Fall 2014

RADIOLOGY CODING CERTIFICATION BOARD

CODINGSTRATEGIES

RCC UPDATE

Radiology Coding Certification Board

From the President

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

Welcome to the Fall 2014 issue of *RCC Update*.

First, I would like to thank Susan Gregg, Immediate Past President, for her dedication and superior service to our organization. We are so fortunate that she plans to remain on the RCCB Board of Directors as the RBMA Liaison.

It is an honor to be named RCCB President and I look forward to serving as we face some of the most challenging times in our careers, the upcoming implementation of ICD-10 and the continued bundling of codes.

We hope you find the content of the *RCC Update* beneficial both in your daily work and your continuing education.

In This Issue

Regulatory

CMS Proposes MPFS Changes for 2015

On July 3 CMS released the Proposed Rule for the 2015 Medicare Physician Fee Schedule (MPFS). This article discusses some of the Proposed Rule provisions relevant to radiology. You can view or download the Proposed Rule from the July 11 *Federal Register* at: http://www.gpo.gov/fdsys/pkg/FR-2014-07-11/pdf/2014-15948.pdf

Digital Mammography

Currently CMS requires providers to report HCPCS codes G0202-G0206 for direct digital mammograms and CPT® codes 77055-77057 for other mammograms. Medicare claims data show that the "vast majority" of mammograms are now being submitted with the G-codes, and there are very few claims for codes 77055-77057. Therefore, CMS sees no need to continue maintaining two separate payment levels. For 2015 CMS

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proposes to delete the G-codes and pay for all mammograms under the CPT® mammogram codes, which would be assigned the same RVUs that are currently assigned to the G-codes. However, the G-code RVUs have not been reviewed since 2002, when the codes were created, and CMS feels it is time to take a close look at the reimbursement for this service. CMS is, therefore, planning to designate 77055-77057 as potentially misvalued codes and is asking the Relative (Value) Update Committee (RUC) and other interested parties to provide recommendations as to the appropriate valuation.

Global Surgical Package

Currently CMS assigns surgical procedures, including many interventional radiology procedures, to one of three global surgical packages (0-day, 10-day, and 90-day). Each of these packages includes payment for the procedure as well as for certain preoperative and postoperative services. CMS is now proposing to transition all of the 10-day and 90-day global codes to 0-day global codes in 2017 (10-day codes) and 2018 (90-day codes). Physicians would then be able to bill separately for medically reasonable and necessary visits during the pre- and post-operative periods, except for the day of the procedure. CMS is looking for comments as to how it should collect data on Evalunation and Management (E/M) services that are currently being furnished during the postoperative period and also how it can avoid creating an incentive for additional postop visits.

Secondary Interpretations

Normally Medicare pays for only one interpretation per imaging study, although a second interpretation may be paid in certain limited circumstances. For example, the Medicare Claims Processing Manual (Chapter 13, Section 100.1) gives the example of an emergency department physician identifying a questionable finding on an imaging study, which necessitates a second interpretation by a radiologist.

In the 2015 Proposed Rule, CMS notes that there may be opportunities to reduce duplicative imaging studies by allowing a second interpretation of the same images. The agency gives the example of a trauma patient who is transferred from a community hospital to a referral center with "high quality CT images sufficient to support an additional interpretation service." CMS is requesting comments regarding Medicare payment for secondary interpretations. For example, the agency would like to know what policies facilities have implemented to determine when existing images can be used, how secondary interpretations should be valued for payment, and whether payment for secondary interpretations would result in a cost savings for the Medicare program. Any planned changes will be published as part of a Proposed Rule.

Substitute Physician Billing Arrangements

CMS uses the term "substitute physician billing arrangements" to include both informal reciprocal billing arrangements where physicians from different practices substitute for each other as needed; and locum tenens (LT) arrangements in which an LT physician covers for an absent physician and is paid on a per diem basis or according to the amount of time worked. CMS is concerned about the use of LTs to fill staffing needs or to replace on a temporary basis physicians who have permanently left a group practice or employer. CMS is asking for comments on substitute physician arrangements to help them determine how these physicians are being used, and whether they should place limitations on their use. Any planned changes will be announced through the regular rulemaking process.

PQRS

CMS is proposing numerous changes to the Physician Quality Reporting System (PQRS), including addition and deletion of measures. There is also a proposed requirement for professionals who provide any face-to-face patient services (including procedures) to report measures from a new "cross-cutting" measures set that deals with issues like tobacco use, immunization status, body mass index, etc. Compliance with these changes for 2015 reporting will determine whether a provider is subject to the payment adjustment (penalty) in 2017.

Provider-Based Departments

When a hospital buys a physician practice, the hospital will often designate the practice's office as an "off-campus provider-based department." This allows the hospital to bill Medicare for a facility charge for office visits, in addition to the charge for the physicians' professional services. CMS is proposing that beginning in 2015, physicians and hospitals would have to apply a modifier to any service rendered in a provider-based department so that CMS can accurately track the impact of

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these services. The agency is asking for comments as to whether this is the best method to accomplish its goal.

Conclusion

Remember that this is a Proposed Rule, and CMS may delete or revise any of the provisions before issuing the Final Rule. It's important to be aware of the CMS proposals so that you can prepare to take action on them if necessary. However, there are usually some significant revisions between the Proposed Rule and the Final Rule.

Note: This article originally appeared in the August 2014 issue of Coding Strategies' *Radiology Coding & Compliance Expert.*

Deadline for Final 2014 RCC Exam is October 6th!

The final RCC exam for 2014 will be held over November 10th to 14th. The deadline to submit an application for the November exam is October 6th. The application for the 2014 exam can be found on the RCCB website - http://rccb.org/applications.

RCCB Exhibiting at Upcoming Meetings

RCCB will be exhibiting at the following meeting:

- RBMA's 2014 Fall Educational Conference on October 19-21, 2014 at the Westin Seattle in Seattle, WA

2014 RCC Exam Tests General ICD-10 Knowledge

The 2014 RCC exam will test general knowledge of ICD-10. The successful applicant should be able to answer basic questions pertaining to ICD-10 regarding:

- Basic structure
- Differences vs. ICD-9
- Definitions
- Applicable clinical settings
- Benefits vs. ICD-9

RCCB's listing of approved continuing education courses contains numerous ICD-10 specific educational sessions - http://rccb.org/ce-sessions-accepted/2014

Successful 2014 examinees are still required to obtain 2.5 CEUs of RCCB-approved ICD-10 continuing education prior to their recertification in 2016.

ICD-10-CM

2015 Implementation Date Confirmed

The Department of Health and Human Services (HHS) has issued a Final Rule that officially confirms October 1, 2015, as the new ICD-10 implementation date. The Rule was published in the *Federal Register* on August 4, 2014, and you can access it here: http://www.gpo.gov/fdsys/pkg/FR-2014-08-04/pdf/2014-18347.pdf

New Implementation Date

As you may recall, ICD-10 implementation had been scheduled for October 1, 2014. However, when Congress passed the Protecting Access to Medicare Act (PAMA) to prevent physician payment cuts that were scheduled to take effect in April of this year, they included a clause prohibiting the Secretary of HHS from adopting ICD-10 prior to October 1, 2015.

Since that time CMS has on several occasions indicated that it expected October 1, 2015, to be the new implementation date, but the possibility remained open that implementation could be pushed back to 2016 or later. HHS stated in the *Federal Register* that it considered a longer delay but concluded that it would be "significantly more costly [than a one-year delay] and have a damaging impact on industry."

HHS issued the 2015 implementation date in the form of a Final Rule. Normally federal agencies are required to issue new regulations in a Proposed Rule with public comment period. There is an exception, however, for situations when this process would be "impracticable, unnecessary, or contrary to the public interest." HHS noted in the *Federal Register* that issuance of the ICD-10 implementation date qualified for a waiver of the usual rulemaking process because "covered entities need to know how to proceed with respect to ICD-9-CM and ICD-10 now, or they will not have adequate time to prepare to accurately submit, process, and pay for health claims."

There was speculation after the passage of PAMA that providers might be allowed to implement ICD-10 on a voluntary basis prior to the official implementation date. However, the Final Rule states that covered entities are required to continue to use ICD-9 through September 30, 2015. This means that providers and payors will all be making the switchover on the same date.

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Testing

In the August 1 issue of the CMS *MLN Connects* provider e-newsletter, CMS announced the new implementation date and also commented on testing. The agency states it is taking a "comprehensive four-pronged approach" to testing, which includes the following components.

- Internal testing of claims processing systems: CMS states that its claims processing systems have been ready for ICD-10 since October of 2013, and it continues to test them on a quarterly basis.
- Beta testing tools available for download: These include NCDs and LCDs that have been converted from ICD-9 to ICD-10, as well as ICD-10 versions of Medicare inpatient and outpatient hospital payment software.
- Acknowledgement testing: This involves submitting Medicare claims that contain ICD-10 codes. Medicare contractors will not adjudicate these claims but will send the submitter an acknowledgement that indicates whether the claims were accepted or rejected. Providers can submit acknowledgement claims at any time between now and the implementation date. Additionally, CMS will conduct three "testing weeks"(11/17-11/21/14, 3/2-3/6/15, and 6/1-6/5/15), during which providers will have access to real-time help desk support.
- End-to-end testing: During 2015 CMS will give a limited number of volunteers the opportunity to submit claims containing ICD-10 codes and have them adjudicated by Medicare contractors. This testing will determine not only whether the provider can successfully submit ICD-10 claims but also whether the contractor can successfully adjudicate the claims and generate appropriate remittance advices. There will be three separate weeks of end-to-end testing, in January, April, and July. CMS plans to release more information about this program soon.

Code Freeze

While the industry is waiting for the big day, the partial code freeze will continue. The code freeze was put into effect by the ICD-9-CM Coordination and Maintenance Committee back in 2011 in an attempt to ease the burden on providers by limiting the number of code changes during the transition period. During the code freeze, there will be no new or revised codes other than those that are needed to capture new technologies and diseases. Other new and revised codes will be tabled until the year following the implementation.

For Medicare program year 2015, which begins October 1, 2014, there are no changes to the Tabular List or Alphabetic Index for either ICD-9-CM or ICD-10-CM. However, there may be changes to the ICD-10-CM guidelines.

For the 2016 program year, which begins October 1, 2015, ICD-9-CM will no longer be updated, and updates to ICD-10-CM will continue to be limited to those needed to capture new diseases and technologies. Regular updates to ICD-10-CM will not begin until October 1, 2016. Since the code freeze will have been in effect for 4 years at that point, it is likely that there will be a very large number of changes, since the Coordination and Maintenance Committee continues to identify conditions for which new and revised codes are needed.

Note: This article originally appeared in the September 2014 issue of Coding Strategies' *Radiology Coding & Compliance Expert.*

RCCs Recertifying in 2014

RCCs recertifying in 2014 must submit their application by the deadline, but no more than 60 days prior to the deadline. For a list of deadlines and fees, please visit the RCCB website at http://rccb.org/dates-deadlines-fees. The recertification form can be found at http://rccb.org/applications. Remember, RCCs applying for recertification by continuing education in 2014 are required to obtain at least 2.5 RCCB-approved CEUs pertaining to ICD-10.

Compliance

CMS Issues Modifier 59 Guidance

BREAKING NEWS

CMS is introducing four new HCPCS modifiers that better define the reason why two procedures are separate and distinct. The new modifiers were announced in Transmittal 1422 (Change Request 8863). In the transmittal CMS notes that there are a number of different circumstances in which modifier 59 can be used, and some of these uses are more often incorrect than others. For this reason CMS decided to create separate modifiers to describe the most common circumstances:

Modifier XE – Separate encounter, a service that is distinct because it occurred during a separate encounter
Modifier XS – Separate structure, a service that is distinct because it was performed on a separate organ/structure
Modifier XP – Separate practitioner, a service that is distinct because it was performed by a different practitioner
Modifier XU – Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

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These modifiers will go into effect January 1, 2015. Modifier 59 will still be valid, but CMS is encouraging "the rapid migration of providers to the more selective modifiers." Eventually some CCI edits will likely require specific HCPCS modifiers in order for both codes to be paid, and CMS is also allowing Medicare contractors to require use of the HCPCS modifiers instead of modifier 59.

We will bring you additional guidance about the use of these new modifiers as it becomes available. Meanwhile, it is important to follow the guidelines in the rest of this article concerning the proper use of modifier 59 on CCI code pairs.

Earlier this year CMS issued a "Special Edition" MLN Matters article (SE1418) titled "Proper Use of Modifier 59." The agency states that the article "only clarifies existing policy" rather than setting new policy. And in fact, if you've read the modifier 59 article posted on the CMS National Correct Coding Initiative (NCCI) web page, the new article will look very familiar. Still, the fact that CMS decided to publish the information in this new format suggests that the agency believes many providers are either not aware of its guidance on modifier 59, or are ignoring it. In this article we'll give you a summary of the CMS guidance so you can keep your claims clean and compliant.

Keep in mind that this guidance applies to Medicare claims. Modifier use varies by payor, and other payors may have different guidelines. You should always follow any modifier guidance that your contracted payors have published.

CPT® Guidelines

According to Appendix A of the CPT® manual, modifier 59 should be used to show that two procedures that are "not normally reported together" are appropriate due to the circumstances. Appendix A states that there must be documentation of one of the following circumstances:

- Different session
- Different procedure or surgery
- Different site or organ system
- Separate incision/excision
- Separate lesion
- Separate injury

Appendix A also notes that modifier 59 is not to be used with evaluation and management (E/M) codes or in situations when there is a "more descriptive modifier" available.

2014 RCCB-Approved Continuing Education Courses

The RCCB has approved over 70 courses for continuing education for 2014 to date. For a complete and current listing of 2014 approved education, go to https://rccb.org/ce-sessions-accepted/2014. Check back often, as new programs are added as they are approved.

CMS Guidance on Modifier 59

In addition to the new "Special Edition" article, the CMS guidelines for modifier 59 also appear in Chapter 1 of the NCCI Policy Manual and in the older modifier 59 article on the NCCI web page. All of these sources emphasize that modifier 59 should generally be used to indicate that two procedures were performed at different anatomic sites or during different patient encounters. They also point out that contiguous structures within the same organ or anatomic region (such as the rotator cuff and the synovium in the same shoulder joint) are not considered to be different anatomic sites.

Likewise, all of these publications all warn against deciding to use modifier 59 on the grounds that the two codes describe different procedures or surgeries, even though this is one of the CPT® manual's criteria for modifier 59. The NCCI manual states that the two codes in a code pair usually do represent different procedures or surgeries (i.e., the codes have different descriptions), but despite this, it is not appropriate to report them together when they are performed at the same anatomic site during the same patient encounter.

There are several limited exceptions when CMS believes it may be appropriate to apply modifier 59 even though the two procedures occurred during the same encounter. Specifically, use of the modifier may be appropriate when:

- Two time-based services are performed sequentially (not overlapping). CMS gives an example of two time-based physical therapy codes (97530 and 97140) that are each billed per 15 minutes. If both of these services are performed during the same 15-minute interval, only the Column 1 procedure (in this case 97140) should be reported. However, if one service is performed for 15 minutes and then the other is performed during a subsequent 15-minute period, both can be billed and modifier 59 can be applied to the Column 2 code.
- A diagnostic procedure is the basis for performing a therapeutic procedure. In order for this exception to apply, the diagnostic procedure must occur before the therapeutic procedure and not be "interspersed" with services required

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for the therapeutic procedure. Additionally, the diagnostic procedure must provide the information needed to decide whether to proceed with the therapeutic procedure. And finally, the diagnostic service must not "constitute a service that would have otherwise been required during the therapeutic intervention" (i.e., the diagnostic service is not integral to the therapeutic procedure).

- A diagnostic procedure follows a therapeutic procedure but is not a common, expected, or necessary follow-up to the therapeutic procedure. In order for this exception to apply, the diagnostic procedure must be performed after the therapeutic procedure and must not be "interspersed with or otherwise commingled with" the therapeutic procedure. Additionally, the diagnostic procedure cannot be a service that is required for the therapeutic intervention.

Examples

The "Special Edition" article provides 11 helpful examples of appropriate and inappropriate use of modifier 59. Here is a summary of the ones that are of interest to radiology professionals. We've kept the original numbering so that you can cross-reference them to the complete article.

Example #2: Ultrasound guidance for needle placement (76942) bundles into laparoscopic radiofrequency ablation (RFA) of liver tumors (47370). Modifier 59 can be applied to the guidance code if the guidance is for an unrelated procedure. However, code 76942 should not be reported if the guidance is for the RFA. (Note: The CMS article does not mention that there is a specific code for RFA guidance, 76940, which does not bundle into the RFA code. This code should be used instead of 76942.)

Example #3: Fluoroscopy (76000) bundles into heart catheterization (93453). Modifier 59 can be applied to the fluoroscopy code if it is performed "for a procedure unrelated to the cardiac catheterization procedure." However, code 76000 should not be reported for fluoroscopy that is related to the heart cath, since that service is integral to the heart cath code.

Example #8: Iliac artery exposure for endovascular repair (34820) bundles into iliac conduit creation (34833). The exposure should not be coded if it is on the same side as the conduit. If the two procedures are on different sides, modifiers RT and LT should be applied rather than modifier 59.

Example #10: Extremity angiogram (75710) bundles into iliac angioplasty (37220). The angiogram can be reported with modifier 59 if a diagnostic angiogram has not been performed previously and the decision to perform the angioplasty was based on the angiogram. Modifier 59 can also be applied if one of the other criteria outlined in the CPT® manual applies—for example, if there has been a change in the patient's condition since the prior angiogram.

Example #11: Two-view chest x-ray (71020) bundles into chest tube placement (32551). It is not appropriate to apply modifier 59 when the chest x-ray is performed following chest tube insertion to make sure the tube was correctly placed. However, code 71020 can be reported with modifier 59 if later that day the patient develops a high fever and chest x-ray is ordered to rule out pneumonia.

Conclusion

This is a good time to re-examine the scenarios where you most often use modifier 59. If they do not involve different encounters and/or different anatomic areas, you should carefully review the CMS guidance to make sure they qualify. Also, be sure to use the laterality modifiers (RT/LT) or other NCCI-associated modifiers instead of modifier 59 when they provide a better explanation of why the procedures are separate and distinct.

You can find the new "Special Edition" modifier 59 article at:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1418.pdf

The CMS NCCI web page contains the NCCI Policy Manual and the previous modifier 59 article:
http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Note: This article originally appeared in the July 2014 issue of Coding Strategies' *Radiology Coding & Compliance Expert.*

Welcome New RCCs!

The RCCB Board of Directors congratulates the following individuals for passing the July 2014 RCC exam:

- Kimberly Denise Cross, RCC
- Leslie Ridgeway Forsman, RCC
- Alexander Galvez, RCC
- Stacie Ann Graham, RCC
- Ingrid Moore, RCC
- Al Moses, RCC
- Casey Dawn Robin, RCC

These individuals have successfully demonstrated the commitment to and expertise in radiology coding that all RCCs share in common. Welcome!