

Pre-Op Chest X-Rays

CMS (Medicare) has special requirements for Pre-op chest x-rays performed prior to a surgical procedure. Services that do not meet the Medicare medical necessity criteria are not covered. Pre-op screening alone is not medically necessary. For a pre-op x-ray to be covered, the patient must have a condition or symptom, which requires assessment or reassessment prior to surgery.

Non covered chest x-rays include:

- Tests performed for purposes of screening (e.g. routine exams). CMS considers a test to be screening in the absence of a condition or symptom. A test on a high-risk patient is also consid-

ered screening. These services should be reported with modifier GY—Items or services statutorily excluded or does not meet the definition of any Medicare benefit.

- Tests performed on request of a third party (e.g., nursing home admission chest x-ray, a chest x-ray for insurance eligibility). These services should be reported with modifier 32—Mandated Services: Services related to mandated consultation and/or related services (e.g., Pro, third party payer, government, legislative or regulatory requirements). ■

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Medicare 2008 vs. 2007 Fees

Effective January 1, 2008, Medicare fees for 2008 are lower in some cases despite the 0.5% increase. The 0.5% pay boost is set to expire June 30th. The reduction is due to the relative value units (RVUS) used to calculate payment. This year there was a cut in the work RVU budget adjuster to 0.8806 from 0.8994. It is essential to streamline your billing as much as possible and make sure every payer is paying correctly, and if not, fol-

lowing up on the payment. In addition to being aware of your Medicare reimbursement, your commercial contracts should be reviewed for correct payments.

The grid on page two represents the changes that have occurred in the Medicare 2007/2008 WI Radiology practice reimbursement.

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Medicare 2008 vs. 2007 Fees

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CPT Code	Description	2007 Fees	2008 Fees
71020	Chest x-ray 2 view	\$10.31	\$9.91
70551	MRI brain/head w/o contrast	\$68.85	\$68.61
72050	Cervical spine 4 view	\$14.39	\$14.01
73564	Knee 4 view	\$10.31	\$9.91
73721	MRI lower extremities w/o contrast	\$62.62	\$62.44
74000	Abdomen A/P	\$8.45	\$8.42
76700	U.S. abdomen complete	\$37.91	\$37.40
76705	U.S. abdomen single organ, follow-up	\$27.59	\$27.49

CMS to Implement New Edit in Carrier Processing System

Effective April 1, 2008, the Centers for Medicare and Medicaid Services (CMS) will implement a recurring edit module in the carrier processing system to allow program safeguard contractors (PSCs) or CMS to monitor beneficiary and provider

numbers they have identified as problematic. The new edits will be especially helpful when identity theft is suspected, but it may slow down legitimate claims. ■