ERRATA for
Diagnostic Radiology Coding Reference
2017 Edition

Text deletions are ~~crossed out~~. New text is **blue and bolded**. Ordered by appearance in text.

Page 17, Modifier Descriptions

MODIFIER PN – NON-EXCEPTED SERVICE PROVIDED AT AN OFF-CAMPUS, OUTPATIENT, PROVIDER-BASED DEPARTMENT OF A HOSPITAL

Modifier -PN is new in 2017 and is appended to the code for the technical component of non-excepted services and procedures performed in an off-campus provider-based department of a hospital. Non-excepted services include all services except those performed at hospital remote locations, satellite facilities, and emergency departments.

Excepted services are items and services furnished after January 1, 2017:

- **By a dedicated emergency department;**
- **By an off-campus PBD that was billing for covered outpatient provider department (OPD) services furnished prior to November 2, 2015, [i.e., the date of enactment of section 603 of the Bipartisan Budget Act of 2015 (Section 603)] that has not impermissibly relocated or changed ownership;**
- **By an off-campus PBD that qualifies for an exception under section 16001 or 16002 of the 21st Century Cures Act*; or**
- **In a PBD that is "on the campus", or within 250 yards, of the hospital or a remote location of the hospital.**

Payment for services reported with a -PN modifier will result in a new payment methodology for the technical component ~~using the Medicare physician fee schedule~~. The new fee schedule combines some of the bundling concepts of the OPPS with the payment to physicians for procedures performed in a non-facility (office) setting. **The technical component payment when the -PN modifier is appended follows the following logic:**

Payment for Nonexcepted Items and Services by OPPS Status Indicator

OPPS STATUS INDICATOR	ITEM/SERVICE CATEGORY	OPPS PAYMENT PRIOR TO SECTION 603 IMPLEMENTATION	MPFS PAYMENT ADOPTED IN THIS INTERIM FINAL RULE WITH COMMENT PERIOD
A	Ambulance Services	Paid according to Ambulance fee schedule	No change relative to current payment
	Separately payable clinical diagnostic laboratory services	Paid according to CLFS fee schedule	
	Separately payable non- implantable prosthetics and orthotics	Paid according to DMEPOS fee schedule	
	Physical, Occupational, and Speech Therapy	Paid according to MPFS Facility Rate	
B	Codes not recognized by OPPS when submitted on outpatient hospital bill type	Not Applicable	
C	Inpatient Procedures	Not Applicable	

OPPS STATUS INDICATOR	ITEM/SERVICE CATEGORY	OPPS PAYMENT PRIOR TO SECTION 603 IMPLEMENTATION	MPFS PAYMENT ADOPTED IN THIS INTERIM FINAL RULE WITH COMMENT PERIOD
D	Discontinued Codes	Not Applicable	
E1	Not covered by any Medicare outpatient benefit category	Not Applicable	
E2	Medicare covered item; no pricing available	Not Applicable	
F	Corneal tissue acquisition	Paid at reasonable cost	No change relative to current payment
	Certain CRNA services		
	Hepatitis B Vaccines		
G	Pass-through drugs and biologicals	ASP+6%	ASP+6%
H	Pass-through device categories	Amount by which the hospital's charges, adjusted to cost, exceeds the OPPS payment rate associated with the device	No change relative to current payment
J1	Hospital Part B services paid through a comprehensive APC	Claim-level packaged payment	Paid 50 % of C-APC rate
J2	Hospital Part B services that may be paid through a Comprehensive APC (Observation)	Comprehensive APC Payment	Paid 50% of C-APC rate
K	Nonpass-through drugs, biologicals, therapeutic radiopharmaceuticals	ASP+6%	ASP+6%
L	Influenza Vaccine	Paid at reasonable cost	Paid at reasonable cost
	Pneumocccal Pneumonia Vaccine		
M	Items and Services not billable to the MAC	Not Applicable	
N	Items and Services Packaged into APC rates	Payment packaged with procedure	No change relative to current payment
P	Partial hospitalization	Separate APC payment	CMHC Rate
Q1	STV-packaged codes	Packaged APC payment if billed on same claim with "S," "T," or "V" procedure	Paid at 50% of APC rate if billed without "S," "T," or "V" procedure; otherwise packaged
Q2	T-packaged codes	Packaged APC payment if billed on same claim with "T" procedure	Paid at 50% of APC rate if billed without "T" procedure; otherwise packaged
Q3	Codes that may be paid through a composite APC	Composite payment when criteria met; otherwise separate APC payment or packaged payment	Paid at 50% of APC rate if composite criteria met; otherwise packaged

OPPS STATUS INDICATOR	ITEM/SERVICE CATEGORY	OPPS PAYMENT PRIOR TO SECTION 603 IMPLEMENTATION	MPFS PAYMENT ADOPTED IN THIS INTERIM FINAL RULE WITH COMMENT PERIOD
Q4	Conditionally packaged laboratory tests	Conditionally packaged APC payment when billed on same claim with HCPCS codes assigned SI J1, J2, S, T, V, Q1, Q2, or Q3; otherwise paid under clinical laboratory fee schedule	Paid at CLFS rate when billed without primary service; otherwise packaged
R	Blood and blood products	Charges reduced to costs	No change relative to current payment
S	Procedure or Service, Not Discounted when multiple	Separate APC payment	Paid at 50% of APC rate
T	Procedure or Service, Multiple Procedure Reduction Applies	Separate APC payment	Paid at 50% of APC rate Existing MPFS Multiple Procedure Payment Reduction Policies Apply
U	Brachytherapy sources	Charges reduced to costs	No change relative to current payment
V	Clinic Visit	Separate APC payment	Paid at 50% of APC Rate
Y	Non-implantable Durable Medical Equipment	Paid according to DMEPOS fee schedule	No change relative to current payment

The professional component will be paid under the existing physician fee schedule.

MODIFIER PO – SERVICES, PROCEDURES AND/OR SURGERIES PROVIDED AT OFF-CAMPUS PROVIDER-BASED OUTPATIENT DEPARTMENTS

Modifier -PO is appended to the code for the technical component of excepted services and procedures performed in an off-campus provider based department (PBD) of a hospital.

Excepted services are items and services furnished after January 1, 2017:

- By a dedicated emergency department;
- By an off-campus PBD that was billing for covered outpatient provider department (OPD) services furnished prior to November 2, 2015, [i.e., the date of enactment of section 603 of the Bipartisan Budget Act of 2015 (Section 603)] that has not impermissibly relocated or changed ownership;
- By an off-campus PBD that qualifies for an exception under section 16001 or 16002 of the 21st Century Cures Act*; or
- In a PBD that is "on the campus", or within 250 yards, of the hospital or a remote location of the hospital.

In many instances, it will be determined by the date the outpatient department was established.

The -PO modifier is never reported by a dedicated hospital emergency room.

Both the -PO and -PN modifiers would never be reported on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a nonexcepted off-campus PBD of the hospital, the -PO modifier should be used on the excepted claim lines, and the -PN modifier should be used on the non-excepted claim lines.

Page 142, Codes

PROCEDURE DESCRIPTION	PROC CODE	APC	TOTAL RVU
~~Low-dose computer tomography for lung cancer screening~~	~~S8032~~	~~N/A~~	~~N/A~~

Page 144, Coding Instructions

12. ~~Use code S8032 for non-Medicare payers that accept "S" codes when low-dose CT lung screening is performed. Do not report code S8032 to Medicare. Use code G0297.~~

Note from ZHealth: The AMA stated that G0297 is also used for private payers, though they referenced information from Medicare.

Page 195, Missing Section - "MRA of the Chest"

The section titled "MRA of the Chest" was inadvertently removed from the 2017 book prior to going to press. This section should start on page 195 (appearing before the section titled "MRA of the Abdomen"). The entire "MRA of the Chest" section is included below for your review and will be added back to the 2018 edition.

MRA of the Chest

PROCEDURE:

MRA of the thorax includes the vasculature of the lungs, as well as the subclavian and brachiocephalic arteries and veins.

From *CPT® Assistant:* "This service involves the application of magnetic resonance angiography to assess the great vessels, including the thoracic aorta (for detection of aneurysm, dissection, or coarctation), the main pulmonary artery (to assess its size), and the relationship between these two vessels (to assess patients with congenital heart disease)."

CLINICAL INDICATIONS:

Thoracic aorta dissection or aneurysm, suspected pulmonary embolism in patients that cannot tolerate iodinated contrast material, pulmonary heart disease, pulmonary hypertension.

CODES:

PROCEDURE DESCRIPTION	PROC CODE	APC	TOTAL RVU
Magnetic resonance angiography, chest (excluding myocardium), with or without contrast material(s) (physician only, not for hospital use)	71555	N/A	2.55
Magnetic resonance angiography with contrast, chest (excluding myocardium) (hospital use only, not for physician use)	C8909	5571	N/A
Magnetic resonance angiography without contrast, chest (excluding myocardium) (hospital use only, not for physician use)	C8910	5523	N/A
Magnetic resonance angiography without contrast followed by with contrast, chest (excluding myocardium) (hospital use only, not for physician use)	C8911	5572	N/A

CODING INSTRUCTIONS:

1. Medicare will cover MRA of the chest for diagnosing a suspected pulmonary embolism only when it is contraindicated for the patient to receive intravascular iodinated contrast material.

2. Medicare will cover MRA of the chest for preoperative and post-operative evaluation of aortic dissection or aneu-

rysm. Unless medically indicated, only MRA or catheter angiography would be performed, not both.

3. Report code 71555 for physician or independent diagnostic testing facility (IDTF) billing.

4. Do not report code 71555 for hospital billing to Medicare. Hospitals use codes C8909-C8911 based on the use of contrast material.

5. Do not report code 71555, C8909, C8910, or C8911 for MRA of the heart or coronary arteries. There are specific codes for cardiac application.

REFERENCES:

Clinical Examples in Radiology, Spring 17:9-10&14

CPT Assistant, Fall 95:1, Dec 05:7, Jan 07:31

Centers for Medicare and Medicaid Services (CMS), NCD for Magnetic Resonance Imaging 220.2, 09/26/11

First Coast Service Options, Inc., LCD for Magnetic Resonance Angiography (MRA) (L34372), 10/01/15