Prepare for the financial impact of the 2005 Deficit Reduction Act

Imagine an $11 billion savings in federal healthcare costs. Congress hopes to realize that goal with the February passage of the Deficit Reduction Act of 2005.

Those savings may seem like good news, but imaging services will bear the brunt of at least one-quarter of those cuts.

“I don’t know how some businesses will survive,” says Cherrill Farnsworth, executive director of the National Coalition for Quality Diagnostic Imaging Services (NCQDIS) and CEO of Houston-based HealthHelp, a radiology consulting firm that specializes in creating quality programs to increase facility savings.

Few thought that the measure would get the go-ahead, not only because of the implications for those in imaging, but also because it cuts funds for student loans and other items.

Payment constraints and radiology business poor bedfellows
Many Americans worry

On the offensive: Associations set to battle congressional cuts to imaging

As dim as the radiology reimbursement bulb burns, many imaging associations believe there’s still time to turn up the light and influence—perhaps even overturn—the Deficit Reduction Act of 2005 before its January 2007 implementation date.

“There will be opportunities to correct this misguided policy error,” James P. Borgstede, MD, chair of the American College of Radiology’s (ACR) Board of Chancellors, told members in a January memo.

Cherrill Farnsworth, executive director of the National Coalition for Quality Diagnostic Imaging Services (NCQDIS), says she spoke with one elected official who claimed he knew nothing about the Deficit Reduction Act’s effect on the imaging industry. “Even though the vote passed, this senator said he would not vote it for it now,” she says.

Despite imaging associations’ lobbying attempts, neither Congress nor the American people seem to understand the pending
Coding corner

Separate procedures key phrase for using modifier -59

If you’re not sure when to use modifier -59, you’re not alone. Many practices have difficulty interpreting guidelines for its use.

Known as the “last resort” modifier, you’ll probably run into situations in which you’ll need modifier -59 to get paid. Understanding the meaning of the term “separate procedures” can help you use the modifier appropriately. If you use it correctly, you’ll be paid correctly.

First thing’s first: Define modifier -59

The CPT manual says to use modifier -59 in situations in which “a procedure or service was distinct or independent from other services performed on the same day.”

For a procedure to qualify for modifier -59, it must be distinguished by either session or patient encounter, procedure or surgery, site or organ system, incision or excision, lesion, or injury. Simply put, for separate and distinct procedures, use modifier -59.

That may be simply put, but as every radiology biller knows, using this modifier becomes tricky at times. When you’re trying to decide whether to use modifier -59, ask yourself the following questions:

- Is the procedure at a separate site, injury, or lesion?
- Was the procedure performed in a separate session?

If you believe the procedures are separate, you can justify your responses, and you have clear documentation proving this, use modifier -59. You should be paid for separate procedures.

Following are three examples of how to use modifier -59:

1. Two different procedures, same session, different sites. Consider selective catheter placements during an arteriogram, says RACRI advisor Jackie Miller, RHIA, CPC, consultant at Coding Strategies, Inc., in Powder Springs, GA.

If you place a catheter into the left common carotid (a first order vessel) and left internal carotid (a second order vessel), you can’t use modifier -59 to get paid for both because they are in the same vascular family.

However, if you catheterize the left vertebral (a second order vessel) and left common carotid, you can charge for both because they are in different families.

In this situation, modifier -59 tells the payer that the procedures are separate and that you should be paid separately for each.

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2. Two different procedures, same session, same site. Modifier -59 can occasionally be used for two services in the same location, as long as they are clearly two separate procedures, says Jo Ann Stiegerwald, RHIT, senior consultant for the Wellington Group in Cleveland.

For example, it may sometimes be medically necessary for a physician to perform a fine-needle aspiration (FNA) and needle core biopsy of a lesion, Miller says.

In this situation, it’s appropriate to bill for both the needle core biopsy and the FNA, as long as you document both services appropriately.

Use modifier -59 on the FNA to avoid having it bundled with the core biopsy.

Nevertheless, be careful when using modifier -59 to bill for two procedures performed during the same session and in the same location.

3. Two different procedures, same site, different sessions, same day. If a physician performs two separate procedures on one patient during the same day, then use modifier -59 to bill separately.

The procedures must be separate and distinct, and you must be able to prove that the two procedures were performed separately.

Billing can also use modifier -59 when a physician performs two different procedures in one location at different times on the same day, says Laureen Jandroep, owner, consultant, and instructor at A+ Medical Management and Education in Egg Harbor City, NJ.

For example, if the patient has an acute abdomen series (74022) in the morning and returns to the radiology department for a single-view abdomen (74000) later that day because he still has pain, you could use modifier -59.

Unless you use modifier -59 to show that the procedures were performed during separate encounters, the single-view abdomen would be bundled into the acute abdomen series.

Code bundling and modifier -59

Use modifier -59 when an ordinarily bundled service is done at a different anatomic site or during a different session on the same day.

Keep an updated copy of the National Correct Coding Initiative (NCCI) edits handy, Stiegerwald says. There you can find information that describes bundled procedures and the circumstances under which bundled procedures can be billed separately.

“[Billers] have to know the bundling edits, and they have to know the circumstances of the surgery,” says Stiegerwald. “If all the surgery was done in the same encounter, the bundling edits themselves will tell them whether this procedure can be billed out separately.”

Practices should refer to the NCCI edits before sending their claims to make sure that everything that needs to be bundled is and that all procedures billed separately are truly separate procedures.

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about the act’s effect on their pocketbooks. However, radiologists across the nation worry about sustaining their businesses and maintaining quality diagnostic healthcare.

The bill includes

• a cap on reimbursement for the technical component of physician office imaging to whichever amount is lesser under the Hospital Outpatient Prospective Payment System or Medicare Fee Schedule Payment, effective January 1, 2007
• reductions in multiple images on contiguous body parts by 25% in 2006 and 25% in 2007, for a 50% overall drop in reimbursement

The bill caps payments on imaging and computer-assisted imaging services. It limits reimbursement for the technical—as opposed to the professional, or interpretation—portion of the imaging service.

Under the new model, all physician office and independent diagnostic testing facility technical component payments fall to the lesser of Medicare physician fee schedule or into the ambulatory payment classification schedule for 2007, says RACRI advisor Thomas W. Greeson, Esq., of Reed Smith, LLP, in Falls Church, VA.

The caps apply to molecular and nuclear imaging, including PET, x-rays, ultrasounds, magnetic resonance imaging, CT, and fluoroscopy.

That’s a long-winded way to say that just about every imaging sector can expect to see a drop in its reimbursement from the federal government.

The act will have a dramatic effect on the industry, says Greeson.

Choosing between payment systems and capping payments based on the lower rate “creates an illogical and punitive precedent—not only for imaging services but potentially for all medical services provided in physician offices,” said James P. Borgstede, MD, chair of the American College of Radiology’s (ACR) Board of Chancellors, in a January press release.

Broad-based cuts extend to 70% on certain services and penalize the imaging specialties because radiologists provide the vast majority of these services, said Borgstede.

These reimbursement cuts, made in conjunction with CMS cuts for scans to contiguous body parts, may prove disastrous to radiology, Borgstede says.

The reimbursement change enacted through the Deficit Reduction Act dramatically affects facilities’ bottom lines, agrees Paul Streiber, vice president of investor relations for Dallas-based Radiologix.

It does so significantly enough that Radiologix cut its revenue estimates for both 2006 and 2007, citing the act as the primary cause for its financial straits.

The company estimates a $1.9 million drop in revenue for 2006 and a $13.3 million drop in revenue in 2007, according to a Reuters report.

Quality saves costs, but try convincing Congress

Farnsworth and Borgstede, among other imaging association members, have worked diligently with the Medicare Payment Advisory Commission (MedPAC) since 2004 on methods to reduce radiology costs by improving quality.

In March 2005, ACR and NCQDIS officials appeared before the House Ways and Means Committee on Health to discuss the growing financial effect of imaging procedures on the healthcare industry.

Diagnostic imaging alone represents a $100 billion industry and the fastest-growing type of physician service expenditure, according to MedPAC. > p. 6
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imaging peril, she says. The public sees athletes receiving detailed three- or four-dimensional scans, and it wants these scans, too. Meanwhile, the government only sees imaging in terms of dollar signs, says Farnsworth.

“It’s not just Congress that needs to understand, it’s the American public,” she says.

So associations began educating government officials about radiology’s needs through MedPAC and CMS as far back as 2004, Farnsworth says.

But at some point, a government official came up with a budgetary number and demanded that imaging meet it, she says.

To effect change, NCQDIS, like the ACR and others, plan to put every effort in the coming months into lobbying members of Congress and mobilizing their membership base.

“We thought we knew how this was going to go,” says Farnsworth. “It was very shocking to us for the vote to happen like this.”

Have a fallout plan for the Deficit Reduction Act’s impact

Whether preparing for a wedding or reorganizing kitchen cabinets, everyone knows that planning and preparation equal success.

To handle the budgetary tempest associated with the Deficit Reduction Act, Cherrill Farnsworth, executive director of the National Coalition for Quality Diagnostic Imaging Services (NCQDIS) and CEO of Houston-based HealthHelp, recommends using the following three-pronged approach:

1. Get involved.
Most people think the cliché “all politics is local” refers to how government spending affects their wallets.

At its essence, however, the refrain refers to the unique opportunity that democratic societies have to effect change—which the radiology industry must recognize if it is to survive the coming financial storm.

“The industry as a whole needs to mobilize now,” Farnsworth says.

She points to reimbursement cuts relating to diabetes treatments in the late 1990s and other specialties over the years.

Although government officials pinched reimbursement pennies relating to those groups in years past, “now it is happening to us,” says Farnsworth.

Farnsworth recommends that radiologists and radiology business managers join one or more of the organizations defending imaging’s financial interests on Capitol Hill.

“You have to join these associations [that] are out there fighting for your businesses,” she says.

But those who do not or cannot afford to join organizations should contact their Washington representatives.

NCQDIS and the ACR, among other organizations, offer sample letters for radiology administrators to send to their congressional representatives (see related tips on p. 7).

2. Get ready.
Look for alternative ways to branch out your business, says Farnsworth.

“Explore alternative business practices. Examine joint venture agreements. Talk to your lawyers. Don’t have your head in the sand,” Farnsworth
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says. “And don’t wait until the fire sale when there’s an abundance of radiology facilities creating a glut on the market. Then hospitals and specialty areas will have their pick of programs at bargain-basement prices.”

Farnswell also recommends renegotiating capital expenditure loans. It may make for difficulties down the road, but it beats defaulting on a loan when healthcare hard times really hit.

“People will default,” she says. “It may mean a longer term debt, but it could also mean the difference between bankruptcy and solvency. [Such ideas] may prove to be an abundance of caution, but you’ll be in a better position in the long run if you put these safeguards in place now.”

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Many healthcare leaders see imaging as an important business investment and a way to augment their healthcare coffers.

On the flip side, overuse of imaging “lowers the quality of patient care, undermines patient safety, threatens the solvency of Medicare, and annually drains the American healthcare system of billions of dollars,” Borgstede said during the Radiology Society of North America’s June 2005 conference.

“It is about abuse versus proper payment,” Greeson says.

The radiology compromise
The government wants to reign in costs and medical misuse. Radiologists want proper reimbursement for the work they perform. The two must reach a compromise somewhere in the middle, Greeson says.

At the conclusion of all discussion lies an elemental question, Greeson says: “Why is the utilization of diagnostic imaging services increasing so rapidly?”

Any number of factors contribute to the industry’s growth, but most of the increase can be laid at the door of physician groups that self-refer.

Many in the industry believe that quality controls can reduce the costs of these problems.

However, “[this] bill fails to take into account quality and access-to-care issues,” Farnsworth said in a memo. “The proposed cuts could have serious impact on access to needed diagnostic services for Medicare patients, particularly those in rural areas.”

Rural areas bear pain from the financial pinch
ACR also suggested that the cuts contained in the Deficit Reduction Act will force physicians to stop offering needed imaging services.

The cuts may even push radiologists to relocate to more metropolitan areas.

“This hurts . . . particularly rural communities that do not have large hospitals convenient to them and rely predominantly on in-office imaging care,” Borgstede said in a January release.

Traditionally, rural areas hold onto fewer healthcare dollars overall, says Farnsworth.

“If those [rural facilities] cut 25%, they’re not cutting from a 25% profit margin. It’s a cut to an already struggling establishment. In many cases, when the government cuts healthcare, rural America is hit hardest,” she says.

And rural America received no exception with this latest round of cuts, she says.
Follow these tips when writing to government officials

The letter is the most popular choice of communicating with a congressional official.

Use the following guidelines to communicate effectively with your government representative.

**Structure your letter for maximum effect**

*Tip:* Address the correspondence formally.

If you send a letter to your senator, use his or her full name and address him or her as “The Honorable [insert name].”

When writing to the chair of a committee or the speaker of the house, address him or her as “Dear Mr. Chairman,” “Madam Chairwoman,” or “Dear Mr. Speaker.”

*Tip:* Write only to your senators and representatives—letters sent to other members of Congress are not effective. Find your government officials by visiting www.firstgov.gov.

*Tip:* State the purpose of your letter in the first paragraph.

If it pertains to a specific piece of legislation, identify the law accordingly (e.g., Deficit Reduction Act of 2005).

**Stay on topic to get your message across**

*Tip:* Keep your letter simple and on topic.

Address only one issue in each letter, and, if possible, keep the letter to one page.

Write legibly, particularly if it is a handwritten letter.

Be courteous and to the point and include key information. Use examples from your own daily experiences to support your position.

Be polite. Don’t write when you’re angry. A threatening, demanding, or abusive tone will ultimately have an adverse effect on your effort.

Finally, write only about key issues. Don’t try to instruct the representative or senator regarding every issue that arises.

**Dial an official to make a personal connection**

Contacting government officials by phone often leads to a more personal connection between the two of you on the issues that matter.

Review these items before picking up the receiver and making your first phone call.

*Tip:* Find the right contact.

You can always call the U.S. Capitol switchboard at 202/224-3121 and ask for the number of your senator’s or representative’s office.

However, the voice on the other end of the line will most likely be a staff member, not the actual member of Congress. Ask to speak with the aide who handles Medicare and healthcare issues.

After identifying yourself, tell the aide that you would like to leave a brief message, such as the following:

*Please tell Senator/Representative [insert name] that I oppose the Deficit Reduction Act of 2005 based on its effect on the radiology industry.*

State the reasons for your opposition of the bill and ask about the senator’s or representative’s stance on the situation. Request a written response to your telephone call.

Questions? Comments? Ideas?

Contact Managing Editor Melissa Varnavas

Telephone: 781/639-1872, Ext. 3711
E-mail: mvarnavas@hcpro.com

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Improving radiology quality could prevent rising costs

James P. Borgstede, MD, chair of the American College of Radiology (ACR) Board of Chancellors, blames erroneous use of imaging for burgeoning expenses.

“The reason for costs is inappropriate utilization economically motivated by self-referrals,” Borgstede told a March 2005 congressional subcommittee.

To curb overuse, ACR recommends that Congress enact standards for

- equipment maintenance
- technologists’ qualifications
- physics inspections of machinery
- image quality
- radiation dosage parameters
- interpretation qualifications

Like ACR, the National Coalition for Quality Diagnostic Imaging Services (NCQDIS) recommends draft legislation implementing quality controls to lower imaging costs, according to Paige Leavitt, NCQDIS spokesperson.

NCQDIS’ proposal would “make payment contingent on compliance standards similar to the existing standards for Medicare and mammography,” according to organization literature.

“This is not a turf battle,” Cherrill Farnsworth, executive director of NCQDIS, told the congressional subcommittee. “It’s about quality and safety . . . Medicare should use the most well-trained person. If we don’t get the diagnosis right, we’re surely not going to get the therapy or the surgery or the pharmacy right.”

However, with the Deficit Reduction Act of 2005 in place (see the related story on p. 1), Farnsworth doesn’t believe that any quality initiatives can take off.

“These two things conflict,” she said. “How are you going to pay for quality initiatives if they’ve just cut the bottom out from your bottom line?”