



CHCPP NEWS

COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

The Commission on Health Care Policy and Practice's Coding and Reimbursement Committee, co-chaired by Kenneth McKusick, MD, and Michael Wilson, MD, continues to accept SNM members' questions on coding and reimbursement pertaining to nuclear medicine. All questions must be submitted in writing and faxed to Wendy Smith, Director of Health Care Policy, at (703) 708-9013. Questions may also be sent by e-mail to wsmith@snm.org. Committee members review questions and try to respond within 30 days. Below are some recent questions submitted by members and responding recommendations from the Committee.

Cardiac

Q: Is there a way to bill for both SPECT myocardial perfusion, rest and stress, and gated blood study?

A: Yes. You should bill a gated SPECT stress/rest myocardial perfusion study as 78465, 78478 and 78480, which describe a rest/stress SPECT myocardial perfusion study with gated wall motion and ejection fraction analysis. CPT code 78465 (Myocardial perfusion imaging; tomographic [SPECT], multiple studies, at rest and/or stress [exercise and/or pharmacologic], and redistribution and/or rest injections, with or without quantification) applies to the rest/stress myocardial perfusion SPECT study.

CPT codes 78478 (Myocardial perfusion study with wall motion, qualitative or quantitative study) and 78480 (Myocardial perfusion study with ejection fraction) are "add-on" codes, which are listed separately, in addition to the code for the primary procedure. There is no separate CPT code for a gated SPECT myocardial perfusion study. The appropriate add-on codes should be used only if wall motion and/or ejection fraction measurements are indicated, assessed and reported. We recommend providing written documentation listing the indication for performing these procedures.

Q: How do I code for myocardial

SPECT when the stress portion is performed on one day and the rest portion is performed on the following day?

A: You are not allowed to unbundle the procedures within CPT code 78465 (Myocardial perfusion imaging; tomographic [SPECT], multiple studies, at rest and/or stress [exercise and/or pharmacologic] and redistribution and/or rest injection, with or without quantification). Rest/stress protocols are reimbursed as one test whether done on the same day or two separate days. The medical record should include the date that the test was completed and reported.

Most Medicare carriers follow this rule, but we advise discussing this with your local Medicare carrier medical director. We have not received a response from the Health Care Financing Administration (HCFA) to an inquiry we sent concerning this issue.

Lymphoscintigraphy/Sentinel Node Imaging

Q: How do I code for sentinel node lymphoscintigraphy for breast cancer or melanoma? How do I bill for the guidance portion of the procedure?

A: CPT code 78195 (Lymphatics and lymph glands imaging) is a global code (like most nuclear medicine procedure codes) and covers all parts of the procedure including patient evaluation, injection, imaging, review of the studies, report of the study, and discussion with referring physicians. Payment is based on the average patient and includes the prolonged time that is required for physician supervision.

You should not code for the injection unless it is the only part of the study that you do, meaning there is no imaging performed. As of January 1, 1999, you may use CPT 38792 (Injection procedure; for identification of sentinel node). There is no CPT code for guidance (probe detection).

Musculoskeletal/Nervous System

Q: What code do I use to describe cisternography delayed images or delayed

views for a three-phase bone scan?

A: CPT codes 78630 (Cerebrospinal fluid flow, imaging [not including introduction of material]; cisternography) and 78635 (Cerebrospinal fluid flow, imaging [not including introduction of material]; ventriculography) are studies that, by definition, have delayed views as part of the standard protocol to view the ventricles and cisterns. The most common indication is normal pressure hydrocephalus. The delayed views (at 24, 48 and sometimes 72 hr) are included in the standard protocol at most imaging departments.

CPT code 78315 (Bone and/or joint imaging; three phase study) includes initial and delayed imaging without specification of the frequency and number of delayed sequences, so no extra views are routinely reimbursed.

Respiratory

Q: How do I code for xenon studies?

A: If you are doing a ventilation/perfusion (V/Q) study, you should use CPT code 78585 (Pulmonary perfusion imaging, particulate, with ventilation; rebreathing washout, with or without single breath), and not the two codes 78580 and 78593, which would be unbundling.

There are two radiopharmaceuticals for this procedure, Tc-99m MAA and Xe-133. For Medicare, you should code the radiopharmaceutical as A4641 twice (once for each radiopharmaceutical).

PET

Q: What PET imaging procedures are currently reimbursed by Medicare?

A: HCFA reimburses for PET myocardial perfusion imaging using HCPCS G codes G0030-G0047. Medicare now reimburses for lung cancer imaging with coincidence gamma cameras and dedicated PET scanners. The HCPCS G codes for PET tumor imaging (CPT code 78810) are G0125 (solitary pulmonary nodule) and G0126 (initial staging of non-small cell lung cancer). For private insurance, the CPT code is used. For Medicare, the HCPCS codes are used.

No other PET studies are currently covered by Medicare. We recommend that you contact your local Medicare carrier for more specific coverage instructions for lung cancer PET.

Radiopharmaceutical Coding

Q: Can I bill adenosine for the amount used?

A: You should use the new HCPCS code JO151 (Injection, adenosine, 90 mg [Adenoscan]). You may bill for the actual cost of the adenosine used for the patient. If, however, you use only part of a vial for a patient and the remainder is not used for another study, you may charge for the entire vial. The HCPCS code J0150 (Injection, adenosine [Adenocard]) is for 6mg, not for the quantity of adenosine used in stress cardiac imaging. Neither of these codes should be used to report any adenosine phosphate compounds. Instead use HCPCS code A9270.

Q: How do I code for strontium 89?

A: You should use HCPCS code A9600 (Supply of therapeutic radiopharmaceutical, Sr-89 chloride, per mCi). HCPCS code J3005 was replaced with A9600 in 1998.

Gastrointestinal

Q: Is it possible to code CPT codes 78201 or 78202 in addition to 78205?

A: It is not possible to bill for CPT code 78201 (Liver imaging; static only) with CPT code 78205 (Liver imaging [SPECT]). You are not allowed to code a planar liver and SPECT code together. We recommend that you use CPT 78205, the SPECT code, only. If you are adding flow to the SPECT study, then use CPT 78206 (Liver imaging [SPECT]; with vascular flow). If you are just doing planar liver imaging with flow, use 78202 (Liver imaging; with vascular flow). For liver hemangioma studies, the new CPT code 78206 provides both SPECT and vascular flow components.

Q: Can we code a hepatobiliary scan with an ejection fraction?

A: You should use CPT code 78223 (Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function). This code includes

quantitative measurement of gallbladder function (ejection fraction).

Q: Can you use a “-21” modifier for biliary scans with ejection fractions?

A: No. There is no “-21” modifier *Prolonged Evaluation and Management Services* in radiology services. CPT code 78223 includes quantitative analysis, which includes gallbladder ejection fraction.

Miscellaneous Questions

Q: What is the payment of a whole body study when performed on the same day as a SPECT study? Why have some of my claims been denied recently?

A: The CPT modifier “-51” *Multiple Procedures* applies only to several nuclear medicine procedure codes as listed below. The additional procedure(s) or service(s) may be identified by appending the modifier “-51” to the additional procedure or service code(s) or by the use of the separate five digit modifier 09951.

In nuclear medicine, the “-51” modifier should be used when a whole body bone, tumor or infection study is performed on the same day prior to a SPECT bone, tumor or infection study, respectively. Payment will be 100% for the SPECT study and 50% for the whole body study.

From the Medicare Part B Carriers Manual, Part 3-Claims Process (HCFA Pub. 14-3 Thru Rev. 1269):

“15022. PAYMENT CONDITIONS FOR RADIOLOGY SERVICES. C. *Nuclear Medicine (CPT 78000 through 79999)*. 2. *Application of Multiple Procedure Policy (CPT Modifier 51)*.—Apply the multiple procedure reduction as set forth in §15038 to the following nuclear medicine diagnostic procedures: codes 78306, 78320, 78802, 78803, 78806, and 78807.”

The Health Care Financing Administration (HCFA) and its contractor, AdminaStar Federal, implemented two incorrect code-pair edits effective April 1, 1998. The Society was alerted to this error when several members reported that Medicare was no longer reimbursing for these procedures and was denying claims. We have since contacted HCFA and its contractor, and they have acknowledged this error in their coding

policy. All reimbursement and correction of denials will be retroactive to April 1, 1998.

Q: How do I code scintimammography?

A: You should use CPT code(s) 78800 (Radiopharmaceutical localization of tumor; limited area) or 78801 (Radiopharmaceutical localization of tumor; multiple areas).

Q: Why are my Medicare claims being denied for CPT codes 78120 (Red cell volume determination [separate procedure]; single sampling), 78270 (Vitamin B-12 absorption study [e.g., Schilling test]; without intrinsic factor), and 78272 (Vitamin B-12 absorption studies combined, with and without intrinsic factor) due to a CLIA issue?

A: CLIA licensure is a requirement of the aforementioned tests. If performed at a hospital, the nuclear medicine department may agree to be under the umbrella of the pathology department’s license. This may save the expense of a separate license.

If the lab is performing the study and has its CLIA code, it may charge for the technical component. The professional component would have to come under the “-26” CPT modifier, and a CLIA number would also be required for the physician. This indicates the need for CLIA certification, and denials will follow if no CLIA number is provided in box 23 of the HCFA 1500 claim form. This policy was effective January 1, 1998.

Q: How do I get reimbursed for the generation of automated data codes 78890 and 78891?

A: For nuclear medicine there are two codes for the generation of automated data: CPT 78890 is for “non complex” computer processing not to exceed 30 min, and CPT 78891 is for “complex manipulations” exceeding 30 min. Processing subtraction studies, renograms and regions of interest calculations are examples of work performed. Some institutions use these codes to reflect the work performed in computer processing for measurements of function (renal) or subtractive imaging (parathyroid).

CPT codes 78890 and 78891 are never paid by Medicare. Some third-party payers do reimburse for these codes. Exam-

ples of when these codes should not be used are 78000 (thyroid uptake; single determination) and 78466 (myocardial imaging, infarct avid, planar; qualitative or quantitative). In addition, these codes should not be used for SPECT or vitamin B12 absorption studies. There is a V/Q scan CPT code with quantitation (CPT 78596), so additional coding for quantitation is unwarranted with this CPT code.

Coding Change for C-14 Urea

As of January 1, 1999, CPT code 83019 (*Helicobacter pylori*, breath test [including drug and breath sample collection kit]) was deleted and replaced by two codes: 83013 (*Helicobacter pylori*, breath test analysis) and 83014 (*Helicobacter pylori*, breath test analysis; drug administration and sample collection). These codes have no professional component. The physician should not bill 83013 or 83014 for collecting the sample. These codes should only be billed by the laboratory that performs the test.

Services related to the explanation of

the test and interpretation of the *Helicobacter C-14* could be billed as evaluation and management (E/M) services by the physician administering the test. The level of E/M billed should be *reflected in the documentation* within the patient's medical record. If the test is administered during the overall evaluation of the patient for the clinical problem requiring the test, the time and effort of the physician administering the test should be taken into consideration in determining the level of E/M service to be billed.

In regard to the professional component, the physician's office could bill CPT code 99201 or 99211 (Evaluation and Management code for a brief visit) for the administration of the C-14 labeled urea and collection of the breath sample. You should use the "-25" modifier with these codes. The "-25" modifier is a *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service*. We recommend that you discuss this coding issue with your local Medicare carrier

medical director.

As noted above, there is no separate nuclear medicine code for the interpretation of a C-14 urea breath test. The Society of Nuclear Medicine is working with the CPT Editorial Panel on this issue.

HCFA Extends Comment Period for Proposed HOPPS

HCFA has extended the comment period another 60 days on its proposed hospital outpatient prospective payment system. The new deadline for submission of comments is March 9, 1999. Please send comments to: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA-1005-P, P.O. Box 26688, Baltimore, MD 21207-0488. In addition, please send a copy of your comments to Wendy Smith, Director of Health Care Policy, Society of Nuclear Medicine, 1850 Samuel Morse Drive, Reston, VA 20190-5316.

—Wendy J.M. Smith, MPH, is the SNM director of health care policy

CME CREDIT

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Will CME Programs Achieve Their Objectives?

The Society's new CME programs could quickly become popular with members, but the actual educational benefits of new SNM programs will take time and effort to determine, according to Nagle. "PEP was developed in close collaboration with practicing nuclear physicians in order to create a CME program that would meet the need for practice-based learning," he said. "We also recognize, though, that obtaining and maintaining accreditation is equally crucial to the program's viability." In conducting a critical survey of its CME programs, the Society leadership is taking its cues from the ACCME, which is becoming increasingly concerned that CME programs meet all of their educational objectives.

Howard J. Dworkin, MD, immediate past chair of the ACCME and chief of nuclear medicine at William Beaumont Hospital, Royal Oak, Michigan, said that the focus of the ACCME has expanded from one of educating physicians to one of improving patient outcomes. "The Council wants to see if CME programs are valuable—meaning that physicians will change their practices, leading to an improvement in patient outcomes," said Dworkin. "Over the next few years, we will begin to ask for data that can directly show that a CME program changed physicians' practice patterns and that those changes led to better patient recoveries, reduced hospital stays, and fewer long-term complications."

Getting that sort of information will require CME providers to conduct surveys to see how many physicians have changed their practices as a result of par-

ticipating in a CME program. Dworkin acknowledges, however, that linking physician learning with improved patient outcomes is a particular challenge in nuclear medicine. "We nuclear physicians typically are just one part of a long chain of events in a patient's care," he said. "So it's hard to determine if our performance alone affected a referring physician's response to, say, the interpretation of a bone scan. Also, in diagnostic specialties, it's hard to show that a practice change resulted from a specific CME program rather than from, say, a discussion with a colleague." Even if this issue is sorted out, funding must be obtained for these outcome studies. Determining who will provide this funding is a question that the medical societies and the ACCME have left unanswered.

— Jill Steuer