

Insurance and Compensation Committee

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Practitioners and facilities ordering and performing CT, CTA, MRI, MRA, Cardiac Nuclear and PET procedures.

Please be informed that RadConsult™, the radiology management program slated to go live on 4/4/2011 has been put on hold. All scheduled training webinars have been cancelled. A new start date for radiology management implementation has not been established at this time. Please monitor this Website for further updates.

Information for Providers

- ? New York State Medicaid Program is preparing to implement a radiology management program to ensure that beneficiaries receive the most clinically appropriate imaging studies. The program will be applied to outpatient non-emergency advanced imaging procedures, for fee-for-service beneficiaries.
- ? Beneficiaries who are eligible for both Medicaid and Medicare (dual eligible) or beneficiaries who are enrolled in a managed care plan are not included.
- ? RadConsult™, administered by HealthHelp, is a consultative, educational program that improves quality and reduces the cost of care by providing expert peer consultation and the latest evidence-based medical criteria for diagnostic imaging. It provides access to consultations with subspecialists affiliated with academic radiology departments.
- ? Providers must be enrolled in New York State Medicaid Fee for Service

Information for Radiology Providers

- If you are performing a CT, CTA, MRI, MRA, Cardiac Nuclear, or PET procedure, you must verify that an approval has been obtained before performing these diagnostic imaging services for New York Medicaid FFS. **Approvals will be required for claims payment.** Failure to obtain an approval number may delay or prevent payment of a claim.

Medicaid Fee schedule for Radiology:

Effective Date: January 1, 2011

<http://www.emedny.org/ProviderManuals/Physician/PDFS/Physician Manual Fee Schedule Sect4.xls>

Empire BlueCross BlueShield

2011 Benefit Changes for the Federal Employee Program: Standard and Basic Option

IMRT – no prior approval is needed for outpatient intensity-modulated radiation therapy related to the head, neck, breast or prostate cancer.

Revised Medical Policies Effective – 01-12-2011

(The following policies were revised to expand medical necessity indications or criteria.)

RAD.00002 - Positron Emission Tomography (PET) and PET/CT Fusion

(The following policies were reviewed and had no significant changes to the policy position or criteria.)

RAD.00004 - Peripheral Bone Mineral Density Measurement

RAD.00015 - Proton Beam Radiation Therapy

RAD.00029 - CT Colonography (Virtual Colonoscopy) as a Screening or Diagnostic Test for Colorectal Cancer

RAD.00037 - Whole Body CT Scanning

RAD.00043 - CT Scans with or without Computer Assisted Detection (CAD) for Lung Cancer Screening

RAD.00047 - Neutron Beam Radiotherapy

RAD.00058 - Real-Time Intra-Fraction Target Tracking During Radiation Therapy

Revised Medical Policies Effective – 03-04-2011

RAD.00011 - Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for

Treating Primary or Metastatic Liver Tumors

RAD.00014 - Brachytherapy for Oncologic Indications

RAD.00033 - Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors (i.e., SIR-Spheres and TheraSpheres)

RAD.00049 - Low Field and Conventional Magnetic Resonance Imaging (MRI) for Screening, Diagnosing and

Revised Medical Policies Effective 05-21-2011

(The policies below might result in services that were previously covered but may now be found to be either not medically necessary and/or investigational.)

RAD.00014 - Brachytherapy for Oncologic Indications

RAD.00033 - Selective Internal Radiation Therapy (SIRT) of Primary or Metastatic Liver Tumors (i.e., SIR-Spheres and TheraSpheres)

RAD.00041 - Intensity Modulated Radiation Therapy (IMRT) (Note: claims reporting IMRT will be reviewed

regardless of the diagnosis reported, including prostate, thyroid cancers and CNS lesions. The new criteria will

apply to claims for members starting a new course of treatment for prostate and thyroid cancers and for CNS lesions

on or after 5/21/11.)

RAD.00057 - Near-Infrared Coronary Imaging and Near-Infrared Intravascular Ultrasound Coronary Imaging

Oxford/ United Healthcare

Medicare Policy Change for Positron Emission Tomography (PET) Scans Performed at National Oncologic PET Registry (NOPR) Facilities for Coverage with Evidence (CED) Trials

Consistent with CMS policy, UnitedHealthcare is no longer covering PET scans through NOPR CED trials. Providers should bill their local carriers and intermediaries, who will make payments on behalf of Medicare Advantage organizations directly to providers of the PET scan, on a FFS basis. This policy change does not apply to UnitedHealthcare commercial products.

UnitedHealthcare will continue to maintain denials of these PET scans under CED trials if they are not performed at a NOPR facility.

Breast Imaging for Screening and Diagnosing Cancer Medical Policy – Additional Clarification

The summary of changes made to the medical policy for **Breast Imaging for Screening and Diagnosing Cancer** was communicated to the provider community in the November 2010 UnitedHealthcare **Network Bulletin** (Vol. 40). The updated medical policy was effective Jan. 1, 2011. We have received numerous inquiries regarding the interpretation and application of this policy. Therefore, **we would like to provide additional clarification about this medical policy.**

- The statement in the summary of changes provided in the November 2010 **Network Bulletin** that reads "Remove the coverage rationale for the following screening/imaging technologies: Digital mammography, breast ultrasound & computer-aided detection (CAD) for mammography," means that these imaging procedures are proven and therefore are not subject to UnitedHealthcare's coverage review process.

- CAD is unproven as an aid for radiologists to interpret contrast-enhanced magnetic resonance imaging (MRI) of the breast and as an aid for radiologists to detect breast cancer with ultrasound. As such, these procedures will continue to be subject to a coverage review. Again, please note that CAD for mammography, as contrasted with MRI, is proven and not subject to coverage review. Read the Breast Imaging for Screening and Diagnosing Cancer Medical Policy on UnitedHealthcareOnline.com.

Proton Beam Radiation Therapy – Revised Medical Policy

UnitedHealthcare has recently revised its medical policy on Proton Beam Radiation Therapy (PBT) and determined that PBT is proven for the treatment of arteriovenous malformations (AVMs) and melanoma of the uveal tract. PBT is equivalent to but not superior to other forms of external beam radiation therapy for the treatment of intracranial and skull base tumors, spinal cord tumors and prostate cancer.

Members having one of these conditions and obtaining services from a participating provider will be eligible for in network benefits. View the PBT policy on UnitedHealthcareOnline.com for additional clinical details and benefit considerations.

REVISED		
Policy Title	Summary of Changes	Revised Coverage Rationale
<p>Radiology Multiple Imaging Reduction Policy/Policy Revision to Eliminate Eleven Diagnostic Imaging Families</p> <p><i>The revised policy is effective Second Quarter 2011.</i></p>	<p>Effective with claims submitted with a date of service on or after June 1, 2011, UnitedHealthcare will adopt the changes in the CMS 2011 multiple imaging reduction payment policy. With this revision, UnitedHealthcare will align with the CMS's multiple imaging payment methodology and treat the services as if they were from a single diagnostic imaging family. The 50 percent imaging reduction will be applied to the allowable amount for the technical component of multiple imaging procedures reported in the same patient session that are considered second and/or subsequent. These changes will apply to all codes that have a CMS multiple procedure indicator of 4 on the CMS National Physician Fee Schedule (NPFS).</p>	<p>UnitedHealthcare's Radiology Multiple Imaging Reduction Policy is sourced to the CMS NPFS. The NPFS multiple procedure indicator 4 denotes which procedures apply for the multiple imaging reduction concept.</p> <p>Historically, the NPFS categorized each procedure into one of eleven diagnostic imaging families. These families were based on contiguous body area and the imaging modality utilized. A reduction was applied to the technical component only when multiple imaging procedures when performed in the same diagnostic imaging family. An imaging reduction was not applied if two or more procedures reported were not from the same diagnostic imaging family.</p> <p>Effective Jan. 1, 2011, CMS amended its 2010 policy (1) to expand the imaging payment reduction to the technical component of nine additional codes and (2) to eliminate the use of the eleven diagnostic imaging families so that all codes with a multiple procedure indicator of 4 are treated as if they are from the same family. With this change, CMS applies the multiple imaging reduction to multiple CT, MRI and ultrasound services performed in the same session without regard to whether the subsequent images involve the same imaging modality or a contiguous body area.</p> <p>Currently, when multiple procedures within the same diagnostic imaging family are performed during the same patient session, by the same physician or health care professional, UnitedHealthcare reduces the technical component portion of all second and subsequent procedures by 50 percent.</p> <p>For claims submitted with a date of service prior to June 1, 2011, UnitedHealthcare will continue to process the multiple imaging reductions according to the CMS 2010 multiple imaging reduction methodology, which uses the 11 diagnostic imaging families. Since the 11 diagnostic imaging families CMS utilized in 2010 did not include the nine new codes added by CMS in 2011, no imaging reductions will be applied to those codes for dates of service submitted with a date of service prior to June 1, 2011.</p>

Aetna's Multiple Procedure Reduction Policy Impacts Technical and Global Payments

For dates of service on or after February 1, 2011, Aetna implemented a new claims payment policy whereby reimbursement for second and subsequent computed tomography, magnetic resonance imaging, or ultrasound studies on the same date of service will be reduced by 50 percent. Aetna based this policy on the Centers for Medicare and Medicaid Services (CMS) multiple procedure reduction policy for diagnostic imaging procedures.

The Aetna policy differs from the CMS policy in that the reduction will apply to global charges, as well as technical charges, for facility and medical claims, including independent radiology centers for scans performed on contiguous body areas. The reduction does not apply to professional fees billed separately and claim lines billed with modifier 59. As such, please note that in order to avoid a 50 percent cut to the professional component for second and subsequent studies you must submit separate claims for technical and professional fees. Aetna contracts may not allow for such separate billing, therefore, carefully check your contract language prior to altering your billing practices.

In a [letter to Aetna](#), the ACR and Radiology Business Management Association strongly objected to Aetna's multiple imaging procedure discount policy being applied to global charges, and requested that any such discounting policy apply solely to the technical component. The letter also questioned the appropriateness of the 50 percent discount on the technical component and stated that actual economies of scale amount to much less than 50 percent. The ACR will continue to vigorously fight this new policy. If you have any questions, please contact Kathryn Keysor at 1-800-227-5463 extension 4950 or kkeysor@acr.org.

Emblem Health GHI HIP

Nothing new for Radiology/RT

Coding

Corrected NCCI Edits To Be Published April 1, 2011 in Version 17.1

Forty (40) National Correct Coding Initiative (NCCI) edits affecting nuclear medicine were implemented incorrectly on January 1, 2011. The Centers for Medicare & Medicaid Services (CMS) will be correcting these edits in their next update, Version 17.1, scheduled for implementation April 1, 2011.

In the meantime, CMS requests that providers refrain from submitting claims for these procedures until after April 1, 2011. After that date, providers may appeal, as well as resubmit or reopen, any previously denied claims. The corrections for the following code pairs will be *retroactive* to January 1, 2011:

Column 1 Code	Column 2 Code	Current Modifier Indicator (Incorrect) January 1, 2011	Corrected Modifier Indicator April 1, 2011
79005	78000-78018	0	1
79101	78201-78223	0	1
79101	78300-78320	0	1
79101	78800-78804	0	1
79101	78808	0	1
79101	78811-78816	0	1
79200	78291	0	1
79403	78803-78804	0	1
79445	78803-78804	0	1

CMS releases NCCI updates quarterly. If you wish to view the most current file of NCCI edits, please visit: http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp

The Food & Drug Administration recently approved equipment used for digital breast tomosynthesis. How is digital breast tomosynthesis coded?

Currently, there is no CPT code that accurately describes a digital breast tomosynthesis study. Until a code is created, it would be appropriate to report the unlisted diagnostic procedure code 76499. It is not appropriate to report a three-dimensional reconstruction code in conjunction with a full-field digital mammography code.

Sources:
Radiology Coding Alert
The ACR Radiology Coding Source
Carrier bulletins and websites