REGULATORY CHANGES AFFECTING RADIOLOGY AND RADIATION ONCOLOGY IN 2013

CMS, the Centers for Medicare and Medicaid Services, annually computes and publishes the physician fee schedule for payment of services under the Medicare program. For 2013 the conversion factor used to convert Relative Value Units (RVU) into the actual fee schedule will be $34.023, a decrease from the conversion factor used in 2012 of only 0.043% as a result of the American Taxpayer Relief Act of 2012 (ATRA) that averted the originally planned 26.5% cut in the conversion factor.

Even with a conversion factor that is virtually unchanged, there are other modifications within the Medicare system that affect the level of payment for individual procedures. For each of Diagnostic Radiology, Interventional Radiology and Nuclear Medicine there will be a 3% decrease in total allowed charges; Radiation Oncology will face a 7% decrease, while Radiation Therapy Centers face a 9% decrease. These changes come from various adjustments within the Relative Value Unit (RVU) system, and include:

- Completion of the 4-year phase-in of data gathered from the Physician Practice Information Survey that affects the Practice Expense portion of the RVUs. This represents 2% of the 3% decrease for radiology and 4-5% of the 7-9% decrease for radiation oncology/therapy centers.
- Revised assumptions as to the rate of interest practices pay to acquire equipment. This accounts for the other 1% of the radiology decrease and it represents 5% of the 9% decrease for radiation therapy centers.
- The effect of new and revised codes, the Multiple Procedure Payment Reduction (MPPR), and other factors. In actual practice, the effect of the MPPR and other changes discussed below are specific to an individual practice and cannot be measured here.

For imaging centers in 2014, the Practice Expense portion of the RVU calculation will be further impacted by another section of the ATRA that changes the assumptions about the utilization of CT and MRI equipment. The new assumption will be that this equipment is utilized 90% of the time, thereby increasing the volume of services provided and lowering the downtime that Medicare includes as a cost of doing business in imaging centers. The Radiology Business Management Association (RBMA) estimates that this will result in a 10% decrease in the Technical Component reimbursement for CT and MRI services beginning in 2014.

Coding, Valuation, Bundling

Radiology
CMS continually evaluates procedures and codes to determine if they are appropriately valued. Among the codes reviewed were x-ray examinations of the lumbosacral spine, pelvis and abdomen; Nuclear Medicine thyroid and parathyroid imaging; CT of the abdomen and CTA of the abdomen and pelvis; and MRI of the upper extremity. Some, but not all, of the reviewed codes were changed.

The majority of new codes established for 2013 are applicable to Interventional Radiology and pertain to head and neck catheterizations. In addition, four new all-inclusive codes have been established for transcatheter thrombolysis and four new codes have been defined for thoracentesis and chest insertion.

For nuclear medicine, three new codes were established for thyroid uptake and imaging. In addition, two new parathyroid codes have been established to capture new technology inclusive for planar imaging with tomographic (SPECT) and CT for anatomical localization. The list of code deletions, revisions and new additions for Radiology is provided in Appendix 1.

Radiation Oncology
CMS will be working with radiation oncologists to create bundled payments for certain services, but that project is not yet completed, and bundling is not in effect for 2013. Payment for IMRT Treatment Delivery (CPT 77418) will be reduced by 15% from the 2012 level, and payment for SBRT Treatment Delivery (CPT 77373) will be reduced by 20%. Payment for IMRT Planning (CPT 77301) will be increased slightly by 1.89% globally and 0.58% for the PC. Beginning April 1, 2013, hospitals will see a decline in their technical component reimbursement for stereotactic radiosurgery of cranial lesions when Cobalt-60 is used (HCPCS 77371), as this payment will be limited to the lower amount that is paid for linear accelerator treatment (HCPCS G0173). This limitation will not affect the professional component or the TC at freestanding centers.

HOPPS CAP Procedures
Since 2005 Medicare has limited payment for the technical component (TC) of certain procedures under the physician fee schedule to the amount that is paid under the Hospital Outpatient Prospective Payment System (HOPPS). For 2013, there are 22 codes that have been added to the list, including DXA, thyroid imaging and catheter placement; 17 codes were deleted. The list of added and deleted codes is provided in Table 1.

Multiple Procedure Payment Reduction (MPPR)
In 2006 Medicare began reducing payment for multiple diagnostic imaging procedures considered to be advanced imaging services (CT, MRI and Ultrasound) performed on a patient in a single session, known as the Multiple Procedure Payment Reduction (MPPR) policy. Initially the MPPR applied only to the technical

component (TC) of payments, but in 2012, it was expanded to include the professional component (PC) of services.

Beginning in 2013, the reduction of the professional component will be further expanded to include the services of any member of a group practice (i.e., under the same group NPI number) who performed a second or subsequent advanced imaging exam for the same patient in the same session. There is great debate as to what constitutes a 'session' for this purpose, and CMS has not clarified this definition. CMS is considering modifying the MPPR policy to procedures furnished on the same day, rather than the same session, but this is still under consideration.

Medicare will allow the full amount of the PC for the highest-paid advanced imaging service and reduce the fee for each additional service by 25% when these services are performed within the same group practice within the same session. The same rule applies to the TC of these services, but the fee for subsequent procedures is reduced by 50%.

The MPPR methodology has applied to certain diagnostic nuclear medicine procedures as far back as 1995 with a 50% reduction of the Technical Component (TC) for the second and subsequent procedures. However, due to a technical error, the MPPR for the TC has not been applied to CPT code 78306 (Bone imaging; whole body) when followed by CPT code 78320 (Bone imaging; SPECT); this will be corrected in 2013.

Finally, CMS has extended the MPPR policy to include a 25% reduction of the TC of diagnostic cardiovascular services in addition to the cardiac CT and MRI procedures that were already subject to the rule. The list of procedures includes interventional procedures, cardiac nuclear medicine, and vascular ultrasound (Doppler). The list of diagnostic cardiovascular services subject to this rule is provided in Table 2.

<u>Place of Service (POS) Reporting and Payment</u>

CMS has issued rules for reporting the place of service on Medicare claims beginning April 1, 2013. These rules determine both the POS Code to be used on the claim as well as the entry of the physical address of the services. The place of service (POS) code should reflect the location where the patient was actually seen – the point of 'face-to-face' contact – with an exception for registered hospital inpatients sent outside for services. When billing the professional component for hospital patients, one should use the appropriate code for the hospital department (Emergency Department, Outpatient Department, or Inpatient) where the patient had face-to-face contact for the exam, regardless of the physician's location while providing the interpretation. In an imaging center or physician office, the Office POS code is used.

The rules also require that the physical address where the services were performed be entered on claims. Radiologists often do not have direct contact with the patient. The address entered will determine the fee schedule to be used based upon its

payment locality. Practices located near the border of payment localities should be aware of the payment levels in each in order to avoid unintended lower payments or to take advantage of higher payment levels.

When the billing entity providing the PC is different from the one providing the TC, e.g., hospital patients, modifier -26 is used and the location (address and zip code) of the interpreting physician is reported. Global billing, indicating the site of patient face-to-face contact, is used when the interpreting physician is a part of the same billing entity as the imaging center *and* when the physician's location while providing the interpretation is in the same payment locality. However, if the interpretation takes place in a different payment locality, split PC/TC billing (using modifier -26 for the PC) must be used with the location of each component reported separately.

An unusual or infrequent location, such as a hotel, is not to be used; instead, the address of the physician's most common practice location is to be used. Many radiologists are able to interpret images from their homes. If used on a regular basis, this could be considered a common practice location, and there is some concern in the radiology community that home addresses will be accessible to patients who might receive copies of claim forms. The Radiology Business Management Association reports that CMS is discussing this issue. There is also concern that practice management systems will not be able to accurately track the actual location of interpretations. Practices have until April 1, 2013 to determine how they will cope with these newly revised regulations.

Quality Measures

Since 2007, the Physician Quality Reporting System (PQRS) has provided an incentive payment to physicians who satisfactorily report data on quality measures for services to Medicare patients. Physicians can earn 0.5% or 1.0% of their Medicare Part B allowed charges in 2013 and 2014 (0.5% for successful participation in reporting clinical quality measures and an additional 0.5% for successfully completing a qualified maintenance of certification program practice assessment).

Beginning in 2015, PQRS is shifting from a bonus program to a penalty program. Physicians who do not successfully report on the clinical quality measures will suffer a 1.5% reduction in Medicare payments; in 2016, the penalty will become 2%. ***CMS will use 2013's PQRS reporting as the basis for determining the penalty to be applied in 2015!*** It is imperative for practices to be sure they are reporting PQRS measures accurately in the coming year.

In addition to the standard claims submission process, practices will now have the option to report PQRS data via their EHR system. This option provides for alignment of PQRS measures with criteria for meeting the Clinical Quality Measure (CQM) component of meaningful use for the CMS EHR Incentive Program. They also have

the option of reporting through a CMS-qualified PQRS Registry. The EHR-system option for submission can either be directly to CMS or through a vendor. The Group Practice Reporting Option (GPRO) will be available to groups as small as two (2) physicians. At this time we do not have final information about the list of clinical quality measures for 2013 but it appears that Measure #10 (Stroke/Stroke Rehabilitation: CT and MRI Reports) will be eliminated and a few new measures may become available. PQRS Measures will be aligned with the six domains of the National Quality Strategy used in the EHR Incentive Program.

Electronic Health Records

Meaningful Use of Electronic Health Records (EHR) is currently an incentive program for practices that choose to enroll; however, in 2015 it will become a requirement for receiving full Medicare payments similar to the change to the PQRS program. CMS has indicated that there is a Hardship Exception for radiologists since they generally lack face-to-face patient interactions and are not typically engaged in follow-up care. This exception will allow radiologists to avoid the payment reduction resulting from not adopting a certified EHR system and reporting meaningful use.

It is expected that the exception will be automatic, but an application may have to be filed by the July 1, 2014 exception deadline. The exception is likely to be temporary (up to 5 years) as the program matures, but it will give physicians and hospitals more time to bring all services into their EHR system. When deciding whether to participate in the EHR Meaningful Use program, all radiologists - including office-, imaging center-, and hospital-based - should consider the incentive benefits and their ability to support the requirements versus the eventual penalties.

The hardship exception *will not* apply to radiation oncologists as they do not meet the "lack of face-to-face contact with patients" or the "lack of need for follow-up care" criteria defined in the exception. However, another hardship exception approved as part of Meaningful Use Stage 2 will apply to eligible professionals, including radiation oncologists, who do not have control over their information technology. For example, a hospital-located radiation oncology group could file for an exception if (1) 50% or more of their services are provided in a hospital setting, (2) they are required to use their hospital's Oncology Information System and (3) it is not certified for meaningful use.

Other

- CPT coding changes take place annually. We have included an Appendix that lists radiology-applicable codes that have been deleted, modified and added for 2013.
- The Office of the Inspector General (OIG) has indicated that one of its areas of focus for 2013 will be a review of high-cost diagnostic radiology tests to determine whether they were medically necessary and the extent to which the same tests are ordered by primary care physicians and physician

specialists for the same treatment. The OIG will also be looking at the practice expenses related to imaging services.

- The use of ICD-10 for diagnosis coding will be required as of October 1, 2014. Implementation will require that coders be trained and systems are updated to accept the new codes.

Action Steps

Having identified all of this information, your billing department or outsourced billing partner should undertake the following actions to better understand the impact of these changes on your business:

1. Estimate the overall effect of the final 2013 Medicare Physician Fee Schedule on your practice using a volume-weighted analysis. The analysis should evaluate procedures that are capped at the HOPPS level and those where payment is limited by the MPPR.
2. While we don't know how commercial insurers will use the changes Medicare has implemented, review your contracts that may have pricing tied to the current year Medicare fee schedule and calculate the effects.
3. Review the CPT coding changes for 2013 so that you can make the appropriate changes in your departmental information systems (and any printed documents) that might be affected.
4. Stay posted regarding the newly proposed Place of Service rule (New rules effective April 1, 2013) so that you can proactively:
    a. Identify the capability of your systems to capture accurate location information and begin to make changes if necessary.
    b. Determine when global or split billing is appropriate in your practice.
    c. Evaluate image transfer procedures to get the maximum reimbursement.
5. Ensure you are capturing and reporting PQRS measures accurately.
6. Identify what education is needed to address the issue of medical necessity and proper ordering.
7. Evaluate the pros & cons of participation in the EHR Meaningful Use Program (incentives, penalties, technology needs, etc.) and in what timeframe. If you choose not to participate, watch for information as to how to file for a hardship exception by July 1, 2014.
8. Develop a plan to become compliant with ICD-10 by October 1, 2014.

TABLE 1: Additions and Deletions to the List of Procedure Subject to the OPPS CAP on Imaging Services

ADDITIONS		DELETIONS	
Code	**Descriptor**	**Code**	**Descriptor**
31620	Endobronchial us add-on	71040	Contrast x-ray of bronchi
36221	Place cath thoracic aorta	71060	Contrast x-ray of bronchi
36222	Place cath carotid/inom art	75650	Artery x-rays head & neck
36223	Place cath carotid/inom art	75660	Artery x-rays head & neck
36224	Place cath carotid art	75662	Artery x-rays head & neck
36225	Place cath subclavian art	75665	Artery x-rays head & neck
36226	Place cath vertebral art	75671	Artery x-rays head & neck
36227	Place cath xtrnl carotid	75676	Artery x-rays neck
36228	Place cath intracranial art	75680	Artery x-rays neck
43206	Esoph optical endomicroscopy	75685	Artery x-rays spine
43252	Upper GI optical endomicroscopy	75900	Intravascular cath exchange
77080	DXA bone density axial	75961	Retrieval broken catheter
77082	DXA bone density vert fx	77424	Intraoperative radiation delivery
78013	Thyroid imaging w/ blood flow	78006	Thyroid imaging with uptake
78014	Thyroid imaging w/ blood flow	78007	Thyroid image mult uptakes
78070	Parathyroid planar imaging	78010	Thyroid imaging
78071	Parathyroid planar imaging w/o subtrj	78011	Thyroid imaging with flow
78072	Parathyroid imaging w/ spect & ct		
88375	Optical endomicroscopy interp		
91110	GI tract capsule endoscopy		
91111	Esophageal capsule endoscopy		
92287	Internal eye photography		

TABLE 2: Diagnostic Cardiovascular Services Subject to the Multiple Procedure Payment Reduction - MPPR

75600	Contrast x-ray exam of aorta
75605	Contrast x-ray exam of aorta
75625	Contrast x-ray exam of aorta
75630	X-ray aorta leg arteries
75658	Artery x-rays arm
75705	Artery x-rays spine
75710	Artery x-rays arm/leg
75716	Artery x-rays arms/legs
75726	Artery x-rays abdomen
75731	Artery x-rays adrenal gland
75733	Artery x-rays adrenals
75736	Artery x-rays pelvis
75741	Artery x-rays lung
75743	Artery x-rays lungs
75746	Artery x-rays lung
75756	Artery x-rays chest
75791	Av dialysis shunt imaging
75809	Nonvascular shunt x-ray
75820	Vein x-ray arm/leg
75822	Vein x-ray arms/legs
75825	Vein x-ray trunk
75827	Vein x-ray chest
75831	Vein x-ray kidney
75833	Vein x-ray kidneys
75840	Vein x-ray adrenal gland
75842	Vein x-ray adrenal glands
75860	Vein x-ray neck
75870	Vein x-ray skull
75872	Vein x-ray skull
75880	Vein x-ray eye socket
75885	Vein x-ray liver
75887	Vein x-ray liver
75889	Vein x-ray liver
75891	Vein x-ray liver
75893	Venous sampling by catheter
78428	Cardiac shunt imaging
78445	Vascular flow imaging
78451	Ht muscle image spect sing
78452	Ht muscle image spect mult
78453	Ht muscle image planar sing
78454	Ht musc image planar mult
78456	Acute venous thrombus image
78457	Venous thrombosis imaging
78458	Vein thrombosis images bilat
78466	Heart infarct image
78468	Heart infarct image (ef)
78469	Heart infarct image (3D)
78472	Gated heart planar single
78473	Gated heart multiple
78481	Heart first pass single
78483	Heart first pass multiple
78494	Heart image spect
93000	Electrocardiogram complete
93005	Electrocardiogram tracing
93015	Cardiovascular stress test
93017	Cardiovascular stress test
93024	Cardiac drug stress test
93025	Microvolt t-wave assess
93040	Rhythm ECG with report
93041	Rhythm ecg tracing
93224	Ecg monit/reprt up to 48 hrs
93225	Ecg monit/reprt up to 48 hrs
93226	Ecg monit/reprt up to 48 hrs
93229	Remote 30 day ecg tech supp
93268	ECG record/review
93270	Remote 30 day ecg rev/report
93271	Ecg/monitoring and analysis
93278	ECG/signal-averaged
93279	Pm device progr eval sngl
93280	Pm device progr eval dual
93281	Pm device progr eval multi
93282	Icd device prog eval 1 sngl
93283	Icd device progr eval dual
93284	Icd device progr eval mult
93285	Ilr device eval progr
93286	Pre-op pm device eval
93287	Pre-op icd device eval
93288	Pm device eval in person

TABLE 2: Diagnostic Cardiovascular Services Subject to the Multiple Procedure Payment Reduction - MPPR (Continued)

93289	Icd device interrogate
93290	Icm device eval
93291	Ilr device interrogate
93292	Wcd device interrogate
93303	Echo transthoracic
93304	Echo transthoracic
93306	Tte w/doppler complete
93307	Tte w/o doppler complete
93308	Tte f-up or lmtd
93312	Echo transesophageal
93314	Echo transesophageal
93318	Echo transesophageal intraop
93350	Stress tte only
93351	Stress tte complete
93701	Bioimpedance cv analysis
93724	Analyze pacemaker system
93784	Ambulatory BP monitoring
93786	Ambulatory BP recording
93788	Ambulatory BP analysis
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study

93888	Intracranial study
93890	Tcd vasoreactivity study
93892	Tcd emboli detect w/o inj
9389	3 Tcd emboli detect w/inj
93922	Upr/l xtremity art 2 levels
93923	Upr/lxtr art stdy 3+ lvls
93924	Lwr xtr vasc stdy bilat
93925	Lower extremity study
93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing

APPENDIX 1: Coding Changes for 2013
Deletions, Changes, Additions

The following codes have been deleted for 2013:

Code	Description	Comment
71040	BRONCHOGRAM UNILATERAL	deleted use 76499-'Unlisted diagnostic radiographic procedure'
71060	BRONCHOGRAM BILATERAL	deleted use 76499-'Unlisted diagnostic radiographic procedure'
75650	ARTERIOGRPHY CERVICOCERBRLARCH	deleted - being bundled into the procedure. Use CPT 36221-36226 **
75660	ANGIO CAROTID/EXTER UNIL SI	deleted to report use 36227 (bundled)
75662	ANGIO CAROTID/EXTER BILAT SI	deleted to report use 36227 (bundled)
75665	ANGIO CAROTID UNILAT SI	deleted to report use 36223, 36224 (bundled)
75671	ANGIO CAROT/CEREB BILAT SI	deleted to report use 36223, 36224 (bundled)
75676	ANGIO CAROT/CERVIC UNILAT SI	deleted to report use 36222, 36224 (bundled)
75680	ANGIO CAROT/CERVIC BILAT SI	deleted to report use 36222, 36224
75685	ANGIO VERT/CERV/CEREB SI	deleted to report use 36225, 36226 (bundled)
75900	EXCHNG PRV PLCD ARTL CATH-THRO	deleted see 37211-37214 (bundled)
75961	PERC FB EXTRACT/VASC	deleted to report use 37197 (bundled)
78000	NM THYROID UPTAKE ONLY	deleted to report use 78012-78014
78001	NM THYROID MULTIPLE DETERMINTN	deleted to report use 78012-78014
78006	NM THYROID SCAN AND UPTAKE	deleted to report use 78012-78014
78007	THYROID IMAGE- MULT UPTAKES	deleted to report use 78012-78014
78010	NM THYROID SCAN ONLY	deleted to report use 78012-78014
78011	THYROID IMAGING W/VASCULAR FLO	deleted to report use 78012-78014

APPENDIX 1: Coding Changes for 2013 (continued)
Deletions, Changes, Additions

Coding Description Changes for 2013:

Code	Old Description	Revised Description
72040	SPINE CERVICAL 2 OR 3 VIEWS	3 views or less
72050	SPINE CERVICAL MIN 4 VIEWS	4 or 5 views
72052	SPINE CERV COMPL INC FLEX/EXT	6 or more views
75896	TRANSCATH THERAPY INFUSION SI	for thrombolysis
75898	ANGIO THRU EXISTING CATHETER	other than thrombolysis
76000	FL-OR FLUORO < 1 HOUR	physician or other qualified health care prof, other than 71023 or 71034 cardiac fluoro
76000	FLUORO UP TO 1 HOUR	physician or other qualified health care prof, other than 71023 or 71034 cardiac fluoro
76000	OR FLUORO UP TO 1HR	physician or other qualified health care prof, other than 71023 or 71034 cardiac fluoro
76001	FLUOROSCOPY- MORE THAN 1 HOUR	physician or other qualified health care prof
76001	OR FLUORO MORE THAN 1HR	physician or other qualified health care prof
76376	ECHO-3D RENDER W/O POSTPROCESS	with image post-processing under concurrent supervision
76376	CT 3D RENDER W/O POSTPROCESS	with image post-processing under concurrent supervision
76377	ECHO-3D RENDER W/POSTPROCESS	requiring image post processing on an independent workstation
76377	CT 3D RENDERING W/POSTPROCESS	requiring image post processing on an independent workstation
76885	US INFANT HIPS DYNAMIC	or other qualified health care professional
76886	US INFANT HIPS LMTD STATIC	or other qualified health care professional
77051	MAMMOGRAM CAD DIAGNSTC ADD-ON	took out word 'physician' review
77052	MAMMOGRAM CAD SCREENING ADD-ON	took out word 'physician' review
78070	NM PARATHYROID SCAN	planar imaging (including subtraction when performed)

APPENDIX 1: Coding Changes for 2013 (continued)
Deletions, Changes, Additions

New Procedural Codes for 2013:	
36221	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, ***and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed***
36222	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation ***and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed.***
36223	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation ***and all associated radiological supervision and interpretation, includes angiography of extracranial carotid and cervicocerebral arch, when performed.***
36224	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation ***and all associated radiological supervision and interpretation includes angiography of the extracranial carotid and cervicocerebral arch, when performed.***
36225	Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation ***and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch when performed.***
36226	Selective catheter placement, vertebral artery, unilateral with angiography of ipsilateral vertebral circulation ***and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed.***
36227	**add on code +** Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation ***and all associated radiological supervision and interpretation.*** (List separately in addition to code for primary procedure)
36228	**add on code +** Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation ***and all associated radiological supervision and interpretation*** (e.g., middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day.
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day.

37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed.
37214	Cessation of thrombolysis including removal of catheter and vessel closure by any method.
32554	Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance.
32555	With imaging guidance.
32556	Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance.
32557	With imaging guidance.
37197	Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g., fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed.
78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed.
78013	Thyroid imaging including vascular flow, (when performed);
78014	Thyroid imaging (including vascular flow, when performed); with single or multiple quantitative measurement(s), (including stimulation, suppression, or discharge, when performed)
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT) and concurrently acquired computed tomography (CT) for anatomical localization

Disclaimer

The information provided with this notice is general reimbursement information only; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. It is always the provider's responsibility to determine and submit appropriate codes, charges, modifiers and bills for the services that were rendered. This information is provided as of January 2, 2013, and all coding and reimbursement information is subject to change without notice. Payers or their local branches may have distinct coding and reimbursement requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer. Third party reimbursement amounts and coverage policies for specific procedures will vary including by payer, time period and locality, as well as by type of provider entity. This document is not intended to interfere with a health care professional's independent clinical decision making. Other important considerations should be taken into account when making decisions, including clinical value. The health care provider has the responsibility, when billing to government and other payers (including patients) to submit claims or invoices for payment only for procedures which are appropriate and medically necessary. You should consult with your reimbursement manager or health care consultant, as well as experienced legal counsel.