Fall 2018

# RCC Update

RCCB
RADIOLOGY CODING CERTIFICATION BOARD
CODINGSTRATEGIES

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

Fall Approaching!

Depending on where you are in the country, this has been an extremely hot summer and we look forward to the cool weather on the way and wish all the examinees sitting for the exam this Fall good luck!

Looking for resources to help prepare for the exam? Click here for a full list of study resources.

Stay tuned for 2019 exam dates!

Sincerely,
Renée C. Engle, RCC, FRBMA

*"Success is the sum of small efforts, repeated day in and day out."* - Robert Collier

***Medicare***

## Some Relief in 2019 MPFS Proposed Rule

On July 12 the Centers for Medicare & Medicaid Services (CMS) released the Proposed Rule for the Medicare Physician Fee Schedule (MPFS) for CY 2019. The Proposed Rule was published in the Federal Register on July 27, and public comments are due by September 10. The Final Rule will be released by early November. See the MPFS Proposed Rule in its entirety at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf

CMS estimates a 2019 conversion factor of $36.05, up from $35.99 in 2018. The estimated conversion factor reflects the 0.25% update specified by the Medicare Access and CHIP Reauthorization Act (MACRA) and a budget neutrality adjustment of -0.12%.

If the provisions in the Proposed Rule are finalized, CMS estimates a neutral (0%) impact for radiology and interventional radiology. However nuclear medicine would see an aggregate 1% decrease and radiation oncology would see a 2% decrease.

With approximately 60 new or revised radiology codes for 2019, CMS is proposing increased relative value units (RVUs) for some codes and decreased RVUs for others.

### Appropriate Use Criteria/Clinical Decision Support

CMS has finalized a date of January 1, 2020 for implementation of appropriate use criteria (AUC)/clinical decision support (CDS) for all advanced diagnostic imaging services. This delay allows more time to develop instructions for claims processing. An "educational and operations testing period" will begin on January 1, 2020 for one year. During this period, ordering professionals will consult AUC, and imaging providers will report AUC information on their claims, but claims will be paid regardless of correct reporting.

CMS is still proposing the use of a series of G codes and modifier for claims processing.

**Some Relief in 2019 MPFS Proposed Rule**
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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 Coding Strategies, Inc.
Tell us what you think at info@rccb.org

## Some Relief in 2019 MPFS Proposed Rule

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CMS proposes that the consultation may be performed by "clinical staff working under the direction of the ordering professional," allowing flexibility, yet achieves the goal of promoting the use of AUC.

CMS also proposes adding independent diagnostic testing facilities (IDTFs) to the definition of "applicable setting," to apply the AUC program across a range of outpatient settings where the applicable imaging services are provided. CMS also invites comment on adding any other applicable settings for the program.

CMS proposes that when ordering advance diagnostic imaging services, physicians who are experiencing insufficient internet access, electronic health record (HER) or clinical decision support mechanism (CDSM) vendor issues, or extreme/uncontrollable circumstances (including natural and manmade disasters) are not required to consult AUC using a qualified CDSM.

Regarding outlier ordering professionals, CMS will not be using the data during the testing period to identify outliers. CMS is therefore inviting public suggestion for methodologies for identification of outliers.

### Site Neutral Payment

The site-neutral payment policy, which was implemented in 2017, applies to non-excepted off-campus provider-based hospital departments (PBDs), such as a physician office that is owned by a hospital and maintained as a hospital outpatient department, is remote from the hospital campus, and did not begin providing services until November 2, 2015, or later.

Medicare currently pays for services provided in non-excepted PBDs under the MPFS at 40% of the Outpatient Prospective Payment System (OPPS) payment rate for the service. For 2019 CMS proposes to maintain this payment rate.

### Proposed Valuation of Specific Codes for CY 2019

CMS proposes valuation changes to several established codes and several new CPT® codes yet to be fully released by the American Medical Association (AMA). Those codes relevant to radiology that are specifically addressed by CMS include:

- Fine needle aspiration (FNA) - 10021, 10X11, 10X12, 10X13, 10X14, 10X15, 10X16, 10X17, 10X18, 10X19, 76942, 77002, and 77021
- PICC line procedures – 36568, 36569, 36X72, 36X73, 36584
- Radioactive tracer – 38792
- Gastrostomy tube replacement – 43X63, 43X64
- Urinary tract dilation – 50X39, 50X40, 52334, 74485
- X-ray of spine – 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, 72120
- X-ray of sacrum – 72200, 72202, 72220
- X-ray of elbow/forearm – 73070, 73080, 73090
- X-ray of heel – 73650
- X-ray of toe – 73660
- X-ray of esophagus – 74210, 74220, 74230
- X-ray of urinary tract – 74420
- Fluoroscopy – 76000
- Echo exam of eye thickness – 76514
- Ultrasound elastography – 767X1, 767X2, 767X3
- Ultrasound of scrotum – 76870
- Contrast-enhanced ultrasound – 76X0X, 76X1X
- Magnetic resonance imaging (MRI) – 76X01
- Computed tomography (CT) scan for needle biopsy – 77012
- Dual-energy x-ray absorptiometry – 77081
- Breast MRI with computer aided detection (CAD) – 77X49, 77X50, 77X51, 77X52

This article will not discuss the specific proposals for the RVU adjustments. Refer to the Proposed Rule for more information.

### Radiologist Assistant

Currently, some diagnostic tests require personal supervision when performed by a radiology assistant (RA). CMS proposes to revise the required physician supervision for those services to direct physician supervision when performed by an RA, when permitted by state lay and state scope of practice regulations. This addresses the stakeholder comments that the current level of supervision is

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restrictive and does not allow radiologists to fully utilize RAs.

## Evaluation and Management Guidelines

In the 2018 Proposed Rule, CMS request public comment on how to bet update 1995 and 1997 Documentation Guidelines for Evaluation and Management (E/M) Services, which are "potentially outdated and need to be revised, especially the history and exam components." In the 2019 Proposed Rule, CMS suggests a step-wise approach that would limit changes to only the office/outpatient E/M code set (99201-99205, 99211-99215). CMS is not ruling out changes or expansion into inpatient and emergency department care, but simply admits that these codes come with "unique clinical and legal issues and the potential intersection with hospital Conditions of Participation (CoPs)."

Specifically, CMS has proposed the following changes to office and outpatient E/M services.

CMS proposes public comments about eliminating or making adjustments or exceptions for the provision in which billing same-day visits by practitioners of the same group and same specialty are not separately billable. The original intent was that these services would not be medically necessary. However, it is becoming more likely that a patient may be seen for different reasons by the same physician or specialty group as physicians cross train into multiple specialties.

CMS proposes allowing physicians to choose a documentation that better serves to support the type of work and visits each physician provides. The choices would be continue utilizing the 1995 or 1997 guidelines, utilize a framework designed around medical decision making as the main component, or utilize a time based framework. CMS believes this change would lessen the burden to practitioners to no longer document irrelevant components or those that are burdensome to include. The same codes (99201-99215) would be used.

CMS is also proposing for only the key components of history or exam for established patients, and only those corresponding items that had changed or have not changed since the last visit would be documented.

Regardless of the selected framework, CMS proposing two different reimbursement values between the 5 levels of new patient visits and two different reimbursement values between the 5 levels of established patient visits.

CMS is also proposing new G codes to reflect the use or more or less resources used by certain specialties.

Finally, regarding teaching physicians, CMS is proposing to allow the presence of the teaching physician to be documented with a note in the medical record by a physician, resident, or nurse. Additionally the extent of the participation and direction of services provided to the beneficiary may be demonstrated by notes in the medical record by a physician, resident, or nurse.

*- Article by Coding Strategies® Staff*

***Diagnosis Coding***

# New and Revised Diagnosis Codes for 2019

The 2019 ICD-10-CM code set includes 279 new codes, 143 revised codes, and 51 deleted codes. These changes go into effect October 1, 2018. This article will review some of the changes that are most important to radiology. You can find the complete ICD-10-CM code set for Fiscal Year 2019 on the website of the National Center for Health Statistics (NCHS):
https://www.cdc.gov/nchs/icd/icd10cm.htm

Please see the separate article in this issue for a discussion of the 2019 changes to the ICD-10-CM guidelines.

## Neoplasms of the Eyelid

There are 44 new codes in the Neoplasms chapter to distinguish between neoplasms of the upper eyelid and lower eyelid. Previously, the codes only identified the eyelid, without specifying if the upper or lower eyelid is affected. These changes are reflected in both the Tabular List as well as the Neoplasm Table. For example:

| | |
|---|---|
| C4A.111 | Merkel cell carcinoma of the right upper eyelid, including canthus |
| C4A.112 | Merkel cell carcinoma of the right lower eyelid, including canthus |

Refer to the ICD-10-CM Manual to see all of the changes.

## Facial Nerve Disorders

Four new codes for clonic hemifacial spasm have been subdivided to create individual codes identifying laterality – G51.31 (right), G51.32 (left), G51.33 (bilateral) and G51.39 (unspecified).

## Muscular Dystrophy

All of the inclusion terms under G71.0 *(Muscular Dystrophy)* were deleted and replaced with 4 new codes and corresponding inclusion terms under this subcategory.

**New and Revised Diagnosis Codes for 2019**
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## New and Revised Diagnosis Codes for 2019

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| | |
|---|---|
| G71.00 | Muscular dystrophy, unspecified |
| G71.01 | Duchenne or Becker muscular dystrophy |
| G71.02 | Facioscapulohumeral muscular dystrophy |
| G71.09 | Other specified muscular dystrophies |

### Cerebral Infarction

Codes I63.219 and I63.239 were revised to read "artery" rather than "arteries" in the code definitions.

There are also 2 new codes under subcategory I63.8 *(Other cerebral infarction)*:

| | |
|---|---|
| I63.81 | Other cerebral infarction due to occlusion or stenosis of small artery |
| I63.89 | Other cerebral infarction |

### Hereditary Cerebrovascular Diseases

A new subcategory has been created to identify hereditary cerebrovascular disease (I67.85). This includes codes I67.850 *(Cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy)* and I67.858 *(Other hereditary cerebrovascular disease)*.

### Acute Appendicitis

The inclusion terms under subcategories K35.2 *(Acute appendicitis with generalized peritonitis)* and K35.3 *(Acute appendicitis with localized peritonitis)* have been deleted and replaced with new codes and corresponding inclusion terms to specify complications such as gangrene and abscess. Subcategory K35.89 *(Other acute appendicitis)* has also been expanded to specify with or without gangrene. See Table 1 for complete code descriptions.

| Code | Description |
|---|---|
| K35.20 | Acute appendicitis with generalized peritonitis, without abscess |
| K35.21 | Acute appendicitis with generalized peritonitis, with abscess |
| K35.30 | Acute appendicitis with localized peritonitis, without perforation or gangrene |
| K35.31 | Acute appendicitis with localized peritonitis and gangrene, without perforation |
| K35.32 | Acute appendicitis with perforation and localized peritonitis, without abscess |
| K35.33 | Acute appendicitis with perforation and localized peritonitis, with abscess |
| K35.890 | Other acute appendicitis without perforation or gangrene |
| K35.891 | Other acute appendicitis without perforation, with gangrene |

**Table 1**

**New and Revised Diagnosis Codes for 2019**

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## New and Revised Diagnosis Codes for 2019

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### Disorders of the Gallbladder and Biliary Tract

Two new codes have been added to identify gangrene (K82.A1) or perforation (K82.A2) of the gallbladder in cholecystitis. In turn, a note has been added under cholelithiasis subcategories K80.0, K80.1, K80.4, and K80.6, and under category K81 *(Cholecystitis)* to "Use additional code if application for associated gangrene of gallbladder (K82.A1), or perforation of gallbladder (K82.A2)."

All of the inclusion terms under subcategory K83.0 (Cholangitis) have been deleted and replaced with new codes and corresponding inclusion terms to distinguish between primary sclerosing cholangitis (K83.01) and other cholangitis (K83.09).

### Multiple Gestation

Three new subcategories and 12 new codes were added for multiple gestation to include more code options to identify the number of placentas and amniotic sacs present, as shown in Table 2.

| Code | Description |
|---|---|
| O30.131 | Triplet pregnancy, trichorionic/triamniotic, first trimester |
| O30.132 | Triplet pregnancy, trichorionic/triamniotic, second trimester |
| O30.133 | Triplet pregnancy, trichorionic/triamniotic, third trimester |
| O30.139 | Triplet pregnancy, trichorionic/triamniotic, unspecified trimester |
| O30.231 | Quadruplet pregnancy, quadrachorionic/quadra-amniotic, first trimester |
| O30.232 | Quadruplet pregnancy, quadrachorionic/quadra-amniotic, second trimester |
| O30.233 | Quadruplet pregnancy, quadrachorionic/quadra-amniotic, third trimester |
| O30.239 | Quadruplet pregnancy, quadrachorionic/quadra-amniotic, unspecified trimester |
| O30.831 | Other specified multiple gestation, number of chorions and amnions are both equal to the number of fetuses, first trimester |
| O30.832 | Other specified multiple gestation, number of chorions and amnions are both equal to the number of fetuses, second trimester |
| O30.833 | Other specified multiple gestation, number of chorions and amnions are both equal to the number of fetuses, third trimester |
| O30.839 | Other specified multiple gestation, number of chorions and amnions are both equal to the number of fetuses, unspecified trimester |

**Table 2**

**New and Revised Diagnosis Codes for 2019**
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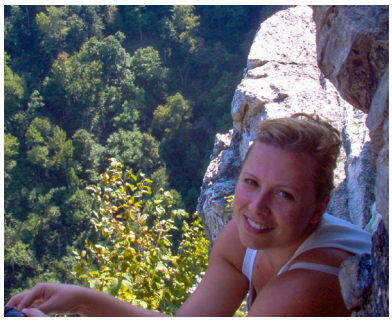
## Shannon Kathleen Murray

8/18/1979 – 5/20/2018



Shannon was a passionate daughter, sister, friend and co-worker who lived to expand her mind and explore life.

In her personal life she appreciated all things beautiful with nature, the outdoors, and animals in need at the top of her list. She loved rescuing dogs and volunteering in a wolf sanctuary. She was adventurous and excelled at all outdoor sports including snow skiing, white water rafting, horseback riding and rock climbing to name only a few. Shannon loved to travel with Colorado and California, West Virginia, and Costa Rica her favorite places to visit.

Her professional life was dedicated to the healthcare compliance field with auditing as her specialty. Shannon was a voracious reader and a lifelong learner mastering everything she attempted. She was always seeking ways to grow professionally and was particularly excited about the tools that RCCB had added to facilitate passing the RCCB examination. Her next endeavor and personal goal was to achieve her RCC credential this year.

In remembrance of Shannon, the RCCB has created the Shannon Murray Memorial Scholarship and will be awarding a scholarship to an individual who would like to further their career and sit for the Radiology Certified Coder (RCC) exam. The scholarship covers the cost of the exam.

**New and Revised Diagnosis Codes for 2019**
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## Congenital Malformation of Uterus

Subcategory Q51.2 *(Other doubling of uterus)* has been divided to specify unspecified (Q51.20), complete (Q51.21), partial (Q51.22), or other specified (Q51.28) doubling of the uterus.

## Coma Scale

Inclusion terms have been added to the coma scale codes under subcategory R40.2 *(Coma)* to indicate the corresponding coma scale scores.

## Abnormal Findings

Subcategory R93.81 *(Abnormal radiologic findings on diagnostic imaging of testis)* has been divided to specify laterality – right (R93.811), left (R93.812), bilateral (R93.813), and unspecified (R93.819).

## Fracture of Finger

The code descriptions have been revised to read "middle" phalanx rather than "medial" phalanx for applicable codes under subcategory S626.6 *[Fracture of other and unspecified finger(s)]*.

## Post-Procedural Infection

All of the inclusion terms under code T81.4 *(Infection following a procedure)* have been deleted and replaced with 6 new codes and corresponding inclusion terms in order to provide more specificity, as shown on Table 3.

| Code | Description |
|---|---|
| T81.40 | Infection following a procedure, unspecified |
| T81.41 | Infection following a procedure, superficial incisional surgical site |
| T81.42 | Infection following a procedure, deep incisional surgical site |
| T81.43 | Infection following a procedure, organ and space surgical site |
| T81.44 | Sepsis following a procedure |
| T81.49 | Infection following a procedure, other surgical site |

**Table 3**

*- Article by Coding Strategies® Staff*

*Medicare*

# Potential Impacts from OPPS Proposed Rule

On July 25, 2018, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Hospital Outpatient Prospective Payment System (HOPPS) for CY 2019. The Proposed Rule was published in the Federal Register on July 31 and public comments are due by September 24. The Final Rule will be released by early November. See the OPPS Proposed Rule in its entirety at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-15958.pdf

## Payment Rates

CMS is proposing an increase of payment rates under the Outpatient Department (OPD) fee schedule with a 1.25% increase to the conversion factor of CY 2018. The CY 2019 conversion factor is proposed to be $79.546; however, for hospitals that fail to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements, CMS is proposing a conversion factor of $77.955.

Ambulatory Surgical Center (ASC) payments are proposed to increase by 1.3% that meet quality reporting under the ASCQR program.

## Standardizing APC Payment Weights

CMS instructs providers to apply current procedure-to-procedure edits and then report all remaining services on the claim form. CMS will only pay for those services which are considered not packaged into another service.

CMS is proposing to continue using HCPCS code G0463 *(Hospital outpatient clinic visit for assessment and management of a patient)* in APC 5012 (Level 2 Examinations and Related Services) as the standardized code for the relative payment weights. A relative payment weight of 1.00 is proposed to be assigned to APC 5012 (code G0463).

## Multiple Imaging Composite APC

For CY 2019 and subsequent years, CMS is proposing to continue to pay for all multiple imaging procedures within an imaging family performed on same date of service using multiple imaging composite APC payment methodology. Standard APC assignments will continue to apply for single imaging procedures and multiple imaging procedures performed across families. A single imaging session performed "with contrast" is part of a composite APC when at least one or more imaging procedures from the same

**Potential Impacts from OPPS Proposed Rule**
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family are also performed with contrast on same date of service.

The five multiple imaging composite APCs established in CY 2009 with CY 2019 proposed reimbursement rates are:

- APC 8004 (Ultrasound Composite), proposed payment rate $302.05
- APC 8005 (CT and CTA without Contrast Composite), proposed payment rate $268.50
- APC 8006 (CT and CTA with Contrast Composite), proposed payment rate $489.03
- APC 8007 (MRI and MRA without Contrast Composite), proposed payment rate $546.23
- APC 8008 (MRI and MRA with Contrast Composite), proposed payment rate $860.89

## 2 Times Rule Exceptions

For CY 2019, CMS is proposing to make exceptions to all of the 2 times rule violation APCs, this meaning no adjustments or movement of codes to other APCs to balance the highest and lowest costing codes. There are four imaging APCs, which are proposed to be excluded from any change. APC 5521 Level 1 Imaging without Contrast, APC 5522 Level 2 Imaging without Contrast, APC 5523 Level 3 Imaging without Contrast and APC 5571 Level 1 Imaging with Contrast.

## Cost allocation for CT and MRIs

In CY 2014, CMS finalized the policy to create new costs centers in relation to calculation of the cost-to-charge (CCR) ratio value assigned to each particular hospital specifically for implantable devices, MRIs, CTs and cardiac catheterizations. The CCR is a value used by CMS to convert charges to estimated costs as a means of determining the reimbursement for any particular APC.

CMS removed the data for those hospitals that used "square feet" as a means or calculating cost allocation. CMS is proposing to extend the practice of removing the cost data from the hospitals using "square feet" for CY 2019.

## New HCPCS Code 0505T

CMS introduced a new HCPCS code effective July 1, 2018, category III code 0505T *(Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion)*.

Code 0505T is proposed to be assigned to APC 5193 (Level 3 Endovascular Procedures) with a status indicator (SI) of J1. All ancillary services are still reported on the claim form, after applying edits, but only the primary code assigned J1 is paid. The other services are considered packaged into the primary service.

## Imaging Procedures and Services (APCs 5521-5524 and 5571-5573)

In CY 2016, CMS conducted a comprehensive review and restructuring of APCs that contained imaging services. The purpose was to better allocate the resource cost and clinical characteristics of the imaging services within each APC. In CY 2017, there were additional adjustments made, in which 17 APCs were reduced to 7. Four of the APCs include imaging services without contrast and three include imaging services with contrast.

For CY 2019, CMS is proposing to maintain the seven APCs as finalized in CY 2017. CMS is not proposing to add another APC as was done for CY 2018 to account for high cost imaging procedures.

## Clinical Families Services in Excepted Off-Campus Departments

Excepted off-campus provider-based departments (PBDs) are settings which were established and billing for services prior to November 2, 2015 and within the previously set distance of 35 miles and are paid at the HOPPS full established rate for each service and considered grandfathered into the payments under HOPPS even if the new distance threshold is not met.

For CY 2019 and subsequent years, CMS is proposing changes for excepted off-campus PBDs. If certain items or services from any of the clinical families were not furnished during the baseline of November 1, 2014 through November 1, 2015, the services are not considered covered under the excepted status and would instead be nonexcepted and paid under MPFS. However, if an excepted off-campus PBD furnishes new services or items from a clinical family for which other services were already provided as part of that family, these services would be considered excepted and paid under HOPPS, as it would not be considered a "service expansion."

CMS is proposing to use the "families" of services and not limit to only the individual CPT® or HCPCS codes reported as this would allow for the expansion of services within the same family service line without the adjustment to reimbursement.

**Potential Impacts from OPPS Proposed Rule**
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## Site-Neutral Payments

For CY 2019, CMS is proposing a site-neutral method for controlling *"unnecessary increases in the volume of covered outpatient department services."* For CY 2019, CMS has proposed to utilize a Medicare Physician Fee Schedule (MPFS) payment rate for code G0463 *(Hospital outpatient clinic visit for assessment and management of a patient)* when billed in excepted off-campus provider-based departments

For CY 2019, CMS is proposing to reimburse outpatient clinic visits billed by excepted off-campus PBDs at the same rate that nonexcepted off-campus PBDs are paid. Only on-campus hospital outpatient departments would be reimbursed at the full HOPPS value for code G0463 in CY 2019. Excepted off-campus PBDs would continue to report G0463 with modifier PO, only the reimbursement would change from what is currently paid in CY 2018.

## Radioisotopes Derived From Non-Highly Enriched Uranium Source

Hospitals report code Q9969 (Tc-99m from non-highly enriched uranium source, full cost recovery add-on per study dose) once per dose along with the diagnostic scan using the Tc-99m, with the caveat the hospital must be able to certify at least 95 percent of the Tc-99m dose is derived from non-HEU sources.

For CY 2019, CMS is proposing to continue to provide an additional $10 payment for radioisotopes produced by non-HEU sources. Once the conversion to non-HEU sources is closer to completion or has completed, CMS will reassess the payment policy.

## Hospital Outpatient Quality Reporting (OQR) Program

For CY 2019, CMS is proposing to remove a total of ten Hospital Outpatient Quality Reporting Program (OQR) measures for CY 2020 and CY 2021 payment determinations.

CMS is clarifying the process for calculating the TCOV for measures PO-11 Thorax Computed Tomography (CT) – Use of Contrast Material (NQF #0513) and PO-14 Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT (no NQF number). These two particular measures actually assess the rate of rare, undesired events for which a lower rate is preferred.

CMS is also proposing to remove OP-9 Mammography Follow-up Rates. The claims-based measure assesses the percentage of patients with mammography screening studies followed by a diagnostic mammography, ultrasound or MRI of the breast in an outpatient or office setting within 45 days.

*- Article by Coding Strategies® Staff*

# RCC and RCCIR Exam Information

**Exam Dates:** November 12-16, 2018

**Exam Location:** Test sites available nationwide, please click here for further information.

**Exam Application Deadline:** October 12, 2018 (must be in RCCB Office)

**Reservation Dates:** Reservations for the test site can be made beginning October 29, 2018. The deadline for making your reservation is November 11, 2018. Reservations not made by this date will be subject to the cancellation policy as stated in the RCC Candidate Bulletin and RCCIR Candidate Bulletin of information.

***Diagnosis Coding***

# Revisions to the ICD-10-CM Guidelines for 2019

The 2019 edition of the ICD-10-CM Official Guidelines for Coding and Reporting were released by the National Center for Health Statistics (NCHS) on July 26, 2018. There are some changes that will affect code assignment for radiology services. This article will highlight only the most important changes relevant to radiology, but the complete guidelines (120 pages) can be downloaded from the NCHS website at:
https://www.cdc.gov/nchs/icd/icd10cm.htm

Please see the separate article in this issue for a discussion of the 2019 ICD-10-CM code changes.

## "With"

The guideline regarding the term "with" has been revised to clarify that it applies when the term "with" or "in" appears under either a main term or a subterm. The 2019 guideline states:

> The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index (either under a main term or subterm), or an instructional note in the

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RADIOLOGY CODING CERTIFICATION BOARD

# CAREER CENTER

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> Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis").

## Documentation by Other Clinicians

Section I.B.14 of the Guidelines has been retitled "Documentation by Clinicians Other than the Patient's Provider." The guideline has been revised to indicate that code assignment for body mass index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) may be based on documentation from clinicians who are not the patient's provider (for example, dietician, nurse, or EMT). However, the associated diagnosis must be documented by the patient's provider.

Also added to this guideline is a statement regarding social determinants of health, such as those found in categories Z55-Z65. Code assignment of social determinants of health may be based on documentation from clinicians who are involved in the patient's care, but are not the patient's provider. The 2019 guideline reads:

> Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions, such as codes for the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.
>
> For social determinants of health, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses.
>
> The BMI, coma scale, NIHSS codes and categories Z55-Z65 should only be reported as secondary diagnoses.

## Hurricane Aftermath

A new section was added for "Coding for Healthcare Encounters in Hurricane Aftermath." These guidelines discuss the use and sequencing of external cause codes for injuries that are incurred as a result of a hurricane. If it is unclear whether an injury is a result of a hurricane, assume that it is. In the aftermath of a hurricane, a healthcare setting "should be considered as any location where medical care is provided by licensed healthcare professionals." See Section I.B.19 for more information.

## Zika Virus

The guideline on Zika virus infections was revised to reflect the new code Z20.821 *[Contact with and (suspected) exposure to Zika virus]*.

## Neoplasms

The guideline for primary malignancy previously excised was revised to clarify that there must be "no evidence of any existing primary malignancy at that site." The phrase "at that site" was added to distinguish between the previous primary malignancy versus a new one at a different site.

Additionally, there is a new paragraph stating that subcategories Z85.0-Z85.7 should be used only for the former site of the primary malignancy, not the site of a secondary malignancy. However codes from subcategory Z85.8 can be used for the former site of a primary or a secondary malignancy.

## Hypertensive Heart Disease

The revised guideline states that hypertension with conditions classified to I50.- or I51.4-I51.7, I51.89, I51.9 are assigned to a code from category I11. This effectively removes code I51.81 *(Takotsubo syndrome)* from the guideline. A later statement regarding coding these conditions separately when documented that they are unrelated by the physician also removes code I51.81.

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## Hypertensive Chronic Kidney Disease

The guideline has been update to read that CKD should not be coded as hypertensive if the provider "indicates the CKD is not related to the hypertension" from "has specifically documented a different cause."

## Pulmonary Hypertension

The guideline has been updated to indicate that sequencing is based on the reason for encounter, except for adverse effects of drugs.

## Myocardial Infarction

A new paragraph has been added to the guideline for subsequent myocardial infarction (MI). It states:

> If a subsequent myocardial infarction of one type occurs within 4 weeks of a myocardial infarction of a different type, assign the appropriate codes from category I21 to identify each type. Do not assign a code from I22. Codes from category I22 should only be assigned if both the initial and subsequent myocardial infarctions are type 1 or unspecified.

Section I.C.9.e.5 was updated to state that a Type 1 MI is assigned to codes I21.0-I21.4 and I21.9.

## Coma Scale

A new paragraph has been added to the guideline stating that the codes for individual or total Glasgow coma scale scores should not be used for a patient in a medically induced coma or for a sedated patient.

## Underdosing

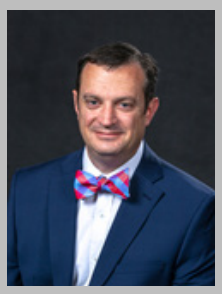
The guideline for underdosing has been revised to specify that when a patient stops the use of a prescribed medication on his or her own initiative, it is also classified as an underdosing.

*- Article by Coding Strategies® Staff*

# New ACR Liason

The Board of Directors has seen a change recently. Matt Hawkins, MD has departed as ACR Liaison. Though we will miss him, we would like to thank him for his invaluable time and wish him luck on his future endeavors.

The new ACR Liaison is Eric Matthew Rubin, MD.



Eric Matthew Rubin, MD
Medical Director of Computed Tomography - Department of Radiology
Crozer-Keystone Health System, Upland, PA

Dr. Rubin, a diagnostic radiologist, is the Medical Director of Computed Tomography in the Department of Radiology at Crozer-Keystone Health System, and is a partner in Southeast Radiology, LTD, a private practice radiology group that provides imaging services to Crozer-Keystone Health System. He received a Bachelor of Arts degree from the University of Pennsylvania and graduated from Robert Wood Johnson Medical School. He, subsequently, completed his diagnostic radiology residency at Thomas Jefferson University Hospital (Philadelphia, PA) and a fellowship in abdominal imaging at Beth Israel-Deaconess Medical Center (Boston, MA). Dr. Rubin currently serves on the editorial board of the AMA/ACR *Clinical Examples in Radiology*, as a member of the ACR Economics Committee on Coding and Nomenclature, member of the ACR Council Steering Committee and is the Alternate CPT Advisor representing the American Roentgen Ray Society. He lives in Media, Pennsylvania with his wife, Aimee, and three children.

Welcome Dr. Rubin!