



RCC UPDATE

Radiology Coding Certification Board

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From the President



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Welcome to the inaugural issue of “RCC Update!” RCC Update is a quarterly publication reporting on radiology coding developments and the latest news from the Radiology Coding Certification Board (RCCB). Future issues will be published in June, September, and December. RCC Update is made possible with our partners at Coding Strategies, Inc.

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Reporting Option	Individual EP	Group Practice
Claims	Yes	
Qualified registry	Yes	Yes
EHR	Yes	Yes
CMS-certified survey vendor		Yes
Measures groups	Yes	
Qualified clinical data registry	Yes	

The administrative claims reporting option has been eliminated for 2014 and two new options—the CMS-certified survey vendor and the qualified clinical data registry—have been instituted. Additionally, measures groups can now be reported only through a qualified registry, not on claims.

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Making Your 2014 PQRS Choices

Although it is now the third month of 2014, many radiology groups are still trying to finalize their PQRS participation strategy for the year. It’s an important decision because groups that fail to meet the minimum reporting requirements during 2014 will have their 2016 Medicare payments reduced by 2%. On the other hand, groups who meet the full reporting requirements will receive an incentive payment consisting of 0.5% of their 2014 Medicare payments, **and** they will avoid the 2% payment reduction in 2016. This article gives you a summary of the options for reporting methodologies and measures.

Reporting Options

The table below summarizes the 2014 reporting options. Note that some options apply only to individual eligible professionals (EPs), some apply only to group practices, and some apply to both individuals and groups.

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The new survey option, which is available only to groups of 25 or more EPs, involves use of the CG CAHPS (Clinician & Group Consumer Assessment of Healthcare Providers and Systems®) patient survey, which must be administered through a CMS-certified survey vendor. In addition to the survey, the group must also perform additional reporting via a qualified registry, direct EHR product, EHR data submission vendor, or the GPRO Web Interface.

The qualified clinical data registry, which is an option only for individual EPs, is different from the qualified registry that can be used for the pre-existing registry reporting option (although the same organization may serve as both types of registry). These new registries may use measures that are outside of the PQRS measure set, and EPs must report measures on all patients rather than on Medicare patients only. The ACR website notes that these registries are “potentially such as the ACR NRDR” (National Radiology Data Registry).

Participation Criteria

Each of the reporting options has two sets of criteria for satisfactory participation—a set of minimum requirements that must be met in order to avoid the 2016 payment reduction, and a set of more stringent requirements that must be met in order to receive the 2014 payment incentive.

For example, in order to qualify for the 2014 incentive via claims-based reporting, the individual EP must report 9 measures, covering at least 3 National Quality Strategy (NQS) domains, for at least 50% of the Medicare Part B fee-for-service (FFS) patients to which the measure applies. Alternatively, if there are fewer than 9 measures that apply to the EP, the EP may report 1-8 measures covering 1-3 NQS domains. It is important to note that measures with a 0% performance rate will not be counted.

If an EP simply wants to avoid the 2016 payment reduction rather than qualify for the incentive, then successful claims-based reporting requires only 3 measures covering one NQS domain for at least 50% of the Medicare Part B FFS patients to which the measures apply. Alternatively, if fewer than 3 measures apply, the EP can both avoid the penalty and earn the incentive by reporting 1-2 measures.

For detailed information about the criteria for successful reporting, see the excellent summary on the ACR website at: <http://www.acr.org/Quality-Safety/Quality-Measurement/PQRS>

Additionally, there is detailed information in the CMS 2014 PQRS Fact Sheet at:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2014PQRS_WhatsNew_F01-09-2014.pdf

Points to Remember

- This is the last year for the 0.5% incentive payment for successful reporting.
- Failure to report during 2014 will result in payment reduction of 2% in 2016.
- The reporting requirements for the incentive are more extensive than those for avoiding the payment reduction.
- Measures groups, including the new OPEIR group for radiation exposure, can now be reported only through a registry.

Individual Measures

The ACR's PQRS web pages list a number of individual measures that radiologists should consider. (See the boxes on the following page.) The specific measures that an individual radiologist reports should be selected based on his or her practice. Some radiologists may choose measures from

both the Diagnostic and Interventional categories. Note that all of these measures were in effect during 2013, although one 2013 measure (#256, Surveillance after Endovascular Abdominal Aortic Aneurysm Repair) has been retired.

As noted earlier, in order to meet the criteria for the 2016 incentive through claims-based reporting, the EP must report at least 9 measures covering at least 3 NQS domains, if applicable. The NQS domains are:

- Patient safety
- Person and caregiver-centered experience and outcomes
- Communication and care coordination
- Effective clinical care
- Community/population health
- Efficiency and cost reduction

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Diagnostic Radiology and Nuclear Medicine Measures

- 145 Radiology: Exposure Time Reported for Procedures Using Fluoroscopy [*Patient Safety*]
- 146 Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening [*Efficiency and Cost Reduction*]
- 147 Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy [*Communication and Care Coordination*]
- 195 Radiology: Stenosis Measurement in Carotid Imaging Reports [*Effective Clinical Care*]
- 225 Radiology: Reminder System for Mammograms [*Communication and Care Coordination*]
- 265 Biopsy Follow-Up [*Communication and Care Coordination*]
- 322 Cardiac Stress Imaging Not Meeting Appropriate use Criteria: Preoperative Evaluation in low Risk Surgery Patients [*Efficiency and Cost Reduction*]
- 323 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI) [*Efficiency and Cost Reduction*]
- 324 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients [*Efficiency and Cost Reduction*]

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- 20 Timing of Antibiotics – Ordering Physician [*Patient Safety*]
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- 24 Communication Following Fracture [*Communication and Care Coordination*]
- 40 Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older [*Effective Clinical Care*]
- 76 Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol [*Patient Safety*]
- 259 Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day) [*Communication and Care Coordination*]
- 344 Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2) [*Effective Clinical Care*]
- 345 Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) [*Effective Clinical Care*]

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The applicable domain is indicated next to each of the measures in the boxed lists.

Measures Groups

EPs who select registry reporting of measures groups have their choice of 24 different measures groups. Interventional radiologists may consider the Perioperative

Measures Group, which was also available in 2013.

Additionally, there is a new measures group for 2014, “Optimizing Patient Exposure to Ionizing Radiation” (OPEIR), which is suitable for diagnostic radiology. It includes the following measures:

- Utilization of a Standardized Nomenclature for Computed Tomography (CT) Imaging Description

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- Count of Potential High Dose Radiation Imaging Studies: Computed Tomography (CT) and Cardiac Nuclear Medicine Studies
- Reporting to a Radiation Dose Index Registry
- Computed Tomography (CT) Images Available for Patient Follow-up and Comparison Purposes
- Search for Prior Computed Tomography (CT) Imaging Studies Through a Secure, Authorized, Media-Free, Shared Archive
- Follow-up CT Imaging for Incidentally Detected Pulmonary Nodules According to Recommended Guidelines

For successful reporting of the OPEIR group, the EP must report at least 20 unique patients (at least 11 of whom are Medicare Part B FFS patients) who have had a specific type of CT service performed during the reporting period. Eligible CT procedure codes include 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, 72292, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74261, 74262, 75571, 75572, 75573, 75574, 75635, 76380, 76497, 77011, 77013, 77078, and 78072.

Note that when reporting on a measures group through a registry, the EP does not need to report a minimum of 9 measures in order to qualify for successful reporting, as is the case with claims-based reporting. However, the EP must report all of the measures in the group.

Conclusion

Even if your radiology group has not participated in PQRS in the past, it's not too late to start. This is the final year for the PQRS incentive payment, but the payment reduction for failure to report is likely to grow in future years. Additionally, large groups run a risk of being penalized twice for failing to report—once through the PQRS payment reduction and once through the Value Modifier program. For all of these reasons, this is a good time to jump aboard the 2014 PQRS train before it leaves the station.

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

**2014 RCC Exam Dates;
No November Exam**

The dates for the 2014 RCC exam are:

- May 12-16 (Deadline April 7th)
- July 21-25 (Deadline June 16th)
- September 15-19 (Deadline August 11th)

ICD-10 implementation is slated for October 1, 2014. RCCB will not be offering a November 2014 exam because: (1) applicants may not have sufficient mastery of ICD-10 to take the RCC exam in November and (2) the 2014 RCC exam assesses only basic ICD-10 knowledge and not the applicant's proficiency with ICD-10.

**Coding Coronary Artery Disease
in ICD-10-CM**

When coding myocardial perfusion, blood pool, and cardiac CTA studies after October 1, 2014, radiology coders will often need to use the ICD-10-CM codes for coronary artery disease and myocardial infarction. This article will give you an orientation to the new codes, including the significant guideline changes that accompany them.

Coronary Artery Disease

Coronary artery disease (CAD) is a narrowing of the coronary arteries, the vessels that supply oxygenated blood to the heart muscle. Atherosclerotic plaque builds up inside the vessel, putting the patient at risk for a clot. If a clot forms and blocks the artery, a portion of the patient's heart muscle will die from lack of oxygen, a condition known as a myocardial infarction.

In ICD-10-CM, CAD is reported with codes from category I25 (Chronic ischemic heart disease). Within that category, the code assignment is based on whether the disease involves the native coronary arteries or coronary artery bypass grafts, and whether or not the patient has angina pectoris (chest pain caused by CAD). If the physician does not specify whether the condition involves the native coronary arteries or bypass grafts, the default is native coronary arteries. Code choices for CAD of the native coronary arteries are:

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Atherosclerosis of Native Coronaries	Codes
Without angina pectoris	I25.10
With angina pectoris	
<ul style="list-style-type: none"> • Unstable angina • Angina with documented spasm • Other angina • Unspecified angina 	I25.110 I25.111 I25.118 I25.119

The ICD-10-CM guidelines (Section I.C.9.b) state that when you use one of the combination codes for CAD with angina, such as I25.110, you do not have to assign an additional code for the angina. Also, the physician does not have to state that the angina is due to the CAD in order for you to assign a combination code. Finally, if the patient has diagnoses of CAD as well as an acute myocardial infarction (MI), you should sequence the MI first.

When looking up atherosclerosis in the ICD-10-CM Index, you will usually end up at the entry for arteriosclerosis. As an example, the requisition for a nuclear stress test lists clinical indications of “CAD, angina.” Looking up “Disease, coronary (artery)” in the Index, you find a note to “see Disease, heart, ischemic, atherosclerotic.” The entry for “Disease, heart, ischemic atherosclerotic, with angina pectoris” tells you to “see Arteriosclerosis, coronary (artery).” The entry for “Arteriosclerosis, coronary (artery)” refers you to code I25.10 as the default when the physician does not document whether the condition is affecting the native coronary arteries or bypass grafts. Turning to the Tabular List, you find that code I25.10 represents arteriosclerosis of native coronary artery without angina pectoris. There are other codes in this category for arteriosclerosis of native coronary artery with angina. Code I25.119 is the best match for the patient’s condition. The code assignment is:

I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris

Disease of Bypass Grafts

There are separate codes in category I25 for atherosclerosis involving coronary artery bypass grafts. The code selection is based on the type of graft and whether the patient has angina. ICD-10-CM recognizes the following types of bypass grafts, though in practice you will probably never see any of these except for the first two.

- Autologous vein graft: The most common type of bypass graft, constructed from the patient’s own saphenous (or other) vein.
- Autologous arterial graft: Constructed from one of the patient’s own arteries, usually the left internal mammary artery.
- Nonautologous biological graft: Constructed from biological materials not taken from the patient’s own body, such as cadaver vein or human umbilical vein.
- Other graft: Any graft that does not fall into one of the categories above and is not in a transplanted heart.
- Unspecified graft: Graft type not documented.

For example, a patient is referred for cardiac CTA due to angina pectoris. This reveals atherosclerosis of a saphenous vein graft to the right coronary artery. The Index entry for “Atherosclerosis, coronary, artery, with angina pectoris” refers you to “Arteriosclerosis, coronary artery.” The entry for “Arteriosclerosis, coronary (artery), bypass graft, autologous vein, with, angina pectoris” refers you to code I25.719. Checking the Tabular List, the code assignment is:

I25.719 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris

Myocardial Infarction

Myocardial infarction (MI) is the necrosis or death of a portion of the myocardium, which is the middle and thickest layer of the heart wall. MI occurs when a blood clot blocks a coronary artery that has been narrowed by atherosclerotic plaque, cutting off the blood supply to the heart muscle.

The ICD-10-CM guidelines (Section I.C.9.e) define an *acute* MI as one that has occurred within the past four weeks (28 days). This is a major change from ICD-9-CM, which defined the acute phase as eight weeks. The acute MI codes can be assigned on multiple encounters during the acute period. For example, if the patient has imaging studies on two different dates during the four-week acute period, you should assign an acute MI code on both visits.

For old or healed myocardial infarctions greater than four weeks old that do not require further care, you should assign code I25.2 (Old myocardial infarction).

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STEMI and NSTEMI

Treatment decisions for acute myocardial infarction are based on the appearance of the patient's EKG, as well as on the symptoms. If the ST segment of the EKG is elevated, the patient most likely has blockage of a coronary artery and will need a reperfusion procedure like angioplasty or stent placement.

There are separate ICD-10-CM codes for ST elevation MI (STEMI) and non-ST elevation MI (NSTEMI). For coding purposes, a subendocardial, nontransmural, or non-Q wave MI should be treated as NSTEMI. "Subendocardial" and "nontransmural" mean that the infarction does not extend through the entire heart wall, while "non-Q wave" means that the patient's EKG does not show pathologic Q waves, which are another sign of heart damage.

The physician may be able to tell which coronary artery is blocked by reviewing the EKG, and there are separate categories for STEMI in different areas of the heart. For example, codes in category I21.0 are used to report STEMI of the anterior wall of the heart, including the left main and left anterior descending coronary arteries. If the radiology report or requisition indicates the specific location of the patient's acute MI, you should assign the most specific code possible.

There is only one code (I21.4) for NSTEMI, regardless of where in the heart the infarction occurs. If the physician describes the MI as NSTEMI but gives a specific heart location, you should still assign the NSTEMI code. For example, you should report the NSTEMI code I21.4 for a

diagnosis of acute nontransmural MI of the posterolateral wall.

Finally, ICD-10-CM contains specific codes in category I22 for subsequent myocardial infarction. You should use these codes in the unusual situation that the patient suffers a second MI within four weeks of the first MI. In this case the new MI is reported with a code from category I22 in addition to the code for the first MI, which is still acute.

Examples

Example #1: A portable chest x-ray is ordered for a patient in the coronary care unit. The clinical history is "Inferior ST elevation MI." In the Index, "Infarction, myocardium, ST elevation, inferior" refers you to code I21.19. The code assignment is:

I21.19 ST elevation (STEMI) myocardial infarction involving other coronary artery of inferior wall

Example #2: A patient is referred for SPECT myocardial perfusion study with clinical history of "CAD, S/P MI 2 years ago." In the Index, "Arteriosclerosis, coronary (artery)" refers you to code I25.10. The Index entry for "Infarction, myocardium, healed or old" refers you to code I25.2. The code assignment is:

I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.2	Old myocardial infarction

Note: This article originally appeared in the December 2013 issue of *Coding Strategies' Radiology Coding & Compliance Expert*.

Points to Remember

- Always start the coding process with the Alphabetic Index. Select the most specific Index entry possible, based on the available documentation.
- Check the Tabular List for instructional notes to ensure correct code assignment.
- In the case of acute MI, remember to watch for the key words that signal NSTEMI—subendocardial, nontransmural, and non-Q-wave.

2014 RCCB-Approved Continuing Education Courses

The RCCB has approved 20 courses for continuing education for 2014 to date. For a complete and current listing of 2014 approved education, go to <http://rccb.org/ce-sessions-accepted/2014>. Check back often, as new programs are added as they are approved.

RCCs Recertifying in 2014

RCCs recertifying in 2014 may do so no sooner than 60 days prior to the deadline date of the current certification. RCCB will be notifying 2014 RCCs to recertify. The recertification form can be found at <http://rccb.org/applications>. Remember, 2014 RCC certificants are required to obtain 2.5 CEUs of RCCB-approved ICD-10.

USPSTF Recommends CT for Lung Cancer Screening

On the last day of 2013, the United States Preventive Services Task Force (USPSTF) issued a final recommendation on CT screening for lung cancer. This article reviews that recommendation and what it means for your organization's reimbursement.

Background

There has been growing interest over the past 5 years in the use of CT to detect lung cancers at an early stage, while they are still easily treatable. In 2011 the National Cancer Institute released the results of the National Lung Screening Trial (NLST), which showed a 20% reduction in lung cancer mortality with low-dose CT screening as compared to chest x-ray. This was a large-scale study involving more than 50,000 current and former heavy smokers. Based on this study and others, in July 2013 the USPSTF issued a "Draft Recommendation Statement on Screening for Lung Cancer," which recommended annual low-dose CT screening for persons at high risk of lung cancer.

Final Recommendation

The Task Force states that their final recommendation "applies to adults who have no signs or symptoms of lung cancer but who are at high risk for developing the disease because of their age or smoking history." Specifically, it recommends annual low-dose CT screening for adults who:

- Are between the ages of 55 and 80
- Have a smoking history of 30 pack-years or more
- Currently smoke or have smoked within the past 15 years

"Pack-year" is a measure of cumulative tobacco consumption. One pack-year is the equivalent of smoking 1 pack of cigarettes per day for a year. A person could accumulate 30 pack-years by smoking 1 pack per day for 30 years, or 2 packs per day for 15 years.

The USPSTF assigns a grade to each of its recommendations. Preventive services with a grade of A or B are recommended for all patients who meet the criteria, those with a grade of C are recommended for selected patients based on the physician's judgment, and those with a grade of D are not recommended, either because they have no benefit or because the risks outweigh the benefits. The lung cancer screening recommendation was given a grade of B, meaning that there is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

The Task Force recommended that physicians discontinue CT lung cancer screening 15 years after a patient stops smok-

ing, or at any time if the patient develops a health problem that significantly limits his life expectancy or ability or willingness to have curative lung surgery. For example, if a patient has a terminal illness, or if he suffers from severe chronic illnesses that make him a poor candidate for lung surgery, then there is no longer any benefit to screening.

The USPSTF also noted that the recommended screening comes with risks as well as benefits. The risks include:

- **False-positive result:** This means that the CT scan shows a tumor when one is not actually present. The USPSTF states that up to 95% of all positive screening CT results may not result in a diagnosis of cancer. These false-positive tests can lead to additional imaging studies and/or invasive procedures.
- **False-negative result:** This means that the patient has a tumor, but it does not show up on the CT scan, so treatment is delayed.
- **Incidental findings:** The scan shows some abnormality other than lung cancer, such as emphysema or coronary artery calcification, which must then be evaluated through further testing.
- **Overdiagnosis:** This is the detection of slow-growing tumors that would not have been detected in the patient's lifetime without screening. Overdiagnosis exposes the patient to unnecessary treatment, since the tumor would not have affected the patient's quality of life.
- **Radiation exposure:** All CT scans entail radiation exposure, which in turn raises the risk of radiation-induced cancer. The patient's cumulative radiation exposure will depend on how many years the screening lasts and how many other medical imaging studies he undergoes.

Note that the USPSTF recommendation calls for low-dose CT. According to the Recommendation Statement, low-dose CT has an average radiation exposure of 0.61 to 1.5 mSv per scan, which is lower than the average annual exposure of 2.4 mSv that everyone receives from background radiation in the environment.

For more information about the USPSTF and links to the Final Recommendation and Fact Sheets, visit the USPSTF website at:

<http://www.uspreventiveservicestaskforce.org/uspstf/usps-lung.htm>

Reimbursement Implications

Under the Affordable Care Act, Medicare and most commercial payors must provide coverage without a deductible for any preventive service that has received a grade of A or B from the USPSTF. Because CT screening for lung cancer received a grade of B, Medicare and most other payors will be required to begin paying for it for those patients who meet the USPSTF criteria.

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CMS is currently asking for public comments regarding Medicare coverage of this service. CMS states that it is particularly interested in “evidence to inform the identification of patients eligible for screening; the appropriate frequency and duration of screening; facility and provider characteristics that predict benefit or harm; precise criteria for test positivity and the impact of false positive results and followup tests or treatments.” The agency is also looking for input regarding “the influence of these factors on patient education and informed consent in Medicare beneficiaries including the elderly and younger disabled populations and persons receiving dialysis treatment for end stage renal disease; and on the integration of smoking cessation interventions for current smokers.”

Public comments will be accepted until March 12, and CMS will hold a MEDCAC (Medicare Evidence Development and Coverage Advisory Committee) meeting on April 30 to review the available evidence.

For more information or to submit comments, please refer to the “National Coverage Analysis (NCA) for Lung Cancer Screening with Low Dose Computed Tomography (CAG-00439N)” tracking sheet, available on the CMS website at: <http://www.cms.gov/medicare-coverage-database/details/nca-tracking-sheet.aspx?NCAId=274&NcaName=Lung+Cancer+Screening+with+Low+Dose+Computed+Tomography&bc=AIAAAAAACAAAAA%3d%3d&>

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

2014 RCC Exam to Test Basic ICD-10 Knowledge

The 2014 RCC exam will include both ICD-9 and ICD-10 questions. The number of diagnosis-related questions on the exam will be weighted predominantly towards ICD-9 vs. ICD-10. The 2014 RCC exam will continue to test the applicant’s specific knowledge and ability to utilize ICD-9 codes as it has done in the past.

The ICD-10 questions on the exam will cover general information about ICD-10. The successful applicant should be able to answer basic questions regarding ICD-10’s:

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

The 2014 RCC exam does not include questions on how to diagnosis code in ICD-10.

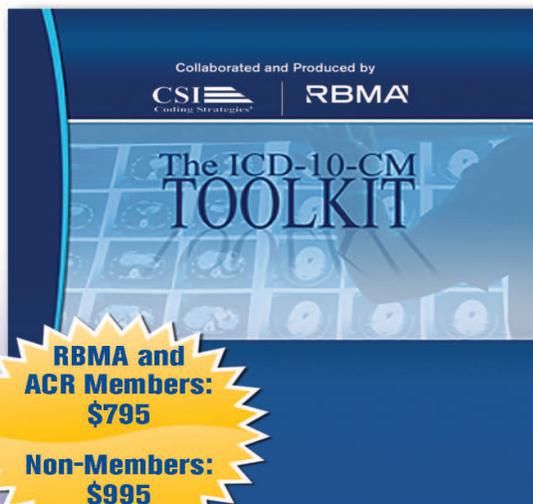
Successful 2014 examinees are still required to obtain 2.5 CEUs of RCCB-approved ICD-10 continuing education prior to their recertification in 2016.

The 2015 RCC exam will be entirely ICD-10.

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