Last year's decision by the U.S. Centers for Medicare and Medicaid Services (CMS) to delay implementation of imaging clinical decision-support (CDS) requirements until 2020 created an opportunity to win over skeptical clinicians, according to a recent webinar from the Society for Imaging Informatics in Medicine (SIIM).

In addition to allowing time for comprehensive testing of CDS software and training of providers, the new deadline will make it possible to implement systems that are optimized and better integrated with electronic medical record software—and therefore more likely to be accepted by ordering physicians, said Dr. Kevin McEnery, director of innovation in imaging informatics at MD Anderson Cancer Center in Houston.

"I believe that first-generation imaging CDS systems rely heavily on an indications-driven workflow, and there are anecdotal results of challenges [due to] that," he said.

"Implementations that really better leverage the electronic medical record are going to be important to this whole process."

The imaging decision-support provisions of the Protecting Access to Medicare Act (PAMA) of 2014 has been pushed back twice, with mandated compliance now set to begin on January 1, 2020. While CMS' timeline for the program has changed, the requirements and scope have not.

Physicians ordering advanced diagnostic imaging exams—CT, MRI, nuclear medicine, and PET—will be required to consult government-approved, evidence-based appropriate use criteria (AUC), namely through a CDS system, McEnery said. These rules apply to outpatient imaging exams and studies performed in the emergency center.

Physicians who are furnishing advanced imaging services will only be paid if reimbursement claims confirm that the appropriate use criteria was consulted, identify the CDS mechanism that was used, and state whether the ordered exam adhered or did not adhere to an acceptable CDS rating.

### Goodbye “G” Codes

Coding and Compliance Tips by Lori Shore, CPC, RCC

Effective 1-1-18 CMS no longer recognizes the “G” codes for mammograms. While the new 70000 series codes have been active since 2017, CMS was not ready to accept them. Since last year, all mammograms, both diagnostic and screening have included the CAD, when performed. I like to use the simple table below to code mammography.

<table>
<thead>
<tr>
<th>Mammography</th>
<th>Diagnostic</th>
<th>Screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral</td>
<td>77066</td>
<td>77067</td>
</tr>
<tr>
<td>Unilateral</td>
<td>77065</td>
<td>77067-52</td>
</tr>
<tr>
<td>Tomosynthesis</td>
<td>G0279</td>
<td>77063</td>
</tr>
</tbody>
</table>

Since the screening study is bilateral in nature; therefore, we must append modifier 52 for reduced service. Some insurances will accept the RT or LT modifier in place of modifier 52. Generally, the reimbursement is cut in half.

Please note that while the “G” codes for mammography are no longer valid, the CPT code G0279 is still valid for diagnostic breast tomosynthesis. This code must be billed with the primary procedure of either 77065 or 77066. The same concept holds true for screening tomosynthesis; CPT code 77063 requires that it’s billed with 77067.
Digital Mammography Isn’t Perfect. Here Are The Top Alternative Approaches To Breast Cancer Screening

3:42 PM on January 29, 2018 by Miriam Szyncer-Taub and Elena Price. The Advisory Board Company (ABC) is the owner and publisher of this article.

Mammography has long been the gold standard for breast cancer detection. According to the Kaiser Family Foundation, nearly 75% of all U.S. women over age 40 report they have had a mammogram in the past two years.

Despite its high profile in the imaging world, there are some concerns about mammography’s effectiveness. According to the American Cancer Society, screening mammograms miss about one in five cancers. Meanwhile, false-positive results bring unwarranted stress and lead to unnecessary tests. Another concern is the increased likelihood of erroneous results among the one-third to one-half of women who have dense breast tissue.

Given these concerns, there is increased interest in breast imaging modalities other than digital mammography. Here are some of the most popular alternatives.

**Digital breast tomosynthesis (3-D mammography)**

We've previously written about the emergence of digital breast tomosynthesis (DBT), sometimes called 3-D mammography. Evidence continues to emerge that DBT may be more effective than digital mammography in detecting cancer and may decrease callback rates. We've spoken to some imaging programs that have made DBT the standard of care for women.

Medicare continues to cover DBT in conjunction with a 2-D digital mammogram and several private payers, including Cigna, Anthem, and UnitedHealthcare, provide national coverage. (Editor's note: The Reading Room is published by Advisory Board, a division of Optum, which is a wholly owned subsidiary of UnitedHealth Group. UnitedHealth Group separately owns UnitedHealthcare.) However, some women are hesitant to make the switch to DBT because it emits twice as much radiation as a standard mammogram.

However, some women are hesitant to make the switch to DBT because it emits twice as much radiation as a standard mammogram. The United States Preventative Services Task Force most recently graded DBT as an "I," saying that there is insufficient evidence to recommend DBT for all women or for those with dense breast tissue.

**MRI**

Breast MRI may be best for women with BRCA 1 or BRCA 2 genes, or for those with a family history of breast cancer. A study in the American Journal of Roentgenology found that for women in these groups, breast MRI identified 12 out of 13 (92.3%) cancers, whereas mammography only detected four of the 13 (30.8%).

However, MRI continues to be criticized for its low specificity, as it rarely identifies a potential lesion with enough specificity to determine if it is cancerous and often requires additional imaging or biopsy. The test frequently results in false positives, leading to increased spending, more time waiting, and higher levels of patient anxiety.

The test's cost is also a common concern for patients. MRI tends to be more expensive than mammography, and some payers do not cover the exam, even for high-risk women.

**Ultrasound**

Ultrasound alone is not accepted as a breast cancer screening tool, as it often generates false positives as well as false negatives. However, breast ultrasound is frequently used as a follow-up screening modality. One study found that using breast ultrasound to supplement mammography in women with dense breast tissue detected more cancers that mammography alone. Read more [here](#).