Spring 2015

# RCC UPDATE

Radiology Coding Certification Board

RADIOLOGY CODING CERTIFICATION BOARD

CODINGSTRATEGIES

## From the President

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

It was my pleasure to participate in the recent strategic planning session of the RCCB Board of Directors. Not only was it nearly 75 degrees in San Antonio, Texas in early February, but because the board approved several new initiatives for RCCB, in general: (1) making the exam more affordable, (2) increasing educational content and offerings, (3) updating the exam to reflect what radiology coders experience on a daily basis, (4) assessing basic coding proficiency for select imaging modalities or subject areas, (5) adding value to being an RCC, and (6) testing the exam overseas. These are major initiatives and they will not happen overnight. If we are successful, these initiatives should bring about a more vibrant, relevant exam and, with it, greater recognition and stature of being an RCC. Stay tuned!

*Diagnosis Coding*

## Reporting Neoplasms with ICD-10-CM

ICD-10-CM diagnosis code assignment for neoplasms follows many of the same rules as ICD-9-CM, but the code numbers are completely new and there are a few new guidelines. This article will give you an introduction to the codes for solid neoplasms and how to use them.

### The Neoplasm Codes

The neoplasm codes are found in Chapter 2 of ICD-10-CM and begin with the letters "C" and "D." There are many more codes for certain types of neoplasms than in ICD-9-CM, including codes for the right and left sides for paired organs like the breasts, lungs, kidneys, etc.

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Like ICD-9-CM, ICD-10 divides the neoplasm codes into the following behavior categories:

- Malignant primary
- Malignant secondary
- In situ
- Benign
- Uncertain behavior
- Unspecified behavior

The uncertain behavior category represents neoplasms that cannot be clearly classified as either benign or malignant by pathology. The unspecified behavior codes are used for vague diagnoses like "bladder tumor" or "brain tumor."

## Code Selection Process

If you know the neoplasm's cell type (histology), you should begin by looking it up in ICD-10-CM's Alphabetic Index. Examples of histologic terms are carcinoma, sarcoma, adenoma, etc. In some cases the Index will refer you to a specific diagnosis code or code range, in which case you can simply verify the code in the ICD-10-CM Tabular List. Checking the Tabular List allows you to make sure you are not missing any additional code characters or any important instructional notes.

As an example, a CT scan is ordered for staging of hepatocellular carcinoma. The Index entry for "Carcinoma, hepatocellular" refers you to code C22.0. The Tabular List confirms that C22.0 *(Liver cell carcinoma)* is the correct code.

More often the Alphabetic Index will refer you to ICD-10-CM's Neoplasm Table to determine the correct code assignment. For example, if you look up "Carcinoma, lobular, specified site" the Index tells you to "see Neoplasm, malignant, by site." This is your cue to turn to the Neoplasm Table. The Table looks very similar to the ICD-9-CM Neoplasm Table, but it is located at the end of the Alphabetic Index rather than in the Index under the letter "N."

The Neoplasm Table is an alphabetic listing of anatomic sites. For each site there are 6 possible code numbers, depending on the neoplasm's behavior. Some entries have a dash following the code, which indicates an additional character is required. However, you should always confirm the code assignment in the Tabular List regardless of whether there is a dash after the code number.

As an example, to code a diagnosis of "Adenocarcinoma of the prostate," you should look up "Adenocarcinoma" in the Alphabetic Index. This entry instructs you to "see also Neoplasm, malignant, by site." Turning to the Neoplasm Table, look up "prostate." The code listed in the "Malignant Primary" column is C61. The Tabular List confirms that C61 *(Malignant neoplasm of prostate)* is the correct code.

## Connective Tissue Neoplasms

Connective tissue neoplasms are those involving the muscles, tendons, ligaments, blood vessels, and peripheral nerves. Most primary connective tissue neoplasms are classified to category C49 *(Malignant neoplasm of other connective and soft tissue)*.

When you look up the cell type of a connective tissue malignancy, the Index will tell you to "see Neoplasm, connective tissue, malignant." You should then turn to the Neoplasm Table and look up "connective tissue." If there is no subentry for the anatomic site under the "connective tissue" heading, you should turn to the entry for the anatomic site.

For example, angiosarcoma is a connective tissue neoplasm. When you look up "Angiosarcoma" in the Alphabetic Index, there is a note to "see also Neoplasm, connective tissue, malignant." If the patient has an angiosarcoma of the abdominal wall, you will find the code listed in the Neoplasm Table under "connective tissue, abdominal wall." The code assignment is C49.4 *(Malignant neoplasm of connective and soft tissue of abdomen)*. On the other hand, if the patient has an angiosarcoma of the spleen, there is no subentry for "spleen" under "connective tissue." Therefore, you should look up "spleen" in the Neoplasm Table and assign code C26.1 *(Malignant neoplasm of spleen)*.

## Overlapping Sites

Most of the primary malignant neoplasm categories have a code for "overlapping sites." You should assign this code when the patient has a single primary tumor that involves two

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# 2015 RCC Exam Dates; No November Exam

The dates for the 2015 RCC exam are:

- May 11-15 (Deadline April 6th)
- July 20-24 (Deadline June 15th)
- September 14-18 (Deadline August 10th)

ICD-10 implementation is slated for October 1, 2015. RCCB will not be offering a November 2015 exam because: (1) applicants may not have sufficient mastery of ICD-10 to take the RCC exam in November and (2) the 2015 RCC exam assesses only basic ICD-10 knowledge and not the applicant's proficiency with ICD-10.

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contiguous (adjacent) sites within the same category, unless the combination is specifically indexed elsewhere.

For example, a patient has a single primary adenocarcinoma involving the middle and lower lobes of the right lung. Because this is a single tumor involving contiguous (adjacent) sites, you should assign the code for "overlapping sites." The code assignment is C34.81 *(Malignant neoplasm of overlapping sites of right bronchus and lung)*.

In addition to the codes for overlapping sites within the same category, ICD-10-CM also contains codes for sites that overlap two or more categories, such as C57.8 *(Malignant neoplasm of overlapping sites of female genital organs)*, which includes primary tumors of fallopian tube with ovary, or uterus with ovary.

## Secondary Malignancies

Additional codes should be assigned for any secondary malignancies, including those caused by metastasis or local invasion. To find the code for a secondary site, simply go to the Neoplasm Table and look up the site. For example, if the patient has lung cancer with metastases to the brain and the liver, look up the terms "brain" and "liver" in the Neoplasm Table and select the "Malignant Secondary" column. The Tabular List confirms that these metastases should be reported with codes C79.31 *(Secondary malignant neoplasm of brain)* and C78.7 (*Secondary malignant neoplasm of liver and intrahepatic bile duct*).

Normally if a patient has active primary and secondary neoplasms, you will code the primary site first. However, when the purpose of the encounter is to treat or evaluate only the secondary site, you should list the code for the secondary site first, even if the primary site is still present. For example, if a patient is having an MRI of the brain to evaluate brain metastases, you should assign code C79.31 *(Secondary malignant neoplasm of brain)* as the first-listed diagnosis and assign the code for the primary tumor as a secondary diagnosis.

## History of Neoplasm

ICD-10-CM contains codes for personal history of neoplasm, indexed under "History." The ICD-10-CM guidelines state that you should assign a personal history code when:

- The primary malignancy has been previously excised or eradicated; and
- There is no further treatment directed to that site; and
- There is no evidence of any existing primary malignancy.

For example, a chest x-ray is ordered for a patient who has a persistent cough and a past history of lung cancer. To code the cancer history, refer to the Index entry for "History, personal, malignant neoplasm, lung." This directs you to code Z85.118 *(Personal history of other malignant neoplasm of bronchus and lung)*.

## Conclusion

This gives you a basic introduction to the ICD-10-CM neoplasm codes, but there are many other guidelines and nuances you will need to become familiar with prior to implementation. Be sure to review the ICD-10-CM Official Guidelines for Coding and Reporting, and practice using the new codes on some of your organization's current reports.

*- Article by Coding Strategies® Staff*

# ACR Joins AMA and Other Medical Specialty Societies in Expressing Concerns to CMS about ICD-10 Implementation

The American College of Radiology (ACR) and other health care organizations have co-signed a March 4, American Medical Association (AMA) letter to the Centers for Medicare & Medicaid Services (CMS) expressing a litany of concerns with the agency's implementation plans for ICD-10. However, the joint medical specialty societies/AMA letter only raised concerns and did not request a delay in the scheduled October 1, 2015 implementation. The medical specialty societies/AMA letter can be viewed on the ACR Advocacy in Action web site http://www.acr.org/Advocacy/eNews (3/6/15).

 

# CMS to Delete DBT/CAD Edit

The National Correct Coding Initiative (NCCI) contractor for the Centers for Medicare and Medicaid Services (CMS) has notified the American College of Radiology (ACR) that effective April 1, CMS will delete the recently implemented NCCI edit for the code pair 77063/77052[0] affecting the procedure-to-procedure edit for screening digital breast tomosynthesis (DBT) and computer-aided breast cancer detection (CAD).

The action was taken in response to a joint appeal from the ACR, American Roentgen Ray Society and Radiological Society of North America.

The medical societies argued that when both *screening digital breast tomosynthesis, bilateral (77063) and computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (77052)* are performed in conjunction with mammography, it would be appropriate to report the base screening mammogram code in addition to the DBT and CAD add-on codes.

The procedure-to-procedure edit will be deleted from the April 1, 2015 volume of the NCCI update. The edit reversal will be retroactive to January 1, 2015.

Radiology practices should resubmit for readjudication or appeal claims denied due to this edit after April 1 based on the requirements of the local A/B Medicare Administrative Contractor or state Medicaid Program.

- *Article provided by American College of Radiology (ACR)*

***Medicare Coverage***

# Medicare to Cover Lung Cancer Screening

On February 5 CMS issued a Decision Memo for Screening for Lung Cancer with Low Dose Computed Tomography (LDCT). You can read or download the Decision Memo on the CMS website at: http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274

This final Decision Memo is very similar to the proposed Decision Memo issued by CMS in November 2014, although the proposed Decision Memo had an upper age limit of 74 years rather than 77 years. Under the final Decision Memo a Medicare beneficiary must meet all of the following criteria in order to qualify for the screening:

# RCCs Recertifying in 2015

RCCs recertifying in 2015 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 2015 are required to obtain at least 2.5 RCCB-approved CEUs pertaining to ICD-10.

- Age 55 – 77 years
- Asymptomatic (no signs or symptoms of lung cancer)
- Tobacco smoking history of at least 30 pack-years
- Current smoker or one who has quit smoking within the last 15 years
- Has a written order for the screening that meets the criteria discussed below.

Note that a "pack-year" is the equivalent of smoking 1 pack (20 cigarettes) per day for one year. For example, a patient could accumulate a 30 pack-year history by smoking 1 pack per day for 30 years or 2 packs per day for 15 years.

## Initial Screening

The initial LDCT lung cancer screening must be ordered during a "lung cancer screening counseling and shared decision making visit" that is furnished by a physician or qualified nonphysician practitioner (nurse practitioner, physician assistant, or clinical nurse specialist). A lung cancer screening counseling and shared decision making visit includes performance and documentation of all of the following elements:

- Determination of beneficiary eligibility including age, absence of signs or symptoms of lung cancer, a specific calculation of cigarette smoking pack-years, and if a former smoker, the number of years since quitting.
- Shared decision making, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure.
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment.
- Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and,

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if appropriate, furnishing of information about tobacco cessation interventions.

- If appropriate, the furnishing of a written order for lung cancer screening with LDCT.

## Subsequent Screenings

Subsequent LDCT lung cancer screenings require a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet all criteria for this type of visit that were described in the previous section.

## Orders for LDCT

Written orders for both initial and subsequent LDCT lung cancer screenings must contain the following information. This information must also be documented in the patient's medical record.

- Beneficiary date of birth
- Actual pack-year smoking history (number)
- Current smoking status; for former smokers, the number of years since quitting smoking
- Statement that the beneficiary is asymptomatic (no signs or symptoms of lung cancer)
- NPI (National Provider Identifier) of the ordering provider

## Interpreting Radiologist

The radiologist who interprets the LDCT screening study must meet all of the following criteria:

- Is board certified or board eligible with the American Board of Radiology or equivalent organization
- Has documented training in diagnostic radiology and radiation safety
- Has been involved in the supervision and interpretation of at least 300 chest CTs in the past 3 years
- Has documented continuing medical education in accordance with American College of Radiology standards
- Furnishes the screening in an imaging facility that meets the criteria listed below.

## Imaging Facility

The imaging facility must meet all of the following criteria:

- Performs LDCT with volumetric CT dose index (CTDIvol) of ≤ 3.0 mGy (milligray) for standard size patients (5'7" and approximately 155 lbs), with appropriate reductions in CTDIvol for smaller patients and appropriate increases for larger patients
- Utilizes a standardized lung nodule identification, classification and reporting system

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# Congressional Leaders Voice Support for ICD-10 Implementation This Year

Congressional leaders in the U.S. Senate and U.S. House of Representatives are currently supporting the planned October 1, 2015 implementation of ICD-10.

On February 6th, the Government Accountability Office (GAO) issued a report on the Centers for Medicare & Medicaid Services' (CMS) readiness for ICD-10 which concluded that the agency had taken, "multiple steps to help prepare covered entities for the transition, including developing educational materials and conducting outreach, and that the majority of the stakeholders we [GAO] contacted reported that both of those activities have been helpful to preparing covered entities for the ICD-10 transition." The GAO's report prompted Senate Finance Committee Chairman Orrin Hatch (R-Utah) to state in a press release, "I see no reason for any delay past the October deadline."

Then, on Wednesday, February 11th, the House Energy and Commerce Health Subcommittee convened a hearing to discuss implementation and the upcoming October 1, 2015, ICD-10 transition. Nearly all of the witnesses supported going ahead with the October 1 implementation date as planned and lawmakers appeared to support the transition too – or at least acknowledged that further delay was unadvisable.

Congress, at any time, can always reverse course on this year's ICD-10 implementation. But, for now, it appears to be full-steam ahead towards October 1st.

 

# 2015 RCCB-Approved Continuing Education Courses

The RCCB has approved more than 20 courses for continuing education for 2015. For a complete and current listing of 2015 approved education, go to http://rccb.org/ce-sessions-accepted/2015. Check back often, as new programs are added as they are approved.

# Make Sure Your Contact Information is Current

Changed jobs? Changed names? Have a new email address? Please contact the RCCB at info@rccb.org to make sure we have your latest information so you do not miss any updates or reminders from RCCB.

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- Makes available smoking cessation interventions for current smokers
- Collects and submits data to a CMS-approved registry for each LDCT lung cancer screening performed

The Decision Memo contains a list of specific data that the imaging facility must report to the registry.

## Registry

The Decision Memo contains a list of requirements for LDCT lung cancer screening registries, as well as instructions on how to apply to become a registry. On March 5, the ACR Lung Cancer Screening Registry became the first registry approved by CMS. For a list of registries, see the following page:
http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Cancer-Screening-Registries.html

## Code Assignment

CMS has not yet issued any coding instructions for LDCT lung cancer screening. Some non-Medicare payors will accept HCPCS code S8032 *(Low dose computed tomography for lung cancer screening)* for this service, while others want it reported as a chest CT scan (71250). It is possible CMS will issue a HCPCS G-code for the screening, since Medicare does not cover S-codes. Watch for further information from CMS or your local Medicare contractor.

By ICD-9-CM coding guidelines, the primary diagnosis code for the screening should be V76.0 *(Special screening for malignant neoplasms, respiratory organs)* with a secondary code to indicate tobacco use (305.1) or history of tobacco use (V15.82). Any significant findings from the screening (lung mass, nodule, etc.) should be reported as a secondary diagnosis. Be sure to watch for and follow any specific coding instructions that your local Medicare contractor issues.

Keep in mind that there are likely to be different coding and billing requirements depending on whether you are filing the claim to Medicare, to a Blue Cross Blue Shield plan, to a managed care plan, or to a commercial insurance company. As with any new benefit, payors are likely to vary considerably in their requirements.

When additional information becomes available, it will be published in a future issue of *RCC Update*.

- *Article by Coding Strategies® Staff*

# Medicare to Cover Low-Dose CT for Lung Cancer Screening; ACR Issues FAQ

On February 5, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a final decision to cover low-dose CT (LDCT) for lung cancer screening. The national coverage memorandum contains the criteria that providers must meet to be paid by Medicare. To help the radiology community to get ready for Medicare coverage for LDCT for lung cancer screening, the American College of Radiology (ACR) answers frequently asked questions (FAQ).

CMS still needs to issue implementation instructions to its local Medicare Administrative Contractors (MACs) which will contain coding and payment guidance. This may take several months. For example, CMS likely will issue a G-code for LDCT and the ACR is hopeful that Medicare payment will be based on CPT® code 71250 (Computed tomography, thorax; without contrast material). But, once these instructions are issued, LDCT claims should be paid retroactive to February 5th. Until the instructions are released, providers are recommended to hold Medicare claims for LDCT for lung-cancer screening.

The following questions and answers, prepared by the ACR, address coverage and reimbursement requirements relating to patient eligibility, center eligibility, accreditation and lung cancer screening designation, radiologist requirements, clinical practice registry, and billing and payment.
http://www.acr.org/Advocacy/eNews/20150213-Issue/20150213-College-Addresses-Lung-Cancer-Screening-Questions