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Part B Insider (Multispecialty) Coding Alert

Part B Payment: Radiology Payment Cuts in 2011 Could Hurt Many Specialties

Multiple imaging procedure reduction will impact all practices that perform imaging.

If your practice depends on revenue from imaging services, keep in mind that pay for those visits will drop next year--whether or not the conversion factor plummets as it's expected to do.

As we reported in last week's Insider, the 2011 conversion factor will be $25.5217, according to the 2011 Medicare Physician Fee Schedule Final Rule, printed in the Federal Register that will be published on Nov. 29. We've received questions from many of our readers asking us to further elucidate the information in the 2,023 page Final Rule, and the following analysis should offer more insight into how practices will fare next year.

Multiple Imaging Procedure Cuts Deepen

Even if Congress steps in and fixes the conversion factor (as most practices hope will happen), you'll still lose money on multiple imaging visits in 2011. That's because CMS will change the multiple imaging procedure cuts starting on Jan. 1.

"In 2011, when you perform multiple radiological procedures that are within the same family (for instance, multiple ultrasounds, or multiple MRIs), you'll collect 100 percent of the global fee for your primary study, but not for the second and subsequent studies," says **Michael A. Ferragamo, MD, FACS,** clinical assistant professor of urology at the State University of New York at Stony Brook. "For the second study, you'll be paid 100 percent of the professional component, but 50 percent of the technical component. That's down from what we've collected in 2010, which was 75 percent of the technical component," he says.

Example: Suppose the surgeon performs an abdominal sonogram (76700) and a bladder sonogram (76857), Ferragamo suggests. "You'll be paid 100 percent for the 76700, but for 76857 you'll get 100 percent of the professional component and 50 percent of the technical component."

If the surgeon then adds a renal sonogram afterward (76775), "assuming the procedures aren't bundled by the payer, you'll get 50 percent for the technical component of that too, since it's another subsequent procedure following the abdominal sonogram," Ferragamo adds.

Tip: "It's important that you put the higher RVU procedure first on your claim," he suggests. "Most likely, the insurer will adjust only the lower-paying procedures, but it's a good idea to put the higher one first on your claim to ensure you get the full payment for the highest RVU service."

Radiologists Growing Frustrated

As we reported last week, radiologists are set to take the biggest hit in 2011, with radiology practices losing up to 14 percent on average in Medicare reimbursement, according to the Fee Schedule. This follows several years in which these practices have already been financially stretched, says **Dianne M. Nakvosas, ACS-RAD**, with Compubill in Orland Park, Ill. She created a chart showing how Medicare has reimbursed practices for code 71020, a two-view chest x-ray, over the past 11 years, as follows:

In addition, the 2011 Fee Schedule indicates that Work RVUs for 71020 will remain the same next year as they are this year. "We are currently pretty much back to the values of the year 1999," Nakvosas laments, despite the fact that costs for performing the procedures have increased since that time. With radiologists already stretched thin, the impact of cuts could be even more troubling in 2011.

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Prepare for Annual Wellness Visits

Several subscribers contacted the Insider for tips on how to document annual wellness visits (AWVs), which you'll report with G0438-G0439 in 2011. Although CMS has not yet dictated specifically what you must document to report these codes, the Fee Schedule does note that the AWV "includes and/or takes into account a health risk assessment and creates a personalized prevention plan for beneficiaries, subject to certain eligibility and other limitations."

The document also notes that during the AWV, the provider must perform the following elements "to be included in a personalized prevention plan:"

Establishment of, or update to, the individual\'s medical and family history

A list of the individual\'s current providers and suppliers

Medications prescribed for the individual

Measurement of height, weight, body-mass index (BMI) or waist circumference, and blood pressure

Detection of any cognitive impairment

Establishment or update of an appropriate screening schedule for the next 5 to 10 years

Establishment or update of a list of risk factors and conditions (including any mental health conditions) for which interventions are recommended or underway

Furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs.

To read the 2,023-page Final Rule in the Federal Register, visit http://www.ofr.gov/OFRUpload/OFRData/2010-27969_PI.pdf.

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