From the President

Time to spring forward by checking your credentials – is it time to renew or are you on track to meeting your continuing education hours? For continuing education credit, visit the RCCB website for approved sessions.

Are you taking the exam in May? Great! To help you get ready, be sure to check out these preparatory resources right at your fingertips. Here is a couple to check out:

- 2018 RBMA Exam Preparation
- 2019 Coding Strategies

In addition, don’t miss these coding webinars scheduled for March and May. Additional webinars are coming in August and October, check back.

Be sure to visit us at the SIR Conference, March 24-27 in Austin, Texas, booth 815 and at the RBMA PaRADigm Conference in Colorado Springs, Co., booth 116 on April 14-17 for a chance to win a free RCC and or RCCIR Examination fee. Transferrable to any coder within your practice.

Thanks for continuing to support RCCB. Let’s get ready for Spring together!

Sincerely,
Renée C. Engle, RCC, FRBMA

Compliance

Diving Deeper into the AUC Program

In the last issue of RCC Update, we discussed the changes to the Appropriate Use Criteria Program made by the Centers for Medicare and Medicaid Services (CMS). In this issue, we will dive deeper into the program and how it impacts coding. To read the article from the last issue, please refer to the RCC Update archives:

Background

The Appropriate Use Criteria (AUC) Program is intended to reduce inappropriate use of advanced imaging exams. It was mandated by Congress as part of the Protecting Access to Medicare Act (PAMA) of 2014. The PAMA requirements apply to advanced imaging exams (CT, MR, and nuclear medicine, including PET) paid under the Medicare Physician Fee Schedule (MPFS), the Hospital Outpatient Prospective Payment System (OPPS), or the Ambulatory Surgical Center (ASC) Payment System.

AUC are designed to assist clinicians in selecting the most appropriate imaging study for a patient with a specific diagnosis or symptom. CMS can only approve AUC that are developed and endorsed by provider-led entities (PLE) such as national professional medical specialty societies.

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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
**Diving Deeper into the AUC Program**

continued from previous page

Once a PLE is qualified, all AUC developed or endorsed by that PLE are considered to be “specified AUC” for purposes of PAMA requirements. A current list of qualified PLEs can be found at:


The ordering physician, practitioner or clinical staff as delegated by the ordering professional and under their direction will access AUC through a qualified clinical decision support mechanism (CDSM). The CDSM is an electronic portal such as a module in an EHR or a web-based system. The patient’s information will either be pulled from the EHR or entered by the ordering professional into the CDSM, and the CDSM will provide feedback on the appropriateness of the proposed imaging exam. A current list of qualified CDSMs can be found at:


**Consultation**

Radiologists are not excepted from the AUC consultation requirements and will be required to consult the AUC for advanced imaging studies they wish to order for patients they are treating.

Ordering professionals must communicate the results of the AUC consultation to the imaging provider, including the imaging facility and the interpreting radiologist. Both the facility and the radiologist must include AUC consultation information on Medicare claims, including which CDSM was used and whether the study was deemed appropriate. While it is the ordering professional’s responsibility to consult AUC, it is the furnishing professional who is responsible for reporting this information on the claim (facility and physician).

**G Codes and Modifiers**

Voluntary reporting began on July 1, 2018 and will continue through December 31, 2019. During this time, modifier QQ (Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional) may be applied to the CPT® code for the imaging service to identify the AUC consultation occurred. For more information on the use of modifier QQ, refer to MLN Matters MM10481.

During the 2020 rulemaking cycle, CMS will develop a series of G codes and modifiers that must be used on claims during the testing period. Ultimately, the G codes will identify the CDSM being used, and the modifiers will identify AUC adherence.

CMS proposes each CDSM would be assigned a G code whose description would contain the name of the CDSM. If multiple advanced diagnostic imaging services are reported on the claim, CMS could link the single G code to all of the applicable imaging services on that claim. This would be appropriate only if each AUC consultation for each service on the claim was through the same CDSM.

In the scenario that different CDSMs are used for different services on the claim, then multiple G codes would be needed. Each G code would appear as a separate line item on the claim. It would then not be possible to link the CDSM to the service for which it was used.

CMS proposes to use modifiers that would appear on the same line as the CPT® code for the imaging. Three modifiers would be developed to report the result of the consultation as:

1. Imaging service adheres to the applicable AUC
2. Imaging service does not adhere to the applicable AUC
3. AUC were not applicable for the imaging service

With these modifiers appended to the imaging CPT® codes, Medicare would more easily be able to link the AUC adherence information with the imaging service.

CMS will release more information on the G codes and modifiers as they are finalized.

**Reporting Concerns**

One of the biggest concerns in reporting the AUC information surrounds the requirement of the ordering professional to perform consultation and provide the furnishing professional the information to be reported on the claim.
Commenters in the CY 2019 MFPS Final Rule noted this poses questions on who bears responsibility during an audit if the information is not available. CMS “will take into account the specific roles of ordering and furnishing professionals and facilities as the program develops and [CMS begins] to engage in program monitoring activities.”

Qualified CDSMs must generate and provide a certification or documentation that includes the CDSM used, the name and NPI of the ordering professional, and information on AUC adherence. In the CY 2019 MFPS Final Rule, some commenters noted concern regarding the lack of clarification of whether the CDSM certification or documentation would include the appropriate G codes and modifiers. The clarification was requested because “(1) Each qualified CDSM will know its G-code and can readily convert their adherence rating system into modifiers, (2) the required data could be transmitted between EHR and CDSM vendors and communicated between professionals in a standardized manner, and (3) accuracy of consultation reporting would improve.” CMS agrees and expects to see CDSMs include the G codes and modifiers as they become available in their certification or documentation. However, if they do not see the adjustment, CMS will consider making it a requirement.

Please see the following resources for more information on AUC/CDS:

MLN Fact Sheet: Appropriate Use Criteria for Advanced Diagnostic Imaging

CMS Appropriate Use Criteria Program

CY 2019 Medicare Physician Fee Schedule Final Rule

ACR Detailed Summary of the Appropriate Use Criteria Provisions of the 2019 Medicare Physician Fee Schedule Final Rule

--- Article by Coding Strategies® Staff ---

**Medicare**

**Oncologic FDG PET Coverage**

A n oncologic FDG PET scan is one in which fluorodeoxyglucose tracer is injected into the patient prior to the scan to help identify cancer. There are many misconceptions when it comes to Medicare reimbursement for oncologic FDG PET scans. It is very important to understand how to correctly code these studies and under what circumstances the scans may be covered.

**Coding FDG PET Scans**

Oncologic FDG PET scans are reported with the PET body scan codes (78811-78816) and/or the PET metabolic brain scan code (78608).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78608</td>
<td>Brain imaging, positron emission tomography (PET); metabolic evaluation</td>
</tr>
<tr>
<td>78811</td>
<td>Positron emission tomography (PET) imaging; limited area (eg, chest, head/neck)</td>
</tr>
<tr>
<td>78812</td>
<td>. . . skull base to mid-thigh</td>
</tr>
<tr>
<td>78813</td>
<td>. . . whole body</td>
</tr>
<tr>
<td>78814</td>
<td>Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)</td>
</tr>
<tr>
<td>78815</td>
<td>. . . skull base to mid-thigh</td>
</tr>
<tr>
<td>78816</td>
<td>. . . whole body</td>
</tr>
</tbody>
</table>

The “limited area” codes are reported when only a single body area is studied, or when the scan does not extend from skull base to mid-thigh. The “whole body” codes are reported when the scan extends from the top of the head (vertex) down to the feet or lower leg.

In order to report the PET/CT codes, the PET and CT scans must be acquired concurrently, meaning at the same encounter on the same scanner.

**Initial Treatment Strategy**

Medicare’s National Coverage Determination (NCD 220.6.17) discusses Medicare coverage for oncologic FDG PET scans:


The NCD classifies oncologic FDG scan as either initial treatment strategy or subsequent treatment strategy. A scan falls into the initial treatment strategy category when it is performed to determine the physician’s initial treatment strategy for a tumor that is “biopsy proven or strongly suspected of being cancerous based on other diagnostic
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imaging.” These scans must be submitted to Medicare with modifier PI [Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing] applied to the scan code. The initial treatment study must be ordered to determine:

- Whether the patient is a candidate for an invasive diagnostic or therapeutic procedure; or
- The optimal anatomical location of the invasive procedure; or
- The anatomic extent of the tumor when that information will determine the treatment recommendations.

The initial treatment strategy category includes scans performed for staging.

The NCD allows coverage for only one initial treatment strategy scan per cancer per patient. For example, an initial treatment strategy scan is performed for breast cancer, and years later, another initial treatment strategy scan is performed for colon cancer. Both scans can be billed as initial treatment strategy scans. Local Medicare contractors and Medicare Advantage plans may cover additional initial treatment strategy scans if desired. It is best practice to document the medical necessity of the second initial treatment strategy scan.

Subsequent Treatment Strategy

Subsequent treatment strategy scans are defined by the Medicare NCD as those performed to “guide subsequent management of anti-tumor treatment strategy after completion of initial anti-cancer therapy.” This is often referred to as restaging. Medicare does not consider subsequent treatment strategy scans as those performed for surveillance purposes in a patient with previously treated cancer who has no clinical evidence of active disease. This would be considered a screening.

Modifier PS [Positron Emission Tomography (PET) or PET/Computed Tomography (CT) to inform the subsequent treatment strategy of cancerous tumors when the beneficiary’s treating physician determines that the PET study is needed to inform subsequent anti-tumor strategy] must be applied to the scan code for subsequent treatment strategy scans submitted to Medicare. The NCD allows coverage of no more than three subsequent treatment strategy scans. If the patient has more than one type of cancer, there is a separate 3-scan limit for each cancer.

Local Medicare contractors and Medicare Advantage plans may cover additional scans if desired. If Medicare criteria are met, modifier KX (Requirements specified in the medical policy have been met) should be applied to the code(s) for the fourth and subsequent scans. Modifier KX is applied in addition to modifier PS, not instead of it. Providers should consider issuing an Advance Beneficiary Notice for the fourth and subsequent scans, as the Medicare contractor may determine they are not medically necessary.

Coverage Limitations

The following table summarizes Medicare coverage for oncologic PET, PET-CT, and PET-MRI scans using FDG. Medicare will pay for the scans listed as covered if the scan is medically necessary, ordered by the treating physician, and submitted with a covered diagnosis code.
Initial treatment strategy scans for prostate cancer are noncovered and will not be paid under any circumstances.

Three types of scans are subject to restricted coverage:

- **Cervical cancer**: Initial treatment scans are covered only for the staging of biopsy-proven cervical cancer. Scans performed for diagnosis of cervical cancer are noncovered.
- **Male and female breast cancer**: Initial treatment strategy scans are noncovered for initial diagnosis and/or staging of axillary lymph nodes. Initial treatment strategy scans are covered for initial staging of metastatic disease.
- **Melanoma**: Initial treatment strategy scans are non-covered for initial staging of regional lymph nodes. All other uses for initial staging are covered.

If it is necessary to submit a claim to Medicare for a study that does not meet Medicare coverage requirements, one of the following HCPCS codes for noncovered PET scans must be reported:

- **G0219** PET imaging whole body; melanoma for non-covered indications
- **G0235** PET imaging, any site, not otherwise specified
- **G0252** PET imaging, full or partial ring PET scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer (e.g. initial staging of axillary lymph nodes)

### Diagnosis Codes

The following link can be found in the Medicare Claims Processing Manual (Chapter 13, Section 60.16) and includes a list of “appropriate diagnosis codes” for oncologic PET scans:


The list is periodically updated, so be sure to review it often. In addition to neoplasm codes, the list includes codes for certain abnormal findings, such as solitary pulmonary nodule (R91.1) and personal history of certain types of malignant neoplasms, such as breast cancer (Z85.3). Claims without a covered diagnosis will be denied.

Medicare denials of oncologic FDG PET scans can be a problem. Always check payer guidelines for coverage requirements and use the information provided to help prevent denials.

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*Article by Coding Strategies® Staff*
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Interventional Radiology

A Closer Look at CVCs

The 2019 CPT® manual included revisions and additions for central venous catheter (CVC) coding. In addition to these changes, the CPT® manual has also provided clarification for midline catheter coding.

The Basics

Central venous catheters provide means of drawing blood and administering substances into the patient’s large central veins. CVCs can also handle a larger volume of fluids than a peripheral IV line. To be considered a central venous catheter, the catheter tip must be positioned in the subclavian vein, brachiocephalic (innominate) vein, iliac vein, superior or inferior vena cava, or the right atrium.

CVCs are either centrally inserted or peripherally inserted. A centrally inserted central venous catheter is inserted into the subclavian vein, jugular vein, femoral vein, or inferior vena cava. A peripherally inserted central venous catheters (PICC) is inserted in any other vein, such as the basilica or cephalic veins.

Midline catheters are not considered to be CVCs. By definition, a midline catheter would terminate in a peripheral vein, rather than a central vein.

Centrally inserted CVCs can be tunneled or non-tunneled and may be connected to a port or pump. PICCs are non-tunneled and may be connected to a port.

CVC Insertion

The codes for CVC procedures are defined in terms of:

- The type of procedure (insertion, replacement, etc.)
- The type of device (centrally vs peripherally inserted, tunneled vs non-tunneled, etc.)

<table>
<thead>
<tr>
<th>Table 1: CENTRALLY INSERTED CVC INSERTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-tunneled</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>Insertion</td>
</tr>
<tr>
<td>(&lt; 5 years)</td>
</tr>
<tr>
<td>(≥ 5 years)</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Fluoroscopic (77001) or ultrasound (76937) guidance is not included in code 36555-36566 and should be reported separately.

PICC insertion is reported with codes 36568-36573. The table below provides a summary of the codes.

<table>
<thead>
<tr>
<th>Table 2: PERIPHERALLY INSERTED CVC INSERTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>w/o port or pump, w/o imaging</td>
</tr>
<tr>
<td>36568</td>
</tr>
<tr>
<td>36569</td>
</tr>
</tbody>
</table>

Notice there are codes that specifically include all associated imaging guidance (36572, 36573). If imaging guidance is used, but position of the catheter tip cannot be confirmed, modifier 52 should be applied to code 36572 or 36573. If imaging guidance is not used, the non-imaging placement codes should be reported (36868-36869).

CVC Repair, Replacement, and Removal

CVC repair is defined by the CPT® manual as “fixing device without replacement of either catheter or port/pump.”
A Closer Look at CVCs
continued from previous page

CVC repair is reported with code 36575 (without port) or 36576 (with port) for both centrally inserted and peripherally inserted CVCs. Some catheters, such as Tesio-style catheters, have 2 catheters. Repair of both catheters would be reported with 2 units of the repair code.

Partial replacement refers to replacing a catheter that is connected to a port or pump without replacing the port or pump. Code 36578 is reported for partial replacement of both centrally inserted and peripherally inserted CVCs. Report 2 units of 36578 is both catheters of a Tesio-style device are partially replaced.

Complete replacement of a CVC not connected to a port or pump is a fairly simple procedure. It is reported with codes 36580-36581 for centrally inserted catheters. For PICCs, it is reported with code 36584, which includes all associated imaging guidance and documentation and S&I required.

Complete replacement of a CVC with an implanted port or pump requires replacement of the port or pump as well as the catheter. This procedure is reported with codes 36582-36583 for centrally inserted catheters or 36585 for PICCs.

For a Tesio-style device, complete replacement would be reported with 2 units of the replacement code.

The catheter will be removed when it is no longer needed or when removal is medically indicated due to infection or other reason. There is no code for removal of non-tunneled catheters, but this service can be reported with a low-level evaluation and management (E/M) code if documentation meets the E/M criteria. Removal of a tunneled CVC without a port or pump is reported with code 36589. For catheters with a port or pump, report the removal with code 36590, which includes removal of the catheter as well as the port or pump. Removal of Tesio-style devices should be reported with 2 units of the removal code.

Report fluoroscopic or ultrasound guidance separately with all of the codes discussed in this section except for code 36584.

Other CVC procedures include repositioning (36597), contrast injection (36598), declotting (36593), and mechanical removal of obstructive material (36595, 36596, 75901, 75902). We will not discuss these procedures in detail in this article.

Midline Catheters

As mentioned before, midline catheters are not considered central venous catheters by definition. Prior to 2019, CPT® Assistant and Coding Clinic for HCPCS provided instructions to assign a PICC placement code for the placement of a midline. The 2019 CPT® manual contains new guidance that instructs you to use the venipuncture codes 36400, 36405, 36406, and 36410 for midline insertion.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36400</td>
<td>Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; femoral or jugular vein</td>
</tr>
<tr>
<td>36405</td>
<td>Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; scalp vein</td>
</tr>
<tr>
<td>36406</td>
<td>Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture; other vein</td>
</tr>
<tr>
<td>36410</td>
<td>Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)</td>
</tr>
</tbody>
</table>

Coding central venous catheter procedures can seem overwhelming. Take the time to carefully read the report to determine what procedure was done and review the definitions and guidelines in the CPT® manual. With the exception of exceptions, all the information you need will be right in front of you.

- Article by Coding Strategies® Staff