

# Billing, Coding and Reimbursement News

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## ADVANCED DIAGNOSTIC IMAGING SUPPLIER: Deadline for TC Accreditation Near

In order to furnish the technical component (TC) of advanced diagnostic imaging (ADI) services and be paid under the Medicare physician fee schedule (MPFS), non-hospital suppliers must be accredited by January 1, 2012, by an approved accrediting organization (AO). Although that deadline is still several months away, it's high time that those who haven't started this process do so.

"Providers who have not already gone through an accreditation survey need to realize that the January 1, 2012, accreditation deadline will arrive before they know it," says Patricia A. Furci, RN, MA, Esq., principal in the Healthcare Consulting Firm, Furci Associates, LLC, West Orange, New Jersey. "Preparation for an initial accreditation can take several months, depending on the supplier's size and structure, and preparation is something that you don't want to overlook because poor performance during an accreditation survey will have an adverse impact on reimbursement."

James H. Thrall, MD, FACR, chair of the American College of Radiology's (ACR) Board of Chancellors, agrees. On its web site, the ACR quotes him as saying: "I strongly urge medical imaging providers to begin the accreditation process as early as possible. Not only will this help them maintain and improve the quality of care they provide to patients, but it will help them avoid the rush to gain accreditation that will almost surely occur as the Jan. 1, 2012, accreditation deadline approaches."

### Important Details

This federal accreditation requirement applies to physicians, non-physician practitioners, independent diagnostic testing facilities, and other non-hospital suppliers. The ADI services affected include magnetic resonance imaging (MRI); computed tomography (CT); and nuclear medicine, including positron emission tomography (PET).

As stated above, the accreditation requirement only applies to the TC of a service and not the physician's interpretation of the images. It also does not apply to services paid under Medicare's hospital inpatient and outpatient prospective payment systems. Also excluded from this policy are the following imaging services: X-ray, ultrasound, fluoroscopy, and diagnostic and screening mammography.

As required by Congress in Section 135(a) of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, the Centers for Medicare & Medicaid Services (CMS) designated three organizations that are accrediting suppliers. In a January 26, 2010, Federal Register notice, CMS announced approval of the following national organizations to which non-hospital providers may apply:

- American College of Radiology (<http://acr.org/accreditation.aspx>);
- Intersocietal Accreditation Commission (<http://www.intersocietal.org/iac/accreditation.htm>); and
- The Joint Commission ([www.jointcommission.org/AdvImaging2012](http://www.jointcommission.org/AdvImaging2012)).

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### Making the Grade

To be designated, the accrediting organizations had to demonstrate that they were experienced in the ADI area and that their accreditation requirements met or exceeded the standards set out in the MIPPA, which made this policy mandatory. Those requirements included checking qualifications of non-physician personnel performing the imaging as well as medical directors and supervising physicians.

In addition, they must have in place procedures to:

- Ensure the safety of the individuals furnishing the imaging procedure and of the persons to whom the services are furnished;
- Ensure the reliability, clarity, and accuracy of the technical quality of the diagnostic images produced by the supplier;
- Assist the beneficiary in obtaining his/her imaging records on request;

- Notify CMS of any changes to the imaging modalities subsequent to the accrediting organization's decision;
- Develop a plan for reducing the burden and cost of accreditation to small and rural suppliers; and
- Provide CMS with detailed information about their survey processes.

In a press release announcing these appointments, CMS stated that it will issue further guidance to suppliers about meeting the accreditation requirements. The agency plans to undertake a provider education outreach program to ensure that all affected suppliers understand the requirements and can comply with them prior to the January 1, 2012, accreditation deadline.

**Information Source:** In addition to checking the web sites of the AOs given above, be sure to review the following CMS transmittal: <http://www.cms.gov/transmittals/downloads/R8580TN.pdf>.

## APRIL UPDATE TO HOSPITAL OUTPATIENT POLICIES: Tips and Reminders for Radiopharmaceuticals

Seems like only yesterday that the 2011 revisions to the hospital outpatient prospective payment system (OPPS) took effect but the Centers for Medicare & Medicaid Services (CMS) recently issued the first quarterly revisions to it (effective date: April 1, 2011).

In transmittal R2174CP (issued March 18, 2011), the agency lists changes to, and billing instructions for, various payment policies. Another recent transmittal (R2172CP) details the additions, changes, and deletions that will be made to the April 2011 integrated outpatient code editor (I/OCE) and OPPS Pricer related to HCPCS codes, ambulatory payment classifications (APCs), modifiers, and revenue codes.

### Therapeutic Radiopharmaceuticals

For 2011, payment for the acquisition cost and associated pharmacy overhead costs for non-pass-through drugs, biologicals and therapeutic radiopharmaceuticals (RPs) is made at a single rate of average sales price (ASP) plus 5 percent. Pass-through items receive a single payment of ASP plus 6 percent, which also includes acquisition and pharmacy overhead costs.

### Diagnostic RPs and Nuclear Medicine

With only one exception, hospitals should report HCPCS codes for products provided in the outpatient department, says CMS. They should not report a HCPCS code and a charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing I/OCE edits.

The only exception, states CMS, is in the case of C9898 (radiolabeled product provided during a hospital inpatient stay).

Hospitals may report this code on outpatient claims to indicate that a product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay.

In the April update, CMS repeated a guideline it initially issued in the October 2009 OPPS update. Although "rare," a diagnostic RP may be administered in a certain calendar year followed (in the subsequent calendar year) by an associated nuclear medicine procedure. When this occurs, hospitals should report the date that the radiolabeled product is furnished as the same date that the nuclear medicine procedure is performed. CMS does not believe many hospitals will encounter this situation.

When a hospital or a nonhospital administers a diagnostic RP for a different hospital providing the nuclear medicine scan, the RP should be reported and billed with the nuclear medicine scan. The first hospital or nonhospital may enter into an arrangement where the second hospital (that provided the scan) bills Medicare for the RP administration and pays some amount to the first hospital or nonhospital. CMS notes that it considers the radiolabeled product and the nuclear medicine scan to be part of one procedure and would expect both services to be performed together.

### Correct Reporting of Units

Once again, CMS reminds hospitals and providers to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always

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capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient; hospitals should bill 10 units, even though only 1 vial was administered.

In the case of radiopharmaceuticals specifically, take, as an example, the following code: A9505—thallium Tl-201 thallous chloride, diagnostic, per millicurie. You see that the description indicates “per millicurie.” When providing thallium for a myocardial perfusion study, if 3 millicuries were given for the initial study, the appropriate units would be “3” on the claim form.

#### Information Sources:

- For the April update, go to <http://www.cms.gov/Transmittals/downloads/R2174CP.pdf> or <https://www.cms.gov/MLN MattersArticles/downloads/MM7342.pdf>.
- For I/OCE details, go to <http://www.cms.gov/transmittals/downloads/R2172CP.pdf> <https://www.cms.gov/MLN MattersArticles/downloads/MM7344.pdf>.

## CODING TIPS: Insights for Getting It Right

- CPT codes 78300–78306 should not be used for PET bone scans. These codes are for use with single photon radiopharmaceuticals and single photon equipment/cameras.
- When procuring the radioactive material for any nuclear medicine procedure, be certain to submit a separate charge for each radiopharmaceutical utilized. Some payers may ask you to submit an invoice when billing for these items. Use the appropriate HCPCS Level II A- or C-codes. C-codes may only be used for Medicare outpatient hospital coding and billing.
- CPT code 78630—cerebrospinal fluid flow, imaging (not including introduction of material); cisternography—does not include the introduction of the radiopharmaceutical. The exact code for the introduction will vary based upon access and method used, but the most commonly used codes are 62311 or 62319. Hospitals should report these codes with revenue code 36X, 49X or 76X.
- Hospital outpatient departments should use modifier FB on claims when the provider receives a radiopharmaceutical free of charge. The hospital can set a token charge of \$1.01 or less for the diagnostic radiopharmaceutical.

## Q & A: Focus on Nuclear Medicine Services

**What code should I assign for a nuclear medicine scan performed for diagnosis on patients who have hepatic hydrothorax? 99mTc is injected into the peritoneal cavity, and scans are done to check for a passageway through the diaphragm into the pleural space.**

Either of the following codes would be correct, depending on the extent of the imaging.

78800	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area
78801	multiple areas

If both the peritoneal cavity and the pleural space were imaged, then 78801 would be the correct choice. If just imaging of the pleural space was performed after the injection, then 78800

would be correct.

Codes 78800–78804 describe tumor localization or distribution of radiopharmaceutical agent(s).

**When we perform an OctreoScan (111In) for a carcinoid tumor, we charge, on the first day, code 78802 for a whole body (four-hour scan). For the second day, we charge 78803 with SPECT in two different areas (chest and abdomen). How would you suggest we code this study? Our current coding is being rejected for coding 78803 x 2. Our system is kicking out an MUE (medically unlikely edit).**

Your system is correct. While you can bill 78802 and 78803 together, you cannot bill 78803 x 2 for the same date of service.

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***Our nuclear medicine department injected a patient for a bone scan, but the patient never returned for the imaging part. What can we bill?***

According to the Society of Nuclear Medicine (SNM), when you administer the radiopharmaceutical, you have begun the test. Code the lowest level CPT code in the intended body area. In the case you describe, that would be 78300, and you should assign

modifier 52 (reduced services) or 53 (staged or related procedure or service by the same physician during the postoperative period). Also code for the radiopharmaceutical given.

If your payer cannot accept modifier 52, it may instruct you to code for the radiopharmaceutical with an administration code. A report documenting the administration of the radiopharmaceutical would be required.

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