

# 2002 Coding & Reimbursement Updates from Mid-Winter Meeting

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It is difficult for physicians and technologists to keep current with the plethora of coding, coverage, and payment changes published, listed, and discussed in many locations and forums, yet Medicare and other payers hold physicians responsible for this task. As part of the NM team, technologists can and should be poised to assist in obtaining accurate coding and billing information for the physician, facility, or hospital.

It is a wonder with all the information and misinformation out there that we ever get the coding right. Often we do not, but surely it is not for a lack of trying to keep up. The effort that technologists and physicians continually put forth was evident with the significant SNM and SNM-TS participation at the SNM Mid-Winter Meeting. This report summarizes just some of the important 2002 coding and reimbursement updates identified at the SNM Mid-Winter Meeting.

At the forum held by the SNM-TS Socio-Economic Affair Committee chaired by April Mann and the Coding and Reimbursement (C & R) Subcommittee chaired by Lynne Roy, we heard a lot about APCs, or Ambulatory Payment Classifications, which pay for the Medicare technical component in the hospital setting. CMS held an APC Advisory Panel meeting January 22-24 in Baltimore, MD, where current APCs and modifications proposed by interested parties were discussed. CMS staff stated that they are updating APC rules, which are scheduled for publication this summer, with a comment period and an implementation date in 2003. Attorneys William Uffelman and Gordon Schatz were invited to provide testimony regarding the movement of the Wholebody Bone Scan Procedure 78306 from NM Level II APC to NM Level I APC. Because this procedure was one of the most frequently performed NM procedures in these two APCs, the reduction in reimbursement would be a significant monetary loss for NM departments.

Dr. Kenneth McKusick gave a report of the NM APC task force, stating that several members met with staff from CMS on February 4. This meeting was also to discuss future refinements of the APC system. Specifics discussed included the lack of clinical and resource homogeneity of the NM procedures in the current APC system, refinement of the radiopharmaceutical descriptions,

and future issues associated with the ending of the pass-through for radiopharmaceuticals scheduled to occur in 2003. Although no specific resolutions came from this meeting, it was quite positive and showed CMS staff interest in continuing to work with the NM APC task force on these issues.

FDG PET coverage and payment to hospitals in the APC system were also a topic of discussion in several committees and educational programs at the Mid-Winter Meeting. Drs. Conti and Coleman have been active participants in PET coverage issues. The Executive Committee of the Medicare Coverage Advisory Committee (MCAC) will be meeting April 16, 2002, to discuss whether FDG PET would be appropriate to use when Alzheimer's disease is indicated. Although no final decision has been reached for Alzheimer's disease, CMS has announced, since the Meeting, that it will cover use of full- and partial-ring scanners for "monitoring tumor response to treatment for women with locally advanced and metastatic breast cancer." Read the Public Affairs Update on page 7 for more information, and visit the SNM and CMS Web sites for future updates.

Another busy committee at the Mid-Winter Meeting was the SNM C & R Committee chaired by Dr. Michael Wilson. The Committee discussed important Practice Expense surveys and the significant progress that the Committee has made this year. Dr. Wilson recently presented at the Practice Expense Advisory Committee (PEAC) and received support for the materials and building-block model he presented.

The C & R Committee also discussed Fusion Imaging (both software and camera) and Radiotherapy and Infusion of Monoclonal Antibodies codes. Providers, in the absence of specific codes, have been using a variety of codes for these procedures, some of which may not be appropriate. This inconsistency is causing confusion in the NM community and undoubtedly within CMS, which uses codes for tracking and setting future payments. To the C & R Committee's knowledge, CMS currently has no written policy or position for coding Fusion Imaging (both software and camera) and Radiotherapy and Infusion of Monoclonal Antibodies procedures. It is important that providers performing these studies check with their local carrier or fiscal intermediary regarding their choice

of codes. Additionally, providers may want to consider giving the patient an Advanced Beneficiary Notification (ABN) for these procedures if the carrier or fiscal intermediary identifies these as non-covered procedures. ABN sample forms and information can be found on the CMS Web site under the coverage section at [www.cms.hhs.gov](http://www.cms.hhs.gov).

During the SNM-TS educational program, another hot topic was the Medicare instructions on ICD-9 CM coding for Diagnostic Tests AB-01-144 and PM B-01-61 dated September 26, 2001, and effective January 1, 2002, located at [www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guide](http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guide). These clarifying policies, published by CMS, give hospitals and physicians' offices detailed guidance when choosing the primary and secondary diagnosis codes reported on Medicare claim forms. It is specifically stated in the policies that referring physicians are required to provide diagnostic information to the testing entity at the time the test is ordered, and physicians are responsible for the accuracy of the information submitted on a bill.

The most widely discussed portion of this coding was the information that physicians should use a confirmed diagnosis as the primary reason for the examination. In the absence of a confirmed diagnosis or non-diagnostic study (i.e., a normal study), the interpreting physician should code the signs or symptoms that prompted the treating physician to order the study. Several technologists stated that they needed to change coding processes in their departments to implement this policy. Many explained that they were coding the reason for examination (signs or symptoms) and did not have mechanisms for the coders to review the final reports. These were just a few of the points discussed from the lengthy CMS instructions. All are advised to review the entire policy, which is packed with clarifying examples.

Remember that Medicare information is public information and if you cannot find it, all you have to do is ask (i.e., Freedom of Information Act). The SNM and the SNM-TS are great resources as are the NM vendors and your colleagues. Keep in mind that the physician is ultimately responsible for knowing and following the appropriate rules.

