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INDUSTRY UPDATES

CMS Delay Of Decision Support Creates Opportunities

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 & Compliance Tips by Lori Shore, Industry and MBMS Expert, 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 mammo codes, both diagnostic and screening have included the CAD, when performed. I like to use the simple table below to code mammography. There is no code for a unilateral screening mammogram 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.

Mammography	Diagnostic	Screening
Bilateral	77066	77067
Unilateral	77065	77067-52
Tomosynthesis	G0279	77063