Winter 2022

RCC Update

RCCB RADIOLOGY CODING CERTIFICATION BOARD

REVENUE CYCLE CODING STRATEGIES

From the President

Renée Engle, RCC, FRBMA, President, RCCB Board of Directors

As we head into the winter, the Radiology Coding Certification Board reminds all RCCs and RCCIRs that applications for the 2023 RCCB Shannon Murray Memorial Scholarship are now open. The deadline to apply is January 31, 2023. Please share this announcement with any medical or radiology coders that you feel may need assistance to become certified. To make a contribution to the scholarship fund, please click here: Donate

Also, please note that there are still two free opportunities to earn CEUs available:

- Revenue Cycle Coding Strategies, Inc. is offering a free on-line webinar (1 CEUs total) for our certificants on December 15th called "2023 Coding Updates for Diagnostic and Interventional Radiology."
- There is still time to take the MedLearn free on-line course (2 CEUs) called "2022 Catheter-based Drainage IR Coding," which is available for any certificant through the end of 2022.

Contact us at info@rccb.org for information about signing up.

On a final note, I wish you all a safe and pleasant holiday season.

Sincerely,
Renée C. Engle, RCC, RCCIR, FRBMA

New NCCI Edits: Abdominal and Retroperitoneal Ultrasound

Each quarter, the Centers for Medicare and Medicaid Services (CMS) releases updates to the National Correct Coding Initiative (NCCI) Procedure-To-Procedure (PTP) and Medically Unlikely (MUE) edits. Both the October 2022 MPFS (Medicare Physician Fee Schedule) and OPPS (Hospital Outpatient Prospective System) updates contained a surprise for the radiology coding community: New NCCI code pair edits for abdominal and retroperitoneal ultrasound (US) when performed during the same encounter or on the same date of service. The modifier indicator for these code pairs was revised to "1," which indicates a modifier is allowed to bypass the edit when appropriate.

Previously, abdominal ultrasound and retroperitoneal ultrasound codes could technically be reported together without a modifier as there was no NCCI PTP edit in place. However, *Clinical Examples in Radiology* (Summer 2013) states that coding for both an abdominal US (76700-76705) and a retroperitoneal US (76770-76775) would be

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In This Issue

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"unusual," and would require documentation of medical necessity by the ordering physician. Beginning October 1, if both of these studies are performed and documented, a modifier (either -59, XE, XP, XS, or XU) will be required on the column 2 code – the retroperitoneal ultrasound code.

Column 1	Column 2	Modifier Indicator
76700	76770	1
76700	76775	1
76705	76770	1
76705	76775	1

When might it be appropriate to report both an abdominal and a retroperitoneal ultrasound? To answer this question, let's take a look at the CPT® guidance and definitions for these codes.

By CPT® definition, a complete abdominal US exam includes documentation of the following structures:

- Liver
- Gallbladder
- Common bile duct
- Pancreas
- Spleen
- Kidneys
- Upper abdominal aorta and inferior vena cava

All of these structures must be documented in order to bill for a complete exam. If a structure cannot be visualized, the report should indicate the reason (for example, the organ is surgically absent or hidden by another structure). If a structure, or the reason for non-visualization is not documented, the exam should be coded as 76705. Code 76705 is also used for exams of soft tissue masses in the abdominal wall or lower back, including abdominal wall hernias.

There are two CPT® definitions for a complete retroperitoneal ultrasound. Normally the exam must include documentation of the following structures:

- Kidneys
- Abdominal aorta
- Common iliac artery origins
- Inferior vena cava

However, the CPT® manual states that "if clinical history suggests urinary tract pathology, complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound." Note that it is not necessary to document a description of the ureters. According to *Clinical Examples in Radiology* (Summer 2013), normal ureters are usually too small to be visualized on ultrasound.

The kidneys can be part of either an abdominal US or a retroperitoneal US. In choosing between the two, consider what was ordered. If a provider orders an abdominal US and the radiologist documents the kidneys, only the abdominal US should be coded. It is not appropriate to assign an additional retroperitoneal US code for the kidneys. Similarly, if the ordering provider orders a retroperitoneal US exam, you should report 76770 or 76775.

The National Correct Coding Initiative Policy Manual (Chapter 9) states when a complete exam of the kidneys and urinary bladder is performed for urinary tract pathology, providers should not report a limited retroperitoneal US (76775) and a limited pelvic US (76857), but instead should report only the complete retroperitoneal US code 76770.

Payer guidance also comes into play. Some payers and contractors have already adjusted their Local Coverage Determinations and Articles (LCDs/LCAs) to further clarify their policies for billing and coding both retroperitoneal and abdominal ultrasound. Palmetto GBA, the Medicare Administrative Contractor (MAC) for Alabama, Georgia, Tennessee, North & South Carolina, Virginia, and West Virginia, has revised their policy effective October 1, 2022 to state "full (complete) or limited abdominal ultrasound (CPT® 76700, 76705, 76706*), views all structures in the abdomen, including those in the retroperitoneal area … It is not appropriate to bill for both a retroperitoneal US study AND a complete (or limited) abdominal US when a retroperitoneal US study is expanded to include organs and structures outside the retroperitoneum."

As above, the specific scenarios in which both a retroperitoneal and abdominal ultrasound would be reported are rare, and both exams should only be reported when the order and medical necessity supports both exams, and payer policy allows both to be reported with the appropriate modifier.

E/M Updates...

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Exploring "X" Modifiers – XE, XP, XS, and XU

Learning when and how to apply billing modifiers to your claims is a consistent source of confusion and frustration for many organizations. The "X" HCPCS modifiers – XE, XP, XS, and XU – have been a particular source of misunderstanding since their creation in 2015. This article aims to explain the "X" modifiers, why they exist, what they mean, and how to use them appropriately.

Under certain circumstances, it may be appropriate to bypass National Correct Coding Initiative (NCCI) bundling edits to indicate that a procedure or service was distinct or independent from other services performed on the same day. It is important to remember that just because an edit can be bypassed does not mean that it always should. Prior to 2015, modifier 59 was the only modifier available to bypass NCCI edits as well as to show that interpretations were performed during separate sessions. In the 2013 Final Rule, the Centers for Medicare and Medicaid Services (CMS) acknowledged that modifier 59 was problematic because it may be applied for reasons related to the NCCI edits as well as because the second exam was interpreted during a separate session. The Rule states, "We are aware of the conflict between use of modifier 59 for NCCI edits and for purposes of bypassing the MPPR when multiple procedures are furnished."

In 2014, the Centers for Medicare & Medicaid Services (CMS) created 4 new HCPCS modifiers (XE, XS, XP, and XU) as replacements for modifier 59 in an effort to allow providers to offer greater specificity about the circumstances of the procedures being billed. These modifiers may be used by all provider types (e.g., physician, hospital, IDTF). It initially appeared that modifier XE (*Separate encounter*) could be used to indicate that two interpretations took place during separate sessions. However, several Medicare contractors have instructed providers not to use this modifier unless the codes are bundled by a NCCI edit. CMS has not released any specific guidance on the use of modifier XE with exams that are interpreted during separate sessions.

At this time, providers may use either modifier 59 or the HCPCS modifiers (but not both) to show that a procedure is separate and distinct. However, CMS plans to eventually modify some NCCI edits so that they can be bypassed only with a specific HCPCS modifier rather than with modifier 59. Additionally, CMS is allowing local Medicare contractors to require use of the HCPCS modifiers when there is evidence that providers are using modifier 59 inappropriately.

Each of the "X" modifiers has a detailed definition and instructions for use:

- **XE –** "Separate Encounter, a service that is distinct because it occurred during a separate encounter." Only use XE to describe separate encounters on the same date of service. Modifier XE should be applied to either the Column 1 or Column 2 service when two services that are normally bundled are separate and distinct because they were performed during two separate encounters. It should not be applied when the exact same procedure code is performed in different encounters (instead, report multiple units or use a repeat procedure modifier).

CMS instructions state to use modifier XE if no other modifier more properly describes the relationship of the 2 procedure codes being reported. XE may also be used for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day that can't be described by one of the more specific NCCI Procedure to Procedure (PTP)-associated modifiers (24, 25, 27, 57, 58, 78, 79, or 91).

Per CMS, modifier XE may be used for reporting 2 services described by timed codes provided during the same encounter only when they are performed one after another. If a physician or other qualified health professional performs 2 timed services in time periods that are separate and distinct, and one service is completed before the next service begins, you may use modifier –XE to identify the services.

- **XS –** "Separate Structure, a service that is distinct because it was performed on a separate organ/ structure"

Modifier XS should be applied to either the Column 1 or Column 2 service when two services that are normally bundled are separate and distinct because they were performed on two separate anatomic areas (e.g., on different organs, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ) during the same encounter. It should not be applied when the exact same procedure code is performed on different areas (instead, report multiple units or use a repeat procedure modifier).
Modifier XS is intended to be used for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that:

- Are performed at different anatomic sites
- Aren't ordinarily performed or encountered on the same day, and
- Can't be described by one of the more specific anatomic NCCI PTP-associated modifiers (RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI).

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If two procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier isn't applicable, modifier XS may be applied. If the two procedures are performed on different sides of the body, use modifiers RT and LT or another pair of anatomic modifiers instead of modifier XS (or 59).

• **XP –** "Separate Practitioner, a service that is distinct because it was performed by a different practitioner" Modifier XP should be applied to either the Column 1 or Column 2 service when two services that are normally bundled are separate and distinct because they were performed by two separate practitioners.

• **XU –** "Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service"

Modifier XU should be applied to either the Column 1 or Column 2 service when two services that are normally bundled are separate and distinct for reasons other than those described by modifiers XE, XP, and XS. For example, modifier XU can be used on the code for an ultrasound exam performed during the same encounter as a duplex study of the same anatomic area (assuming two separate and complete, medically necessary studies were performed). Modifier XU should not be applied when the exact same procedure code is reported more than once (instead, report multiple units or use a repeat procedure modifier).

CMS instructions clarify that when a provider performs a diagnostic procedure before a surgical procedure or non-surgical therapeutic procedure and the decision to perform the surgical procedure or non-surgical therapeutic procedure is based on the diagnostic study, you may consider the diagnostic procedure to be a separate and distinct procedure if it:

- Occurs before the therapeutic procedure and isn't "mingled" with the services the therapeutic intervention requires,
- Clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and
- Doesn't constitute a service that would have otherwise been required during the therapeutic intervention.

If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

Furthermore, when a diagnostic procedure is performed following a surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered a separate and distinct procedure if it:

- Occurs after the completion of the therapeutic procedure and isn't "mingled" with the services that the therapeutic intervention requires
- Doesn't constitute a service that would have otherwise been required during the therapeutic intervention.

If the post-procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Remember that while CMS and Medicare contractors accept the "X" modifiers, not all payers do. It is important to review individual payer policy to ensure whether they require modifier 59 or XE, XP, XS, XU in specific scenarios.

Knowing when to apply the "X" modifiers and which to use can be intimidating, but by becoming acquainted with the guidance above, you can prepare for nearly any coding scenario and determine how to assign "X" modifiers appropriately and effectively.

Ultrasound Guidance for Vascular Access: How and When to Assign Code 76937

Coding ultrasound guidance for vascular access continues to be a source of confusion for many coding professionals. It can be difficult to make sense of when ultrasound guidance is included in a procedure and what documentation is necessary to report this code. This article will discuss the nuances of assigning code +76937 and help to alleviate the uncertainty surrounding coding for this procedure.

Ultrasound guidance for vascular access (e.g., vein access), when allowed to be coded separately, is reported with add-on code +76937 - *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure).* Medicare has designated this code as a service that requires personal supervision, so in order to bill this code, the provider must be physically in the room with the patient.

The ultrasound section of the CPT® manual states, "Ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized."

Per the CPT® description, code +76937 requires documentation of the following services:

- Evaluation of potential access site(s)
- Selected vessel patency
- Concurrent real-time ultrasound visualization of needle entry

The American College of Radiology (ACR) 2022 *Ultrasound Coding User's Guide* states, "It is not appropriate to report code +76937 when ultrasound is used only to identify a vessel, mark a skin entry point, and proceed with a non-guided puncture."

The CPT® code description for +76937 also requires documentation of the patency of the selected vessel. The Summer 2014 issue of *Clinical Examples in Radiology* states "comments about the vessel being patent, narrowed, aneurysmal, or even thrombosed" would qualify as documentation of selected vessel patency.

Code +76937 also requires storage of permanent images, either on film or digital. *Clinical Examples in Radiology* Summer 2014 states there must be a permanent image of the vessel, but not necessarily an image of the needle in the vessel. It is strongly recommended that the provider document capture of these images in the procedure note—for example, "Verification images were obtained." This will help to prevent retrospective denials if a payer audits the provider's records. Note that code +76937 should not be assigned when the provider uses a hand-held ultrasound device to guide vascular access but does not perform all of the above-listed services, including permanent image storage.

Code +76937 is not restricted to use with central venous catheter procedures. This code can be used with other interventional procedures provided that the requirements of the code description are met and provided that the interventional procedure is not one that includes ultrasound guidance by definition, such as vena cava filter insertion.

When ultrasound guidance is used for vascular access, CPT® coding guidelines permit the reporting of code +76937 together with several of the interventional and angiographic procedure codes, as long as all of the requirements for the code are met. The National Correct Coding Initiative (NCCI) edits do not bundle +76937 into the most of these codes. However, code +76937 is designated by CMS as a Type II Add-On Code, meaning that Medicare contractors have the authority to limit the base codes with which it is reported. If denials are received for the guidance service, check the Medicare contractor's policies. Refer to the CPT® manual for a list of procedures that should not be reported with +76937.

Some payers do not reimburse separately for ultrasound guidance for vascular access. Under the Hospital Outpatient Prospective Payment System (OPPS), code +76937 has a status indicator of N, meaning that this code is paid under OPPS, but its payment is packaged into payment for other services, including outliers. Therefore, there is no separate payment by Medicare, but other payers may reimburse for this service.

By familiarizing yourself and your team with the coding and documentation requirements above, you can take the pain out of accurately coding for US guidance for vascular access.

Upcoming RCCB sponsored webinar.

Revenue Cycle Coding Strategies® will be presenting the webinar: 2023 Coding Updates for Diagnostic and Interventional Radiology

December 15, 2022
1 pm ET (noon CT) – 2 pm ET

Click here to register.

RCCB CODING CORNER

Q: If a venous duplex of the right *lower* extremity and a venous duplex of the left *upper* extremity are both performed, how should this be coded?

A: According to *Clinical Examples in Radiology* (Winter 2008), it is appropriate to report 2 units of code 93971 when the study includes one upper extremity and one lower extremity. However, Medicare will pay for only 1 unit of 93971 per day. This code has an MUE adjudication indicator of 3, so the only way to receive payment is to appeal the denial.

Q: What is the correct coding for the injection of contrast into the shoulder joint under fluoroscopic guidance for an MR arthrography?

A: The injection of contrast for an MR shoulder arthrogram is coded using CPT® 23350. The fluoroscopic guidance for needle placement is appropriately coded as 77002. The MRI portion should be coded as a *with contrast* study of an upper extremity joint, 73222.

Q: Are screening mammograms covered if performed as an inpatient?

A: Per the *Medicare Claims Processing Manual,* "Screening mammography services, screening pelvic examinations, and screening pap smears when provided to an inpatient of a hospital may be covered under Part B, even though the patient has Part A coverage for the hospital stay, if applicable conditions of coverage are met and the applicable frequency limitations have not been exceeded by the patient."

Q: What is the current coding guidance for billing abbreviated or limited breast MRI studies?

A: The protocol for obtaining breast MRI images will be up to the radiologist and based on the best answer to the clinical question and reason for the imaging. The breast MRI codes do not differentiate between the length of the study; the codes are applied per the definition regardless of the length of the study. Per ACR *Radiology Coding Source™ "Breast Imaging Frequently Asked Questions Updated 2021,"* page 12, "It may be appropriate to append modifier 52, *Reduced services,* to designate to the payer that the services provided are less than those typically performed or add modifier 22, *Increased procedural services,* to indicate to the payer that the service provided was substantially greater than that typically required."

Most payers do not cover MRI of the breast for screening purposes unless the patient has specific risk factors such as a known genetic marker like BRCA. Additionally, many payers have established coverage limitations for diagnostic breast MRI. Be sure to review your payer's published coverage policies and obtain precertification if possible. The decision to request patient payment for these types of services should be made internally by practice management.

Q: Does the indication of "renal failure" support a complete retroperitoneal ultrasound when both kidneys and bladder are evaluated?

A: According to *CPT® Assistant* (March 2015), "Code 76770, *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete,* would be reported if a routine complete ultrasound examination of the urinary tract (eg, kidneys, ureters, and urinary bladder) is performed."

Note: This is a correction from the Q&A from the Ultrasound Coding Tips, Traps and Tricks webinar held on June 15, 2022.

Do you have a billing and coding question you would like an answer to in the upcoming newsletter? Submit your questions for possible selection to RCCBQA@RCCSinc.com**.**