



Radiology Trends

Coding and Compliance Tips by Lori Shore, CPC, RCC Billing For Physician Extenders

The key to billing for physician extenders is understanding the acronyms:

- NP – Nurse Practitioner
- PA – Physician Assistant
- RA – Radiology Assistant

Medicare only recognizes nurse practitioners (NP) and physician assistants (PA), meaning they will credential them and assign them their own provider numbers. Physician extenders are paid at 85% of the Medicare Physician Fee Schedule (MPFS) rate. Currently, because Medicare will not credential radiology assistants (RA), we cannot bill for their services under Medicare Part B. On May 17, 2016 Senators John Boozman (R-AR) and Bob Casey (D-PA) introduced [S. 2940](#), the Medicare Access to Radiology Care Act of 2016, to ensure patients have access to timely and quality imaging services by enhancing the role of radiology assistants (RAs) and recognizing qualified RAs as non-physician providers. If enacted, the bill would authorize Medicare coverage for procedures performed by RAs in states with laws that license and recognize their expanded role. Currently, 31 states have laws regulating RA practices. The American College of Radiology (ACR) has supported the recognition of RAs for many years and supports the enactment of S. 2940 and its House companion legislation, H.R.4614. Recognition of the RA designation by Medicare will allow radiologists to be available for more complex procedures, consultations with referring physicians and imaging study interpretation. We would also need to credential RAs in a similar manner to other physician extenders.

CMS Further Clarifies What End of ICD-10 Flexibilities Mean -- Q&A

With the October 1, 2016 deadline approaching, CMS recently released new FAQ's from healthcare providers regarding the upcoming changes and how to best be prepared. For more questions and answers, please visit: <https://www.cms.gov/Medicare/Coding/ICD10/Clarifying-Questions-and-Answers-Related-to-the-July-6-2015-CMS-AMA-Joint-Announcement.pdf>
Some of the questions included:

Q: How does the end of the ICD-10 flexibilities affect audits that began after October 1, 2016 but are for claims with dates of service before October 1, 2016?

A: Beginning October 1st, all CMS review contractors are able to use coding specificity as the reason for an audit for a denial of a reviewed claim to the same extent as they did prior to October 1, 2016.

Q: Has Medicare updated its NCDs and LCDs to reflect the new ICD-10 codes that take effect on October 1, 2016?

A: CMS and its contractors update the NCDs and LCDs when new codes are added, as was the practice prior to implementation of ICD-10.

Q: Where can I find a list of the ICD-10 codes associated with each NCD and LCD that reflects these updates?

A: Please visit the [CMS ICD-10](#) website for transmittals that contain code updates for NCDs. LCDs can be found in the Medicare Coverage Database.

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Did You Know?

A new analysis of screening intervals for CT colonography (CTC) found that it may be safe to wait as long as five to ten years to screen again after initial negative scan.

CMS Offers Solutions As Improper Medicaid Payments Rise

Improper Medicaid payments totaled \$30 billion last year, according to CMS. Now, the agency is giving states some tools to help address this issue. Medicaid's improper payment rate was 9.8% for 2015, nearly double what it was in 2013. The agency is anticipating the rate to hit 11.5% this year. "States are facing greater challenges keeping pace with stricter enrollment requirements, tracking providers who have been excluded from other states' or federal health care programs, and generally adapting to changing regulations for qualifications of certain provider types," CMS said in an alert. An improper payment can occur when funds go to the wrong recipient, the right recipient receives the incorrect amount of funds, documentation is not available to support a payment or the recipient uses funds in an improper manner. The tally also includes fraudulent claims.

Another issue is that CMS' improper payment figures may not adequately address questionable billings that have already been corrected by the states, said Tony Rodgers, a principal at the firm Health Management Associates and former deputy administrator for strategic planning at CMS.

To educate states about the issue, the agency is using a new tool known as E-Alerts, which informs relevant stakeholders of a concern and the factors that may be causing it. The agency also outlined possible solutions, and states are likely to be pleased with the solutions outlined to curb improper payments. While not necessarily new ideas, this is believed to be the first time all the possible solutions were outlined in a single document. "Given all the new requirements in the ACA and elsewhere, it's very helpful to have them in a centralized place and to remind everyone about available resources," said Matt Salo, executive director of the National Association of Medicaid Directors. "States also have to struggle with the fact that the vast majority of providers are good," said Kip Piper, a Washington-area consultant and former senior official at CMS. "When new program integrity safeguards are put in place, they often fall on all the providers, not just the bad actors. So there is a strong push back," Piper said.

Changes to ACA Exchanges May Be Enough To Keep Them Afloat

Proposed changes to help stabilize the Affordable Care Act health insurance exchange markets should be enough to stop the losses, but further changes will likely be needed next year. The rule, which was released a couple of months earlier than expected, includes changes in 2018 to the ACA risk-adjustment program as well as changes to plan requirements.

The rule changes are a response to tumult in the exchanges as Aetna, Humana and UnitedHealth Group have all said they will be significantly scaling back their plan offerings in 2017. That and overall low enrollment from consumers has led some to question whether the exchanges can remain viable. There have also been concerns about double-digit premium increases in some states, although the HHS released an analysis stating that coverage would still be affordable for most consumers who receive premium subsidies.

The risk-adjustment changes are particularly key, as insurers have been saying consumers enrolling in the plans are sicker and have higher costs than expected. Risk adjustment will now factor in prescription drug data for disease such as hepatitis C, HIV/AIDS, end-stage renal disease and diabetes. Risk adjustment will also begin accounting for people who enroll outside of the open enrollment period. The next administration and Congress will likely have to make additional changes by the middle of next year to keep the exchanges afloat, such as network adequacy provisions, said Elizabeth Carpenter, senior vice president at the consulting firm Avalere Health. Other changes in the proposed rule are focused on encouraging more young and healthy people to enroll by giving them more options for less costly plans that offer less coverage. CMS is proposing a standardized option, or Simple Choice plan, at the bronze level of coverage that qualifies as a high-deductible health plan that can be used with a health savings account. The rule states that high deductible plans are "an option valued by many consumers."