As of mid-June, the Centers for Medicare & Medicaid Services still have not issued the final compliance date for implementation of the ICD-10 coding system. As reported in the previous issue, CMS proposed that the date be October 1, 2014, and the healthcare industry is wondering if that will, indeed, be the final decision. In the meantime, most providers and other covered entities (including suppliers and payers) are continuing with their progress toward implementation. The general consensus among industry experts, which includes CMS, is “full steam ahead.”

In fact, CMS officials hope that the delay in the ICD-10 implementation will give covered entities more time to prepare and fully test their systems “to ensure a smooth and coordinated transition to these new code sets.” Subsequent to this comment, one CMS official urged providers to not delay their transition work while awaiting a final rule. Failure of any one industry segment to achieve compliance with ICD-10 will negatively impact all other industry segments and result in rejected claims and provider payment delays.

Learn to Focus on Specificity

The primary impact on nuclear medicine will be the need for greater specificity in documentation for all procedures. Nuclear medicine staff will need to be trained to request and document the most specific clinical indication when physicians order tests. Certain documentation also will be required from the radiologist to support the procedure performed.

Physicians performing and interpreting those tests must document diagnoses with as much detail (i.e., specificity) as possible so that staff can choose the most appropriate code(s).

Currently, non-specific diagnosis codes are assigned to most radiology claims because complete information is either not provided or does not make it through the system to the final dictated report. While non-specific codes are available for use in ICD-10, it is believed that as new policies are written by payers, these non-specific codes may become non-payable.

Coding Primer

Hospital health information management (HIM) staff must re-learn procedure coding for inpatients. To choose an ICD-10-PCS code, they must consult specific charts that contain multiple options, such as the one for nuclear medicine therapy below, and “build” a specific code by choosing the right element.

<table>
<thead>
<tr>
<th>Section: C—Nuclear medicine</th>
<th>Body System: W—Anatomical regions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: 7—Systemic nuclear medicine therapy: introduction of unsealed radioactive materials into the body for treatment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Radionuclide</th>
<th>Qualifier</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0—Abdomen</td>
<td>N—Phosphorus 32 (P-32)</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td>3—Chest</td>
<td>Y—Other radionuclide</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td>G—Thyroid</td>
<td>G—Iodine 131 (I-131)</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td></td>
<td>Y—Other radionuclide</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td>N—Whole body</td>
<td>8—Samarium 153 (Sm-153)</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td></td>
<td>G—Iodine 131 (I-131)</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td></td>
<td>N—Phosphorus 32 (P-32)</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td></td>
<td>P—Strontium 89 (Sr-89)</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td></td>
<td>Y—Other radionuclide</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
<tr>
<td>Y—Anatomical regions, multiple</td>
<td>Y—Other radionuclide</td>
<td>Z—None</td>
<td>Z—None</td>
</tr>
</tbody>
</table>

NEW! Your coding questions answered

Looking for advice on coding and compliance issues – turn to MedLearn Publishing, a leading authority on matters of medical coding, compliance and reimbursement. MedLearn Publishing has launched a web portal dedicated to Triad Isotopes’ customers and their questions, providing an easy and efficient means to get answers from a very qualified source.

http://survey.constantcontact.com/survey/a07e5n1v6wczg1dc6bw/start

In partnership with MedLearn Publishing, Triad Isotopes’ customers will be charged a discounted rate of $125 for each question submitted.

Join us for a free webinar!

WHAT: Nuclear Medicine Therapies

WHEN: Thursday, July 19, 2012
• 12:00–1:30pm Eastern
• 11:00–12:30pm Central
• 10:00–11:30am Mountain
• 9:00–10:30am Pacific

RSVP: Space is limited; reserve your seat now using the link below!
http://mp163422.cdn.medialplatform.com/163422/wc/mp/4000/15208/15211/15722/Lobby/default.htm

For more information, please contact Marcia Caton at mcaton@triadisotopes.com
Using the chart above, in ICD-10-PCS, thyroid ablation using I-131 would be coded as CW7GGZZ. Under the current ICD-9 system, this would be coded as 92.29—other radiotherapeutic procedure. Thus, in ICD-10-PCS, the specific therapy is documented instead of the generic “other.”

The greater detail and specificity in ICD-10-CM and ICD-10-PCS is not just for billing and payment, though they will be a benefit. It will also allow for much better data for measuring the efficacy of care, conducting research and developing clinical trials, and setting health policy. Tracking of new diseases worldwide will be easier when we all are using the same classification system.

**Information Sources:**
Many references are available to help in the transition to ICD-10 diagnosis and procedure coding. Listed below are a few of the most comprehensive.

- Centers for Disease Control and Prevention (CDC): [http://www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm)

### QUESTIONING TEST ORDERS:
**Guidelines Now Available from Specialty Organizations**

The American Society of Nuclear Cardiology (ASNC), the American Society of Clinical Oncology (ASCO), the American College of Cardiology (ACC), and the American College of Radiology (ACR) are four of the nine medical specialty organizations participating in the Choosing Wisely® campaign ([http://choosingwisely.org/](http://choosingwisely.org/)). In early April, the specialty organizations issued lists of five tests or procedures commonly used in their field, whose necessity should be questioned and discussed.

According to the ABIM Foundation and Consumer Reports, the primary campaign sponsors, the intent of these lists, entitled “Five Things Physicians and Patients Should Question,” is to “spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments.”

Few would argue that the information provided on these lists will contribute to a higher quality of patient care and, if followed, may help prevent denials for unnecessary tests. On the flip side, imaging centers could be negatively impacted if their referring physicians have been ordering a lot of the listed tests and if patients ask more questions about tests being ordered and performed. In addition, payers may use these lists to craft medical policies and that could cause additional denials.

To take proactive steps toward such backlash, radiologists could use these lists along with the American College of Radiology’s (ACR) Appropriateness Criteria when discussing medically necessary exams with referring physicians.

**Sample Directives**

A few examples of interest to nuclear-medicine providers are provided below, although note that each specialty organization lists five tests as well as clinical details about them.

**From the ASNC list:** Don’t perform stress cardiac imaging or coronary angiography in patients without cardiac symptoms unless high-risk markers are present.

**From the ACC list:** Don’t perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.

**From the ASCO list:** Don’t perform positron emission tomography (PET), computed tomography (CT), and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.

Evidence does not support the use of these scans for staging of newly diagnosed low grade carcinoma of the prostate (stage T1c/T2a, prostate-specific antigen [PSA] <10 ng/ml, Gleason score less than or equal to 6) with low risk of distant metastasis. Unnecessary imaging can lead to harm through unnecessary invasive procedures, over-treatment, unnecessary radiation exposure, and misdiagnosis.

**More Lists to Come**

Eight more groups recently joined the campaign and their lists will be posted in the fall. They include the American Society of Echocardiography and the Society of Nuclear Medicine, whose name will change, in the near future, to Society of Nuclear Medicine and Molecular Imaging.

**CASE STUDY:** Three-Phase and Whole Body Bone Scans

**Clinical Statement:** Bilateral hip contusion, pelvic pain, recent fall

**Technique:**

- **Radiopharmaceutical:** Tc-99m methylene diphosphonate IV
- **Dose:** 31 mCi
- **Angiographic, soft tissue and delayed osseous images of:** pelvis and anterior and posterior whole body scans

**Findings:** There is normal blood flow in the region of the pelvis. There is mildly increased radiopharmaceutical uptake on the soft tissue phase images, likely representing early osseous uptake. There...
is increased osseous radiopharmaceutical uptake in the LEFT sacral ala, medial aspect of the LEFT acetabulum, as well as the RIGHT pubic body region. Given clinical history of recent fall, this is likely increased activity due to fractures.

Osseous whole body images demonstrate otherwise normal distribution of radiopharmaceutical in the skeleton. There is symmetric activity demonstrated in the shoulders, knees, and ankles, which is likely degenerative in nature. Bilateral hip prostheses are noted without significant periprosthetic activity.

Impression: Intense activity involving the LEFT sacral ala, medial aspect of the LEFT acetabulum, and RIGHT pubic body region. Given the history of a recent fall, these are compatible with fractures.

Case Discussion
A review of possible options shows that CPT includes the following codes for bone imaging.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78300</td>
<td>Bone and/or joint imaging; limited area</td>
</tr>
<tr>
<td>78305</td>
<td>multiple areas</td>
</tr>
<tr>
<td>78306</td>
<td>whole body</td>
</tr>
<tr>
<td>78315</td>
<td>3 phase study</td>
</tr>
<tr>
<td>78320</td>
<td>tomographic (SPECT)</td>
</tr>
</tbody>
</table>

Based upon the above dictated report, the following correct codes should be assigned:

- A9503 Technetium Tc-99M medronate, diagnostic, per study dose, up to 30
- 78315 Bone and/or joint imaging; 3 phase study

Level II HCPCS code A9503 must be assigned by the entity procuring, or incurring the expense of, the radiopharmaceutical. The code should only be submitted once, even though the physician injected 31 millicuries (mCi) instead of the listed dose of 30 mCi. Like many other radiopharmaceutical descriptions, the A9503 code description states “per study dose,” which indicates that a single injection of the radiopharmaceutical is allowed for imaging/scanning.

Hospitals will report A9503 on the UB-04 claim form with revenue code 0343 (nuclear medicine diagnostic radiopharmaceuticals).

Even though the documentation defines both whole-body and three-phase imaging, providers cannot submit both 78306 and 78315. While either code would be reimbursed if charged by itself, only one is correct for the above case. (See Coding Tips below.)

Revenue code 0341 (nuclear medicine diagnostic procedures) should be assigned on the UB-04 form for any of the CPT codes (i.e., 78300–78399) that define diagnostic nuclear medicine bone imaging.

**CODING TIPS: Three-Phase Bone Imaging**

Two excellent reference documents support the decision that only CPT code 78315 should be assigned for the above procedure. The first one, which follows, contains a question submitted to and answered by the American Medical Association (AMA) in its monthly publication, *CPT Assistant* (January 2002, page 10).

**Question:** If a physician performs a three-phase bone imaging study, and three hours later also performs a whole body bone scan, should codes 78315 and 78306 be reported?

**AMA Comment:** A three-phase study refers to a bone scan that starts immediately with a blood flow study. The blood flow study is done during and immediately after injection of a bone seeking radiopharmaceutical agent and consists of sequential short interval images of one area followed by a static image of the same region right after the bolus of blood has diffused. A bone scan is performed three to four hours later, which consists of a limited, multiple or a whole body bone scan. Therefore, it would not be appropriate to report code 78306, Bone and/or joint imaging; whole body, in addition to code 78315, Bone and/or joint imaging; three-phase study, since the whole body bone scan is considered to be a component of the three-phase study.

The second, more recently published reference, appeared in the *Clinical Examples in Radiology Newsletter* (Spring 2010, Issue 2, Volume 6, page 9) published on a quarterly basis by the AMA and the American College of Radiology.

**Question:** How is a three-phase, whole-body bone study reported?

**Answer:** A three-phase, whole-body bone study is reported with CPT 78315, Bone and/or joint imaging; 3 phase study. A three-phase study includes initial vascular flow followed by blood pool imaging and followed by delayed statis bone scans. Therefore, it is not appropriate to report a planar, limited (CPT 78300); multiple areas (CPT 78305); or whole-body (CPT 78306) bone scan or non-cardiac vascular flow study (CPT 78445) in conjunction with a three-phase bone study, as they are all considered to be part of the three-phase bone study. If an additional delayed phase (referred to as a four-phase study) is performed, it is also considered included in CPT code 78315 and not reported separately. This three-phase with a whole body combination should be rate, as there are few clinical situations in which this combination would be considered medically necessary.

While the difference between the first and the second reference is subtle, conceptually they both reinforce the same concept: Only a single code should be submitted when performing whole-body and three-phase bone imaging on the same patient during the same encounter and that the three-phase code (78315) supersedes that of the whole-body imaging (78306).

**Information Sources:**
Q & A: Focus on Nuclear Medicine

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 this case, code 78300 (bone and/or joint imaging; limited area) should be assigned in addition to a for the radiopharmaceutical given.

Modifier 52 (reduced services) or 53 (discontinued procedure) should be assigned. However, 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.

Is A9503 included in the procedure, or can we (hospital) bill it separately?

According to Addendum B of the 2012 hospital outpatient prospective payment system (OPPS), this is packaged. It should be coded but will not be paid separately. (For Addendum B, go to http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html. On the left side, scroll down to Addendum A and Addendum B Updates, click, and follow the prompts given.)