MEDICAL BILLING EXPERTS

CLUB NEWS

COMPLIANCE & LEGISLATIVE UPDATES FOR BILLING

ISSUE 8 — NOVEMBER 2015

The PAMA Bill and what it means for Radiology

In April, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014, H.R. 4302 ("PAMA"). PAMA is an "extender" bill and prevented a scheduled 24% reduction in physician reimbursements rates under Medicare last year.

PAMA also extended several expiring provisions of the law, authorized new health programs and quality incentives and initiatives.

Highlights for Radiology:

- Quality Incentives for Computed Tomography Diagnostic Imaging
  - Effective January 1, 2016, Medicare providers must ensure that CT equipment meets NEMA Standard XR 29-2013, or face a 5% per scan payment reduction in the technical component of outpatient procedures. (See article "New Guidelines for CT Dose Management").
- Clinical Decision Support
  - Beginning January 1, 2017, physicians ordering advanced diagnostic imaging exams (CT, MRI, nuclear medicine, and PET), must provide documentation that a government-approved, evidence-based appropriate-use criteria system was consulted in order to be reimbursed by Medicare. (See article "Appropriate Use Criteria").
- Accurate Valuation of Services under the Physician Fee Schedule
  - The act allows HHS to collect information on physicians' services in determining relative values for medical services. The Secretary will examine, among other factors, potentially misvalued codes, codes that account for the majority of spending under the MPFS, and codes for which there are anomalies in the relative values within a family of codes. Significant RVU reductions will be phased in over a period of time.

IN THIS ISSUE

For more information or if you would like to submit possible topics for future newsletters, please contact our coordinator Karen Schepler by email: **kschepler@mbxperts.com**. Thank you for your readership. If you would like more information on how MBX can assist you with your Revenue Cycle Management goals or to schedule a consult, please contact Ian Farmer by visiting **mbxperts.com/contact-us**.

MBX Medical Billing Experts, LLC
124 South 400 East, Suite 340
Salt Lake City, UT 84111
800.789.4629 • mbxperts.com

MEDICAL BILLING EXPERTS

New Guidelines for CT Dose Management

The purpose of NEMA Standard XR 29-2013 ("XR-29") is to ensure CT scans are performed on safe equipment that delivers high-quality images at the lowest possible dose to the patient. Medicare providers who fail to attest to this standard by January 1, 2016 will face a technical component payment reduction of 5%, and in 2017 and subsequent years the penalty will be 15% per scan.

This penalty applies to scans performed in hospital outpatient settings, imaging centers and physician offices; it does not apply to scans billed under the hospital inpatient setting, interventional radiology procedures, CT simulation for radiation therapy, or PET/CT.

CT scanners meeting the XR-29 Standard have the following:

- DICOM compliant radiation dose structured reporting – allowing radiation dose information to be included in the patient record
- CT dose check – an automatic check that helps clinicians confirm correct settings prior to a scan
- Pediatric and adult reference protocols – allowing the radiation a patient receives to be better tailored to the specific exam and clinical indication
- Automatic exposure control – automatically adjusts radiation dose to the patient's anatomy for a consistently minimized dose

Many resources are available for providers to determine if their CT equipment is compliant with XR-29, and MITA (Medical Imaging & Technology Alliance) has issued a whitepaper for this purpose:

http://www.medicalimaging.org/wp-content/uploads/2015/05/Is-Your-CT-Smart-Dose-Compliant_Whitepaper_Final.pdf

Claims for services provided on non-compliant CT equipment will be submitted to Medicare with the appropriate modifier.

Appropriate Use Criteria

PAMA included a mandate that beginning January 1, 2017, any physician ordering advanced diagnostic imaging exams (including CT, MRI, nuclear medicine and PET) must first consult HHS-sanctioned appropriate-use criteria. Consultations will not apply to inpatient services, or to those ordering providers meeting certain hardship criteria (such as lack of access to high speed internet). Consultation of appropriate-use criteria will be required prior to ordering advanced diagnostic imaging services in a physician office, hospital outpatient, and emergency department. As the mandate currently stands, ordering physicians do not have to adhere to the appropriate-use criteria, but must confirm the guidelines have been consulted.

Many physicians have sought guidance from the American College of Radiology which is pushing CMS to meet statutory deadlines for the implementation of appropriate-use criteria and clinical decision support. Since CMS has stated they anticipate further discussion on this mandate, currently they do not intend to require ordering physicians meet this requirement by January, 2017.

What do clinical decision support ("CDS") systems tell physicians? Many times, the CDC will affirm the physician's decision, other times it may recommend an alternative test be considered. CDS systems will provide additional information, including links to ACR criteria for the physician to use to understand the CDS recommendations. CDS systems encompass a wide variety of tools including computerized alerts and reminders for providers, clinical guidelines, condition-specific order sets and diagnostic support.

Update on Lung Cancer Screening

From the RBMA: *Beginning January 4, 2016, Medicare contractors will accept claims for low-dose computed tomography (LDCT) lung cancer screening retroactive to the date of the national coverage determination (NCD) (Feb. 5, 2015). The Centers for Medicare and Medicaid Services (CMS) posted claims billing instructions for lung cancer screening with low-dose computed tomography, including details on beneficiary screening eligibility, shared decision making and counseling visits, written order, radiologist, registry and imaging center requirements. CMS has clarified that Medicare coinsurance and Part B deductible are waived for this preventive service. CMS further states that unless specifically covered in the NCD, in statute or regulations, preventive services are non-covered by Medicare.*

The following two new G codes should be used for the shared decision-making visit (G0296) and LDCT lung cancer screening (G0297). Note that Medicare will deny G0296 and G0297 for claims that do not contain ICD-9 code V15.82 (ICD-10 Z87.891, personal history of tobacco use/personal history of nicotine dependence).

- **G0296 — Counseling visit to discuss need for lung cancer screening (LDCT) using low-dose CT scan (service is for eligibility determination and shared decision making)**
- **G0297— Low-dose CT scan (LDCT) for lung cancer screening**

G0296 may be billed on the same day as an E & M visit with the use of the -25 modifier.

CMS will assign a work RVU of 1.02 for G0297 (identical to 71250 CT chest without contrast), and a work RVU of 0.52 has been proposed for G0296.

"Reprinted with permission from RBMA, The Washington Insider, Nov. 9, 2015"

ICD-10 Update

The American Medical Association and CMS have reached an agreement regarding ICD-10 transition:

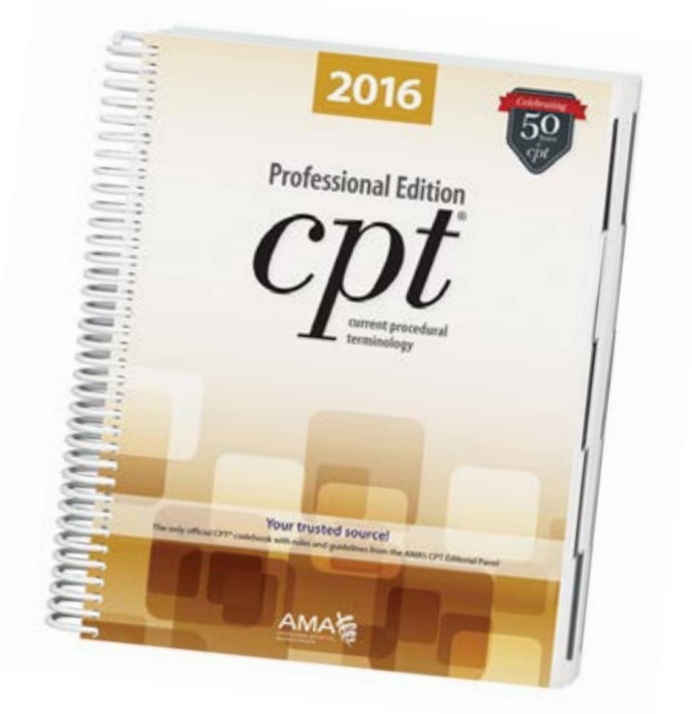
- For the first year ICD-10 is in place, Medicare claims will not be denied for the specificity of the diagnosis codes as long as they are from the appropriate family of ICD-10 codes
- CMS will not subject physicians to penalties for PQRS, value based modifier, or meaningful use based on the specificity of diagnosis codes as long as they are from the correct family of ICD-10 codes
- In the event Medicare contractors are unable to process claims as a result of ICD-10 related issues, CMS will authorize advance payments to physicians
- CMS will establish an ICD-10 communication center to monitor and resolve issues, which will include an "ICD-10 ombudsman" devoted to dealing with physician issues

ICD-10 Diagnosis Codes for Bone Mass Measurement

The Medicare Learning Network has issued MLN Matters Number SE1525 which addresses recent issues with the ICD-10 diagnosis codes for the condition of osteopenia being inadvertently omitted from the National Coverage Determination. The Change Request has an implementation date of January 4, 2016 and a corresponding effective date of October 1, 2015. The MLN report can be found here:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1525.pdf

2016 CPT Code Change Highlights for Radiology



Diagnostic

- Existing codes for scoliosis have been revised or deleted with new codes more accurately identifying the hierarchy of the spine codes and number of views.
- Hip x-ray codes have been deleted and new codes developed to reflect the inclusion of the pelvis. Codes are based on laterality and number of views.
- The CPT code for a femur x-ray has been replaced with two new codes: one view, 2+ views.

MRI

- Two new codes for fetal MRI were released; first gestation, each additional gestation.

Nuclear Medicine

- Two additional codes describing gastric emptying studies were released; small bowel, colon transit studies. The existing gastric emptying study code has been revised.

Non-Vascular

- New codes in the biliary and urinary systems were developed to now include the radiologic supervision and interpretation.

Biliary

- New comprehensive codes were introduced for percutaneous transhepatic cholangiograms and biliary drainage catheter procedures.

Urinary

- New comprehensive codes were created for nephostogram and nephrostomy procedures and ureteral stents, bundling the radiologic supervision and interpretation.

800.789.4629 | mbxperts.com

MBX Medical Billing Experts, LLC
124 South 400 East, Suite 340
Salt Lake City, UT 84111