The American College of Radiology (ACR) has issued new guidance for reporting percutaneous transluminal angioplasty (PTA) used to treat a stenosis in an arteriovenous (AV) dialysis circuit.

In ACR’s March/April 2010 Radiology Coding Source, a question and answer segment noted that “if the stenosis in the AV fistula or graft that is treated is at the arterial anastomosis, it may be coded with arterial angioplasty codes 35475 and 75962. This code would then apply to all other stenoses treated within the AV dialysis ‘vessel.’”

Previous Guidance

This is a change from previous guidance issued by the ACR and the Society of Interventional Radiology (SIR). SIR’s 2010 Interventional Radiology Coding Users’ Guide Online Supplement states, “Once a venous angioplasty has been performed, then the venous angioplasty codes are to be used (35476 and 75978), even if an angioplasty at the arterial anastomosis has been performed as well.”

An ACR representative confirmed that the new guidance replaces the previous rule. Sources tell Coding Strategies SM that ACR and SIR worked together on the new guidance, and that SIR will release information in June similar to that from ACR.

When the Rules Apply

Non-functioning AV fistulas and grafts often require angioplasty, and the radiologist may use an angioplasty balloon to treat stenosis of the arterial anastomosis, the body of the graft, the venous anastomosis, or the outflow veins.

You should code all balloon angioplasty of an AV dialysis access with one set of angioplasty codes, regardless of the number of stenoses the radiologist treats within the AV dialysis circuit, according to ACR. Most often, this is a venous angioplasty, and you would report that with 35476 for the venous PTA and 75978 for the radiological supervision and interpretation (RS&I).

On the other hand, if the stenosis is at the arterial anastomosis, you should treat this as an arterial PTA and report it with 35475 for the procedure and 75962 for the RS&I. “In other words, all angioplasty within the AV dialysis circuit (considered from the peri-anastomotic vessels near the arterial anastomosis through the axillary vein), would be coded with either 35475 and 75962 or 35476 and 75978,” ACR states. “The appropriate code is chosen dependent upon whether a true arterial anastomotic stenosis is treated.”

And if the interventionalist uses PTA to treat a stenosis at the arterial anastomosis as well as a venous anastomotic stenosis, you may still report only one angioplasty code because the fistula or graft is considered a single vessel, ACR notes. Under the new guidance discussed earlier, you should report this using the arterial PTA codes 35475 and 75962.
Payor Policy

Highmark Medicare Demands Proof That Ultrasonic Guidance Is Necessary for Knee Injections

When reporting ultrasonic guidance for knee injections to the Highmark Medicare Services, you must be able to prove medical necessity for the guidance, or you could be facing denials, the Medicare contractor stated in a May 18 Provider Bulletin.

Highmark is the Medicare contractor for Delaware, the District of Columbia, Maryland, New Jersey and Pennsylvania. And the payer’s Medical Review Department recently audited claims that included 76942 (Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation). As a result, Highmark noted that “the documentation did not provide any information which would support the medical necessity for using ultrasonic guidance for knee injections.”

Defining Medical Necessity

According to the Highmark Provider Bulletin, “medical necessity is defined as the need for an item(s) or service(s), to be reasonable and necessary for the diagnosis or treatment of disease, injury or defect. The need for the item or service must be clearly documented in the patient’s medical record.” Further, the Medicare contractor identified medically necessary services/items as those that fit the following criteria:

• Appropriate for the symptoms and diagnosis or treatment of the patient’s condition, illness, disease or injury; and
• Provided for the diagnosis or the direct care of the patient’s condition, illness, disease or injury; and
• In accordance with current standards of good medical practice; and
• Not primarily for the patient’s or provider’s convenience; and
• The most appropriate supply or level of service that can be safely provided to the patient.

Based upon this definition, the payor stated that it would consider ultrasound guidance for knee injections medically reasonable and necessary if the radiologist’s documentation supported one of the following:

• The failure of the initial attempt at the knee joint injection where the provider is unable to aspirate any fluid
• The size of the patient’s knee(s), due to morbid obesity or disease process, inhibits the provider’s ability to inject the knee(s) without ultrasound guidance
• The provider is planning to drain a popliteal (Baker’s) cyst.

Highmark conceded that there was medical research to support that ultrasonic guidance improves the provider’s accuracy during knee joint injections and therefore reduced the patient’s pain in many cases. At the same time, “the data does not support improved clinical outcomes to support the coverage of ultrasound guidance for all knee joint injections,” the payor said.

Coding the Joint Injection

For those knee injections for which you can show medical necessity for ultrasonic guidance, you would be able to assign codes for both the injection and the guidance. The most common type of knee injection is a corticosteroid-anesthetic combination to decrease inflammation and pain. Alternatively, the radiologist may insert a needle into the knee joint to aspirate fluid for pathologic evaluation.

To report the knee injection, you will use 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)). This code includes both aspiration (arthrocentesis) and intra-articular injection, but you should assign only one code per joint regardless of whether the physician aspirates fluid, injects medication or both.

The physician may occasionally perform bilateral knee injections, in which case you would append modifier 50 (Bilateral procedure) — or RT (Right side) and LT (Left side), depending upon payor preference — to 20610.

And if the radiologist uses ultrasonic guidance to perform the procedure, you also assign 76942. Keep in mind that this code requires permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report for the knee injection procedure.
Recognize ICD-10’s Separate Components and Simplify Your Implementation Planning

If you are using ICD-9-CM diagnosis and/or procedure codes, you will likely use the same component under ICD-10 when it takes effect Oct. 1, 2013. But that probably will not be the only coding system you will rely on.

ICD-10, like ICD-9, has two separate components: the diagnosis classification, which is referred to as ICD-10-CM (Clinical Modification) and the procedure classification, which is referred to as ICD-10-PCS (Procedure Coding System) for inpatient procedure reporting.

Use ICD-10-CM for Diagnoses

Although the ICD-10-CM codes may look very different from ICD-9-CM, ICD-10-CM has the same hierarchical structure as ICD-9-CM. “Primarily, changes in ICD-10-CM are in its organization and structure, code composition, and level of detail,” according to the Centers for Medicare and Medicaid Services (CMS) in its ICD-10-CM Quick Reference Guide (http://www.cms.gov/ICD10/Downloads/ICD-10QuickRefer.pdf).

You will use ICD-10-CM to report the patient’s condition, much as you currently use ICD-9-CM. The guidelines for applying the diagnosis codes under ICD-10-CM are generally the same as ICD-9-CM. The biggest change will be the appearance and number of diagnosis codes available for any given disease or condition. For example, you would report renal artery stenosis as 440.1 under ICD-9-CM, but with ICD-10-CM, you would use I70.1 to represent the same condition.

And all health care providers — including physicians, hospitals and independent diagnostic testing facilities (IDTFs), among others — will use ICD-10-CM to report patient diagnoses.

Save ICD-10-PCS for Inpatients

ICD-10-PCS is a procedure coding system that hospitals will use “to collect data, determine payment, and support the electronic health record for all inpatient procedures performed in the United States,” according to the ICD-10-PCS Reference Manual available on the CMS Web site (http://www.cms.gov/ICD10/13_2010_ICD10PCS.asp).

CMS is responsible for maintaining ICD-10-PCS and has developed the following chart to illustrate the differences between ICD-9 and ICD-10-PCS:

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10-PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follows ICD structure (designed for diagnosis coding)</td>
<td>Designed/developed to meet health care needs for a procedure code system</td>
</tr>
<tr>
<td>Codes available as a fixed/finite set in list form</td>
<td>Codes constructed from flexible code components (values) using tables</td>
</tr>
<tr>
<td>Codes are numeric</td>
<td>Codes are alphanumeric</td>
</tr>
<tr>
<td>Codes are three through four digits long</td>
<td>All codes are seven characters long</td>
</tr>
</tbody>
</table>

For example, ICD-9 code 39.79 represents a uterine artery embolization. Under ICD-10-PCS, hospitals will report uterine artery embolization as 04LE3DZ.

Remember that only hospitals will use ICD-10-PCS and only for inpatient procedure coding. And you can review the code tables on the CMS Web site at http://www.cms.gov/ICD10/13_2010_ICD10PCS.asp#TopOfPage.

Although the push is on to report patient diagnoses with ICD-10-CM and inpatient procedures with ICD-10-PCS by October 2013, physicians will still use the American Medical Association’s CPT® codes to report all professional services, and hospitals will still use CPT® to report their outpatient services and procedures.

ACR, continued from page 1
Radiologist’s Interpretation of Outside Films Offers 2 Coding Options

A radiologist may interpret imaging studies from another facility or practice for one of two reasons. And that specific reason will determine how to report that service, if at all.

The reasons a radiologist may review outside films include the following:

1. To compare them with a current study that she is interpreting.
2. At the request of another physician for an opinion regarding the imaging study.

Comparison Is Included

If the radiologist reviews outside films for comparison with a current study that she is interpreting, then you should include the review of the outside films in the interpretation of the current study and not bill it separately.

“When a radiologist reviews prior images performed either at the same institution or from an ‘outside’ facility at the time he or she interprets an ‘inside’ study, it is not appropriate to code separately for the review of the previous examination,” according to the American College of Radiology’s (ACR) Radiology Coding Source (March-April 2007). “The review of the outside institutional examination is no different from reviewing old inside studies at the time of the interpretation of the new inside services. A comparison with old studies, when available, is an integral part of the interpretation of any study, regardless of where they were performed.”

And the American Medical Association (AMA) made an almost identical statement in the July 2007 CPT® Assistant.

Second Opinion Is Separate

On the other hand, if another physician requests the radiologist’s opinion regarding an imaging study that was performed at another facility, the radiologist can bill separately for that interpretation, assuming that he dictates a report. In this case, you would assign the regular CPT® code for the exam that was interpreted, and you would append it with modifier 26 (Professional component) because the interpreting radiologist is not performing the technical portion of the code.

“When a physician's opinion is requested by another physician and, upon examination of the [imaging study], the consulting physician provides his or her opinion to the referring physician in a written report, the specific procedure code with modifier 26, professional component, should be reported,” the ACR and AMA state in the Spring 2009 Clinical Examples in Radiology.

For example, a radiologist at hospital A requests an opinion from a neuroradiologist at hospital B regarding a patient’s brain MRI. The neuroradiologist sends the referring physician a written report of findings. In this case, the neuroradiologist can bill the MRI code (7055X-26), and the date of service will be the date when he issued his report.

Code 76140 Not a Likely Answer

The CPT® manual also offers 76140 (Consultation on x-ray examination made elsewhere, written report), which was originally intended for radiologists to use for second opinions on outside films. Code 76140 is a professional-only code that the radiologist could use when asked to provide a second opinion of an imaging exam taken elsewhere.

But Medicare and many other payors do not pay for 76140 because there is no way to value it. Since 76140 does not reflect a specific exam, CMS is unable to assign relative value units (RVUs) to it. Consequently, several Medicare contractors have advised physicians to use the regular exam code instead.

For instance, “If a provider provides a separately billable reinterpretation of a patient’s X-ray, bill the professional component of the appropriate radiology code,” according to Trailblazer Health Enterprises, the Medicare contractor for Colorado, New Mexico, Oklahoma and Texas. “For example, for re-interpreting a simple, single-view chest X-ray, bill 71010-26 (professional component). Attach modifier 77 to indicate a repeat procedure by another physician.”

So be sure to review your payors’ policies before reporting the radiologist’s interpretation of outside imaging exams.

No Technical Component Charge

Although the radiologist can bill for a consultation on outside films, the hospital or imaging center should not submit a technical component charge for this service. The facility’s reimbursement represents the cost of performing the imaging study, and since no imaging was performed, there is no facility charge.

Ready … Set … Code!

Now, it’s your turn. Try your hand with the following real-world case. When you feel you have the answer, turn to page 8.

Scenario: An interventional radiologist performs a percutaneous endovascular repair of an infrarenal abdominal aortic aneurysm as primary surgeon. There is no co-surgeon. The physician punctures both common femoral arteries, inserts catheters into the aorta from both sides, and inserts and deploys a unibody bifurcated prosthesis, all under imaging guidance. What codes should the interventional radiologist report for this procedure?
If your radiologists are working as teaching physicians, you know that merely reporting the CPT® codes that represent their services is not enough, especially where Medicare is concerned. When the residents help conduct evaluation and management (E/M) services, diagnostic imaging interpretation and/or interventional procedures, among other procedures and services, you will need to use HCPCS modifier GC.

**What It Means**

A teaching physician is a physician (other than another resident) who involves residents in the care of his or her patients, according to the Medicare Claims Processing Manual (Chapter 12, §100, http://www.cms.gov/manuals/downloads/clm104c12.pdf). And Medicare provides payment under the Medicare Physician Fee Schedule for services performed by teaching physicians under certain limited criteria. Specifically, Medicare contractors will pay for teaching physician services if they meet the following conditions:

- Personally furnished by a physician who is not a resident;
- Furnished by a resident as long as the teaching physician was physically present during the critical or key portion of the service; or
- Furnished by a resident under the “primary care exception.”

Keep in mind that a hospital is paid for services provided by residents under Medicare Part A.

**GC Important for Partial Resident Service**

Of the criteria listed above, when the resident is involved with part of a procedure or service under the teaching radiologist’s direction, you should report the code(s) for the teaching physician’s work appended with modifier GC (This service has been performed in part by a resident under the direction of a teaching physician). And you can use this modifier on both procedure and E/M service codes.

But GC does not affect payment to the teaching physician. Instead, it simply informs the Medicare contractor that a resident was involved in the patient’s care.

“Submit this modifier with services that were performed by a resident in a teaching facility under the direction of a teaching physician,” according to Palmetto GBA, the Medicare contractor for Jurisdiction 1 — American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands — and Jurisdiction 11 — North Carolina, South Carolina, Virginia and West Virginia. “This modifier is informational only and may be submitted with all HCPCS and CPT® codes,” the contractor states.

**Residents Involved in Diagnostic Services**

Medicare has issued specific guidance regarding the teaching physician’s involvement with interpreting diagnostic images. Prior to 2003, the Medicare teaching physician rules for diagnostic radiology were located in the Medicare Carriers Manual (Part III, §15016.C.5). But when the Centers for Medicare and Medicaid Services (CMS) moved the teaching physician rules into the new Medicare Claims Processing Manual in 2003, it accidentally deleted the diagnostic radiology section of the rules. In 2006, the agency corrected this error with Transmittal 811 (CR 3928), which added a new section to the Claims Processing Manual for diagnostic radiology (Chapter 12, §100.1.2.A.6).

Since that time, the diagnostic radiology rules have once again disappeared from the Claims Processing Manual. CMS has not issued a transmittal to indicate that the diagnostic radiology section was being deliberately deleted, so it is probably safe to assume that the rules are still in effect, even though they do not currently appear in the manual.

“If a resident prepares and signs the interpretation, the teaching physician must indicate that he/she has personally reviewed the image and the resident’s interpretation and either agrees with it or edits the findings,” according to the now-missing section of the Medicare Claims Processing Manual (Chapter 12, §100.1.2.A.6). “Medicare does not pay for an interpretation if the teaching physician only countersigns the resident’s interpretation.”

For example, a Medicare patient undergoes a three-view knee x-ray (73562(-26)). The resident views the images and
See for Yourself

The latest version of the ICD-10-CM diagnosis classification is available on the NCHS Web site at http://www.cdc.gov/nchs/icd/icd10cm.htm#10update. It includes the following separate files:

- **Index to Diseases and Injury** — This is the index to the entire diagnosis classification except for the codes for external causes of morbidity (the codes that begin with V, W, X and Y). Those have their own separate index, just like the E codes do in ICD-9-CM. Also, in ICD-9-CM, the Table of Neoplasms and Hypertension Table are included in the Index, but in ICD-10-CM, there is no Hypertension Table, and the Table of Neoplasms is a separate file, not embedded in the Index.
- **Tabular List** — Same as the ICD-9-CM tabular list, this is the listing of all codes in alphanumeric order.
- **Index to External Causes of Injury** — This is the index to the codes for external causes of morbidity (like the E codes do in ICD-9-CM). Also, in ICD-9-CM, the Table of Neoplasms and Hypertension Table are included in the Index, but in ICD-10-CM, there is no Hypertension Table, and the Table of Neoplasms is a separate file, not embedded in the Index.
- **Table of Drugs and Chemicals** — There is a Table of Drugs and Chemicals in ICD-9-CM, and this one serves the same purpose, although the codes and table structure are different. It is in alphabetical order by the name of the substance.
- **Table of Neoplasms** — This is structured the same as the ICD-9-CM Table of Neoplasms.

You can download all of these files in PDF format and browse through them to get a sense of how the classification is set up.
Reimbursement

Advanced Imaging Services Often Call for Precertification From Private Payors

Although Medicare relies on national and local coverage determinations to inform radiology service providers when it will cover an advanced imaging service, many private payors require preapproval before you can perform these types of imaging services for beneficiaries. And failing to follow the payors’ precertification rules can seriously affect your reimbursement.

Many large commercial payors mandate that you precertify or preauthorize advanced imaging services, such as computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET) and others, before the patient undergoes them.

Another term frequently used to accomplish a similar goal is “preauthorization.” This is similar to precertification but is typically performed by a third-party organization that contracts on behalf of a payor to interact with the providers. The process for prior authorization is very similar to precertification, so the process described below will cover both types of approvals.

How Precert Works

Usually by payor contract, the referring physician is responsible for obtaining the precertification by contacting the payor and providing the medical necessity for the exam. Once the payor approves the imaging study, a precertification number is issued that both the facility that performs the imaging and the radiologist who interprets the exam must submit with their claims. If the payor refuses to approve the imaging, it will not pay either the facility or the physician, regardless of the findings that result from the exam.

The payor provides the precertification number based upon the performance of a specific exam, and payors most frequently base the preauthorization on a CPT® procedure code. If the facility and/or physician fail to submit the exact code that the payor approved, then the payor typically will not pay for the service because it does not match the precertification information.

On the other hand, some payors will approve a range of procedure codes instead of just one code, but this is not a widespread practice. For example, a payor might approve 74150-74170 (CT of the abdomen) instead of just 74150 (CT of the abdomen without contrast).

Regardless of whether the payor approved the correct code or code range, if the referring physician requested the incorrect exam, you cannot make any changes without first contacting the referring physician’s office and obtaining a new order and precertification. Failure to do so could mean lost reimbursement for both the imaging facility and the interpreting physician.

Medicare Is Different

Unlike commercial insurers, Medicare does not require precertification for advanced diagnostic imaging. Instead, the Centers for Medicare and Medicaid Services (CMS) and the Medicare contractors issue national and local coverage determinations (NCDs and LCDs). Health care providers must review these rules to determine if Medicare will pay for a particular service for a beneficiary.

In particular, Medicare states that it will cover diagnostic tests only when ordered by the physician who treats the patient, but be sure to obtain specific guidance from your payor to ensure compliance. And you can find CMS’ specific rules regarding ordering diagnostic tests in Chapter 15 of the Medicare Benefit Policy Manual (§80.6, www.cms.gov/manuals/Downloads/bp102c15.pdf). In addition, CMS also has its National Coverage Determinations Manual, which you can download at www.cms.gov/Manuals/IOM/list.asp.

According to CMS, an order is “a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary.” The order may conditionally request an additional diagnostic test if the initial test yields a certain value determined by the treating physician—for example, if a diagnostic mammogram is positive, perform an ultrasound if clinically indicated.

An order may include the following forms of communication:

- A written document signed by the treating physician, which is hand-delivered, mailed or faxed to the testing facility
- A telephone call by the treating physician or his office to the testing facility
- An e-mail from the treating physician or his office to the testing facility

Keep in mind that Medicare does not require the treating physician or other health care practitioner to sign the written order, but the provider must document his intent to order the test in the patient’s medical record.
Scenario: An interventional radiologist performs a percutaneous endovascular repair of an infrarenal abdominal aortic aneurysm as primary surgeon. There is no co-surgeon. The physician punctures both common femoral arteries, inserts catheters into the aorta from both sides, and inserts and deploys a unibody bifurcated prosthesis, all under imaging guidance. What codes should the interventional radiologist report for this procedure?

Answer: The interventional radiologist should report the following codes:

- 34804 — Deployment of the unibody bifurcated prosthesis
- 36200 — Catheter placement in aorta, initial side
- 36200-59 — Catheter placement in aorta, second side
- 75952-26 — Radiologic supervision and interpretation of aortic repair

In the past, placement of an endoprosthesis in the aorta required at least one cutdown, so interventional radiologists usually performed these procedures jointly with vascular surgeons. Today, however, percutaneous endovascular repair procedures are becoming more common.

In most cases the physician will place one or two closure devices in the femoral artery prior to passing the endoprosthesis. At the procedure’s completion, the physician will tighten the sutures on the closure device, thus closing the relatively large femoral puncture without surgical repair. This is referred to as the “preclose technique.”

The physician should not report an additional code for placement of the closure device. The Centers for Medicare and Medicaid Services (CMS) defines code G0269 (Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g. angioseal plug, vascular plug)) as a bundled service that is included in the other procedures performed during the encounter. Although CMS has instructed hospitals to report packaged services (including G0269) on their Medicare claims, it has not instructed physicians to report bundled services on their claims.

How Do You Stack Up?

Take the Coding Metrix Challenge for RADIOLOGY and Find Out!

If you are responsible for radiology coding or administration, then don’t miss this FREE self-assessment! This 10-question quiz will test your skills when it comes to radiology coding and compliance.

FREE Assessment & 25% Discount!

*Discount valid on all CSI and Coding Metrix products. Offer excludes CSI consulting services and other offers.

CHECK YOUR E-MAIL, THEN TAKE THE CHALLENGE OR CALL 1.877.6.CODING
www.codingmetrix.com

CSI’s 11th Annual CROWN Seminar Series
December 6-9, 2010 - Philadelphia, PA
January 10-13, 2011 - Atlanta, GA

MARK YOUR CALENDAR
Early Registration Discounts Valid Through October 29, 2010
SPECIALTY-SPECIFIC SESSIONS FOR: CARDIOLOGY • RADIOLOGY • PAIN MANAGEMENT • ONCOLOGY

©2010 Coding Strategies™ www.codingstrategies.com – 1-877-6-CODING