim and is tracked by Medicare. Registry-

based reporting is reported through a Medicare approved provider at a cost to the practice. Medicare is steering the program in this direction by limiting reporting options to the registry method.

To learn more about participating registries go to:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013ParticipatingRegistryVendors_05172013.pdf

RIT Shows Promise in Curing HIV

Ekaterina Dadachova, Ph.D., professor of radiology, microbiology and immunology at the Albert Einstein College of Medicine in Bronx, NY presented her research at the Radiological Society of North America (RSNA) showing that radioimmunotherapy

(RIT) used in conjunction with highly active antiretroviral therapy (HAART) was able to reduce the HIV virus to undetectable levels in patients. Dadachova and her researchers treated 15 HIV patients with both HAART and RIT at the Einstein-

Montefiore Center for AIDS Research.

"In RIT, the antibodies bind to the infected cells and kill them by radiation. When HAART and RIT are used together, they kill the virus and infected cells, respectively.", explained Dadachova.

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Coding and Compliance Tips by Lori Shore, CPC, RCC

In addition to the new CPT codes released each year, new Category III codes, or temporary codes, are released bi-annually. This year there are seven “T” codes that may be used in radiology. These codes are to be used rather than unlisted procedure codes. Based on their usage they may or may not be assigned a permanent CPT code.

0334T—Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive, including imaging guidance, when performed

0336T—Laparoscopy, surgical, abla-

tion of uterine fibroid (s), including intraoperative ultrasound guidance and monitoring, radiofrequency

0337T—Endothelial function assessment, using peripheral vascular response to reactive hyperemia, non-invasive, unilateral or bilateral

0338T—Transcatheter renal denervation, percutaneous, with fluo-

roscopy, all inclusive, unilateral

0339T— bilateral

0340T—Ablation, primary tumor(s), including pleura and chest wall when involved with tumor extension, percutaneous, cryoablation, unilateral

+0346T—Ultrasound, elastography

Please look for the full descriptions in the appendix of the CPT book.

More than 50% of Imaging Payments to Non-Rads

Dr. David Rosman from Massachusetts General Hospital presented some alarming facts at the recent RSNA meeting. The total percentage of Medicare Physician Fee Schedule (MPFS) payments for diagnostic imaging to non-radiologists exceeded the payments to radiologists in 71% of states and in every Census Bureau region. The mean national spending per beneficiary for diagnostic imaging was \$220.37. Of that money, only \$95.43 or 43.3% was made to a radiologist while \$124.95 or 56.7% was made to a non-radiologist. The percentages varied regionally with only 35.5% going to non-radiologists in North Dakota while 71% of payments were made to non-radiologists in South Carolina.

Spending on diagnostic imaging also varied with the low being Hawaii at \$197.08 per beneficiary, and the high being New Jersey at \$368.83.

Why is this data important? As we move away from the traditional fee-for-service payment models to more bundled or capitated models, we need to make sure that radiology is adequately represented and compensated.