MEDLEARN® PUBLISHING

March 2020 | Volume 23, Number 3

Radiology Compliance manager

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THE RALLY FOR RADIOPHARMACEUTICALS:
A Case to Congress

At the end of January, amidst the busy start of the new year for radiology, the Society of Nuclear Medicine and Molecular Imaging (SNMMI) along with other prominent industry stakeholders co-hosted a congressional briefing entitled "A New Hope: Advancements in Diagnostic Imaging and Alzheimer's." The objective of the briefing was to create a compelling case for more access to diagnostic radiopharmaceuticals, most notably those used for amyloid PET imaging for the diagnosis of Alzheimer's while creating an educational opportunity for congressional representatives through physician, patient, and industry insight. Of key importance, event speakers advocated for the equal and fair payment of radiopharmaceuticals along with the passage of the Medicare Diagnostic Radiopharmaceutical Payment Equity Act of 2019 (H.R. 3772). Among the other important co-hosts were the Council on Radionuclides and Radiopharmaceuticals (CORAR), and the Medical Imaging Technology Alliance (MITA).

Breakdown of the MDRP Equity Act

Sponsored by Representative Scott Peters (CA-52), George Holding (NC-2) and Bobby Rush (IL-1), the Medicare Diagnostic Radiopharmaceutical Payment Equity Act of 2019 was originally introduced on July 16, 2019 as a bipartisan bill. The bill received widespread support by significant stakeholders including the American Society of Radiology Technologists (ASTR), SNMMI, the Medical Imaging and Technology Alliance, and the Council on Radionuclides and Radiopharmaceuticals. The bill is designed to guarantee fair Medicare payment for diagnostic radiopharmaceuticals administered in precision testing while maintaining patient access to emerging and innovative imaging procedures. In particular, it targets structural issues of the Medicare packing methodology.

At the core of the bill, H.R. 3772 attempts to change the way in which Medicare operates radiopharmaceutical reimbursement for providers by unbundling them from the overarching Medicare reimbursement applied to nuclear medicine procedures.

Despite the fact that Medicare provides separate payment for diagnostic radiopharmaceuticals as drugs in clinician office settings, the Centers for Medicare and Medicaid Services (CMS) started acting as though diagnostic radiopharmaceuticals were supplies and bundling, or "packaging," the drugs with the procedure cost in hospital outpatient settings in 2008. With this method, many providers are deterred from using several of the radiopharmaceuticals in the Medicare hospital outpatient setting. Consequently, in the view of advocates, this results in less patient access while discouraging and constraining research and innovation.

According to ASTR, *"Diagnostic radiopharmaceuticals are drugs, as defined by statute, but despite acknowledging concerns about growing patient access issues as the industry evolves, CMS has treated them as supplies and has packaged them into procedural bundles, known as Ambulatory Payment Classifications. This bundling of radiopharmaceuticals as part of the APC has proved to be problematic since diagnostic radiopharmaceutical costs may vary widely within a nuclear medicine APC and may at times exceed the complete APC payment. This translates into a strong disincentive for hospitals to utilize innovative, targeted radiopharmaceuticals, serves to discourage investment in and research for new diagnostic radiopharmaceuticals and may impede patient access to the most appropriate diagnostic tools at readily accessible health care locations."*

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Radiopharmaceuticals ... continued from cover

ASTR also acknowledged that this could result in incorrect diagnoses along with insufficient treatment plans.

Terri Wilson, senior director of patient access and healthcare policy at Blue Earth Diagnostics and current Chair of the MITA PET Group, commented in a press release that "Under the current Medicare Hospital Outpatient Prospective Payment System (OPPS), cutting edge, effective radiopharmaceutical drugs are inappropriately packaged, which limits patient access and discourages innovation. The Medicare Diagnostic Radiopharmaceutical Payment Equity Act of 2019 fixes this structural flaw, allowing patients much-needed access to diagnostic radiopharmaceuticals for life-threatening conditions."

The Promise of Advocacy

Among the speakers at the briefing were Alzheimer's patient and caregiver team Geri and Jim Taylor. Both recognize the power behind appropriate and equitable pay and how this impacts the larger picture of treatment and caregiving. As strong advocates they stated:

"Geri and I are here because we so adamantly believe that the coverage and payment issues related to Alzheimer's PET scans must be corrected. The issue of low participation in clinical research goes hand in hand with the radiopharmaceutical reimbursement issue discussed here today."

Ultimately, the stakeholders hope the enaction of H.R. 3772 will help patients to "receive the best available nuclear medicine and molecular imaging tests leading to quick and complete diagnoses, accurate treatment plans and ultimately a successful cure for Alzheimer's disease, Parkinson's disease, cardiovascular disease, cancer, and other illnesses."

Information Source:

http://www.snmmi.org/NewsPublications/NewsDetail.aspx?ItemNumber=33361

https://www.medicalimaging.org/2019/07/17/mita-applauds-introduction-of-h-r-3772-the-medicare-diagnostic-radiopharmaceutical-payment-equity-act-of-2019/

http://cqrcengage.com/asrt/HR3772

https://www.auntminnie.com/index.aspx?sec=sup&sub=mol&pag=dis&ItemID=128000

REVISIONS TO SOM IMPACTS RADIOLOGY:
New requirements for portable X-Ray

Revisions to the *State Operations Manual (SOM), Appendix D*, brings noteworthy updates for surveyors and operators of portable X-rays. In the manual, the original text is outlined in black with new text and policy signified in red italics. The original text is provided below with the updates in italics. The effective and implementation date started as of February 21, 2020. Notify your staff of these updates.

Portable X-Ray Updates

Under 486.104 describing standard qualifications of technologists, new text was added to item one stating

- Successful completion of a program of formal training in X-ray technology ***at which the operator received appropriate training and demonstrated competence in the use of equipment and administration of portable x-ray procedures; or***
- ***(2) Successful completion of 24 full months of training and experience under the direct supervision of a physician who is certified in radiology or who possesses qualifications which are equivalent to those required for such certification.***

Under section §486.106 "Condition for Coverage: Referral for service and preservation of records" new text was added to state:

- ***All portable X-ray services performed for Medicare beneficiaries are ordered by a physician or a non-physician practitioner as provided in §410.32(a) of this chapter or by a non-physician practitioner as provided in §410.32(a)(2) and records are properly preserved.***

In terms of interpretive guidelines, the manual notes that this guidance is pending, and providers should expect that this guidance will be updated during a future release.

In addition, the following changes were made:

- §486.106(a) Standard - referral by a physician ***or non-physician practitioners***

Portable X-ray examinations are performed only on the order ***of a physician*** licensed to practice in the ***State or by a non-physician practitioner acting within the scope of State law. Such non-physician practitioners may be treated the same as physicians treating beneficiaries for the purpose of this paragraph.*** The supplier's records show that:

(1) The ***portable*** X-ray test was ordered ***by a physician or a non-physician practitioner acting within the State scope of law***; and

(2) ***Such physician or non-physician practitioner's order meets the requirements at § 410.32 of this chapter, and includes a statement concerning the condition of the patient which indicates why portable X-ray services are necessary.***

- §486.106(b) Standard - Records of Examinations Performed. The supplier makes for each patient a record of the date of the ***portable*** X-ray examination, the name of the patient, a description of the procedures ordered and performed, the referring physician ***or non-physician practitioner***, the operator(s) of the portable X-ray equipment who performed the examination, the physician to whom the radiograph was sent, and the date it was sent.

Information Source:

https://www.cms.gov/index.php/files/document/r200soma.pdf

NEW ANALYSIS SHEDS LIGHT ON MRI/CT REIMBURSEMENT:
Downward Trend Takes Shape

New analysis offers insight on reimbursement trends for MRI and CT scans provided at private physician practices, which include radiology specialties, offering a bleak outlook. The analysis was released in the *Journal of the American College of Radiology* and examined Medicare Part B payment data. Among those leading the analysis were Sarah I. Kamel, MD, Laurence Parker, Ph.D., Vijay Rao MD, and David C. Levin, MD respectively. The study continues to add perspective to a volatile issue for many radiology stakeholders.

Insights Revealed

The study notes that at its height, reimbursement totals trended around $1.1 billion in 2006. However, the following decade saw a drop in reimbursement of more than 54% for MRI studies performed in independent practices. Furthermore, Medicare reimbursement for CT scans fell by 48% over the course of a ten-year period which ended in 2016. This occurred from a high of $705.6 million.

Unsurprisingly, this trend is reflective of decreases for other private specialists, like cardiologists, who provide MRI and CT services. If the trend continues, independent practitioners may need to create new strategies as they plan their day to day operations.

"These trends suggest the financial viability of private office practice may be in jeopardy," wrote Sarah Kamel, MD, "However, certain recent policy changes could promote a resurgence."

The master Medicare files examined provided payment data for all CPT codes. From the files, appropriate MRI and CT codes were selected by the researchers. Global and technical component claims were counted within the analysis. Using Medicare specialty codes, payments were identified that were made to NRPs and radiologists, and place-of-service codes specified payments directed to their private offices.

Ultimately, the mission of the analysis was to assess the delivery of imaging at non-radiologist practices in more recent years. Previous analysis showed rapid growth in MRI and CT in private offices, driven primarily by a loophole in federal regulations.

The Deficit Reduction Act was an impactful factor in the downward trend of reimbursement since it mandated lesser fees for imaging exams performed in these settings. Other factors influencing this trend were reduced payment for providers that complete multiple procedures in a single encounter and plans that bundle reimbursement for an entire care episode.

Over the same decade beginning in 2006, non-radiologist providers saw a significant drop in imaging reimbursement. Payment reached a high of $247.7 million during 2006 falling to $101.6 million in 2016, revealing a total downturn of 59%. Likewise, CT payments were at a high of $284.1 million in 2006, before falling 67%.

However, there may be hope on the horizon. Further insight from author Marty Stempniak, who analyzed the study, indicated that revisions by major insurers such as Anthem and United Healthcare could reveal a turning point in trends. These payers recently acted to deny coverage for non-emergency exams administered at hospital outpatient departments, which could drive patients back to freestanding imaging centers that provide overall cheaper tests.

Ultimately, the team reflected on the insurer policy implication stating, "It could lead to a resurgence of private office imaging among both radiologists and non-radiologist providers."

Information Sources:

https://www.jacr.org/article/S1546-1440(19)30834-8/fulltext

https://www.radiologybusiness.com/topics/healthcare-economics/imaging-reimbursement-private-radiology-practices

CORE BIOPSY KNOWLEDGE:
Helpful Breakdown

Ultrasound-guided biopsies are common procedures in interventional radiology. There are two types of biopsies typically performed in IR: aspiration biopsies, where cells or fluid are obtained for cytologic evaluation; or core biopsies where a larger core of tissue is removed for evaluation. Both aspiration and core are needle biopsies, but coding is different for each type, and documentation should indicate the type of biopsy performed so the appropriate code may be assigned. Here is a breakdown of tips and guidance to solidify knowledge of these procedures.

Core Biopsy Other than Breast

Biopsies in IR are usually performed using imaging guidance. Unless otherwise indicated in the code description or parenthetical notes, the appropriate guidance code should be assigned in addition to the biopsy code. In 2019, FNA biopsy codes were revised to include imaging guidance, therefore, no additional guidance codes should be assigned when coding an FNA biopsy. For non-aspiration biopsies, it is important to pay attention to code descriptions as some bundle the imaging guidance (i.e., breast) and some do not (i.e., lung, liver).

According to the Society for Interventional Radiology (SIR), an FNA biopsy is commonly performed at the same setting as a core biopsy. Under the circumstances, the results of the FNA are available right away (i.e., a pathologist is onsite, giving real-time interpretation of the specimen) and the results from the needle aspiration demonstrate the need for a core biopsy, both services should be separately reported.

However, often no medical indication exists to sustain reporting for more than one service. As a result, it is recommended to report the most intensive service, which is usually the core biopsy, combined with the imaging modality-specific needle guidance code (if allowed). Understand, that current Correct Coding Initiative (CCI) narrative instructions do contradict this guidance. The following is verbatim from the 2020 *NCCI Manual: Chapter 3, Section L:*

#12. Fine needle aspiration (FNA) biopsies (CPT codes 10004–10012, and 10021) shall not be reported with a biopsy procedure code for the same lesion. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the physician shall report only one code, either the biopsy code or the FNA code. (CPT code 10022 was deleted January 1, 2019.)

Core Biopsy of Breast

Codes 19083 and 19084 are reportable for breast core biopsies using ultrasound guidance.

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QUESTIONS AND ANSWERS:
Focus on Radiology Services

Inflammation Scan Codes

Q. Inflammation Scan Codes 78805–78807 are not in my new CPT book, is that an error?

A. No, this is not an error. Codes 78805–78807 were deleted and the indication was added to codes 78800–78835. This code series, which includes both old codes and new codes, may now be used for scans to localize tumors, evaluate for inflammatory processes, and to follow the distribution of radiopharmaceutical agents.

For instance, the code description for 78800 now states:

78800 Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); limited planar, single area (eg, head, neck, chest, pelvis), single day imaging

Lumbar Puncture Codes

Q. I understand there are new lumbar puncture codes. Was 62270 deleted, or can I still use it?

A. Both diagnostic lumbar puncture code 62270 and therapeutic lumbar puncture code 62272 remain. Two new codes were added (62328 - diagnostic, and 62329 - therapeutic). The appropriate code to use now depends on whether imaging guidance was used and what type of guidance. Codes 62270 and 62272 are reported when either no imaging guidance is used, or when ultrasound or MR guidance is used. New codes 62328 and 62329 are reported when fluoroscopic or CT guidance is used for the lumbar puncture.

Guidance supervision and interpretation (S & I) codes 77003 and 77012 may not be used with any of these codes. S & I codes 76942 and 77021 may be reported with 62270 and 62272 when appropriate.

The full code descriptions are

62270 Spinal puncture, lumbar, diagnostic;

62328 with fluoroscopic or CT guidance

62272 Spinal puncture, therapeutic for drainage of cerebrospinal fluid (by needle or catheter);

62329 with fluoroscopic or CT guidance

Absolute Quantification

Q. May we report code 0482T (absolute quantification) along with the new cardiac positron emission tomography (PET) codes in 2020?

A. Category III code 0482T was transitioned to a Category I CPT code effective January 1, 2020. The new code is 78434. This code is an add-on code and may be reported in addition to codes 78431 and 78492. The full code description is as follows:

78434 Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)

Core Biopsy ... continued from page 3

19083 Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance

+19084 Biopsy, breast, with placement of breast localization device(s) (e.g., clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure)

These codes include clip or other localization device placement along with the imaging guidance and specimen radiography itself, when performed. Codes for breast biopsies using other forms of imaging guidance (stereotactic, magnetic resonance) are structured in the same way as 19083 and +19084.

Reporting and Billing Advice

- 19083 should be reported only once per operative session. If additional biopsies are done on the same or contralateral breast using ultrasound guidance, bill for add-on code 19084 as appropriate. Should more biopsies be completed using different imaging modalities, report another primary code for each additional modality.
- 76942 should not be reported in addition to the above procedures.
- Codes 19083 and 19084 must not be reported in combination with needle localization codes 19281–19288 or surgical specimen imaging code 76098 for the same lesion.
- Ordinarily, CPT surgical codes (10xxx–69xxx) are billed with revenue code 036x, 049x, or 0761. Understand, you should always ask your payer which revenue code is required.

Published monthly by Medlearn Publishing, 445 Minnesota Street, Suite 514, St. Paul, MN 55101.

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