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Radiology Trends

Medical Billing and Management Services

Not just billing….a business partner

Did You Know?

The AMA reported that the cumulative error rate for paid medical claims among the top seven private payors dropped to 9.5% in 2012. This is a significant decrease from a rate of 19.3% in 2011.

The U.S. Supreme Court upheld the Patient Protection and Affordable Care Act, better known as Healthcare Reform or "Obamacare," in a decision announced on June 28, 2012. Chief Justice John Roberts in his majority opinion wrote that while the government cannot force Americans to purchase insurance it is legal to tax those who choose not to purchase insurance. Republicans have already promised a vote to repeal.

What's a Radiologist?

A study at the University of Arizona recently tried to answer the above question from the patient's perspective. Patients having outpatient CT and MRI studies were surveyed between February and March of 2011. 60% of those surveyed believed radiologists were specially trained physicians. 36% believed they were technologists who performed the exam and 4% thought a radiologist was a registered nurse with special training. Lead researcher Dr. Melanie Kuhlman commented that, "Radiologists have traditionally remained 'behind the curtain' when it comes to patient care, the voice without a face."

64% of those surveyed would like to meet the radiologist who interpreted their exam. 12% of those surveyed said they would like to get abnormal test results from the radiologist and 73% said they would like the results as quickly as possible regardless of who delivered them.

The study authors wrote, "Whether in person or through reports, by communicating directly with patients, radiologists add value by providing accurate, authoritative information. As radiologists, we need to re-evaluate the established model of communication for reporting radiologic results and consider the positive impact on patient care and on the vitality of the radiology profession by directly communicating with patients."

Time Limits Set for Medical Boards

In an effort to prevent doctors from using the term "board eligible" for an indefinite period of time, the American Board of Medical Specialties will implement time limits in which doctors must complete their medical boards following their residencies. Time limits will range from 5-7 years for the 24 medical boards with varying implementation dates. To see a complete list of eligibility and transition periods go to:

http://www.abms.org/News_and_Events/downloads/ABMS_Board_Eligibility_Policy_by_Board_060612.pdf

ICD-10 Corner

Coding for CVA will require a specific patient history and report in order to properly code in ICD-10. The first piece of information the coder will need is whether or not the patient has a history of CVA with residual effects. This will determine whether to code the condition as a sequelae or current condition. Secondly, the coder will need to know if it was a hemorrhagic or thrombotic stroke.

I69.021—Sequelae of dysphagia following non-traumatic subarachnoid hemorrhage

Z86.73—Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits

I63.031—Cerebral infarction due to thrombosis of right carotid artery

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Coding and Compliance Tips by Lori Shore, CPC, RCC

The National Correct Coding Initiative (NCCI) edits is a list of code pairs that CMS feels should NOT be routinely billed together. The list also has status indicators that allow or disallow the use of modifier 59 to by-pass the edits. Just because a code pair allows the use of modifier 59 does not mean it is always appropriate to do so. Medical necessity, as always, should be the deciding factor in whether both codes in a NCCI edit pair should be billed together. A good example of this is transabdominal and transvaginal pelvic ultrasounds. Codes 76856 and 76830 have an NCCI edit with a status indicator that allows the edit to be by-passed with modifier 59. Does this mean it is okay to bill these codes together most of the time? I say, no. By the mere fact that the code pair has an NCCI edit tells us that CMS doesn't think they should always be billed together. What advantage does one study have over the other in diagnosing the patient?

If a transabdominal study is normal there is really no medical necessity to do a transvaginal study. However, if a transabdominal study reveals an ovarian cyst or mass and you want to get a closer look to access it, the transvaginal study may be considered necessary. The change of technique and the reason for doing so would need to be documented.

These studies are often billed together but rarely both paid. Don't send up any red flags by over using codes with NCCI edits and when necessary, document your need for both studies.

Look for us in the 2012 RBMA Buyers Guide