

# Radiology Compliance manager

## inside

publications | consulting | seminars | online learning

- More on the 2009 MPFS Proposal
- Source for 2009 ICD-9-CM Codes
- Focus on Radiology Documentation
- Questions You Asked

## CCI NEWS ON ANGIOPLASTY AND STENTING SERVICES: CMS Returns to Previous Policy

The Centers for Medicare & Medicaid Services (CMS) will “temporarily rescind” a restrictive policy that has, since October 1, 2007, prevented providers from reporting more than one non-coronary angioplasty, stent or atherectomy performed in the same vessel at the same clinical setting. Note that this policy never affected other non-coronary interventions (i.e., thrombectomy, infusion therapy, and embolization) performed in the same anatomic site at the same clinical setting.

In a letter dated August 12, 2008, to MedLearn, Niles R. Rosen, M.D., medical director for Correct Coding Solutions, LLC—a Medicare contractor that maintains and updates the NCCI edits under a contract with the Centers for Medicare & Medicaid Services (CMS)—indicated that CMS would again adopt the previously published policy, which is provided below.

### “D. Cardiovascular System

16. When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the most comprehensive atherectomy that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section M).”

The above will be published on October 1, 2008, in version 14.3 of the *National Correct Coding Initiative Policy Manual for Medicare Services* (Chapter V—Surgery: Respiratory, Cardiovascular, Hemic and Lymphatic Systems, CPT Codes 30000–39999) as well as the online version. This policy replaces the following restrictive policy (version 13.3), which took effect on October 1, 2007, as well as in the online version of the manual. This change will be retroactive to October 1, 2007.

### “D. Cardiovascular System

16. If an atherectomy fails to adequately improve blood flow and is followed by an angioplasty at the same site/vessel during the same patient encounter, only the successful angioplasty may be reported. Similarly if an angioplasty fails to adequately improve blood flow and is followed by an atherectomy at the same site/vessel at the same patient encounter, only the successful atherectomy may be reported. If atherectomy and/or angioplasty fail to adequately improve blood flow and are followed by a stenting procedure at the same site/vessel during the same patient encounter, only the successful stenting procedure may be reported. These principles apply to percutaneous or open procedures.”

### Future Repercussions

MedLearn wholeheartedly welcomes this change, which allows both facilities and providers to code separately for multiple, medically necessary procedures performed at the same clinical setting (i.e., angioplasty and stenting services). While this is excellent news, it also should be noted that CMS has left the door open regarding revisiting this subject at a later date. The letter from Rosen says the following:

“CMS remains concerned about this issue and has encouraged national healthcare organizations to work with other interested parties to address coding for reporting atherectomy, angioplasty and stenting in non-coronary arteries.”

As always, providers and facilities are encouraged to closely monitor transmittals, special notices and bulletins from their state-specific Medicare fiscal intermediaries, carriers or Part A/B Medicare administrative contractors (MACs) regarding this policy.

**Information Source:** For the home page for the NCCI edits, go to <http://www.cms.bhs.gov/NationalCorrectCodInitEd/>.

## 2009 MEDICARE PFS CHANGES, PART 2: Misvalued RVUs, Quality Initiative and Radiology

As reported in the August issue (page 3), the Centers for Medicare & Medicaid Services (CMS) has issued the Medicare physician fee schedule proposed rule for 2009. Last month's article addressed the following topics:

- Standards for all diagnostic testing;
- Anti-markup provisions; and
- Multiple-procedure payment reduction policy.

Two more topics of interest to radiology providers are provided below.

### Evaluating Misvalued Services

Is the CMS process of reviewing physician fee schedule relative value units (RVUs) effective for identifying potentially overvalued procedures? Does CMS favor specialized services over primary care services? These are two questions that the Medicare Payment Advisory Commission (MedPAC), primary care physicians, members of Congress, and others have been asking.

In response to these concerns, CMS proposed a multi-year project involving the American Medical Association's Relative Value System Update Committee (RUC). (The RUC provides recommendations to CMS for the valuation of new and revised codes and codes identified as misvalued under the five-year review of work.) The RUC will address services with potentially unexplained high RVUs. In Table 25 of the proposed rule, CMS lists some high-volume CPT codes, which include several computed tomography (CT) and interventional codes.

To determine whether there are inequities in fee schedule payments, CMS also proposes to review non-surgical services frequently billed together more than 60 percent of the time. Before this rule, the RUC identified CPT codes 78465, 78478 and 78480 as codes billed together over 90 percent of the time. Also proposed is the creation of a process to update the prices for high-cost supply items paid under the practice expense methodology. The list

includes several interventional cardiology supplies.

After it receives public comment on this proposal, CMS will consider whether it should bundle additional services or expand the multiple procedure payment reduction list to additional services.

### PQRI Improvements

CMS launched the Physician Quality Reporting Initiative (PQRI) in 2007. The Medicare Improvements for Patients and Providers Act (MIPPA) (see page 4 of the August issue) extended the PQRI through 2010.

For 2009, CMS proposes to implement more than 170 reporting measures—more than 50 measures from last year. The total includes current measures as well as new measures endorsed by the National Quality Forum (NQF), adopted by the AQA Alliance, or now being considered by one of these organizations. No financial incentive payment would be associated with submission of these new test measures for either 2008 or 2009, or for reporting data on (non-test) quality measures under the proposed 2009 PQRI.

Pages 38558–37565 of the 2009 proposed rule includes a list of 134 PQRI measures from 2008 that CMS proposes to adopt for 2009 as well as several other tables of additional proposed measures. Among those listed are the following:

- T144 radiology: computed tomography (CT) radiation dose reduction;
- T145 radiology: exposure time reported for procedures using fluoroscopy;
- Radiology: inappropriate use of “probably benign” assessment category in mammography screening;
- Nuclear medicine: correlation with existing imaging studies for all patients undergoing bone scintigraphy;
- Screening mammography; and
- Body mass index screening and follow-up.

Eligible professionals who are not already participating in the PQRI this year will have the opportunity to begin reporting quality measures relating to their clinical practice in July 2008 to qualify for an incentive payment. Those eligible professionals who have reported PQRI data successfully for the full year can earn an incentive payment based on their total Medicare allowed charges for services furnished in 2008, while those who begin reporting in July can earn an incentive payment based on their total allowed charges from July 1 through December 31, 2008.

However, no financial incentive payment would be associated with submission of new test measures for either 2008 or 2009, or for reporting data on (non-test) quality measures under the proposed 2009 PQRI.

**Information Source:** For the proposed MPFS rule, go to <http://edocket.access.gpo.gov/2008/pdf/E8-14949.pdf>.

## TIME FOR NEW ICD-9-CM CODES: Where to Go to Download

As you know, the fiscal year (FY) 2009 annual ICD-9-CM update takes effect for dates of service on and after October 1, 2008. For institutional providers, this date applies to discharges on or after October 1, 2008. The new, revised, and discontinued ICD-9-CM diagnosis codes are available on the Centers for Medicare & Medicaid Services (CMS) website at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers), and for all institutional claims. It is not required for ambulance supplier claims.

## DOCUMENTATION IS KEY TO RIGHT RADIOLOGY PAYMENT:

### Focus on Clear and Comprehensive Records

To bill for any procedure, radiology providers must meet medical necessity requirements. To prove medical necessity, they must have documented clear and complete clinical information regarding the procedure.

Documenting this information allows hospital or clinic billing staff to assign diagnosis codes (ICD-9-CM) at the highest level of specificity. Medicare and other third-party payers demand this information in order to correlate “what’s wrong” (the diagnosis codes) with “what is to be done” (the HCPCS or CPT codes). If the two parts do not match, the claim will be rejected or held, thereby either stopping or slowing reimbursement.

However, according to the Department of Health & Human Services Office of Inspector General (OIG), lack of medical necessity is the number one reason for improper payments in the Medicare system. Documentation errors and insufficient documentation follow closely behind.

All physicians, including radiologists and referring physicians, should be educated about, and be reminded regularly about, the importance of documentation and its need to support medical necessity. When claims are denied due to insufficient documentation, it’s time to get serious about uncovering and solving the problems. A few of the most common documentation errors found in radiology records are provided below.

#### Ultrasound with Color Flow Doppler

In many ultrasound departments, it is protocol to study organ vascularity with duplex imaging and color flow Doppler when performing ultrasound of the abdomen and/or pelvis. For example, when billing for a complete abdominal ultrasound, the following code is reported.

76700 Ultrasound, abdominal, real time with image documentation; complete

Usually, code 93975 also is reported for the duplex imaging with color flow Doppler.

93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study

Medicare now has an edit that prohibits the reporting of code 93975 with code 76700.

However, modifier 59 may be assigned to code 93975 if the documentation supports that a full and complete duplex imaging with color flow was necessary, and a finding was reported.

The American College of Radiology recommends that the interpreting physician indicate within his/her dictated report why the duplex imaging with color flow was required and what information was gleaned from it. Complete documentation will support the coding and billing of both studies.

#### Number of Views

Several years ago, the American Medical Association (AMA) revised the descriptions of the radiology codes for extremities from partial and complete studies to the number of views obtained. For example, code 73100 describes a radiological exam, wrist; two views. Code 73110 describes a wrist x-ray, complete; with three views.

However, many physicians fail to indicate within their report the number of views obtained. To be in full compliance, the American College of Radiology (ACR) recommends that within the body of the report the interpreting physician indicate how many views were obtained.

#### Pulmonary Embolism Protocol

The current methodology to determine if a patient has a pulmonary embolism is to perform a CTA of the chest with image post-processing. Invariably the interpreting physician does not indicate within his/her dictated report that the CTA images were post-processed. Therefore, it is inappropriate to bill the examination as a CTA.

According to the ACR, the difference between a computed tomography (CT) and a CTA is post-processing into 2D or 3D image reconstructions. If the images were not post-processed or if the reconstruction is not mentioned within the physician’s dictated report, then the study should be coded and billed as a CT in lieu of a CTA.

#### Additional Selective Study

The procedure identified by the following code is generally performed after a bilateral lower extremity run-off is performed from a distal aortic injection.

75774 Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (S&I) (List separately in addition to code for primary procedure)

The physician performs a contralateral catheter placement into the common femoral artery to perform an additional selective study of the contralateral lower extremity. However, the physician does not explain why the selective procedure is performed.

To insure that medical necessity is met, the physician should describe within his/her dictated report why the study was required. Examples of documentation include the following: “to better delineate the vessels of the lower extremity” or “to determine the severity of the stenosis in the distal SFA.”

#### Abdominal Aortography with Run-off

With the advantages of digital imaging and technology, the most common way to perform abdominal aortography and bilateral lower extremity run-off is with two catheter placements. For example, the catheter is advanced from the common femoral access to the supra-renal aorta, and abdominal aortography is performed. The catheter is then repositioned at the aortic bifurcation, and lower extremity run-off is performed.

The aforementioned describes full and complete evaluations of the abdominal aortography and lower extremity angiography. These two separate and identifiable examinations are reported with the following codes:

75625 Aortography, abdominal, by serialography, radiological S&I

75716 Angiography, extremity, bilateral, radiological S&I

However, some physicians do not identify within their dictated reports that the catheter was repositioned at the bifurcation. The report states that “the catheter was advanced from the common femoral access to the supra-renal aorta, and abdominal aortography with runoff was performed.” This dictation only allows for one code 75630 (aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological S&I) and results in loss of reimbursement both for the facility and the physician. (Excellent references for this scenario can be found in *CPT Assistant*, Fall 1993 and January 2001.)

## QUESTIONS AND ANSWERS:

### Focus on Radiology Services

#### Single Vascular System Coding

**Q.** Can you tell me why we don't or can't code for initial venous access into the femoral vein separately from the selective catheterization of the right pulmonary artery when these are separate vascular families?

**A.** All coding is based upon where you start and where you end up. Like other (single) vascular systems that might be studied, you only code for the most ultimate distal placement as it includes the work (relative value units [RVUs]) of getting into the vascular system as well as end placement.

#### Closure Device

**Q.** Is HCPCS code C1760 a facility code, or can the radiologist bill (PC) for it?

**A.** Usually, C codes, including C1760 (closure device, vascular [implantable/insertable]) are used by hospitals under the outpatient prospective payment system (OPPS). The radiologist may use the following code for the professional component (PC) of placing the device:  
 G0269 Placement of occlusive device into either a venous or arterial access site, postsurgical or interventional procedure (e.g., angiaseal plug, vascular plug)

However, radiologists who do interventional radiology procedures in their offices may need to bill for the closure device. The device itself, and not the placement of the device, will be bundled into the other surgical codes.

#### Ventilation/Quantification Scan

**Q.** When coding for a lung scan, gas, ventilation and perfusion, we charge for both of the following codes:

- 78594 Pulmonary ventilation imaging, gaseous, with rebreathing and washout with or without single breath; single projection
- 78580 Pulmonary perfusion imaging, particulate

I checked these codes in the correct coding initiative, and there doesn't seem to be any bundling issues. During a recent in-house audit, I began questioning this, and wondered if we should instead be charging the single code 78585.

Which would be the most accurate way to charge for these? Is there something in the

wording of each option that would make them different?

**A.** Based upon what you stated, it appears that you have unbundled the charges. VQ lung scans using 133Xe (gas) and 99mTc MAA (particulate) performed at the same time are correctly coded with CPT code 78585—pulmonary perfusion imaging, particulate, with ventilation; single breath.

If an aerosol (99mTc DTPA) and MAA are used for the VQ lung, the correct code would be 78588—pulmonary perfusion imaging, particulate, with ventilation imaging, aerosol, one or multiple projections.

#### Mammography Orders

**Q.** We have a doctor's office sending patients to us with the following order: Bilateral mammogram for annual screening and/or additional views or ultrasound as recommended by radiologist. This doctor is saying that we should just schedule the patient and perform the additional views or ultrasound based on this order. I know that Medicare guidelines say that the order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test reveals the need for additional testing.

We are a freestanding imaging center, not an IDTF or hospital outpatient department. Would this cover bringing the screening mammography patient back for an ultrasound and/or additional views, or would we still need an order from the referring doctor?

**A.** According to the definition of "order" in Chapter 15, Section 80.6.1, of the *Medicare Benefits Policy Manual*, "The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y)."

What this means is that the treating physician must specifically state the outcome in the first test that would trigger the performance of the additional diagnostic procedures. For example, for Medicare compliance, the treating physician could request a breast ultrasound study if the screening mammogram yields positive or equivocal results that a diagnostic mammogram may not fully clarify.

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### » Comments, Questions?

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