2010 Fee Schedule Changes

A look at the changes in the Physician Fee Schedule that will affect your practice in 2010.

BY KATHARINE L. KROL, MD

As Congress continues to debate health care reform, changes in payment policy are already being implemented. Several changes went into effect in 2010 that will affect your practice.

NEW CODES FOR 2010

There are several new codes* that became effective as of January 1, 2010 that should be noted by endovascular and interventional practices. Basic guidance for use of these codes is provided in this article. More detailed guidance can be found through your specialty society.

AV Dialysis Fistulagram Codes

- 36147: Fistulagram, includes needle/catheter placement, all imaging from arteries just proximal to arterial anastomosis through cava.
- +36148: Second puncture or catheterization of dialysis arteriovenous (AV) access when needed for intervention.
- 75791: AV dialysis fistulagram, radiological supervision and interpretation only.

The codes previously used for reporting AV dialysis fistulagraphy have been retired, and new codes have been created. The new fistulagram code includes both the surgical and the radiological components of work, and most fistulagrams will now be reported with a single code, 36147. Code 36148 is an add-on and will not be recognized unless it is reported with 36147. Code 36148 is to be used when a second puncture of the AV dialysis access is performed, typically in order to complete an intervention. Code 75791 describes the work of radiological supervision and interpretation only for a fistulagram, and this would be used in instances when a direct puncture/catheterization of the AV dialysis access is not used to perform the fistulagraphy. Examples of appropriate use of 75791 include:

1. Interpretation of an operative fistulagram being reported by a radiologist who had not actually performed the fistulagraphy;
2. Performance and interpretation of fistulagram obtained through a needle that had been previously placed in dialysis;
3. Performance and interpretation of a fistulagram obtained as part of an upper extremity arteriography, with access to the vessel achieved by femoral artery catheterization.

Sacroplasty

- 0200T: Sacroplasty, unilateral, including use of a balloon or mechanical device.
- 0201T: Sacroplasty, bilateral, including use of a balloon or mechanical device, two or more needles.

These codes are Category III Current Procedural Terminology (CPT) codes, meaning that they are codes for developing technology that does not have enough research or literature documentation of their effectiveness to qualify for Category I CPT codes. These Category III codes should be used when reporting sacroplasty, but they have not undergone the valuation process and may not be paid without some negotiation and communication with your carrier.

The imaging guidance for these procedures is coded with existing CPT codes.

- 72291: Fluoroscopic guidance for vertebroplasty/sacroplasty, radiological supervision and interpretation.
- 72292: Computed tomography (CT) guidance for vertebroplasty/sacroplasty, radiological supervision and interpretation.

Pleural Therapies

- 32560: Instillation, via chest tube/catheter, agent for pleurodesis (eg, talc for recurrent or persistent pneumothorax).
- 32561: Instillation(s), via chest tube/catheter, agent for fibrinolysis; initial day.
- 32562: Subsequent day.
- 32552: Removal of indwelling tunneled pleural catheter with cuff.

Cardiac Imaging

Several new codes are now available for cardiac imaging; however, coverage may still be limited. You will need to check with your carrier to determine if these specific services are covered.

- +75565: Cardiac magnetic resonance imaging (MRI) for velocity flow mapping (add-on code, to be used with basic service code).
- 75571: CT, heart, without contrast, with coronary calcium evaluation.
- 75572: CT, heart, with contrast, for evaluation of cardiac structure and morphology (includes three-dimensional postprocessing, assessment of cardiac function, and evaluation of venous structures if performed).
- 75573: CT, heart, with contrast, for evaluation of cardiac structure and morphology, congenital heart disease (includes three-dimensional, left ventricle cardiac function, right ventricle structure and function, and evaluation of venous structures if performed).
- 75574: CT angiography, heart, coronary arteries and bypass grafts, with contrast, including evaluation of cardiac structure/morphology, assessment of cardiac function, and evaluation of venous structures if performed.

Fiducial Marker Placement

Two new codes are available to report percutaneous placement of fiducial markers for radiation therapy guidance. They describe two anatomical areas and should be used with the appropriate imaging guidance code.

- 49411: Percutaneous placement of interstitial device(s) for radiation therapy guidance, intra-abdominal, intrapelvic (except prostate), and/or retroperitoneum, single or multiple.
- 32553: Percutaneous placement of interstitial device(s) for radiation therapy guidance, intrathoracic, single or multiple.

Facet Injections

- 64490: Injections (diagnostic or therapeutic), paravertebral facet joint, with imaging guidance (fluoroscopic/CT), cervical or thoracic; single level.
  - +64491: Second level.
  - +64492: Third and any additional levels.
- 64493: Injection(s) (diagnostic or therapeutic), paravertebral facet joint, with imaging guidance (fluoroscopic/CT), lumbar or sacral; single level.
  - +64494: Second level.
  - +64495: Third and any additional levels.

CHANGE IN REPORTING DIALYSIS ACCESS ANGIOPLASTY

The Centers for Medicare & Medicaid Services (CMS) has also made changes in its policies for CPT coding for dialysis access management. CMS created G-codes for percutaneous transluminal angioplasty (PTA) of dialysis access several years ago (G0392, G0393). The 2010 Physician Fee Schedule inactivates those G-codes, and they can no longer be used. PTA for dialysis access should again be reported with CPT codes.

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- 35476, 75978: Venous angioplasty, surgical and radiological components.
- 35475, 75962: Brachiocephalic arterial angioplasty, surgical and radiological components.

Correct Coding Initiatives edits will not allow reporting of both arterial and venous angioplasty at the same time. PTA should be reported as venous angioplasty anywhere from the periarterial anastomosis through the axillary vein and should be reported only once for this segment, which is classified as a single "vessel," thus including all angioplasties performed within this segment. If a true arterial anastomotic stenosis is treated with angioplasty, it may be coded as 35475/75962, but these codes should then be used to include any and all PTA performed in the AV dialysis access "vessel" from the arterial anastomosis through the venous anastomosis and outflow to the axillary vein.

MODIFICATIONS IN EXISTING CPT CODES

In addition, modifications of note were made to several existing codes. These codes were modified and now include moderate sedation. Sedation codes should no longer be additionally reported with these services.

- 50200: Percutaneous renal biopsy.
- 36481: Percutaneous portal vein catheterization, any method.
- 47525: Change of percutaneous biliary drainage catheter.
- 47382: Radiofrequency ablation (RFA), one or more liver tumor(s), percutaneous.
- 37183: Revision of transjugular intrahepatic portosystemic shunt (TIPS).
- 22520: Vertebroplasty, thoracic.
- 22521: Vertebroplasty, lumbar.

ADDITION OF PRACTICE EXPENSE VALUES TO SUPPORT NONFACILITY PROCEDURES

Several codes were modified, now having additional practice expense value that will support these services

to be provided in a nonfacility, freestanding, or office environment. All four of these procedures now have additional practice expense payment that covers the technical expenses of performance of these services in a freestanding office/laboratory.

- 50200: Percutaneous renal biopsy.
- 47382: RFA, > one liver tumor, percutaneous.
- 36481: Percutaneous portal vein catheterization.
- 37183: Revision of TIPS.

CHANGE IN METHODOLOGY TO CALCULATE PRACTICE EXPENSE

In addition to the above good news regarding practice expense valuation, there are other changes in practice expense that will result in decreased payments. These decreases will affect freestanding centers more than facility-based practices because the practice expense payment for physicians is typically very small for hospital-based procedures. The technical component payment for much of the procedure is in the practice expense value for freestanding/office-based procedures, and this is where most of the payment for equipment, staff, and devices is found. The decreases that will be seen this year result from a change in the methodology CMS uses for calculating the practice expense. These changes will be phased in during the next 4 years, and the decreases affect interventional/endovascular procedures by a higher percentage than the average decrease for all medical services described in the Physician Fee Schedule.

CHANGE IN EQUIPMENT UTILIZATION RATE

Further reductions in pay were proposed based on recalculation of equipment utilization rates. However, for interventional/endovascular practices, many of these reductions were limited or reversed, meaning that the decreases in payments that would have resulted from this policy change were less than originally predicted. CMS has changed the equipment utilization rate assumed for diagnostic equipment costing > $1 million. They now assume that diagnostic imaging equipment is in use 90% of the time (vs 50% through 2009), which results in reduction of the payment for individual procedures. Angiographic equipment was carved out of this determination, because it is used for therapeutic rather than diagnostic purposes, and the reductions were not applied to procedures performed using angiographic equipment. Therefore, reimbursement for freestanding procedures performed with angiographic equipment will not be affected. General x-ray/fluoroscopy, ultrasound, CT, and MR will all be affected by this policy change, and imaging centers will see some reductions in payment for these services.

CHANGE IN CODING FOR CONSULTATIONS

For physicians providing Evaluation and Management services for Medicare patients, changes to coding and payment for consultation services went into effect January 1, 2010. CMS has determined that they will not pay for consultation Evaluation and Management codes.

- 99241–99245: Office or other outpatient consults.
- 99251–99255: Inpatient consultations.

They will pay for consultation services, but those services should be coded with the CPT code that most accurately defines the service (other than the consultation code).

- 99201–99205: New patient seen in office or outpatient setting.
- 99221–99223: New or established patient—inpatient hospital care.

CHANGES ON THE HORIZON

Beginning in 2011, more extensive changes to coding of endovascular and interventional procedures are expected. There is increasing pressure to bundle services, including endovascular procedures. There is a strong push to create more comprehensive CPT codes and to decrease the use of component coding whenever possible. These changes will almost certainly result in a significant decrease in payment for these procedures. One very important way to help yourself and your practice is to respond thoughtfully and carefully if asked to fill out RUC surveys for your society. RUC stands for the Relative-Value Update Committee of the American Medical Association (AMA) and is the body that determines valuation for all CPT codes. These values are driven by data contributed by physician experts (you), through a rigorous survey process. Although daunting and time-consuming, completing these surveys is the best way to receive a fair valuation for a code. ■

**CPT codes are copyrighted by the AMA, so the exact descriptors are not included in this text. Please see the 2010 CPT Manual for full descriptors.*

Katharine L. Krol, MD, is Director of Vascular and Interventional Radiology at Clarian Arnett Health in Lafayette, Indiana.

CONTACT US

Send us your thoughts via e-mail to letters@bmctoday.com.