Radiology Administrator's
Compliance & Reimbursement Insider

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IN FUTURE ISSUES

- Focusing on ethics
- Stark changes looming?

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CMS issues proposed MPFS rule

By Jackie Miller, RHIA, CPC

CMS is proposing drastic changes to radiology reimbursement as part of the 2006 Medicare Physician Fee Schedule (MPFS) proposed rule, which appeared in the August 8 *Federal Register.* This article will discuss the most important changes in the schedule. Providers will have to wait until the final rule is published this fall to learn whether all the proposals are adopted.

Contrast material

As part of last year's final rule, CMS eliminated the medical necessity requirements for low osmolar contrast material (LOCM) and now pays separately for LOCM regardless of the patient's condition. Under the 2006 proposed rule, CMS would also pay separately for high osmolar contrast material (HOCM). Providers would bill for HOCM using the Q codes published in a recent Medicare transmittal (Change Request 3847, June 30).

CMS currently includes the cost of contrast in the relative value units (RVU) for some imaging services and plans to deduct it in 2006, resulting in a small decrease in payment for certain contrast exams.

Multiple procedure discounting

In March, the Medicare Payment Advisory Commission (MedPAC), an independent body that advises Congress on Medicare payment issues, recommended that CMS reduce the technical component payment when a practitioner performs multiple exams on adjacent areas of the body. CMS plans to adopt this policy for technical component payment under the Physician Fee Schedule in 2006. (The agency also plans to adopt a similar policy for hospital reimbursement under the outpatient prospective payment system.)

This will not affect payment for the professional component.

The agency has defined 11 "families" of exams. Each family includes exams performed with the same modality (e.g., CT, magnetic resonance [MR], ultrasound) on contiguous body areas. When two exams from the same family are performed, the technical component payment for the lower-paying procedure will be reduced by 50%. The reference tables on pp. 2–3 show the families.

For example, if an imaging center bills for the technical component of a CT of the abdomen (74150) and a CT of the pelvis (72192), the pelvis exam (which has the higher RVUs) will be paid at 100% and the abdomen exam will be paid at 50%.

For globally billed services, only the technical RVUs of the second exam will be reduced. The global payment is equal to the

(continued on p. 2)

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MPFS RULE (continued from p. 1)

professional RVUs plus the technical RVUs.

CMS intends the new policy to reflect the savings that CMS believes the facility experiences when adjacent areas are imaged using the same modality.

CMS projects a significant savings to the Medicare program from the proposed changes. If the multiple procedure reduction rules had been in place in 2004, there would have been an 18.9% decrease in payments for family 2 procedures (CT and CTA of chest/thorax/abdomen/pelvis).

FAMILY 1: Ultrasound (chest/abdomen/pelvis-non-OB)	
76604	Ultrasound exam, chest, b-scan
76645	Ultrasound exam, breast(s)
76700	Ultrasound exam, abdomen, complete
76705	Echo exam of abdomen
76770	Ultrasound exam abdomen back wall, complete
76775	Ultrasound exam abdomen back wall, limited
76778	Ultrasound exam kidney transplant
76830	Transvaginal ultrasound, non-OB
76831	Echo exam, uterus
76856	Ultrasound exam, pelvic, complete
76857	Ultrasound exam, pelvic, limited

FAMILY 2: CT and CTA (chest/thorax/abdomen/pelvis)	
71250	CT thorax without dye
71260	CT thorax with dye
71270	CT thorax without and with dye
71275	CTA, chest
72191	CTA, pelvis without and with dye
72192	CT pelvis without dye
72193	CT pelvis with dye
72194	CT pelvis without and with dye
74150	CT abdomen without dye
74160	CT abdomen with dye
74170	CT abdomen without and with dye
74175	CTA, abdomen without and with dye
75635	CTA abdominal arteries
0067T	CT colonography; dx

FAMILY 3: CT and CTA (head/brain/orbit/maxillofacial/neck)	
70450	CT head/brain without dye
70460	CT head/brain with dye
70470	CT head/brain without and with dye
70480	CT orbit/ear/fossa without dye
70481	CT orbit/ear/fossa with dye
70482	CT orbit/ear/fossa without and with dye
70486	CT maxillofacial without dye
70487	CT maxillofacial with dye
70488	CT maxillofacial without and with dye
70490	CT soft tissue neck without dye
70491	CT soft tissue neck with dye
70492	CT soft tissue neck without and with dye
70496	CTA, head
70498	CTA, neck

FAMILY 4: MRI and MRA (chest/abd/pelvis)	
71550	MRI chest without dye
71551	MRI chest with dye
71552	MRI chest without and with dye
71555	MRI angio chest with or without dye
72195	MRI pelvis without dye
72196	MRI pelvis with dye
72197	MRI pelvis without and with dye
72198	MRI angio pelvis with or without dye
74181	MRI abdomen without dye
74182	MRI abdomen with dye
74183	MRI abdomen without and with dye
74815	MRI angio, abdomen with or without dye

FAMILY 5: MRI and MRA (head/brain/neck)	
70540	MRI orbit/face/neck without dye
70542	MRI orbit/face/neck with dye
70543	MRI orbit/face/neck without and with dye
70544	MRA head without dye
70545	MRA head with dye
70546	MRA head without and with dye
70547	MRA neck without dye
70548	MRA neck with dye
70549	MRA neck without and with dye
70551	MRI brain without dye
70552	MRI brain with dye
70553	MRI brain without and with dye

FAMILY 6: MRI and MRA (spine)	
72141	MRI neck spine without dye
72142	MRI neck spine with dye
72146	MRI chest spine without dye
72147	MRI chest spine with dye
72148	MRI lumbar spine without dye
72149	MRI lumbar spine with dye
72156	MRI neck spine without and with dye
72157	MRI chest spine without and with dye
72158	MRI lumbar spine without and with dye

FAMILY 7: CT (spine)	
72125	CT neck spine without dye
72126	CT neck spine with dye
72127	CT neck spine without and with dye
72128	CT chest spine without dye
72129	CT chest spine with dye
72130	CT chest spine without and with dye
72131	CT lumbar spine without dye
72132	CT lumbar spine with dye
72133	CT lumbar spine without and with dye

FAMILY 8: MRI and MRA (lower extremities)	
73718	MRI lower extremity without dye
73719	MRI lower extremity with dye
73720	MRI lower extremity with and without dye
73721	MRI joint of lower extremity without dye
73722	MRI joint of lower extremity with dye
73723	MRI joint of lower extremity without and with dye
73725	MRA lower extremity with or without dye

FAMILY 9: CT and CTA (lower extremities)	
73700	CT lower extremity without dye
73701	CT lower extremity with dye
73702	CT lower extremity without and with dye
73706	CTA lower ext without and with dye

FAMILY 10: MRI (upper extremities and joints)	
73218	MRI upper extremity without dye
73219	MRI upper extremity with dye
73220	MRI upper extremity without and with dye
73221	MRI joint upper extremity without dye
73222	MRI joint upper extremity with dye
73223	MRI joint upper extremity without and with dye

FAMILY 11: CT and CTA (upper extremities)	
73200	CT upper extremity without dye
73201	CT upper extremity with dye
73202	CT upper extremity without and with dye
73206	CTA upper extremity without and with dye

Changes to self-referral prohibition

Under the Stark regulations, physicians may not refer Medicare patients for certain types of services (designated health services, or DHS) to a facility with which the physician or an immediate family member has a financial relationship. Currently, diagnostic and therapeutic nuclear medicine services are not defined as DHS, but this would change in 2006 under the terms of the proposed rule. If adopted, this provision will place the same self-referral restrictions on PET scans and radiation therapy as those that currently exist for CT, MR, and other modalities. CMS believes that this change will help limit the growth of imaging services by removing the incentive to perform services for financial gain rather than medical necessity.

Financial impact

Absent any intervention by Congress, CMS anticipates a 4.3% reduction in the conversion factor for 2006. This reduction, combined with the impact of the other changes outlined above, is projected to result in a 6% *decrease* in payments to radiology providers in 2006. ■

Editor's note: **RACRI** *will bring you the terms of the final rule when it is published.*

Insider *source*

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ASK THE *INSIDER*

Diagnostic testing and recovery from sedation

Q: Should hospitals that code for diagnostic testing (e.g., radiology services) code from the physician's order (script diagnosis) or the radiologist's interpretation as documented in the radiologist's report?

Also, what if the diagnosis provided by the ordering physician conflicts with the documentation provided by the radiologist? For example, a patient comes in for a dual-energy x-ray absorptiometry (DEXA) bone densitometry scan. The script says the diagnosis is osteoporosis; the radiologist's report does not reveal osteoporosis but instead indicates a normal exam.

A: The ICD-9-CM coding guidelines for outpatient diagnostic services state that providers must report diagnoses based on test results (you can also confirm this information in CMS PM AB-01-144). If a radiologist or pathologist interprets the report, code the finding after the interpretation. You can do this because the interpreting party is a licensed physician.

Keep the following in mind: If the results of the diagnostic test are normal or nondiagnostic and the referring physician records a diagnosis preceded by words that indicate uncertainty (e.g., probable, questionable, suspected, rule out, working), do not code the referring diagnosis or diagnoses.

Instead, report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as uncertain are considered unconfirmed by the ICD-9-CM coding guidelines, so do not report them. This practice is consistent with the requirement to code the diagnosis to the highest degree of certainty.

To answer your question regarding the DEXA bone densitometry scan, if the diagnostic test reveals normal results or does not provide a definitive diagnosis, code the osteoporosis. After examining the patient, the physician considered this the highest degree of certainty. This sign or symptom of osteoporosis influenced the physician to order the DEXA bone densitometry scan. The diagnosis also supports medical necessity. Refer to the American Hospital Association's *Coding Clinic,* first quarter 2000, p. 4; *Coding Clinic,* second quarter 2002, p. 3; *Coding Clinic,* second quarter 1990, p. 15; and PM AB-01-144 for more details.

Also refer to Part 3 of the *Medicare Claims Process Manual,* Transmittal 1787, CR 2410, dated January 24, 2003, and Chapter 23 of the *Claims Processing Manual.* You can find both at *www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf.*

Q: Our catheter lab department sees patients for heart catheters as well as interventional radiology procedures. In the catheter lab, our staff perform minor sedation and recover their own patients. The ambulatory payment classification (APC) system payment includes recovery, but can we report recovery (719) on the itemized bill and UB-92 where other payers may pay?

A: Medicare allows you to report medically necessary recovery time (i.e., billed with separate charges) as long as you do not report healthcare common procedural coding system (HCPCS) or current procedural terminology codes to receive separate APC payment for recovery time. Medicare considers recovery room charges to be related items or services provided with HCPCS-coded medical visit or procedures.

Therefore, do not report HCPCS codes with revenue code 710 or 719 when reporting recovery time. Most hospitals use the general category 710 to report recovery time in the postanesthesia care unit (PACU) and 719 to report recovery time in other departments.

The medical record documentation should support the separately billed recovery time. This documentation is easier in situations in which the patient is transferred from the catheter lab to the short-stay unit, for example.

When the recovery takes place in the same department as the procedure, the medical record documentation must clearly note the time and demonstrate monitoring of the patient to support the medical necessity of the separately billed recovery time.

At cost report time, Medicare will match up the 719 charges to the PACU department, which could result in skewed cost-to-charge ratios. Cost report staff can make the appropriate adjustments once they know that non-PACU departments billed charges under 719. ■

Insider *source*
Glenn Krauss, RHIA, CCS, CCS-P, CPUR, independent consultant, Maryville, TN.

Large pay gap between academic and private practice in radiology

Radiologists who work in an academic setting make considerably less money than their private sector counterparts, despite considerable pay increases in the past few years, according to the Medical Group Management Association's (MGMA) *2005 Academic Practice Compensation and Production Survey for Faculty and Management*.

From 2000 to 2004, radiologist compensation increased the most of all academic specialties, the survey showed. In 2000, academic radiologists earned $205,313, but by 2004, that number jumped to $286,114, a 39.4% increase.

However, even with the sharp rise in compensation, radiologists in academic settings earn approximately $124,000 less than if they worked in the private sector—a private-sector group practice radiologist currently earns an average of $410,250, according to the MGMA survey. It's not easy to lure physicians into teaching with that pay difference, says **MarieAnn North, MBA, FACMPE,** director of Navigant Consulting, Inc., who works exclusively with faculty practices and schools of medicine.

"If you're newly graduated and you have huge school loans and a family to support, you're not going to take a teaching position where you're going to lose as much as six figures in your salary," she says.

The MGMA survey tallied responses from 359 clinical science departments to determine trends in physicians' compensation at medical schools.

"In the academic setting, you have to be pretty creative at finding the dollars because there isn't much [money] to begin with. Then you have to figure out how to distribute the money so faculty [doctors] don't leave and go into private practice," says North.

Formula for payment

Medical schools determine compensation using a method similar to formulas used in private practice—they generally start with a fixed base (often determined by faculty rank such as associate professor versus division chair), plus a variable component.

The variable in academia is unlike that of private practice, however. Instead of basing compensation on physician productivity, a school may use the number of patient visits, an annual contract, or the amount of grant revenue generated by the physician. Also, medical schools may include incentives as part of the compensation formula if they have enough money to do so.

In the private sector, large patient demand and an ever-increasing specialty physician shortage are often cited as the reason for rising salaries; the same is true for academic medicine.

However, "the larger compensations in the private market drive a lot of specialty physicians out of working at medical schools entirely," says **Edward Grab,** president and CEO of University Physicians Group, which manages 13 clinics in San Antonio and is affiliated with the University of Texas Health Science Center.

Academic specialties see gains

Overall, the median salary for specialists in academic settings rose by a margin of 7.9%. From 2003 to 2004, the average median specialist's salary increased from $180,668 to $195,000. Interestingly, private practice specialists had a similar gain, averaging a 7.95%

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PAY GAP (continued from p. 5)

pay increase. Their median income went from $274,639 in 2003 to $296,464 in 2004, the survey notes.

"We find that the primary care pay disparities don't exist to the degree that they do in specialties," says Grab.

The largest one-year compensation increase occurred for infectious disease providers, going from $125,456 to $141,697, up 12.9%. Other academic specialists with large pay boosts were neonatal medicine physicians (12.5%) and orthopedic surgeons (10.9%).

Anesthesiologists also recorded a high four-year compensation jump of 25.2%, going from $193,492 in 2000 to $242,297 in 2004, the MGMA survey notes.

"Anesthesiology and radiology are two highly compensated subspecialties, and when the difference between private practice and academic practice is as much as $250,000, well, that's a lot of money to leave behind to teach," Grab says. "Schools know this, and they struggle to pay physicians more in these areas to stay a bit more competitive, but they'll never come close to the private sector numbers."

Sources for academic revenue

Medical schools may pull from as many as eight sources for providers' wages, some of which include

- federal and nonfederal grants and contracts
- faculty practice plans
- hospital revenues
- state and local appropriations
- endowments and gifts
- tuition

Despite the large funding pool, most academic institutions cannot compete with the private sector, North says. And the salary chasm between private practice and academia is leading to short-staffed medical schools.

"There are some real physician shortages [in medical schools], just as there are a great number of shortages in some of these private practice fields," she says. "But without the teachers, we're going to see even greater doctor shortages overall—and reciprocally, you'll see even greater pay increases for those specialties with the greatest shortages."

Still, the doctors who love academic medicine and teaching choose to give up the huge salary to help educate the next generation of physicians, North says. "And these doctors get a different kind of payment for their work." ■

Insider *sources*

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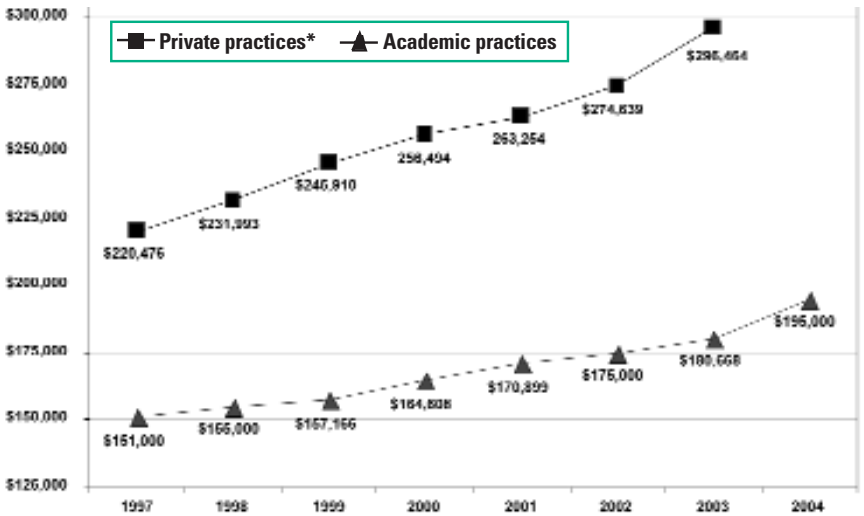
Specialist compensation—Academic and private practices: 1997–2004



* Note: Private practice numbers are based on the *Physician Compensation and Production Survey: 2004 Report* (based on 2003 data).

Source: Academic Practice Compensation and Production Survey for Faculty & Management: 2005 Report *(based on 2004 data), published by the Medical Group Management Association, Englewood, CO. Reprinted with permission.*

Radiologist compensation up—but so are the workloads

Over the past three years, compensation for radiologists has jumped to $410,250 for interventional radiologists and $364,899 for noninterventional radiologists—15.24% and 20.55% increases, respectively, according to the American Medical Group Association's (AMGA) *2005 Compensation and Productivity Survey*.

The AMGA, which aims to promote the interests of medical groups nationwide, compiled the annual report based on 2004 data received from 197 groups that represent more than 34,000 physicians.

To ensure confidentiality for survey respondents, the AMGA contracted with an independent consulting firm, RSM McGladrey, Inc., to collect and compile the data.

From 2003 to 2004, the majority of group practice specialties experienced an overall wage increase greater than inflation (3.17% as of July), with the highest increases in general surgery (8.89%), pediatrics and adolescent care (8.76%), and hematology and medical oncology (8.52%), according to the AMGA report. Interventional radiology remained flat during this year, and noninterventional radiology saw an increase of 5.58%.

Many in healthcare point to the aging population and the physician shortage as key factors for increasing wages in some specialties, such as noninterventional radiology and dermatology, as noted in the AMGA report.

The elderly population (those ages 65 and older) continues to grow, as do its needs for medical care.

The geriatric population is expected to double, from 35 million to 70 million, and make up 20% of the population by 2030, according to the John A. Hartford Foundation Institute for Geriatric Nursing.

That's an increase in the elderly population that is consistent with what **Leonard Berlin, MD,** professor of radiology at Rush Medical College in Chicago and chair for the department of radiology at Rush North Shore Medical Center, has seen in the field of radiology.

"The shortage of doctors is contributing to that, but also the demand is certainly outpacing the supply," says Berlin. "We have increased longevity of people."

"The use of technology has just exploded in radiology—certainly MRI [magnetic resonance imaging] and CT scan use is way up."

—Leonard Berlin, MD

The use of high-tech ancillary equipment may also contribute to the higher wages, says AMGA President and CEO **Donald Fisher, PhD.**

"The use of technology has just exploded in radiology—certainly MRI [magnetic resonance imaging] and CT scan use is way up," Berlin says. "This type of technology also has a higher reimbursement."

Working harder for the money

Despite the benefits of earning more money, heftier paychecks often bring heavier workloads.

For example, radiologists and several other provider types reported logging longer work hours, according to the survey.

The AMGA survey tracked relative value units (RVU), and radiologists increased and outpaced their colleagues in other specialties by nearly double.

In 2004, noninterventional diagnostic radiologists logged 7,679 RVUs versus 6,156 in 2001, a four-year swell of 24.74% (or 1,523 units).

"There's an acute shortage of radiologists that's developed over the past seven to eight years, yet the utilization is up," Berlin says. "In the 'old days,' we [radiologists] went home at 5 p.m. or 6 p.m. Now hospitals want around-the-clock coverage by us."

Gastroenterologists logged the next greatest increase in RVUs. From 2001 to 2004, these providers went from 6,281 to 7,298, an increase of 16.18% (or 1,017 RVUs).

Dermatology came in behind radiology and gastroenterology, increasing by 11.04% from 5,910 in 2001 to 6,563 in 2004.

"It's not surprising that some specialties are seeing such huge increases in productivity RVUs," Fisher says.

"The physician shortages in many of these fields are very real, so you'll see those RVUs going up for the next several years—after all, these doctors are working harder to make up for the shortage of staff," he adds. ■

Insider *sources*

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IMAGING NEWS

Modality-specific education put on the back burner

In a document issued on August 12, the Food and Drug Administration (FDA) said it is considering deleting its requirement for modality-specific continuing education and is delaying enforcement of those requirements indefinitely.

The FDA had established a new requirement, set to take effect in 2006, that would have mandated technologists and interpreting physicians to obtain at least six of the required 15 continuing education credits in classes related to each mammographic modality that they use.

The requirement was designed to ensure that mammography professionals continued to expand their job-specific knowledge. However, the National Mammography Quality Assurance Committee and Insititute of Medicine recommended against this new standard, which resulted in the change.

Digital mammography trial results expected September 16

In October 2001, the American College of Radiology Imaging Network (ACRIN), a cooperative group funded by the National Cancer Institute, began a clinical trial to determine whether digital mammography is as effective as screen-film mammography in detecting breast cancer.

The results are now in, and the trial's principal investigator, Etta Pisano, MD, a professor of radiology at the University of North Carolina in Chapel Hill, will release them during the ACRIN meeting on September 16. Many facilities anticipate that the results will help guide their decision to either purchase digital equipment now or hold off for a few more years.

Digital mammography equipment can cost a half-million dollars, a sizeable expense for a mammography facility. **RACRI** will give you the latest information about the trial as soon as the results are released.

CT scans useful in predicting weight of Wilms tumor

CT scans can predict Wilms tumor weight, according to researchers from the National Wilms Tumor Study group trial, reported *Medical Devices & Surgical Technology Week.*

"Wilms tumor weight can be predicted based on a simple estimate of tumor volume on a preoperative CT scan. CT-estimated volume may replace weight as a prognostic factor and in guiding management," said researchers, according to the publication. The researchers used the process to recruit subjects for the Wilms tumor trial.

PET/CT more effective than other imaging procedures at detecting head and neck cancer

A new study shows that PET/CT is more likely to spot the spread of head and neck cancer than other imaging procedures currently used, according to *Medical Devices & Surgical Technology Week.*

"PET/CT is very helpful in determining where we should pinpoint our biopsies for recurrent disease," Dr. Carol Shores, assistant professor of otolaryngology/head and neck surgery at University of North Carolina and the report's senior author, told *Medical Devices & Surgical Technology Week.*

"We can pick up cancer where we thought none existed. The new scans are so precise that in some cases cancer had been detected that probably would not have been through any other noninvasive imaging exam," Shores said.

Study: CTLM effective in finding malignancies

CT laser mammography (CTLM) may hold promise in detecting breast cancer, according to a new study reported in *Health Insurance Week.*

Researchers said that more laser light was absorbed on the CTLM scans when a malignant tumor was present and that even higher absorption rates were found when the tumor was very aggressive.

"We observed that CTLM was able to visualize the majority of malignant lesions in our study. Thus, we believe that optical mammography is a promising technology, which warrants further investigation," stated Dr. Daniel Flory of the department of radiology. ■

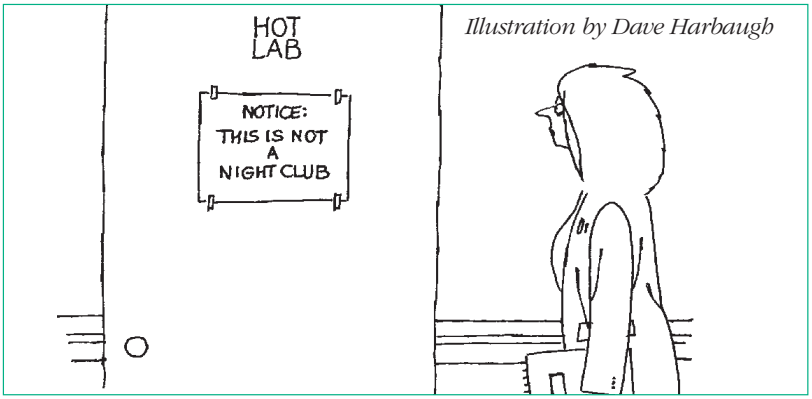

Illustration by Dave Harbaugh