Winter 2019

RCC Update

RCCB
RADIOLOGY CODING CERTIFICATION BOARD
CODINGSTRATEGIES

From the President

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

Season's greetings!

As we prepare to usher in 2019, we want to thank you for another great year! Over 80 people have taken the RCC and RCCIR exams this year and we are excited to see the influx of individuals who are eager to be certified. To our current RCCs who continue to renew year after year, the Board of Directors want to thank you for your continued commitment to maintaining your credential. The 2019 exams dates are May 13-17 and October 20-25. If you want to learn more about these exams, please visit the RCCB website at www.rccb.org.

In this issue, learn about upcoming changes and their impact on your practice. For instance, what you should know about the 2019 Final Rules for the Medicare Physician Fee Schedule (MPFS) and the Outpatient Prospective Payment System (OPPS), get updates for the AUC Program, and learn what new procedure codes are in place to simplify the reporting of radiology services and/or provide a way to report new services other than using an unlisted procedure code.

Whether a new coder or a seasoned veteran, RCCB strives to provide opportunities to increase your skill, knowledge, and abilities. Please let us know how we are doing.

We look forward to connecting with you in 2019!

Sincerely,
Renée C. Engle, RCC, FRBMA

Procedure Coding

Changes Ahead for Radiology Coders

Radiology coding professionals should welcome most of the 2019 procedure code changes, as many of them will simplify the reporting of radiology services and/or provide a way to report new services other than using an unlisted procedure code. We will review some of the most significant procedure code changes relevant to radiology.

Biopsy Codes

There are major revisions to the fine needle aspiration codes. Code 10022 *(Fine needle aspiration; with imaging guidance)* has been deleted, while code 10021 *(Fine needle aspiration biopsy, without imaging guidance; first lesion)* has been revised. The following codes have been added for additional lesions and for FNA with imaging guidance:

10004	Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion
10006	. . . each additional lesion (List separately in addition to code for primary procedure)

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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

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10007	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion
10008	. . . each additional lesion (List separately in addition to code for primary procedure)
10009	Fine needle aspiration biopsy, including CT guidance; first lesion
10010	. . . each additional lesion (List separately in addition to code for primary procedure)
10011	Fine needle aspiration biopsy, including MR guidance; first lesion
10012	. . . each additional lesion (List separately in addition to code for primary procedure)

Fluoroscopy

Code 76001 *(Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)* has been deleted for 2019.

Abdominal Ultrasound

Codes 76978 and 76979 have been established to describe a contrast ultrasound exam either of the liver for focal liver lesions or of the urinary tract in pediatric patients for vesicoureteral reflux. Previously, this exam was reported with deleted code C9744.

76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion
76979	. . . each additional lesion with separate injection (List separately in additional to code for primary procedure)

Elastography

Elastography is a technique for evaluating tissue elasticity, or stiffness, often used to identify malignant tumors, as well as to diagnose conditions like fibrosis and cirrhosis that cause an organ to become more firm. Code +0346T *[Ultrasound, elastography (List separately in addition to code for primary procedure)]* has been deleted and replaced with codes 76981-76983. Code 76391 was also established for MR elastography.

76391	Magnetic resonance (eg, vibration) elastography
76981	Ultrasound, elastography; parenchyma (eg, organ)
76982	Ultrasound, elastography; first target lesion
+76983	. . . each additional target lesion (List separately in additional to code for primary procedure)

Breast MRI

Breast MRI codes 77058 and 77059 have been deleted and replaced with codes 77046-77049. Codes 77046-77047 describe breast MRI without contrast. Codes 77048-77049 describe breast MRI without and with contrast and include CAD, when performed.

77046	Magnetic resonance imaging, breast, without contrast material; unilateral
77047	. . . bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77049	. . . bilateral

Knee Arthrography

Code 27370 has been deleted and replaced with code 27369 *(Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography)*.

B-12 Absorption Study

Codes 78270-78272 for vitamin B-12 absorption studies, or the Schilling test, have been deleted as the test is now obsolete.

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PICC Insertion and Replacement

Several revisions were made to the codes for peripherally inserted central venous catheter (PICC) insertion and replacement. Codes 36568 and 36569 have been revised to include "without imaging guidance," codes 36572 and 36573 have been added, and code 36584 has been revised to include all imaging guidance and radiological S&I.

36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; without imaging guidance, younger than 5 years of age
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; without imaging guidance, age 5 years or older
36572	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age
36573	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement

Additionally, the CPT® Manual states that midline catheters are not central venous access devices and cannot be reported with the codes for PICC services. Rather, midline catheter placement should be reported with the venipuncture codes (36400, 36405, 36406, and 36410).

G-Tube Replacement

The non-imaging gastrostomy tube replacement code (43760) has been deleted. Two new codes have been created for gastrostomy tube replacement without imaging. The codes differential whether revision of the gastrostomy tract is required.

43762	Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract
43763	Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract

Urinary Tract Dilation

The existing code for urinary tract dilation for nephrostomy track creation (50395) has been deleted and is being replaced by two new codes (50436-50437) that differentiate whether a new access is required. Radiological S&I code 74485 was revised to specify that the code only applies to the ureter(s) or urethra rather than a nephrostomy track.

Category III Codes

Ultrasound bone density measurement is a technique for measuring appendicular bone density using a portable ultrasound device that measures the cortical thickness of the tibia. This is coupled with other patient data to estimate the bone mineral density in the hip.

0508T	Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia

Code 0337T has been deleted. It was reported for endothelial function assessments.

HCPCS Level II Changes

The 2019 HCPCS Level II file is now available on the CMS website at:
https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html

The most significant HCPCS Level II changes are the changes to the breast MRI codes. The codes for MRI without contrast (C8904, unilateral and C8907, bilateral) have been deleted. Also, code C8937 *[Computer-aided detection, including computer algorithm analysis of breast MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation (List separately in addition to code for primary procedure)]* has been added for computer-aided detection for breast MRI.

Code C9744 *(Ultrasound, abdominal, with contrast)* has also been deleted for 2019.

- Article by Coding Strategies® Staff

Medicare

CMS Issues Guidance for 2019

There are important action items for radiology providers in the 2019 Final Rules for the Medicare Physician Fee Schedule (MPFS) and the Outpatient Prospective Payment System (OPPS). This article summarizes the most important changes. For information about the Appropriate Use Criteria Program, please see the separate article on page 5.

Site Neutral Payment

Medicare's site-neutral payment policy, which was implemented in 2017, applies to non-excepted off-campus provider-based hospital departments (PBDs). For example, the policy applies to 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 OPPS payment rate for the service. For 2019, the payment rate will continue at 40% of the OPPS rate.

Hospitals must continue to apply modifier PN *(Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital)* to unexcepted services provided in unexcepted PBDs so that the Medicare contractor can identify these services and pay them appropriately.

Alternatively, excepted services must be reported with modifier PO *(Excepted service provided at an off-campus, outpatient, provider-based department of a hospital)* and are paid in the normal manner under OPPS.

Radiologist Assistant

CMS finalized its proposal to allow radiologist assistants (RAs) and radiology practitioner assistants (RPAs) to perform diagnostic tests under direct supervision when permissible by respective state law and state scope of practice.

CMS Issues Guidance for 2019
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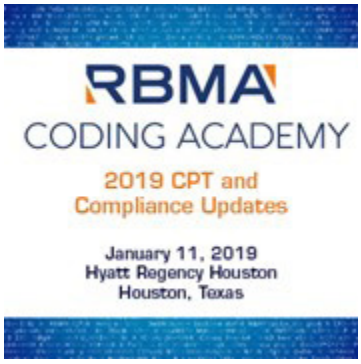
RCC and RCCIR Exam Information

Exam Dates:

- May 13-17, 2019
- October 20-25, 2019

Note that registration does not open until January 2, 2019.



Register for the RBMA Coding Academy:
2019 CPT Codes and Compliance Updates

How do the 2019 CPT and compliance updates affect your practice? Attend RBMA's Coding Academy on Jan. 11, 2019, in Houston, Texas, to learn about the latest code and compliance changes and discover how these changes impact your practice.

RBMA Coding Academy
Jan. 11, 2019
Hyatt Regency Houston
Houston, Texas

Two half-day sessions will be offered:

Morning session
2019 CPT Updates for Radiology
Bethany Geiger, MBA

Afternoon session
Compliance Plan: Who's Watching Your Practice? 2019 Updates to Compliance
Karna W. Morrow, CPC, RCC, CCS-P, AHIMA-approved ICD-10-CM Trainer

Participants have the option of attending either the morning or afternoon half-day session or may elect to attend the full-day course for the best value!

Application has been made for the following Continuing Education Credits:

- AAPC
- ASRT
- RCC
- RCCIR

For more details and to register for this course click here.

RBMA
Radiology Business Management Association

CMS Issues Guidance for 2019
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This does not change the level of physician supervision required for exams, nor will a new supervision indicator be created. Rather, this simply allows RAs and RPAs to perform diagnostic imaging tests under direct supervision that otherwise require personal supervision. This does not affect diagnostic imaging exams that require general supervision.

Evaluation and Management Services

Many changes were proposed in relation to evaluation and management (E/M) services this year. CMS will be implementing only some of these changes effective January 1, 2019. Requirements for teaching physician documentation will be revised to allow the presence and extent of participation of the teaching physician to be documented in the notes of a physician, resident, or nurse. The revisions are "intended to align and simplify teaching physician E/M service documentation requirements . . . [and] reduce burden and duplication of effort for teaching physicians."

CMS also implemented changes to "simplify and reduce redundancy in documentation." For new and established patients, documentation of history and exam obtained by ancillary staff or the patient does not need to be re-entered by the physician. The physician should, however, indicate in the medical record that the information has been reviewed and verified. Additionally, when the medical record of an established patient already contains the relevant information for the visit, the physician only has to document pertinent information on what has changed or not changed since the last visit. The physician should also indicate that the previous documentation was reviewed.

CMS has also committed to revamping and updating reporting and reimbursement of office/outpatient E/M services for new and established patients. They admit a stepwise approach is necessary, and therefore, are focusing only on changes to CPT® codes 99201-99205 and 99211-99215 for now. These changes have not been finalized and have been delayed until 2021.

MIPS (Merit-Based Incentive Payment System)

CMS announced that 91% of MIPS eligible clinicians participated in the CY 2017 transition year. The data from CY 2017 was used to estimate eligibility and payment adjustments for CY 2019 MIPS performance period. CMS also noted that significantly more clinicians are expected to participate in MIPS using the group reporting option for CY 2019.

CMS is estimating there will be approximately 798,000 MIPS eligible clinicians for CY 2019 MIPS performance period. CMS is also estimating payment adjustments of approximately $390 million, including negative and positive adjustments.

For 2019, the following provider types are being added to the list of MIPS eligible clinicians:

- Physical therapist
- Occupational therapist
- Qualified speech-language pathologist
- Qualified audiologist
- Clinical psychologist
- Registered dietitians or nutrition professional
- Group that includes such clinicians

MIPS has 4 performance categories. For CY 2019, the categories and contributions are as follows:

- Quality – 45%
- Cost – 15%
- Improvement Activities (IA) – 15%
- Promoting Interoperability (PI) – 25%

Note that the Promoting Interoperability category replaces the former category of Advancing Care Information (ACI).

- Article by Coding Strategies® Staff

Compliance

Updates for the AUC Program

In the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, the Centers for Medicare and Medicaid Services (CMS) provided updated guidance for the Appropriate Use Criteria Program.

Background

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

Program Changes and Updates

In the Final Rule, CMS reaffirmed the mandatory January 1, 2020 implementation date. The first year will be an "educational and operations testing period" with a go live date of January 1, 2021. CMS will develop a series of HCPCS Level II G codes and modifiers during the 2020 rulemak-

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ing cycle to be used on claims in order to meet the aforementioned timeline. CMS will continue to pay claims regardless of whether this information is completely accurate on the claims.

CMS continues to consider future opportunities to use a unique claim identifier (UCI) number, but they have not committed to a timeline to transition to the use of UCIs. The benefit of using a UCI is that this information would come directly from the Clinical Decision Support Mechanism (CDSM) rather than potentially having manual intervention to assign G codes and modifiers. CMS has not indicated how long the G code with modifier approach to claims-based reporting will be utilized.

During the initial testing period, ordering professionals will consult AUC through a qualified CDSM. Furnishing providers will report corresponding G-codes and modifiers on their facility and physician claims. The most recent list of qualified CDSMs is available on the CMS website:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM.html

CMS added independent diagnostic testing facilities (IDTFs) to the list of applicable settings which also includes physician offices, hospital outpatient departments (including emergency departments), and ambulatory surgical centers. Because services provided in an IDTF require physician supervision and written orders must be furnished, CMS considered IDTFs to be a provider-led outpatient setting, and thus, appropriate to be added to the list. CMS also believes adding IDTFs to the list will ensure consistency of the AUC Program across all outpatient settings where advanced diagnostic imaging is provided.

CMS also finalized that ordering professionals experiencing internet issues, EHR or CDSM vendor issues, or extreme and uncontrollable circumstances (including natural and manmade disasters) will not be required to consult the AUC using a qualified CDSM, and the AUC consultation information would not be required to be listed on the claim. These circumstances will be self-attested at the time of placing the order. The claim submitted by the rendering provider and facility would report the necessary HCPCS Level II modifier to reflect the hardship self-attestation.

CMS also clarified that if the referring physician does not personally perform the consultation, then "when delegated by the ordering professional, clinical staff under the direction of the ordering professional may perform the AUC consultation with a qualified clinical decision support mechanism." The ordering physician is still responsible for the consultation, since his or her NPI is reported on the claim. It is also the ordering physician who would be identified as an outlier and be subject to prior authorization requirements based on ordering patterns. While CMS has not clarified where on the UB-04/CMS1450 claim form the ordering physician's NPI should appear, they have acknowledged that they need to identify where it should be reported.

For more information on the AUC program, see the CMS website:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html

- Article by Coding Strategies® Staff