Winter 2023

RCC Update

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 **2024 RCCB Susan Gregg & Shannon Murray Memorial** Scholarship are now open. The deadline to apply is January 31, 2024. 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 is still time to take the MedLearn free on-line course "2023 Diagnostic and Therapeutic Dialysis Shunt Interventional Radiology Coding" which is available through the end of 2023 (2 CEUs). To register, please visit: **This link**.

Contact us at **info@rccb.org** *for questions or information about the RCCB programs.*

On a final note, I wish you all a safe and pleasant season as the holidays soon arrive.

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

New Breast Density Codes

Dense breast tissue refers to the appearance of breast tissue on a mammogram. While it is a normal and common finding, it appears as a solid white area on a mammogram, which makes it difficult to see through. Depending on the density of the breast tissue, it can make detecting signs of breast cancer more difficult, which may increase a patient's risk of breast cancer. The denser the breast tissue, the harder it is for the physician to see through on a mammography.

In the United States, the Food and Drug Administration (FDA) regulates mammography facilities at the federal level. In March 2023, the FDA published a rule stating that mammogram reports sent to patients must include the patient's breast density status, which should be described as either "dense" or "not dense." The American Cancer Society recently published an article titled Breast Density and Your Mammogram Report which details the new State and Federal regulations.

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In This Issue

RCC Update is a quarterly publication reporting on radiology coding developments and the latest news from the Radiology Coding Certification Board (RCCB). RCC Update is made possible with our partners at Revenue Cycle Coding Strategies LLC.
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Due to the new Federal mammography laws, which go into effect on September 10, 2024, a patient's breast density status will now be documented in the vast majority of mammography reports. Keep in mind that this new law is specific to notifying patients of their breast density status, and not to the coding of breast density to the patient's medical record. While the documentation of a patient's breast density will increase on mammography reports, there have been no changes to coding guidelines regarding breast density.

In the past, breast density was typically only documented in a patient's medical record if it was suspected of obscuring findings, or if the density was a driving factor in ordering an additional exam. In addition, there was only one ICD-10-CM diagnosis code that existed for dense breast tissue. Code R92.2 *Inconclusive mammogram*, included the descriptors of "Dense breasts NOS" and "Inconclusive mammography due to dense breasts."

Effective October 1, 2023, the descriptors of "Dense breasts NOS" and "Inconclusive mammography due to dense breasts" have been deleted from R92.2, which should now only be assigned for an inconclusive mammogram. Thirteen new ICD-10-CM codes have been created identifying five specific breast density findings. Code R92.30 *Dense breasts, unspecified* should be assigned for breast findings of low or unspecified density. If the documentation only states "dense breasts" then the unspecified code of R92.30 should be assigned. Code R92.31- should be assigned for fatty tissue density, R92.32- for fibroglandular density, R92.33- for heterogenous density, and R92.34- for extreme density. The specific type of density must be documented to assign a code from the R92.31- through R92.34- range.

The code range R92.31- through R92.34- requires a 6th digit, indicating laterality, to complete the code. A 6th digit of 1 indicates the right breast, 2 indicates the left breast, and 3 indicates bilateral breasts. Laterality coding guidelines remain the same for all radiology and may be assigned based on the order, or the stored images if not documented.

The status of a patient's breast density can be a normal variant that is incidental to the mammography. Not all breast density is considered a finding or diagnosis, and not all patients with dense breasts will be called back for an additional exam. Some patients just have dense breasts. If the breast density is incidental, or is not the driving force for the exam, it should not be coded.

Examples:

The patient has a screening mammography. The physician documents low breast density with no findings and for the patient to continue with routine screenings every 2 years.

Diagnosis: Z12.31 Encounter for screening mammogram for malignant neoplasm of breast

Rationale: The breast density was documented but was incidental to the screening mammogram and therefore not coded.

The patient has a screening mammography. The physician documents extreme density in bilateral breasts and orders a diagnostic mammography.

Diagnosis: Z12.31 Encounter for screening mammogram for malignant neoplasm of breast

R92.343 Mammographic extreme density, bilateral breasts

Rationale: The breast density is issued as a secondary diagnosis as it is the driving force for the patient being called back for an additional exam.

New Code for SI Joint Fusion (Arthrodesis)

The sacroiliac (SI) joints connect the base of the spine to the pelvis. If the ligaments or bony surfaces of the joint(s) are damaged, they can cause extreme pain that may radiate down the leg(s). Arthrodesis, which is also referred to as joint fusion, is the surgical immobilization of a joint by fusion of the adjacent bones. A sacroiliac joint fusion is a surgical procedure that fuses the iliac bone of the pelvis to the sacrum. The sacrum is a triangular bone just below the lumbar vertebrae that forms the base of the spine and the center of the pelvis. The surgical fusion of the ilium to the sacrum provides stabilization, which stops movement between the bones and helps to resolve sacroiliac joint pain. Other common conditions requiring treatment with a sacroiliac joint fusion include trauma, infection, cancer, and spinal instability.

There are many sacroiliac joint fusion devices, which require different surgical approaches for placement. One minimally invasive technique involves the posterior placement of a non-transfixing implanted device, such as a bone graft, into the sacroiliac joint. This procedure differs from procedures that place a transfixing device through the ilium, across the sacroiliac joint, and into the

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sacrum. Procedures that place transfixing devices should be reported with CPT® 27279 *Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device.*

In the past, non-transfixing sacroiliac joint fusion (arthrodesis) was reported with category III code 0775T. This code has been deleted for 2024, and replaced with new CPT® code 27278 *Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg bone allograft[s], synthetic device[s]).* This code includes imaging guidance. Radiological supervision and interpretation (S&I) is not reported separately. Bilateral procedures are typically performed on separate dates of service. However, if a patient does undergo a bilateral procedure at the same encounter, modifier 50 should be appended. CPT® code 27278 represents minimally invasive techniques that do not transfix the sacroiliac joint and should be assigned for percutaneous placement of an intra-articular stabilization device (implant) into the sacroiliac joint.

New Codes for Virtual Reality Patient Procedural Dissociation

Virtual reality (VR) technology is being used to assist health care providers in achieving better treatments and patient outcomes. A huge benefit of this technology in healthcare is that it can be utilized to modify a patient's perception of anxiety, pain, or discomfort during a procedure or radiological imaging, by distracting the patient's brain with a virtual reality.

Patients, including children, are being provided with a virtual world to escape to, which can help them to better tolerate treatments, procedures, or imaging studies. Virtual relief from pain, anxiety, or discomfort can reduce, and at times replace the need for pain relieving or sedating pharmaceuticals. When a patient's need for sedation is lowered, the patient has a greater ability to respond to verbal commands and stimuli, leading to better treatments and patient outcomes.

Radiological imaging is one of the most common uses of VR technology in healthcare. CPT® describes VR patient procedural dissociation as:

> A VR-based state of altered consciousness that supports and optimizes the patient's comfort, increases procedural tolerance, and decreases the patient's pain during the associated procedure. VR procedural dissociation establishes a computer-generated audio, visual, and proprioceptive immersive environment in which patients respond purposefully to verbal commands and stimuli, either alone or accompanied by light tactile stimulation. (AMA, 2023)

Four new category III codes were added in 2024 to report virtual reality patient procedural dissociation. CPT® codes 0771T and +0772T are reported when the physician that is providing the VR service is the same physician that is performing the procedure that the VR service is supporting. CPT® codes 0773T and +0774T are reported when the physician that is providing the VR service is not the physician that is performing the procedure that the VR service is supporting. These codes are not reported for moderate sedation or anesthesia services. VR services less than 10 minutes and services provided to patients under the age of 5 years old are not reported.

VR procedural dissociation codes are determined by the intraservice time used, which is clearly defined in the 2024 CPT® manual. Intraservice time begins with the administration of immersive VR technology, which at a minimum should include audio, video, and proprioceptive feedback. Continuous face-to-face attendance of the physician or other qualified health care professional is required. Intraservice time ends once the procedure, administration of VR technology, or continuous face-to-face time with the patient has ended. Additional face-to-face time occurring after the end of the initial VR session should not be added to the total intraservice time.

The first 10-22 minutes of VR procedural dissociation are reported with CPT® codes 0771T or 0773T, as appropriate. Additional intraservice time over 22 minutes should be reported with add-on codes +0772T or +0774T, as appropriate, with the correct number of units appended. One unit of an add-on code represents 15 minutes beyond the initial 22 minutes. The full 15 minutes does not have to be utilized in order to report an additional unit of the add-on code.

Examples:

A qualified health care professional, other than the physician that is performing the procedure, provides 47 minutes of VR procedural dissociation intraservice time for a 6-year-old patient.

CPT® Codes: 0773T, +0774T x2

Rationale: Code 0773T represents the first 22 minutes of intraservice time. The first unit of add-on code +0774T represents an additional 15 minutes of intraservice time. The remaining 10 minutes of intraservice time are reported with a second unit of add on code +0774T.

A physician that is the same physician performing the procedure provides 23 minutes of VR procedural dissociation intraservice time for a 9-year-old patient.

CPT® Codes: 0771T, +0772T

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Rationale: Code 0771T represents the first 22 minutes of intraservice time. The remaining 1 minute of intraservice time is reported with add on code +0772T.

Guidance added to for the use of Unlisted Codes

Sometimes there is no CPT® code to accurately describe the service rendered. In these situations, it is appropriate to assign an "unlisted" CPT® procedure code. In the past, unlisted codes were only assigned when no CPT® code existed to accurately describe the service performed. However, with the evolution of medicine, procedures, and CPT® mechanisms of reporting, there are now many times in which multiple CPT® codes must be assigned to fully capture the totality of the services rendered. Due to this evolution, guidance for the use of unlisted codes has been added to the 2024 CPT® manual. There have been multiple updates to the methods of reporting unlisted CPT® codes. Updates include guidance on reporting multiple unlisted codes together, the allowance of reporting unlisted codes with specific CPT® codes, and an explanation regarding modifier use with unlisted codes.

The new 2024 guidance permits the reporting of multiple unlisted procedure codes. If two procedures are performed on two separate sites, by the same provider, on the same date of service, it is appropriate to report two different unlisted CPT® codes to fully capture the services rendered. If two unlisted procedures are performed, and the procedures share an unlisted code, multiple units of the same unlisted code should be reported, with a 59 modifier appended to the second unit to fully capture the services rendered.

CPT® 2024 guidance also allows the reporting of unlisted procedure codes in conjunction with defined CPT® procedure codes. If there is a separately reportable portion of a procedure or service that is not described in the existing CPT® code, an unlisted code may be assigned in addition to the existing CPT® code.

A change has been made to the guidance regarding the use of modifiers with unlisted codes. Old guidance from the CPT® manual indicated that modifiers should not be assigned to unlisted codes, because these codes do not describe a particular service, and therefore cannot be modified. This guidance has been changed for 2024. CPT® still upholds their position that unlisted code descriptions do not specify procedure components. Therefore, modifiers that describe the alteration of a procedure, such as modifier 52, reduced services, are not appropriate to append to an unlisted code. However, modifiers that indicate laterality, distinction, assistant-at-surgery, and place of service, may now be used, when indicated.

Example:

Two unlisted arthroscopic procedures are performed, one on the left knee and one on the left hip, by the same physician, on the same date of service.

CPT® Codes: 29999, 29999-59

Rationale: Two separate joints may be reported with two units of the same unlisted code. Modifier 59 should be appended to the additional unit.

2024 E/M Updates

Revisions have been made to the evaluation and management (E/M) section of the CPT® manual code set for 2024. These revisions support an effort to decrease the administrative burden of documentation on providers, as outlined in Medicare Physician Fee Schedule (MPFS) 2024 final rule. Updates include time requirement changes for outpatient visits, and a guideline expansion for split or shared visits.

The revisions to the E/M codes, which has been taking place since 2021 by the American Medical Association (AMA), included defining the total time which must be met for each level. Within the office/outpatient new and established patient codes the AMA included a range of time, but in all other code changes there was a threshold which must be met or exceeded. In order to align the application of total time for the E/M services the AMA removed the time ranges from CPT® codes 99202-99205 and 99212-99215. Now, the time is a single value which must be met or exceeded in order to support this level of visit.

For example, CPT® 99202 for new patient office visit currently lists a time range of 15-29 minutes. Effective January 1, 2024, the time threshold will be 15 minutes of total time must be met or exceeded, in order to bill. The same rationale applies for the established patient visits. For example, CPT® 99214 currently lists a time range of 30-39 minutes. This is changing to a threshold of 30 minutes must be met or exceeded. It is important for providers to specifically state how long they spent for the total time related to the encounter.

CMS has revised their guidance for split (or shared) visits. They have changed their previous final ruling and have aligned with the updated AMA definition. Now when a physician and nonphysician practitioner of the same practice see a patient in the facility setting, time is not the only factor in determining the substantive portion of the visit.

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When time is used for code selection for an E/M service for which two professionals act as a team, the E/M service is reported by the professional who spent the majority of the time (i.e., the substantive portion of the time) providing the service.

When medical decision making (MDM) is used for code selection for an E/M service for which two professionals act as a team, the E/M service is reported by the professional who made or approved the patient's management plan, and then takes responsibility for that plan. The patient's management plan is developed for *the number and complexity of problems addressed at the encounter* and the responsibility of that plan carries with it an inherent *risk of complications and/or morbidity or mortality of patient management* (i.e., the substantive part of the MDM).

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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**.**