A recent report in the Journal of American College of Radiology details the impact of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, and the U.S. Centers for Medicare and Medicaid Services 2016 implementation proposal, on radiologists. The report from the Harvey L. Neiman Health Policy Institute describes how, under MACRA, radiologists will be paid through the Merit-Based Incentive Payment System (MIPS). MIPS applies adjustments, both positive and negative, to fee-for-service payments. Because the performance assessment begins in 2017 for payment adjustments in 2019, radiologists must start preparing now, taking actions to ensure future success with the payment program, said Dr. Andrew Rosenkrantz, lead study author. "MIPS will provide special considerations for physicians with a limited degree of face-to-face patient interaction," said Dr. Bibb Allen Jr., chair of the Neiman Institute advisory board and past chair of the American College of Radiology Board of Chancellors. For more information, please visit: http://www.jacr.org/.

Report Details MACRA's Impact On Radiologists, ACR Advice

Each year we anxiously await the release of the new CPT codes for the following year; however it is not just the codes that impact your practice. In the last several years, CMS has published lengthy narratives to define what can and cannot be billed. The 2017 edition is no exception. While the codes may not have changed for fluoroscopic guidance, codes 77002 and 77003 are being reclassified as “add-on” codes for 2017. This means that they can no longer be billed alone and must be billed with a primary procedure. If your practice provides guidance to other surgeons or providers this could have a substantial financial impact. There are 57 codes with which 77002 (fluoro guidance for needle placement) can be billed and 14 codes with which 77003 (fluoro guidance for spinal or paraspinal procedures) can be billed.

Computer-aided detection is being bundled into the new mammography codes. While this was never a big ticket item, it is still lost revenue. The moderate conscious sedation codes are being unbundled for 2017 but come with definitive guidelines for billing. In order to bill for the initial 15 minutes, at least 10 minutes conscious sedation must be documented. The clock begins when the sedating agent is given and end when the procedure is completed. For each additional 15 minute increment at least 8 minutes of sedation time must be administered. The codes are now defined by patient ages over and under age 5.

More To CPT Changes Than Just The Codes

Coding and Compliance Tips by Lori Shore, CPC, RCC

Further prohibit chest x-rays following pleural drainage procedures, thoracentesis or chest tube insertions. The American College of Radiology (ACR) is disputing the rule that comparative imaging studies performed to assess potential complications or completeness of a procedure (i.e. post-reduction, post-intubation, post-catheter placement, etc.) are not billable for the professional component but remain billable for the technical component. Also, because foot x-rays include both the toes and calcaneus, these cannot be billed together on the same date of service. And lastly, ultrasound guidance for needle placement (76942) cannot be billed in the same anatomic region more than once per day regardless of whether the procedures were done at different encounters.

Complete and detailed documentation is the key to helping us help you!
A bare-bones budget resolution acting as a vehicle to break apart the Affordable Care Act will get a House Floor vote soon, according to a memo from Rep. Greg Walden (R-Ore.), the incoming chairman of the House Energy and Commerce Committee. “They are eager to prove they are capable of governing and keeping their promises,” said John Gorman, a former CMS official who is now a Washington healthcare consultant.

Should the ACA be repealed by GOP leaders, the process would allow Republicans to strip funding for major parts of the healthcare law, such as cost-sharing subsidies, Medicaid expansion and premium stabilization programs. GOP leaders also signaled that they will ax the mandate requiring people to enroll in health coverage as soon as possible. Leaders in Healthcare warn that delaying a replacement plan could cause the individual insurance market to collapse and endanger hospitals that would provide uncompensated care for the more than 20 million people who would become uninsured once the ACA program is dismantled. Many leaders in the Healthcare industry have urged the incoming administration under President-elect Donald Trump to put transition period policies in place to keep the individual market afloat until a new plan is in place. For example, industry lobbying group America’s Health Insurance Plans has warned against repealing the cost-sharing subsidies. It’s not known whether the GOP leaders plan to retain any key ACA provisions.

“Budget reconciliation bills can only include provisions with a budgetary impact and do not raise spending, so there would likely be a delay before implementation.”

CMS has declined a request by advocates for CT colonography to reconsider its 2009 decision not to pay for the imaging-based colon cancer screening exam. The ACR said it has been informed by CMS that the agency would not be reopening the coverage review. The decision is a serious blow to the CT Colonography Coalition. This group includes ACR and several major colorectal cancer screening advocacy groups. The coalition had submitted a formal request for CMS to review in August, after the U.S. Preventive Services Task Force (USPSTF) included colonography (CTC) among the colon cancer screening tests that it recommended, even giving the exam an “A” rating earlier this year. “Abundant efficacy and cost-effectiveness evidence demonstrates that CTC (also known as virtual colonoscopy) is a front-line colorectal cancer screening tool,” said Dr. Judy Yee. Yee heads the ACR’s colorectal cancer working group and serves as chief of radiology at the San Francisco Veterans Affairs Medical Center. Representatives of the coalition and the ACR met with CMS recently to discuss its reasoning for the decision, and vowed to keep working for the approval. “The ACR will work closely with CMS to resolve any issues that they may still have about CTC,” the ACR said. “The college will also continue to work with the colorectal cancer care advocacy groups, patients, lawmakers, and other decision-makers to secure Medicare coverage for CT colonography.”