ARPE, CBRPA & RPAS NEWSLETTER

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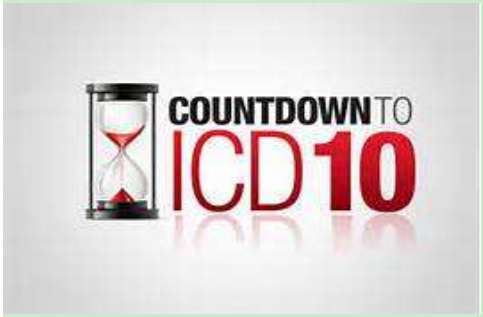
RPA REPORT

2014 Coding Changes Bring Cuts and System Re-Design

Changes to the coding system in 2014 will bring extensive shifts in how you capture charges and code for your services industry experts said. There are a few bright spots for the next 12 months, but overall, this next year will likely push you to tighten your belt.

The biggest change — implementation of the new ICD-10 coding system — won't go into effect until Oct. 1, but experts expect it to dominate coding conversations throughout the year. To me, 2014 is all about ICD-10," said Melody Mulaik, president of CSI Coding Strategies. "It will dwarf everything else."



Once in place, ICD-10 will expand the current 14,000-code ICD-9 system to 69,000 codes, requiring providers and referring physicians to be more specific with their diagnoses and documentation. While there won't be any changes to existing coding groups, your coding processes will be different.

Codes up to seven digits long will replace the current three-to-five digit ICD-9 codes, and a dummy place holder has also been added to allow for further expansion in the future. This change has caused concern within the American College of Radiology (ACR) because current coding systems weren't designed to accept longer codes. Consequently, practices and facilities are facing updates or upgrades to their existing systems.

Unfortunately, ICD-10 will also put radiologists at the mercy of referring physicians. Most reimbursement for imaging services requires proof of medical necessity — something that must be documented by the referring doctor.

"There is a differentiator [between radiology] and other specialties. Physicians will code or they have a coder looking at their documentation," Mulaik said. "But because radiologists are so reliant on the hospital or other systems for information, problems can easily arise if a radiologist doesn't receive enough documentation from the referring physician."

Most radiologists will struggle with ICD-10, however, because they haven't taken the time to adequately prepare for it, she said. There is still time, though, to ready yourself for the transition if you start now. Mulaik recommended you take advantage of the ICD-10 Tool Kit from the Radiology Business Management Association that offers guidance for both providers and coders about how to best handle this transition.

It is curious that physical courage should be so common in the world and moral courage so rare.

~Mark Twain

Upcoming payment cuts

There are plenty of coding changes to worry about before October, though. In the final rule, CMS mandated cuts to breast biopsy codes, as well as various CT and MRI studies. The most substantial reduction affects

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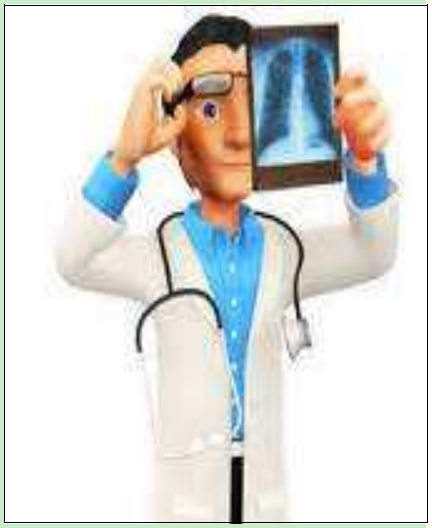
the breast imaging codes. According to ACR analysis, you can anticipate anywhere between a 29 percent and 50 percent reduction for these codes, mostly as a result of bundling. "These are significant because anything with the breast is always significant," said Kathryn Keysor, ACR's director of economics and health policy.

Specifically, six new codes — 19081 to 19086 — bundle breast biopsy with imaging guidance for stereotactic, ultrasound or MRI studies. Eight additional new codes (19281 to 19288) bundle marker placement with imaging guidance for stereotactic, ultrasound, mammographic or MRI studies. This last set of codes will actually bring a 17 percent *increase* in payment for 2014.

You will also see a dip in payment for the CT and MRI procedures you provide, specifically with MRI brain, MRI spine and CT head. CMS will now require separate cost centers for CT and MRI services to provide more clarity on how to allocate the costs associated with each service. The average reduction for these code changes falls between 30 percent and 40 percent, Keysor said.

CMS also determined that ultrasound guidance for needle placement code 76942 has been mis-valued. To date, the time and payment allotted for the guidance was more than the time and amount tied to the procedure itself. Consequently, CMS has mandated a roughly 77 percent cut to the ultrasound guidance code.

The "good" news



The final rule also offers some good news this year but it comes mostly in the form of postponed changes. In a break from the past few years CMS opted not to implement any further multiple procedure payment reductions (MPPR). The cuts have applied to imaging services rendered by the same physician to the same patient during the same encounter.

It's very positive that CMS didn't expand the MPPR policy this year," Keysor said. "It's due in large part to the education ACR has done this year in showing CMS how this policy affects radiology." However, CMS did leave the door open to introducing more MPPR cuts in the future to continue increasing efficiencies.

In addition, talk of putting comprehensive APC codes in place has been pushed to 2015, Mulaik said. With this change, ambulatory surgical center payments would mimic DRG payments for inpatient stays — facilities would receive a fixed pot of reimbursement dollars to be divvied up among all providers involved in a patient's care.

This will likely be a problem for radiology, she said, because imaging codes will be bundled in with all other services. In many cases, imaging codes will be coded outside the provider's department, making charge capture even more difficult.

How can you prepare?

The actual economic impact on a practice will depend on how many of the affected services are provided. So it isn't possible to craft specific advice on how one can minimize the financial pinch you will feel, Mulaik said.

But there is one way that most practices can try to recoup the lost reimbursement, Keysor said. "Members should make sure they negotiate with private payers that aren't tied to the fee schedule each year," she said. "They can have contracts based on the 2008 fee schedule, or one from another year, rather than the current year. There is wiggle room to negotiate with many private payers."

It's important to remember, she said, that the reimbursement cuts that come with the coding changes apply only to Medicare billing. Should you choose to discuss reimbursement levels with your private payers, the ACR has contract evaluation guidelines available to walk you through a successful negotiation.

Source: Howell, Whitney, Diagnostic C Imaging, Practice Management December 26, 2013

http://www.diagnosticimaging.com/2014-coding-changes-bring-cuts-and-system-re-design#sthash.zAYdOTcA.dpuf

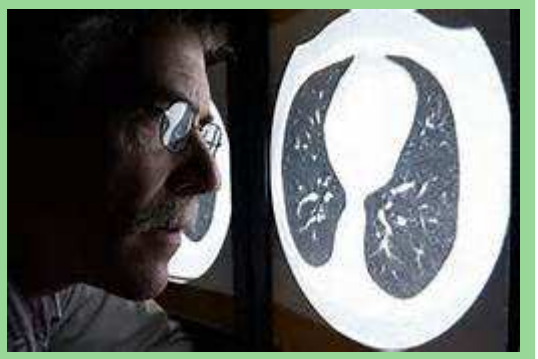
CT Lung Screening Approved

After years of discussion and evidence gathering, the U.S. Preventive Services Task Force (USPSTF) this week gave its final approval for annual screening with low-dose CT for individuals at high risk for lung cancer.

In February 2012, LCA developed its National Framework for Excellence in Lung Cancer Screening, aimed at preparing centers across the U.S. to screen for lung cancer using best practices. The USPSTF recommendation is on par with previous recommendations for breast, colon, and cervical cancers, for which survival has increased dramatically following implementation of screening recommendations for those diseases, Fenton Ambrose said in her statement.

ACR said it is in the process of developing CT lung cancer screening Appropriateness Criteria and corresponding practice guidelines and standards, which will be completed in the coming months.

The recommendation is subject to a month of public comments and then revision before it can be finalized but it offers most of what screening advocates had asked for, including screening criteria that are a little broader than those used in the major study driving the recommendations, the National Lung Screening Trial (NLST). In 2011 the NLST found a mortality benefit of at least 20% in long-term smokers who underwent annual low-dose CT screening



Decision will affect millions

The community of ex-smokers numbers in the millions. Lung cancer is the leading cause of cancer death in the U.S. and is diagnosed in more than 200,000 people each year, said USPSTF chair Dr. Virginia Moyer in a statement accompanying the draft recommendation.

Almost 90% of those who are diagnosed die from the disease because it isn't detected until it has reached an advanced stage. By screening those at high risk, lung cancer will be detected at earlier stages when it is more likely to be treatable, Moyer said. The risk of lung cancer increases with the duration and extent of smoking.

Rather than limiting screening recommendations to heavy smokers ages 55 to 74 years as the NLST did in its inclusion criteria, the USPSTF draft recommends screening for ages 55 through 79. Like NLST, the draft requires a smoking history of 30 or more pack-years for inclusion and if the individual has quit smoking, he or she must have quit within the past 15 years.

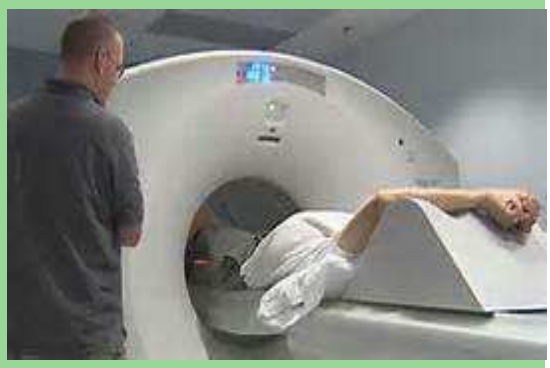
However, unlike NLST's screening recommendation of three annual low-dose CT scans, the draft does not specify the number of annual screenings leaving that question, for now, to the discretion of patients and healthcare providers.

USPSTF conferred a grade B recommendation to CT screening which denotes a high certainty of moderate benefit or moderate certainty of moderate-to-substantial benefit. At the same time, the draft cautions against the screening of individuals with significant comorbidities who are at risk of death from other causes, particularly heart disease, before lung cancer could claim their lives. In practical terms, grade B means that the recommendation, if approved, will be automatically included for Medicare coverage under the terms of the Patient Protection and Affordable Care Act (PPACA), which takes full effect next year according to Fenton-Ambrose. "Because of the way the Affordable Care Act looks at these ratings, if it's an A or a B it becomes an essential health benefit and is then accorded coverage," she said

CT Lung Screening Approved

Separately many private insurers are already stepping up to the plate to offer CT lung cancer screening. The draft recommendation comes a little earlier than expected and from here things could progress rapidly with a final decision and Medicare coverage possibly rendered by the end of the year Fenton-Ambrose believes. "We're going to do everything possible to keep this process moving forward as rapidly as possible," she said.

The draft recommendation was based on an extensive review of published lung cancer studies. It was the product of a request made by USPSTF which sought to update its 2004 report showing insufficient evidence to conclude a significant benefit from CT lung cancer screening. USPSTF joined with the Agency for Healthcare Research and Quality (AHRQ) to formulate key questions about the harms and benefits of screening focusing on populations, interventions, outcomes and harms associated with low-dose CT. The review was published concurrently with the draft recommendation in the *Annals of Internal Medicine* (July 29, 2013).



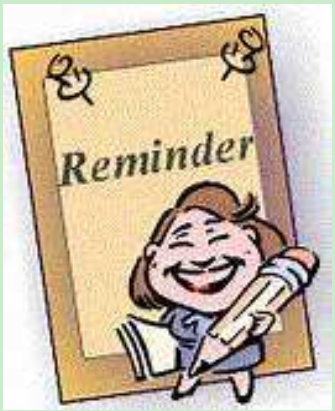
The review found "strong evidence" that low-dose screening with CT can reduce both lung cancer mortality and death from all causes. While cautioning that CT screening of long-term heavy smokers must balance the benefits of screening with the harms, the review authors concluded that evidence favored CT screening of high-risk individuals.

Source: Bassett, Mike, "USPSTF issues final lung cancer screening recom-

STILL HOLDING.....

Approximately 15 RPAs have paid their fees, but have not submitted their ACLS or radiography cards so their renewal can be processed. Others have not forwarded their new address and the mail is returned to CBRPA. To solve this problem, perhaps CBRPA should have a policy stating RPAs can never move or get married or divorced.

However, the problem will be resolved with a new computer program being developed wherein all registrations will be on-line and all ACLS and radiography cards will be submitted electronically at the time fees are paid. Everyone will be notified when this new program goes into effect.



If you were registered in 2004, you will have to take the Recertification Examination during your birth month. If you are not sure when you finished, look at your ID card—the first two numbers is the year you became an RPA. Instructions are on the CBRPA./org web site. When the exam fee is paid, you will be sent the internet address to the test and the password to access the test. The chi-tester program is used for the test so everyone should be familiar with that testing program.

Due to requests, the Recertification Seminar being held during the ARPE Educational Symposium will be open to any RPA who wishes to attend, even if it is not your year to recertify. Everyone is welcome to attend the four-hour seminar.

High-tech glasses enable surgeons to visualize cancer cells

Surgeons at Barnes-Jewish Hospital and Washington University School of Medicine in St. Louis this week used new glasses that enabled them to visualize and distinguish cancer cells from healthy cells, according to the school. The technology developed by Samuel Achilefu, a professor of radiology and biomedical engineering at Washington University and fellow colleagues, uses "custom video technology [and] a head-mounted display." A "targeted molecular agent" sticks to the cancer cells, causing them glow through the glasses. "A limitation of surgery is that it's not always clear to the naked eye, the distinction between normal tissue and cancerous tissue," Ryan Fields, a Washington University assistant professor of surgery who plans to wear the glasses this month, said in a statement. "With the glasses we can better identify tissue that must be removed."

Julie Margenthaler, an associate professor of surgery at Washington University who performed the operation, said the hope is that the glasses will reduce or eliminate the need for secondary procedures. "We're in the early stages of this technology, and more development and testing will be done, but we're certainly encouraged by the potential benefits to patients," Margenthaler said. "Imagine what it would mean if these glasses eliminated the need for follow-up surgery and the associated pain, inconvenience and anxiety."

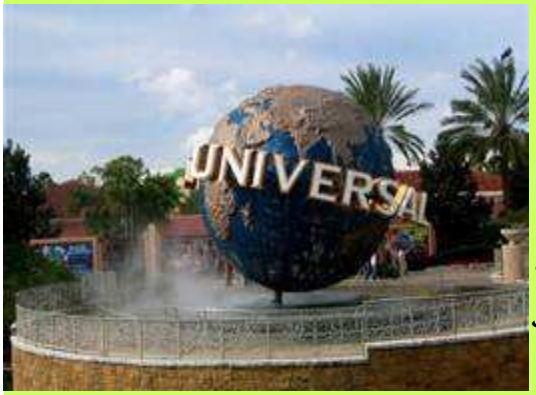
The other big technology-powered eyewear currently being used by surgeons, of course, is Google Glass. While in the eyes of some healthcare professionals, the technology holds promise as an innovative and effective tool in the OR; to others its privacy-disaster potential looms large. Glass, so far, has been used more as a means to enable real-time remote consulting during live operations.

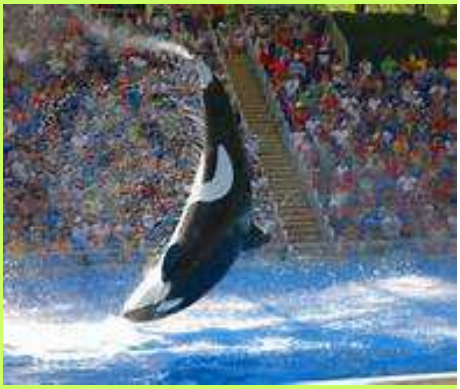
In other cancer detection news, the use of a SFRP2-molecularly targeted contrast agent with ultrasound could provide physicians with a less expensive and radiation free-alternative for detecting and monitoring cancer compared to modalities such as X-ray, CT and MRI, according to research out of the University of North Carolina. With the technique, described in an article in PLOS ONE, researchers led by Nancy Klauber-DeMore, M.D., were able to use the imaging technique to visualize lesions created by angiosarcoma, a cancer that develops on the walls of blood vessels.

Source: Bowman, Dan, February 11, 2014 http://www.fiercehealthit.com/story/high-tech-glasses-enable-surgeons-visualize-cancer-cells/2014-02-11#ixzz2ttzM4Ufe

October 16-18 Place: Orlando, FL What? ARPE Meeting

Want to try something different, entertaining, spectacular, and relaxing? Then attend the ARPE Educational Symposium in Orlando. An exceptional educational program is planned and you can get your ACLS renewed . Join and enjoy your peers —see ya' there!





Dirty Scrubs and Other Disease Laden Attire

What should conscientious medical clinicians wear to avoid contaminating their patients with bacteria that can lead to infections? A better question is what should they not wear and where should they not wear it?

Hospital workers have been seen wearing their scrubs:

** In grocery stores

** At the bank

** Walking their dog

** At the mall

Female clinicians seem to wear a lot of necklaces and bracelets. Some men wear neckties. A few have dangling hospital IDs on lanyards around their necks and almost all of them wear rings.

A paper from the Guidelines Committee of the Society for Healthcare Epidemiology of America addressed many of these issues, outlining what is known about infection transmission through attire and offered the following guidelines to reduce it.

1. Bare below the elbows. This means short sleeves, no wristwatches, no jewelry and no ties during clinical practice. Encourage providers to wash their hands between every patient or use a sanitizer.
2. Clothing that comes into contact with the patient should be laundered daily using a high water temperature and adequate soap to kill bacteria and spores. If the clothing is worn home, clean scrubs or lab coats should be changed daily. It would be best to have everyone don their scrubs at work and leave the soiled ones at work.
3. Coat hooks should be provided where white coats and other long sleeved outwear can be placed prior to patient contact. Enough coat hooks should be available for each clinician.
4. Neckties can become colonized with pathogens especially since neckties are hardly ever washed (unless by mistake). Neckties can dangle onto patients, devices, wounds or skin transmitting pathogens. If a necktie is worn, it should be tucked into the shirt or wear a tie pin or clip or wear a bowtie.
5. Footwear should have closed toes, low heels and non-skid soles.
6. Shared equipment, including stethoscopes, should be cleaned between patients.
7. Lanyards can be flipped around to the back when working over a patient. One must also be careful with pagers and cell phones.
8. Rings should not be of the type that would easily carry pathogens or spores. Some countries prohibit providers from wearing rings during direct patient contact.
9. Hair should be pulled to back of the neck and not allowed to come into contact with the patient.

Infections rates in hospitals tend to be on the rise and many patients develop infections during their stay or immediately after being discharged. Every effort should be made to reduce the infection rates.

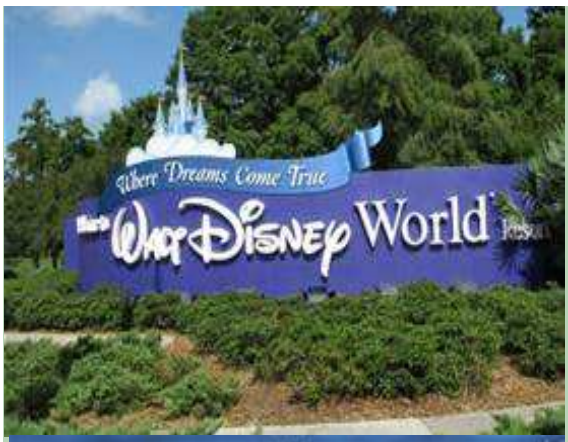
Source: Clark, Cheryl, "Dirty Scrubs and Other Disease-Spreading Attire, January 30, 2014

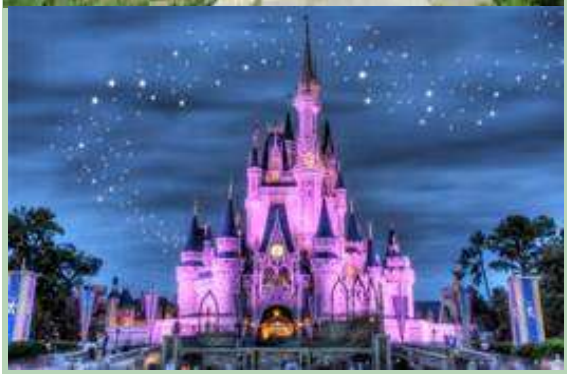
RPAS REPORT

According to the web site, www.GovTrack.us , There are 7,196 bills and resolutions currently before the United States Congress. Of those, only about 5% will become law or approximately 360 of them.. They must be enacted before the end of the 2013-2015 session (the "113th Congress"). To have an opportunity for the bill proposed by SRPE/ACR/ARRT/ASRT , every RPA and RRA must contact their representative to show support. Significant support must be demonstrated for the Medicare Access to Radiology Care Act (MARCA), in order for the bill to be passed out of committee. Contact SRPE for information on how to contact your representative or go to the SRPE.org web site.

Missouri Society of Radiologic Technologists are sponsoring legislation to have licensing for Radiologic Technologists, assistants and practitioner assistants. Members of the state society visited with lawmakers in February to seek support for the bill. Nebraska is also working on a licensing bill, but radiologist support is lacking.

RPAS will be revising their web site and it will be available in the near future. If you have suggestions for any project you would like to see undertaken, for a current contact with RPAS, send your ideas to CBRPA . All ideas or suggestions are welcome.





October 16-18

Great place!!

Terrific weather!

Superb meeting!

Excellent topics!!

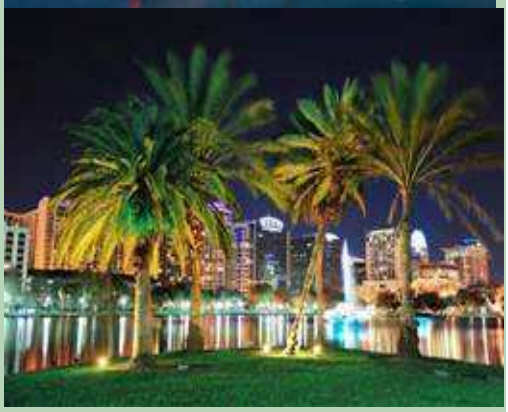
Good friends!

New friends!

Excellent hotel!!

Cuisine variety!

New experiences!



RPA REPORT

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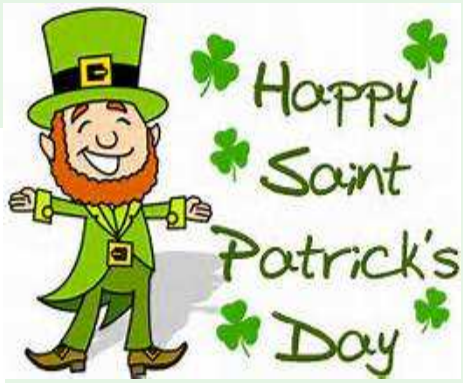
Web Sites

ARPE — rpeacademy.org

CBRPA — cbrpa.org

RPAS — RPASociety.org

Time change on Sunday, March 9 !!



May your blessings outnumber
The shamrocks that grow,
And may trouble avoid you
Wherever you go. ~
An Irish Blessing

Our health care system is changing and becoming more patient-focused and more competitive. Remember you may be the only sales person for your facility that has significant contact with some patients. Always treat them with kindness and preserve their dignity because you just may be preserving your own job..

Spring is not very far away and winter will end—hopefully!

During my second year of nursing school our professor gave us a quiz. I breezed through the questions until I read the last one: "What is the first name of the woman who cleans the school?" Surely this was a joke. I had seen the cleaning woman several times, but how would I know her name? I handed in my paper, leaving the last question blank. Before the class ended, one student asked if the last question would count toward our grade. "Absolutely," the professor said. "In your careers, you will meet many people. All are significant. They deserve your attention and care, even if all you do is smile and say hello." I've never forgotten that lesson. I also learned her name was Dorothy. ~JoAnn C. Jones, Guideposts.