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2017 CPT Changes for Radiology



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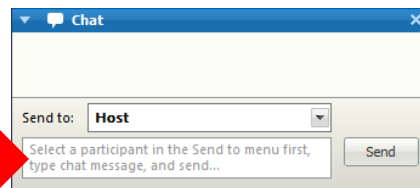


Wendi J. Krumm, RCC
January 26, 2017

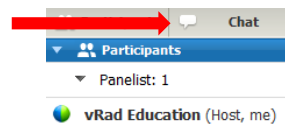
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2017 Changes in Radiology Coding



Wendi Krumm, RCC

January 26, 2017

Disclaimer

- This presentation is designed to provide participants with reimbursement and coding related news, updates and guidance
- The materials and documents presented are not intended to supersede any policies, procedures, or templates that vRad or your facility has approved and implemented, unless specifically noted
- The information, while accurate, to the best of our knowledge, at the time of production, may not be current at the time of use
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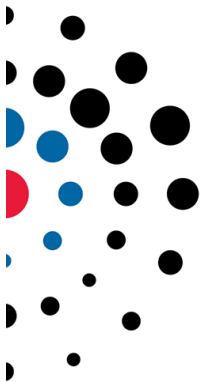
- This presentation covers the CPT® code changes that were deemed to be most relevant to vRad and radiology
- This presentation does not include all changes, additions, or deletions to the *2017 AMA CPT® Manual*
- This presentation does not include all CPT guidelines, parenthetical notes, or NCCI edit changes. There are numerous new parenthetical notes and coders should refer to these to ensure proper use of the codes
- For a complete understanding of all changes, refer to the 2017 AMA CPT® Manual
- All CPT and HCPCS codes were effective January 1, 2017. There is no grace period

Our Agenda

- 2017 Code Changes for Diagnostic & Interventional Radiology
- 2017 NCCI Policy Manual Revisions
- 2017 Medicare Physician Fee Schedule Final Rule
- Change Request 9603: JW Modifier Use



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2017 Changes in Radiology Coding



New CPT for AAA Ultrasound Screening

76706 Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)

- Replaces HCPCS code G0389 (a Category III code)
- Benefit of the “Initial Preventive Physical Examination (IPPE) or “Welcome to Medicare Physical”
- The requirement for deductible and coinsurance is waived
- All policies in place for HCPCS code G0389 will be applied to CPT code 76706

For US or duplex US imaging other than for a screening indication, see 76770, 76775, 93978, 93979



Mammography Coding Changes

- No coding distinction between Analog and Digital mammography anymore
- Computer-aided detection (CAD), when performed, is now included in the new mammography codes

77065 Diagnostic mammography, including computer-aided detection, when performed; unilateral

77066 Diagnostic mammography, including computer-aided detection, when performed; bilateral

77067 Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed

2017 Deleted CPT Codes

77055 Mammography; unilateral

77056 Mammography; bilateral

77057 Screening mammography, bilateral (2-view study of each breast)

77051 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)

77052 Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)

Mammography Coding for Medicare

CMS is not accepting the new mammography codes due to system processing issues

- Continue billing HCPCS codes G0202, G0204, and G0206 for Medicare
- These HCPCS codes were revised to mimic the same description of the new CPT codes
- CMS is expected to accept the new CPT mammography codes in 2018
- Check with commercial and other payers to determine their payment policies on these new CPT codes (77065-77067)

G0202 Screening mammography, bilateral (2-view study of each breast), *including computer-aided detection (CAD) when performed*

G0204 Diagnostic mammography, *including computer-aided detection (CAD) when performed; bilateral*

G0206 Diagnostic mammography, *including computer-aided detection (CAD) when performed; unilateral*

Fluoroscopic Guidance Revisions

+77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

(List separately in addition to code for primary procedure)

(See appropriate surgical code for procedure and anatomic location)

77002 may be billed with 57 codes (see parenthetical notes)

*(77002 is included in all arthrography radiological supervision and interpretation codes. See **Administration of Contrast Material[s]** introductory guidelines for reporting of arthrography procedures)*

+77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)

(List separately in addition to code for primary procedure)

77003 may be billed with 14 codes (see parenthetical notes)

Existing codes 77002 & 77003 have been reclassified as add-on codes

Must be reported with the base procedure code.

In other words, the provider billing the guidance must be the same provider billing for the procedure code!



CMS Unbundles Moderate Sedation from Surgical Services

New codes to separately report moderate sedation were created to prevent double-payment in instances where moderate sedation is provided by a second provider:

- Deleted codes 99143-99145 and 99148-99150
- Six new codes (99151-99157) that are selected based on:
 - Patient age
 - Intra-service time in 15 minute increments
 - Whether the same provider is performing the diagnostic or therapeutic services and the moderate sedation, or
 - Whether the moderate sedation is being provided by a physician or qualified professional other than the clinician performing the diagnostic or therapeutic service
- Appendix G has been eliminated (*Summary of CPT Codes that Include Moderate Sedation*)
- Elimination of the moderate sedation symbol (●) from all codes in the CPT code set that were previously noted to inherently include moderate sedation services
- Relative value units (RVUs) for all services previously identified in Appendix G were revalued to no longer include the cost associated with moderate sedation



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Moderate Sedation Guidelines

- Requires the presence of a trained independent observer with no other duties than to monitor the patient's physiological status
- Intra-service time is used to determine the appropriate CPT code(s) to report moderate sedation services
 - Time increments changed from 30 to 15 minutes increments
 - Intra-service time:
 - Begins with the administration of the sedating agent(s)
 - Ends when the procedure is completed, or
 - 1.) the patient is stable for recovery status, and
 - 2.) the clinician providing sedation ends face-to-face time
- The 8-Minute Rule:
 - A unit of time is attained when the midpoint has been passed. Eight minutes of intra-service time must be documented to bill for the initial 15 minutes
 - For each additional 15 minute increment, at least an additional 8 minutes of sedation time must be documented (23 minutes total)

Documenting to Support Moderate Sedation Billing

Radiologist performed an interventional procedure on a 68 year old patient using moderate sedation:

Versed and fentanyl were administered intravenously for moderate sedation and the patient was continuously monitored by an independent observer under my supervision.

Total monitored sedation intra-service time was 50 minutes

99152, 99153 x3



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New Moderate Sedation Codes

The portion of the code descriptor preceding the semicolon is common to both CPT codes 99152 & 99153 (99156 & 99157). The difference is the portion following the semicolon

99151 Moderate sedation services provided by the **same physician** or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status ; **initial 15 minutes** of intra-service time, patient **younger than 5 years of age**

99152 **initial 15 minutes** of intra-service time, patient **age 5 years or older**

+99153 **each additional 15 minutes** intra-service time
(Use 99153 in conjunction with 99151 or 99152)

99155 Moderate sedation services provided by a physician or other qualified health care professional **other than the physician or other qualified health care professional performing the diagnostic or therapeutic service** that the sedation supports ; **initial 15 minutes** of intraservice time, patient **younger than 5 years of age**

99156 **initial 15 minutes** of intraservice time, patient **age 5 years or older**

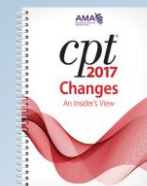
+99157 **each additional 15 minutes** intraservice time
(Use 99157 in conjunction with 99155 or 99156)

Cardiovascular System, Dialysis Circuits

DEFINITIONS:

Dialysis Circuit

- Begins at the arterial anastomosis and ends at the right atrium of the heart
- These dialysis circuits can be created as either an AV fistula (AVF) or an AV graft (AVG)
 - (AVF) (uses an arterial-venous anastomosis)
 - (AVG) (uses a prosthetic graft between an artery and a vein)

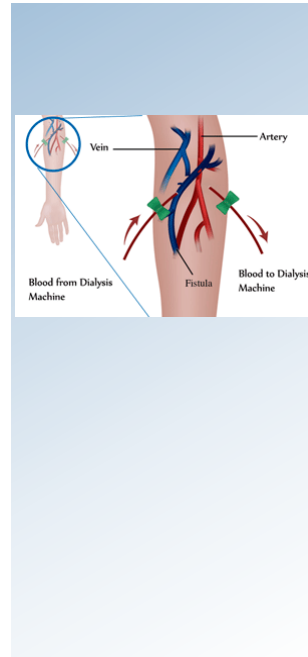


**Dialysis Circuit Procedures:
Complete Restructuring in 2017**

**Two-pages of new introduction
notes in the CPT manual**

“Dialysis Circuits” Defined by the AMA

- “Dialysis Circuits” have now been split into two parts:
 1. **Peripheral Dialysis Segment** - starts at the arterial anastomosis, extends to the central dialysis segment & includes the “peri-anastomotic region”
 - Upper Extremity - (through the axillary vein or entire cephalic vein if a cephalic-venous outflow)
 - Lower Extremity - (through the common femoral vein)
 2. **Central Dialysis Segment** - all draining veins central to the peripheral dialysis segment
 - Upper extremity (veins central to axillary & cephalic veins including subclavian & innominate veins through the SVC)
 - Lower Extremity (veins central to common femoral vein including external & common iliac veins through the IVC)

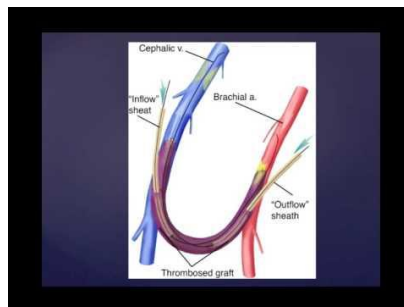


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“Dialysis Circuits” Defined by the AMA

Peri-anastomotic Region: area of dialysis graft near the anastomosis including a small segment of the parent artery, the anastomosis, and a short portion of the dialysis circuit that is adjacent to the anastomosis. This region is considered part of the Peripheral Dialysis Segment



Definition:

Anastomosis – connection between two blood vessels that are normally diverging or branching

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New Dialysis Circuit Codes

- New dialysis circuit angiography, angioplasty, stent placement, thrombectomy and embolization bundled codes were created to reflect the work related to dialysis circuit diagnosis and interventions
- Codes 35475, 35476, 36147, 36148, 36870, and 75791 were deleted as a number of these codes were identified as being frequently reported together in various combinations
- New comprehensive codes are arranged in logical, building-block fashion
 - Imaging (36901)
 - Angioplasty (36902)
 - Stent (36903)
 - Thrombectomy and/or thrombolysis (36904-36906)
- See extensive coding guidelines in the *CPT 2017* codebook

Dialysis Circuit Access Coding

36901 Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the superior and inferior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;

This code includes :

- Direct access points
- Diagnostic angiography via antegrade and/or retrograde puncture(s) of the dialysis circuit
- All catheter manipulations
- All accessory veins accessed



- Code once per operative session
- Do not report with 36833, or 36902-36906
- US guided puncture, though rare, is separately reported when required elements for reporting it are documented

Dialysis Circuit Access Coding

- 36902** Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the superior and inferior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; **with transluminal balloon angioplasty, peripheral dialysis segment**, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
(Do not report 36902 in conjunction with 36903)
- 36903** **with transcatheter placement of intravascular stent(s), peripheral dialysis segment**, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment

Dialysis Circuit Access Coding

- 36904** Percutaneous transluminal mechanical **thrombectomy** and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);
- 36905** **with transluminal balloon angioplasty, peripheral dialysis segment**, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
- 36906** **with transcatheter placement of intravascular stent(s), peripheral dialysis segment**, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit

Dialysis Circuit Access Coding

- +36907** Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty

List in conjunction with 36818-36833, 36901-36906

- +36908** Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)

List in conjunction with 36818-36833, 36901-36906

- +36909** Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)

List in conjunction with 36901-36906

New Angioplasty CPT Codes

- 37246** Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; **initial artery**

- +37247** **each additional artery**
Use 37247 in conjunction with 37246

- 37248** Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; **initial vein**

- +37249** **each additional vein**
Use 37249 in conjunction with 37248

New Comprehensive Codes for Angioplasty

- Replaced deleted arterial and venous angioplasty codes 35471-35476 and 35450-35460
- Now include radiologic supervision & interpretation
- Previous RS&I codes deleted: 75962, 75964, 75966, 75968, 75978
- Previously differentiated by vessel treated and the approach used
- Now differentiated by whether performed on an artery or vein
- Refer to the CPT codebook introductory note guidelines and code parentheticals notes

Nervous System: Spine and Spinal Cord Section

Interlaminar Epidural or Subarachnoid Injections

New Codes replacing deleted codes:

- Codes 62310, 62311, 62318 and 62319 have been deleted
- Replaced by injection codes 62320-62327
- The new codes are now differentiated by:
 - spinal region
 - whether performed with or without imaging guidance
- Detailed coding guidelines are provided in the *CPT 2017* codebook



Interlaminar Epidural or Subarachnoid Injections

62320 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, *cervical or thoracic*; **without imaging guidance**

62321 **with imaging guidance** (ie, fluoroscopy or CT)
Do not report 62321 in conjunction with 77003, 77012, 76942

62322 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, *lumbar or sacral* (caudal); **without imaging guidance**

62323 **with imaging guidance** (ie, fluoroscopy or CT)
Do not report 62323 in conjunction with 77003, 77012, 76942

Interlaminar Epidural or Subarachnoid Injections

62324 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, *cervical or thoracic*; **without imaging guidance**

62325 **with imaging guidance** (ie, fluoroscopy or CT)
(Do not report 62325 in conjunction with 77003, 77012, 76942)

62326 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, *lumbar or sacral* (caudal); **without imaging guidance**

62327 **with imaging guidance** (ie, fluoroscopy or CT)
(Do not report 62325 in conjunction with 77003, 77012, 76942)

Category III Codes

New Category III Codes

0438T Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance

0440T Ablation, percutaneous, cryoablation, including imaging guidance; upper extremity distal/peripheral nerve

0441T lower extremity distal/peripheral nerve

0442T nerve plexus or other truncal nerve (eg, brachial plexus, pudendal nerve)

Category III Codes

Deleted Category III Codes

0169T	Stereotactic placement of infusion catheter(s) in the brain for delivery of therapeutic agent(s), including computerized stereotactic planning and burr hole(s)
0282T	Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar; for trial, including removal at the conclusion of trial period
0283T	permanent, with implantation of a pulse generator
0284T	Revision or removal of pulse generator or electrodes, including imaging guidance, when performed, including addition of new electrodes, when performed
0285T	Electronic analysis of implanted peripheral subcutaneous field stimulation pulse generator, with reprogramming when performed
0286T	Near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)
0287T	Near-infrared guidance for vascular access requiring realtime digital visualization of subcutaneous vasculature for evaluation of potential access sites and vessel patency

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Category III Codes

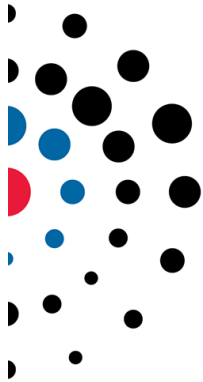
Extended Category III Codes

These radiology Category III codes were scheduled to retire in 2017. Based on specialty society input these codes will be extended until the procedures have met the criteria for CPT Category I code status

0159T	Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure)
0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation (List separately in addition to code for primary procedure)
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation

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2017 Revisions to the National Correct Coding Initiative (NCCI) Manual



NCCI Policy Manual Revisions: Chapter 1

Update to the codes, no changes to the guideline (pages 8-9):

A physician should not unbundle a bilateral procedure code into two unilateral procedure codes. For example if a physician performs bilateral mammography, the physician should report CPT code **77066** (*Diagnostic mammography... bilateral*). The physician should not report CPT code **77065** (*Diagnostic mammography... unilateral*) with two units of service or **77065LT** plus **77065RT**

CAUTION: do not manipulate patient scheduling to avoid MUE or NCCI edits! (page 9)

MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits

The NCCI is a CMS national policy program implemented to promote correct coding methodologies and to control improper coding of code pairs that are inappropriate to bill in combination

Each year the NCCI Policy Manual addresses annual changes in CPT codes and instructions, additions, deletions, or modifications of existing codes or instructions



NCCI Policy Manual Revisions: Chapter 1

Misuse of Modifier 59 (page 25):

This section was updated with an example of a circumstance involving ultrasound scanning prior to a needle placement service where use of modifier 59 is inappropriate:

When a diagnostic procedure precedes a surgical or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical or non-surgical therapeutic procedure is made, that diagnostic procedure may be considered to be a separate and distinct procedure as long as:

- (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention;*
- (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and it does not constitute a service that would have otherwise been required during the therapeutic intervention. If the diagnostic procedure is an inherent component of the surgical or surgical therapeutic procedure, it should not be reported separately*

For example, a physician should not report a diagnostic ultrasound CPT code and CPT code 76942 (ultrasonic guidance for needle placement...) when performed in the same anatomic region on the same date of service

NCCI Policy Manual Revisions: Chapter 3

Update to the codes, no changes to the guideline (page 13) :

6. If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (e.g., 19281, 19282), the physician should not separately report a post procedure mammography code (e.g., **77065-77067**, G0202-G0206) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure

NCCI Policy Manual Revisions: Chapter 5

Further clarification on bundling chest exams with chest drainage procedures (pages 10-11) :

16. A pleural drainage procedure (e.g., CPT codes 32556, 32557), thoracentesis procedure (e.g., CPT codes 32554, 32555), or chest tube insertion procedure (e.g., CPT codes 32550, 32551) is often followed by a chest radiologic examination to confirm *adequacy of the procedure, lack of complications, or* the proper location and positioning of the chest tube. A chest radiologic examination CPT code (e.g., 71010, 71020) should not be reported separately for this radiologic examination

NCCI Policy Manual Revisions: Chapter 6

New edit guideline on coding biliary debris removal with a percutaneous biliary tract procedure (page 11):

14. CPT code 47544 (removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous...) is a Type I add-on code. The primary codes are defined by the CPT Manual and include CPT codes 47531-47540 (percutaneous biliary tract procedures). The CPT Manual also includes a separate instruction stating that CPT code 47544 should not be reported with CPT codes 47531-47540 for incidental removal of debris. Thus, CPT code 47544 may be reported with CPT codes 47531-47540 only for percutaneous removal of calculi or non-incidental debris

NCCI Policy Manual Revisions: Chapter 9

Further clarification on bundling post-procedural comparative imaging studies (page 7):

3. When a comparative *imaging* study *is* performed *to assess potential complications or completeness of a procedure* (e.g., post-reduction, post-intubation, post-catheter placement, etc.), *the professional component of the CPT code for the post-procedure imaging study is not separately payable and should not be reported. The technical component of the CPT code for the post-procedure imaging study may be reported*

Update to the codes, no changes to the guideline (page 9) :

15. CPT code 77063 is an add-on code describing screening digital tomosynthesis for mammography. Since this procedure requires performance of a screening mammography producing direct digital images (HCPCS code G0202), CPT code 77063 may be reported with HCPCS code G0202. However, CPT code 77063 should not be reported with CPT code *77067* which describes screening mammography using radiography

NCCI Policy Manual Revisions: Chapter 9 cont.

New edit guideline on bundling radiological imaging of the spine by the sum of the total number of views (page 9):

17. If a physician performs a procedure described by CPT codes 72081-72084 and at the same patient encounter performs a procedure described by one or more other codes in the CPT code range 72020-72120, the physician should sum the total number of views and report the appropriate code in the CPT code range 72081-72084.

The physician should not report a code from the CPT code range 72081-72084 plus another code in the CPT code range 72020-72120 for services performed at the same patient encounter

New edit guideline on bundling foot and toe radiologic examinations (page 9):

18. Since the foot includes the toes and calcaneus bone, CPT code 73630 (radiologic examination, foot; complete, minimum of 3 views) includes radiologic examination of the toes and calcaneus. A physician should not report CPT code 73650 (radiologic examination; calcaneus, minimum of 2 views) or 73660 (radiologic examination; toe(s), minimum of 2 views) with CPT code 73630 for the same foot on the same date of service

NCCI Policy Manual Revisions: Chapter 9 cont.

Update to the codes, no changes to the guideline (page 12) :

11. If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (e.g., 19281, 19282), the physician should not separately report a post procedure mammography code (e.g., **77065-77067**, G0202-G0206) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure

Update to the codes, no changes to the guideline (page 14) :

3. Myocardial perfusion imaging (CPT codes 784**51**-784**54**) is not reportable with cardiac blood pool imaging by gated equilibrium (CPT codes 78472-78473) because the two types of tests utilize different radiopharmaceuticals

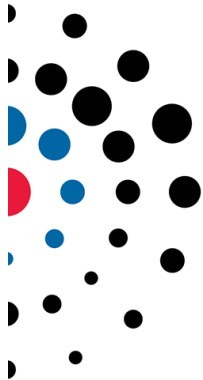
NCCI Policy Manual Revisions: Chapter 9 cont.

New edit guideline on bundling a diagnostic study with the guidance for a needle placement procedure (page 23):

9. Evaluation of an anatomic region and guidance for a needle placement procedure in that anatomic region by the same radiologic modality at the same or different patient encounter(s) on the same date of service are not separately reportable. For example, a physician should not report a diagnostic ultrasound CPT code and CPT code 76942 (ultrasonic guidance for needle placement...) when performed in the same anatomic region on the same date of service. Physicians should not avoid these edits by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service

NOTE: The NCCI Policy Manual is FREE, updates on January 1st annually, and can be easily obtained from the CMS Medicare website at the following link:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>



Other Significant Changes Impacting Radiology



2017 Medicare Physician Fee Schedule (MPFS) Final Rule

CT Modifier Reduction Changes from 5% to 15%

- In 2016, a payment reduction of 5 percent was applied to Computed Tomography (CT) services furnished using equipment that is inconsistent with the CT equipment standards and for which payment is made under the Part B physician fee schedule (NEMA XR-29 Standard)
- In 2017 and subsequent years, the payment reduction increases to 15 percent
- Reduction applies to the technical component (and the technical component of the global fee)
- Non-compliant CT studies must be billed with modifier-CT

Multiple Procedure Payment Reduction (MPPR) on the Professional Component (PC)

- The MPPR of the PC of the second and subsequent procedures was reduced from 25% to 5% of the physician fee schedule amount
- MPPR on the technical component (TC) remains at 50%

X-ray Reduction for Film (incentive to use digital radiography)

- Technical component (TC) payments under the Medicare Physician Fee Schedule (MPFS) are reduced by 20% for x-ray imaging services that are taken using film
- New Modifier **FX** (X-ray taken using film) must be used on claims for x-rays using film

Billing Discarded from Single Dose Vials

- CMS is revising the discarded drug policy to require uniform use of the JW modifier for all claims with discarded Part B drugs
- Use the JW modifier for claims that include unused drugs or biologicals from single use vials or single use packages
- Requires the use of the JW modifier on a separate claim line
- General billing rules may require a charge be included on each line on the claim. Contact your local MAC for specific billing guidance.
- JW modifier is not permitted when the actual dose of the drug or biological administered is less than the billing unit
- Appropriately discard and document:
 - Maintain accurate (medical and/or dispensing) records for all beneficiaries
 - Maintain accurate purchasing and inventory records for all drugs that were purchased and billed to Medicare

Single Dose Vials



JW Modifier

Drug amount discarded/not administered to any patient

This rule applies to providers who buy and bill Medicare Part B covered drugs, including supplies that are an integral part of a procedure that is a diagnostic or therapeutic service, including radiopharmaceuticals and low osmolar contrast media

This guideline does not apply to drugs provided under the Competitive Acquisition Program (CAP) for Part B

Examples on How to Bill Single Dose Vials

Appropriate Use of the JW modifier:

A single use vial of contrast contains 10 mg

The billing unit of the drug is 1 mg

[Units are calculated according to the applicable HCPCS code descriptor]

7 mg is administered to the patient. The remaining 3 units is discarded

- The 7 unit dose is billed on one line
- The discarded 3 units is billed on a separate line with the JW modifier

Example where it is inappropriate to bill the discarded drug with the JW Modifier:

A single use vial of contrast contains 10 mg

The billing unit of the drug is 10 mg

7 mg is administered to the patient. The remaining 3 units is discarded

- One unit is billed

When the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted

Resources

- *2017 AMA CPT® Manual, Professional Edition*
- *2017 Changes: An Insider's View CPT ®*, American Medical Association
- **Federal Register** / Vol. 81, No. 220 / Tuesday, November 15, 2016 / *Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017*
- *National Correct Coding Initiative Edits (NCCI) Policy Manual for Medicare Services:*
<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/nationalcorrectcodinited/>
- MLN Matters® Number: MM9250, *Payment Reduction for Computed Tomography (CT) Diagnostic Imaging Services*
- MLN Matters® Number: MM9647, *Multiple Procedure Payment Reduction (MPPR) on the Professional Component (PC) of Certain Diagnostic Imaging Procedures*
- MLN Matters® Number: MM9727, *Payment Reduction for X-Rays Taken Using Film*

Resources, continued

- MLN Matters® Number: MM9603, *JW Modifier: Drug Amount Discarded/Not Administered to any Patient*
- *Medicare Claims Processing Manual*, Chapter 17, Section 40, *Discarded Drugs and Biologicals*
- *JW Modifier Frequently Asked Questions:* <https://www.cms.gov/Medicare/Medicare-Fee-for-Service.../JW-Modifier-FAQs.pdf>

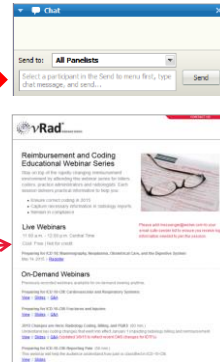
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