2013 Medicare Physician Fee Schedule Payment Update

In the 2013 Medicare Physician Fee Schedule final rule, the Centers for Medicare and Medicaid Services (CMS) released the relative value unit (RVU) information for new, existing and revised CPT® codes. There were increases as well as decreases in the payment rates for radiology services. However, in this ever-changing health-care landscape, radiology and all medical specialties are challenged with reimbursement reductions. All specialties are experiencing cuts as we are in the middle of major systematic changes as the Medicare system moves away from the traditional fee-for-service system and policy makers desire to flatten payments between specialists and primary care.

Bilateral Surgery MUE Program Revisions Effective April 1, 2013

Studies by the Government Accounting Office and the Office of Inspector General found that some providers are being overpaid for bilateral surgery (modifier 50) procedures. Based on these findings, the Centers for Medicare and Medicaid Services (CMS) notified the AMA that they will revise the Medically Unlikely Edits (MUE) program for the reporting of bilateral surgery procedures effective April 1, 2013.

The one common error was the reporting of bilateral surgical procedures on two lines with a unit of service of one. Therefore, CMS is adjusting the current MUE edit from a unit of service (UOS) claim line edit to a date of service (DOS) edit for some MUE values. Currently, Medicare contractors look at this frequency edit as a claim line edit on the maximum UOS or number of times a physician or other provider would report a procedure code for the same patient on the same date of service.

To avoid claim denials, physicians and other providers (except ambulatory surgical center facilities) are being instructed to report bilateral surgery procedures (<70000 series codes) on a single claim line with modifier 50 and one (1) UOS. Anatomic modifiers (RT, LT, FA, F1-F9, TA, T1-T9, E1-E4) should continue to be used on separate lines when appropriate.

It should be noted that the bilateral surgery (modifier 50) reduction does not apply to the bilateral radiology codes (70000 series). It is appropriate to report bilateral radiology 70000 series procedure codes on separate lines using the RT and LT modifier when the descriptor does not specifically state it is a bilateral procedure. See the Medicare Physician Fee Schedule 2013 Layout for Medicare’s 2013 payment policy indicators [0, 1, 2, 3, and 9] for bilateral surgery procedures and what type of payment adjustment Medicare will apply.

Also, please read the CMS letter to the AMA in its entirety for more details on how to avoid claim denials when using modifier 50.
Bundled Payments for Care improvement

The Centers for Medicare and Medicaid Innovation have announced that over 500 organizations will begin participating in the Bundled Payments for Care Improvement initiative. Through this new initiative, made possible by the Affordable Care Act, CMS will test how bundling payments for episodes of care can result in more coordinated care for beneficiaries and lower costs for Medicare. Click on the link to the fact sheet to see a listing of the sites and episodes of care that will be studied.

The ACR encourages members who work at these sites to participate in the demonstration so that radiology can be recognized as an integral component to bundled episodes of care. If you are participating in one of these studies, the ACR would like to know. Members can contact the Economics Department at econ@acr.org.
Carotid Angiography Codes Bilateral Indicator to Be Revised by Medicare

The Centers for Medicare and Medicaid notified the AMA’s specialty society CPT advisors that the 2013 Medicare Physician Fee Schedule (MPFS) will be revised to correctly denote that the new carotid angiography codes (36222-36226) will be eligible for a 150 percent payment adjustment for a bilateral procedure. CMS responded to a multi-specialty society request stating that the bilateral surgery modifier indicator will be changed at the earliest possible time to allow billing for each side (when appropriate), retroactive to January 1, 2013. This revision was in response to a request from Dr. Donald Denny on behalf of the Society of Interventional Radiology, ACR, American Society of Neuroradiology, and Society of Vascular Surgeons (and with the support from the American Roentgen Ray Society, Radiological Society of North America, American College of Cardiology, American Association of Neurological Surgeons, and Congress of Neurological Surgeons).

The MPFS currently lists a bilateral indicator of “0”, which does not allow for the 150% payment adjustment for a bilateral procedure. Currently, if a bilateral procedure is reported with modifier -50 or with modifiers RT and LT, the bilateral procedure will be paid as a unilateral procedure and not the expected 150 percent paid for a bilateral procedure.

Please reference the detailed guidelines published in the CPT® 2013 codebook prior to the 36222-36228 code section, which instruct coders to report bilateral carotid and/or vertebral arterial catheterization and imaging when performed using modifier 50. The MPFS modifier indicator will be changed to “1” which will allow the appropriate bilateral procedure payment of 150 percent by Medicare contractors.
General, Small, and Rural Network Looking for Members

The ACR is in the process of forming an American College of Radiology General, Small, and Rural Network. With the ongoing implementation of the Patient Protection and Affordable Care Act (PPACA) and healthcare reform initiatives, the ACR strives to be as valuable a resource to our membership as possible. In order to understand and respond to the needs of ACR members, it is imperative to gather and disseminate information on what is happening with radiology practices across the country, especially small and rural practices.

The ACR goal is to gather representatives from around the country to form a “Network” of ACR members who are part of small and rural practices. As part of the Network, members will have the ability to effectively communicate with other members in similar practices around the country. As we begin to see changes to practices as a result of the Physician Quality Reporting Initiative (PQRI), formation of accountable care organizations, capitation contracts with insurers, and health insurance exchanges, to name a few, members can share their experiences with the Network and learn from the experience of others.

This Network will only be successful with active participation of ACR members. The Chair of the Network, Dr. Charles Bowkley, along with current Network members and ACR staff are aggressively recruiting members. If you are interested in participating or hearing more information about the Network, please contact ACR staff Katie Keysor at kkeysor@acr.org or (703) 648-8900 extension 4950.
Supervision Revisions Proposed by CMS for Radiological Services in ASC Settings

The Centers for Medicare and Medicaid Services (CMS) posted a February 7, 2013 Proposed Rule announcing revision to the supervision requirements for radiological services performed in Ambulatory Surgical Centers (ASCs). The revisions include reduced supervision levels for nuclear medicine services Condition of Participation, and standard radiologic services. The Proposed Rule would reform Medicare and Medicaid regulations in an effort to promote program efficiency, transparency and reduce burdens under Executive Order 13563.

**Nuclear Medicine Service Conditions of Participation**

Based on the Society of Nuclear Medicine and Molecular Imaging’s recommendations, CMS is proposing revisions to the nuclear medicine services Conditions of Participation (CoP) § 482.53(b)(1) to remove the “direct” modifier requirement for in-house preparation supervision. Currently the presence of a pharmacist, doctor of medicine (MD), or doctor of osteopathy (DO) is required during the delivery of off-hour nuclear medicine tests. Hospitals reported that the presence of a pharmacist or physician to be overly burdensome, especially for off-hour nuclear medicine tests that require minimal in-house preparation of radiopharmaceuticals. The proposed change would reduce the current supervision requirement in a hospital setting for such tests.

**Standard: Radiologic Services**

CMS also proposes to loosen restrictions on supervision in ASC settings by removing § 416.49 (b)(1) and (2) for standard radiologic services and replacing it with two new requirements (see language below), which would allow an MD or DO to supervise radiologic services in ASC settings.

CMS believes ASCs have significant challenges with covering the off-hour radiology supervision requirements and considered this to be an overly aggressive measure, as ASCs do not require interpretation for diagnosis for radiologic services. CMS noted that surgeons are expected to be competent in using imaging as an integral part of the surgical procedure and believes that an MD or DO would be effective in assuming the quality and safety of supervision of radiologic services for ASCs.

**Governing Body (§482.12)**

CMS proposes to remove the requirement for a medical staff member, or members, to serve on a hospital’s governing body. Instead, CMS proposes to require a hospital’s governing body to directly consult with the individual responsible for the organized medical staff of the hospital or his or her designee, which, at minimum, would involve a discussion of matters related to the quality of medical care provided to patients of the hospital. CMS further proposes that this direct consultation must occur periodically throughout the fiscal or calendar year and at a minimum of twice a year.
Rural Health and Primary Care

CMS also proposes to eliminate a requirement generally requiring a physician to be present in a Critical Access Hospital (CAH), rural health clinic or Federally Qualified Health Center at a minimum of at least once every two weeks to provide medical direction, medical care services, consultation and supervision of other clinical staff. In addition, for CAHs, CMS proposes that a doctor of medicine or osteopathy would be present for sufficient periods of time to provide medical direction, consultation and supervision for the services provided in the CAH, and would be available through direct radio or telephone communication for consultation, assistance with medical emergencies, or patient referral.

The ACR is currently reviewing this rule to determine if we will submit comments by the April 8, 2013 deadline. If you have any questions or comments, please submit them to the Economics and Health Policy Department at econ@acr.org.
USPSTF Colorectal Cancer Screening Recommendations To Be Reviewed

The ACR’s Colon Cancer Committee submitted a formal request in August 2012 to the United States Preventive Services Task Force (USPSTF) asking that their colorectal cancer screening recommendations, specifically CT colonography recommendations, be reviewed ahead of the next scheduled review date. The request included supporting information and a list of over 35 references that specifically address the concerns raised by the USPSTF in their prior review. The USPSTF responded in late that the colorectal cancer screening recommendations will be reviewed in the second half of 2013. While this is not officially an “early” review, USPSTF staff indicated in a May 2012 meeting with the ACR, American Gastroenterological Association, and Medical Imaging & Technology Alliance that they are running behind schedule and a request for early reconsideration would ensure it would be put on the 2013 schedule. The USPSTF also indicated in their response that the ACR would be included in the stakeholder work group, and will be informed of the opportunity for public comment as the review takes place.
CMS Provides Clarification on MPPR Modifier 59

Marc Hartstein, Director of Hospital and Ambulatory Policy Group for the Centers for Medicare and Medicaid Services (CMS), recently responded to a request from the ACR for clarification of the Professional Component (PC) Multiple Procedure Payment Reduction (MPPR) policy and the use of modifier 59. In his response, Hartstein clarified that the appropriate use of modifier 59 (distinct procedural service) in the application of the imaging MPPR is to distinguish interpretation performed in separate sessions. CMS does not agree with the ACR that a different clinical problem alone is sufficient rationale for using modifier 59.

The only instance when modifier 59 should be used to bypass the PC MPPR is, as CMS states in the Medicare Physician Fee Schedule Final Rule 2012, is for interpretations performed at “widely different times.” CMS has not provided any further definition of a session, but has informed the ACR that they are considering refining the definition of what constitutes a session to apply to services performed on the same calendar day to resolve some of the operational issues and conform to the policy for all other MPPRs. Currently, it is up to the physician to determine what is meant by widely different times.

The ACR has and will continue its ongoing discussion with CMS opposing the MPPR. The ACR has consistently voiced its opposition to the technical component and professional component advanced diagnostic imaging MPPR policy. The College believes the reductions are a policy decision that is not supported by data or consistent with conventions of the resource-based relative value scale. Specifically, CMS used the Government Accounting Office’s flawed data that looked at a small subset of codes for the same modality to justify the PC MPPR expansion. A more methodologically sound was performed by a panel of experts and published in the JACR and shared with CMS in 2011. See the article titled Professional Component Payment Reductions for Diagnostic Imaging Examinations When More Than One Service Is Rendered by the Same Provider in the Same Session: An Analysis of Relevant Payment Policy published in the JACR/Vol. 8, No. 9, Sept. 2011 for a copy of the analysis.

Also see the ACR 2011 and 2012 Final Rule comment letters for more details on the ACR efforts.

The ACR will publish additional guidelines and any changes made by CMS to the MPPR policy as they evolve.

References:

Jan/Feb 2012 ACR Radiology Coding Source, MPPR FAQs
Nov/Dec 2012 ACR Radiology Coding Source, Q&A
Q&A

What is (are) the appropriate CPT code(s) to report a cardiac CT stress perfusion study?

A cardiac CT stress perfusion study should be reported using CPT code 75574 (Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post-processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) and one of the appropriate cardiac stress test codes (93015-93018). The total volume of contrast given for stress, and rest imaging if performed, and the stress test agent should be reported as well.

If rest perfusion imaging is performed in addition to stress perfusion imaging, it is not appropriate to report a second cardiac CT study code. Only one cardiac CT code should be reported.