PREVIEW OF THE 2020 CODING CHANGES:
Bundling of “Misvalued” Services Continues

For 2020, radiology codes and guidelines will undergo several changes and revisions. Like previous years, the American Medical Association’s (AMA) Relativity Assessment Workgroup (RAW) created numerous codes because of bundling rules. The purpose behind RAW’s action is to identify what the group believes are possibly “misvalued” services–code pairs that the Centers for Medicare & Medicaid (CMS) have identified as being performed together 75 percent or more of the time. When this occurs, the codes are referred to the CPT Editorial Panel for bundling.

As a reminder, there are three types of CPT codes:
- Category I: Procedures that are consistent with contemporary medical practice and are widely performed.
- Category II: Supplementary tracking codes that can be used for performance measures.
- Category III: Temporary codes for emerging technology, services and procedures.

An April 30, 2019 online posting by the American College of Radiology (ACR) (“CPT 2020 Anticipated Code Changes”) provided a preliminary guide of changes that radiology providers should expect to see in 2020. However, it emphasizes that the code changes are not yet final. Instead, they reflect the most recent actions taken by the CPT Editorial Panel, but future panel actions may affect these items below. Here is an outline of the potential changes that may help prepare your staff for the 2020 update season.

Once the final codes are released in August, radiology providers will need to review and assess how the bundled and new code changes may impact their practices and coding protocol. For more information, look out for an impact analysis of the 2020 coding changes by the ACR on its Economics and Health Policy eNews section.

### Know the Areas of Change

Imaging procedures such as upper gastrointestinal tract imaging and lumbar puncture will likely be bundled come next year. Nuclear medicine will include a new family of codes specifically for single photon emission computed tomography (SPECT/CT) studies. Code 0482T for absolute quantitation of myocardial blood flow (AQMBF) and code G0365 for duplex scan arterial inflow and venous outflow upper extremity will be converted to category I.

The ACR states that providers should also expect revisions, bundling or new codes for the following:
- Duplex scan arterial inflow and venous outflow upper extremity for hemodialysis imaging
- Myocardial positron emission tomography (PET) 3D anatomic modeling.

### Gastrointestinal Tract Codes

For codes 74210, 74220, 74230, 74240, 74246, 74250, 74251, 74270, and 74280, anticipate the arrival of two new codes along with revisions. Codes 74241, 74245, 74247, 74249 and 74260 will be deleted.

74241 Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB
74245 with small intestine, includes multiple serial images
74247 Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB
74249 with small intestine follow-through
74260 Duodenography, hypotonic

RAW recommended that fluoroscopy be bundled and the family of gastrointestinal tract code family be reduced. Revisions to these codes will help clarify the anatomic region while more specifically detailing the components that are included to better correlate with other codes in the radiology code set.

### Lumbar Puncture

RAW recommended that the CPT Editorial Panel bundle code 62270 based on imaging guidance. Expect this code and 62272 to receive revisions and two new codes that bundle diagnostic and therapeutic lumbar puncture with fluoroscopic or CT guidance.

62270 Spinal puncture, lumbar, diagnostic
62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)

This article will be continued in part two in our July 2019 edition.
HOSPITAL OUTPATIENT PPS JULY UPDATES:
CPT Category III Code Additions

The July update of the hospital outpatient prospective payment system (OPPS) contains ten new Category III codes for radiological services that the Centers for Medicare & Medicaid Services (CMS) will implement on July 1, 2019 (also the effective date). The codes and their status indicators (SIs) are shown in Table 1 below. CMS presented this information in transmittal 4313 published on May 24, 2019. Be sure to notify billing staff of these changes.

As a reminder, the American Medical Association (AMA) states, “CPT Category III codes are a set of temporary codes that allow data collection for emerging technologies, services, procedures, and service paradigms. These codes are intended to be used for data collection to substantiate widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process.” The AMA releases the CPT Category III codes twice per year: in January, for implementation beginning the following July, and in July, for implementation beginning the following January.

Specifically, CMS has re-assigned CPT code 0541T from “E1” to “S” (procedure or service, not discounted when multiple; paid under OPPS; separate APC payment). This code is grouped to APC 5722 (Level 2 Diagnostic Tests and Related Services).

CPT code 0542T has been re-assigned from “E1” to “M” (items and services not billable to the MAC, not paid under OPPS) effective July 1, 2019. The payment rate for CPT code 0541T is located in Addendum B of the July 2019 OPPS update, which is available on the CMS website and found in our information links below. As usual, Medicare contractors will not search their files to either retract payment or retroactively pay claims but will adjust claims brought to their attention.

Information Sources:
https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientppsexempts.html

Table 1: New CPT Category III Codes

<table>
<thead>
<tr>
<th>CPT Category III Codes</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0553T</td>
<td>Percutaneous transcatheter placement of iliac arteriovenous anastomosis implant, inclusive of all radiological supervision and interpretation (S &amp; I), intraprocedural road-mapping, and imaging guidance necessary to complete the intervention</td>
</tr>
<tr>
<td>0554T</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a computed tomography (CT) scan; retrieval and transmission of the scan data, assessment of bone strength and fracture risk and bone mineral density, interpretation and report</td>
</tr>
<tr>
<td>0555T</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a CT scan; retrieval and transmission of the scan data</td>
</tr>
<tr>
<td>0556T</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a CT scan; assessment of bone strength and fracture risk and bone mineral density</td>
</tr>
<tr>
<td>0557T</td>
<td>Bone strength and fracture risk using finite element analysis of functional data, and bone-mineral density, utilizing data from a CT scan; Interpretation and report</td>
</tr>
<tr>
<td>0558T</td>
<td>CT scan taken for the purpose of biomechanical CT analysis</td>
</tr>
<tr>
<td>0559T</td>
<td>Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure</td>
</tr>
<tr>
<td>0560T</td>
<td>Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0561T</td>
<td>Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide</td>
</tr>
<tr>
<td>0562T</td>
<td>Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

Table 2: Myocardial Imaging Code Updates

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>0541T</td>
<td>Myocardial imaging by MCG for detection of cardiac ischemia, by signal acquisition using minimum 36 channel grid, generation of magnetic-field time-series images, quantitative analysis of magnetic dipoles, machine learning-derived clinical scoring, and automated report generation, single study;</td>
</tr>
<tr>
<td>0542T</td>
<td>interpretation and report</td>
</tr>
</tbody>
</table>
NEW BILL SEeks REIMBURSEMENT FOR RAs: Non-Imaging and Imaging Services at Stake

A new proposed piece of federal legislation seeks to allow radiologists to submit Medicare claims for non-imaging services that are administered by radiology assistants (RAs) in hospitals and imaging services administered in the hospital or office setting.


Reasons to Change the Rules

The American Society of Radiologic Technologists (ASRT) states “these bills propose a law that amends Medicare reimbursement policy for radiologist assistants to align it with state radiologist assistant licensure laws.”

As you may know, an RA is a radiographer with advanced-level knowledge who performs duties and procedures under the direct supervision of a radiologist. RAs are required to complete a challenging academic program with nationally recognized curriculum along with a radiologist-directed clinical preceptorship and certification examination.

In part, the position of an RA is designed to give radiologists more time for interpretations, which increases positive patient outcomes. RAs may perform assessments and procedures but are not allowed to provide image interpretation or offer prescriptions or therapies. Instead, many must deal with other tasks such as patient procedure preparation, getting patient consent, and modifying exam protocols for improved diagnostic quality.

Timely medical imaging services are a clinical necessity as demand for radiology services continues to increase. Medicare is also looking to identify value-based solutions that efficiently optimize patient outcomes.

Before 2019, the Centers for Medicare & Medicaid Services (CMS) mandated personal supervision by a physician when an RA provided diagnostic imaging services. MARCA of 2016 aimed to scale down the level of supervision from personal to direct as detailed by a state-recognized scope of practice. (The new bills would amend Medicare reimbursement policy for RAs to align with state radiologist assistant licensure laws.)

Recently, Medicare updated its rules under the 2019 Medicare Physician Fee Schedule (MPFS) and now allows RAs to perform diagnostic tests services under “direct supervision.” Ultimately, this update no longer requires radiologists to be present in the room where the exam is happening, but they must be in the facility and available to offer assistance as needed. Examples of diagnostic tests include fluoroscopy procedures such as cystography, upper gastrointestinal tract (UGI), endoscopic retrograde cholangiopancreatography (ERCP), and barium swallow.

Note that MPFS supervision rules apply only to diagnostic tests (70000 series codes) in the hospital outpatient setting, independent diagnostic testing facilities (IDTFs) and physician offices. In order to be paid in the hospital setting for non-diagnostic services, present regulations mandate the physician to perform and not the RAs.

Even though RAs are newly recognized by Medicare to administer diagnostic imaging services, the practices that employ them cannot submit claims to Medicare for procedures or non-diagnostic services that RAs provide in hospitals. Radiologists are restricted from billing for procedures that RAs could administer in an office setting where the study is not considered “incident to” the radiologist.

Legislation Impact

The new legislation is crucial in order to successfully utilize RAs to their maximum capabilities. Without proper legislation, Medicare cannot recognize the full capacity of RA services, which include needle placements, biopsies and injections that can come with the diagnostic imaging study and are a component of patient services.

Key community stakeholders of this legislation, including the American Society of Radiologic Technologists endorse the bill, along with over 100 national state and local organizations and companies, such as the American Registry of Radiologic Technologists, the American College of Radiology and the Society for Radiology Physician Extenders.

The MARCA 2019 bill allows for a less limiting version of the “incident to” rules since not all criteria must be met to bill in the office setting for non-diagnostic services. Should it be enacted, the bill will provide Medicare recognition of RAs and radiology practitioners as midlevel providers operating under the supervision of a radiologist.

Information Sources:

https://www.congress.gov/bill/116th-congress/senate-bill/1544?q=%7B%22search%22%3A%0A%5B%22s1544%22%5D%7D&r=1

https://www.acr.org/-/media/ACR/Files/Advocacy/AAAR/Annual-Meeting---19---MARCA-TPs_pk.pdf


Myocardial Infarction (MI) Coding Tips

The three CPT codes below can be used to report evaluation of an acute MI as follows: CPT 78466 is for planar imaging, CPT 78468 is for planar plus ejection fraction by first pass flow technique, and CPT 78469 is for planar plus SPECT imaging.

78466  Myocardial imaging, infarct avid, planar; qualitative or quantitative
78468  with ejection fraction by first pass technique
78469  tomographic SPECT with or without quantification

Guidance

• For myocardial sympathetic innervation imaging, planar or planar plus SPECT imaging see 0331T or 0332T.
• Do not report for studies using technetium PYP for cardiac amyloidosis, see 78800 or 78803.
QUESTIONS AND ANSWERS:
Focus on Radiology Services

Renal Artery Angiogram

Q. When coding interventional radiology (IR) reports, one of my providers uses language such as “catheter is placed into the opening of…” and some say, “catheter is placed at the ostium of…” I understand the difference between selective and non-selective placements, but I am struggling with how to code this scenario.

A. “Into the opening of” is not the same as “at the ostium of.” Ostium means “an opening or orifice.” Think of a long hallway where you can look into a room from the hallway, or you can go into the room. Using the left renal artery and the abdominal aorta to illustrate this question, consider the following.

The renal artery arises from the aorta. An angiogram can be performed of the renal artery by either injecting directly into the renal artery via a catheter placed into the renal artery—“into the opening of the renal artery” (36251) or via a catheter placed into the abdominal aorta at the renal artery—at the ostium of the renal artery” (36200 and 75625). Lack of clear documentation as to where the catheter was precisely placed affects ultimate code assignment and charging.

Abdominal Ultrasound

Q. What criteria must be met in order to assign code 76700, US abdomen complete? If two quadrants are imaged, would that be sufficient?

A. An abdominal ultrasound (76700) includes imaging from the diaphragm to the area of the umbilicus. Within that area, the following required elements must be evaluated and documented: liver, gallbladder, common bile duct, pancreas, spleen, both kidneys, upper abdominal aorta, and the inferior vena cava (IVC). Any demonstrated abdominal abnormality should be documented as well.

Other elements within the abdominal region can be evaluated, but the above elements are required. If you try to evaluate one or more of the required elements that cannot be seen, documenting why the element cannot be seen will allow it to be counted toward a complete exam. To emphasize, the documentation must state why an element could not be seen, not just that it couldn’t be seen. If even one required element is not evaluated and/or documented, the limited exam 76705 must be reported instead of 76700. Evaluating just two quadrants is not sufficient for a complete abdominal ultrasound.

MRI Neurography

Q. We have an order for an “MRI neurography.” What code is assigned to it?

A. Magnetic resonance imaging (MRI) neurography involves the nerves. The appropriate code would depend on the body area of the nerves. For instance, an MRI looking at the sacral plexus would be an MRI pelvis (72195–72197). MRI of the brachial plexus could be MRI of the upper extremity codes (73218–73223), MRI scan of the chest (71550–71552), or an MRI scan of the orbit, face, and neck (70540–70543) depending on the area of the brachial plexus that is being imaged.

Because of this variation, physicians should document according to CPT terminology, not by protocol or non-standard terminology. The technique of the exam should clearly indicate what body area was examined and whether IV, intrathecal, or intra-articular contrast was used.

When or If Performed

Q. What does the phrase “when performed” or “if performed” mean when I see this in CPT code definitions such as 93452, 92933, 74174, 36226, 37191 or many other codes?

A. The terms “when performed,” “if performed,” “including,” “with and/or without” all basically refer to the same concept, which is whether the additional study mentioned in the code description was performed or not. In either case, it is included in the procedure and not coded separately.