

RADIOLOGY TRENDS

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ACR Releases New, Revised Guidelines To Take Effect This October

The American College of Radiology recently released four new and 23 revised documents for its 2018 Practice Parameters and Technical Standards, according to a [statement](#) from the organization. The new guidelines will take effect in October.

The ACR's four new practice parameters are the ACR-ASNR-SIR-SNIS Practice Parameter for the Performance of Endovascular Embolectomy and Revascularization in Acute Stroke, the ACR Practice Parameter for the Performance of Digital Breast Tomosynthesis, the ACR Practice Parameter for the Performance of Gallium-68 DOTATATE PET/CT Neuroendocrine Tumors and the ACR-ACNM Practice Parameter for the Performance of 18F-Fluciclovine PET/CT for Recurrent Prostate Cancer.

"Each of these practice parameters and technical standards has undergone extensive review and promotes the latest in safe and effective radiology," Matthew Pollack, MD, chair of the ACR Committee on Practice Parameters and Technical Standards, said in the statement. "We are pleased to have collaborated with 13 national medical specialty societies on these new documents, which will advance radiology science and improve the quality of service to our patients."

Changes To Expect In 2019 CPT

Coding and Compliance Tips by Lori Shore, CPC, RCC

There won't be too many changes to the "Radiology" chapter of CPT per se; however, there will be changes to surgical codes used by radiologists. [Clinical Examples in Radiology](#) published its Update Bulletin with a list of anticipated changes. When code pairs are reported together more than 75% of the time they are referred to the Relativity Assessment Workgroup (RAW) for bundling. Ultrasound-guided fine needle aspirations are one such example. It is anticipated that CPT code 10022 will be replaced by nine new codes that bundle the procedure with the radiological supervision and interpretation (RS&I). CPT 10021 – FNA without guidance is expected to be revised. The same bundling is expected to produce two new peripherally inserted central catheter (PICC) codes that include

guidance, image documentation, and RS&I.

Radiology will see four new breast MRI codes with the deletion of 77058, 77059 and 0159T. The new codes will allow breast MRI to be reported with and without contrast and two additional codes will include CAD. A new code to report magnetic resonance elastography (MRE) is also expected.

Ultrasound elastography (USE) is expected to graduate from a Category III code to three new CPT codes. The new codes are expected to report by first target lesion and each additional lesion. Two additional codes are also proposed for Contrast-enhanced ultrasound (CEUS). Bone density ultrasound is expected to receive a Category III code in 2019. Knee arthrograms are also under review and CPT 27370 is ex-

pected to be replaced by a code to report the injection for CT or MRI knee arthrography. It is thought that 27370 is being incorrectly reported as arthrocentesis or aspiration.

Two codes are being replaced due to changes within the specialties. 50395 will likely be replaced by two new codes to report dilation of the urinary tract for endourologic procedures. 43760 is proposed to be deleted and replaced with codes for simple and complex replacements of gastrostomy tubes.

A new Category III code is expected for PET absolute quantitation myocardial blood flow. And finally, 76001 is expected to be deleted due to lack of use.

What Medicare's 2019 proposed rule means for imaging CDS

10:15 AM on July 24, 2018 by Erin Lane and Catherine Kosse. *The Advisory Board Company (ABC)* is the owner and publisher of this article.

Earlier this month, **CMS released** the Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) proposals for calendar year 2019. For imaging, many of the biggest updates concern the imaging clinical decision support (CDS) mandate, also known as the Medicare Appropriate Use Criteria (AUC) Program.

Notably, the agency upheld the January 1, 2020 start date and provided guidance around provider consultation and documentation. Read on to get our six major takeaways from this year's rulemaking—and our guidance on how to respond.

The 6 key takeaways from recent CMS proposals

1. *AUC Program on track to begin in 2020*

In this year's proposed rule, CMS reinforced the January 1, 2020 program start date finalized last year. This means that in 2020, ordering providers must consult AUC, and furnishing providers (radiologists and imaging managers) must document this consultation on both professional and technical claims submitted to Medicare.

The mandatory first year is deemed an "educational and testing" period, meaning claims will be paid regardless of documentation. Beginning January 1, 2021, Medicare will deny claims that do not include necessary information (more on documentation below).

In the meantime, the voluntary reporting period in which providers can report consultation using modifier, QQ, began in July. Ordering providers can attest to CDS consultation to earn Improvement Activity credit and Prompting Interoperability (formally called Advancing Care Information) bonus points in QPP's Merit Based Incentive Payments System (MIPS). For MIPS credit, providers do not need to report the modifier, but they must maintain documentation of CDS for six years. For more information on the AUC program's alignment with MACRA, **review our analysis** of the 2018 final rules.

Guidance for providers: Although CDS is not mandated for another year and a half, organizations should develop an implementation strategy now. This approach provides the opportunity to conduct comprehensive product testing, educate and train ordering providers on CDS, and slowly roll out CDS across the health system. Encourage ordering providers to participate in voluntary reporting, and emphasize the potential to earn MIPS credit as a benefit to early adoption. To learn more, **check out** our tools and resources designed to help imaging leaders throughout the implementation process.

2. *CMS outlines documentation, but returns to G-codes and modifiers*

Ordering providers consult CDS, but furnishing providers are responsible for reporting that consultation took place. This claims-based reporting must include three separate items:

- CDSM consulted;
- AUC adherence (adherent, not adherent, or not applicable); and
- National provider identification (NPI) number of the ordering professional.

CMS proposes to use G-codes for CDSM consultation and modifiers for AUC adherence. CMS requests feedback from stakeholders, as the agency withdrew a similar proposal from the calendar year 2018 rules citing reporting challenges. Read more [here](#).



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