Consulting Radiologists Ltd.

RADIOLOGY 101

Ruby O'Brochta-Woodward, BSN, CPC, CPMA, CDEO, CEMC, CPCO, CPB, COSC, CSFAC, CPC-I

Coding Educator Twin Cities Orthopedics/Revo Health

AAPC Chapter Association Board of Directors 2015-2019

2018-2019 Chair

luvfeet53@gmail.com

1

DISCLAIMER

This presentation is for education purposes only. The information presented is not intended to be legal advice. The information presented was current at the time presented and when applicable, based upon guidelines published by the AMA, ACR, CMS, and NCCI.

2

Consulting Radiologists Ltd.

THE BASICS

Radiology 101

3

ORDERS

- "Non-hospital Medicare 42 CFR410.32
  - All diagnostic tests must be ordered by the treating physician
    - If not ordered by treating physician considered not reasonable and necessary
    - Treating physician is one who furnishes a consult or treats a beneficiary for a specific medical problem
      - Uses the results of the diagnostic test for the management of the beneficiary's medical condition
      - A radiologist who performs a therapeutic intervention = treating physician
    - Treating physician is responsible to provide diagnostic indication for tests in words

Consulting Radiologists Ltd.

4

General Guidelines

- "A written report (eg. Handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation."
- "With regard to CPT descriptors for imaging services, "images" must contain anatomic information unique to the patient for which the imaging service is provided. "Images" refer to those acquired in either an analog (ie. Film) or digital (ie. Electronic) manner."

Contrast

- "With contrast"
  - Administered intravascular, intraarticular or intrathecal
  - Injection of IV contrast is part of the "with contrast" code
  - Intraarticular use the appropriate joint injection code
    - Shoulder 23350
    - Elbow 24220
    - Wrist 25246
    - Hip 27093/27095
    - Knee 27369
    - Ankle 27648
  - Spine w/contrast = intravenous or intrathecal
    - If intrathecal use 61055 or 62284
  - Oral/rectal administration alone ≠ with contrast

GUIDANCE

- All imaging guidance codes require:
  - Image documentation in the patient record
  - Description of imaging guidance in the procedure report
- "Ultrasound guidance requires permanently recorded images of site to be localized as well as documentation of description of localization process

RADIOLOGIC SUPERVISION & INTERPRETATION

- Requires
  - Image documentation in the patient's permanent record
  - A procedure report or separate imaging report that includes written documentation of the interpretive findings contained in the images and radiologic supervision of the service

ULTRASOUND GUIDELINES

- Define structures that must be included for a complete exam
  - If all not documented reported as limited exam
  - Considered reported if documentation on why not seen
- Duplex requires documentation of both color and spectral Doppler

9

MODIFIERS

Radiology 101

10

MODIFIER 52

- 52-Reduced services- Used to indicate a procedure was partially reduced or eliminated at the discretion of the provider
  - Bilateral procedures when only one side done
- NGS, Palmetto, Noridian and many other payers want supporting documentation
  - Notation in Box 19 of why less
    - Noridian note "reduced services" and why
- Reduction in payment often up to 50%
  - Noridian for radiology procedures and others not requiring anesthesia

11

MODIFIER 52

Radiology services

- # of views taken is less than code descriptor
- Discontinued radiology procedures and others not requiring anesthesia (Palmetto)
- Screening mammogram done unilaterally
- RS&I codes when only an interpretation is done
  - When the radiologist did NOT supervise an ERCP and only interpreted the images, you would need to code 74328-26-52
- RR Medicare when the supervision and interpretation components are performed by different providers submit CPT w/26 and 52 modifier

12

MODIFIER 53

- Discontinued procedure-used to indicate that circumstances existed that were a threat to the patient's well being or extenuating circumstances and the procedure was discontinued
  - Noridian prior to or after the administration of anesthesia
  - Surgical or diagnostic procedures (Noridian)
- Attached to the CPT code for the service to have been furnished
- May require documentation be submitted
  - Procedure was started
  - Why stopped
  - Amount if any performed

13

MODIFIER 53

- Puts patient in global period when applicable
  - If return to "OR", need to append global modifier
- Not to be used for elective cancellations
- Reduction in payment varies by health plan
  - Medicare based upon the % of the procedure
    - Noridian says to bill based upon % of procedure performed
  - Commercial plans varies

14

MODIFIER 59

- Distinct Procedural Service
  - Different surgical session
  - Different procedure
  - Different site/organ system
  - Separate excision/incision
  - Separate lesion or injury
- Codes listed as bundled in the NCCI edits and with an indicator of “1”
- Codes with “separate procedure” designation when meets distinct procedural service criteria

MODIFIER 59

- Should be used only when *there is no other appropriate modifier (RT/LT, T and F modifiers)*
- For Medicare effective 07.01.2019 may be appended to either bundled code
- Generally will require documentation to be submitted

Modifier 59

Inappropriate use

- Exact same procedure was performed on the same day
- No edit in CCI (tables or guidelines)
- Modifier indicator of “0” in MFS or CCI
- Lack of supporting documentation
- Submission of weekly radiation therapy management codes 77427

EPSU Modifiers

- Used in lieu of modifier -59 to provide the reason why the service is separate and distinct
- Must first have a bundling edit
- Must meet the separately reportable criteria i.e. modifier 59 criteria
- Report only one!
  - XS-separate **S**ite/**S**tructure/lesion
  - XP-separate **P**rovider
  - XE-separate **E**ncounter
  - XU-**U**nusual non-overlapping service

MODIFIER 50

- Bilateral Procedure
- When performing a procedure bilaterally during one session ***and*** the Medicare Physician Fee Schedule Relative Value File (MPFSRVF) (also known at the Medicare Physician Fee Schedule Database (MPFSDB) BILAT SURG indicator is 1 or 3.
- Report codes with a BILAT SURG indicator of 1 on one line, appending modifier 50 and submit one unit of service. ***(Note: this differs from Current Procedural Terminology (CPT) instruction)***
- When performing the procedure on bilateral body parts
- Payment is 150% of MFS if indicator is 1
-

MODIFIER 50

- Not commonly used on diagnostic radiology
- Caution on services designated as unilateral
  - UCare, Humana want submitted one line -50 modifier
  - Will combine payment and deny 2nd
  - Breast Ultrasound 76642

OTHER MODIFIERS COMPONENT/GLOBAL MODIFIERS

- -26 Professional component
  - Used on procedures with both a professional and technical component
  - Identifies physician component
  - Physician interpretation of a test
  - Not to be reported for a reread of an interpretation already done
  - Not to be used if the global service was performed by the reporting provider

21

OTHER MODIFIERS COMPONENT/GLOBAL MODIFIERS

- -TC technical component
  - Used on procedures with both a professional and technical component
  - Equipment, technicians, space
  - Purchased services where the technical component is provided elsewhere
  - If Part A SNF, billed to SNF

22

REPEAT PROCEDURES 76/77

- -76 repeat procedure by same physician
- -77 repeat procedure by another physician (originally performed by another physician)
- NGS, Noridian criteria states procedure was repeated in a separate session on the same day
- Requires exact duplicate fields on claim
  - Same patient
  - Same DOS
  - Same procedure code
  - Surgeries, x-rays, injections
- Coding requirements
  - Bill 1st procedure w/o modifier
  - Bill duplicate procedures w/ appropriate modifier, one line and units if more than one
  - Not all insurances recognize for same group and instead will use 59/XP modifier

REPEAT PROCEDURES 76/77

Example: Physician orders a 71045 radiologic examination, chest; single view, frontal.

1. First, 71045 performed at 8:00 a.m. by NPI 1
2. Second, repeated at 1:00 p.m. by NPI 1
3. Third, repeated at 3:00 p.m. by NPI 1
4. Fourth, repeated at 6:00 p.m. **by different NPI** 2
5. Fifth, repeated at 10:00 p.m. **by different NPI** 2

- Detailed line one: 71045 billed with 1 unit of service by NPI 1
- Detailed line two: 71045 76 with 2 units of service by same NPI 1
- Detailed line three: 71045 77 with 2 units of service by **different NPI** 2

From NGS Job Aide

Other Modifiers Radiology Specific Modifiers

- -GG performance and payment of a screening and diagnostic mammogram on the same patient, same day
  - Added to the diagnostic mammo (59 to the screening)
- -PI PET/PET CT to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous on other diagnostic imaging
  - Only payable once/cancer diagnosis
- -PS PET/PET CT to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treating physician determines that the PET study is needed to inform subsequent anti-tumor strategy
  - Medicare allows 3 subsequent PET or PET/CT scans
  - Additional requires KX plus PS
- Modifier FX-x-ray taken using film
  - 20% reduction in payment
- Modifier FY- computed radiography X-ray
  - 7% reduction through 2022 then 10%

Other HCPCS Modifiers

- RT/LT
  - If the procedure is unilateral by description or anatomically, payors appear to want the RT/LT
  - Do not append to breast biopsies , FNA
  - Not needed w/59 or X modifiers unless there is a dual edit
- Finger modifiers-FA-F9
- Toe modifiers TA-T9
  - Starts with the left thumb/big toe, ends with right 5th
  - Can be used in lieu of 59 modifier to differentiate separate procedure
- JW
  - Drug amount discarded/not given to patient
  - Used only for single use vials where entire dose is not administered
- JZ
  - Single dose vial when entire dose administered
- KX
  - Requirements of medical policy met
  - Append to gender specific exams when patient has or is in transition for gender reassignment procedures
  - Append to >3 PET scans for Medicare if patient otherwise meets coverage criteria
    - Submit w/PS modifier

PRICING MODIFIERS

- Should be first listed
  - 26, TC
  - 53
- Should precede any non-pricing modifier but may be listed in position other than 1st
  - 50
- Should be placed **after** all pricing modifiers (not all inclusive)
  - ABN modifiers GA, GZ, GY
  - Hospice GV, GW
  - 22,52
  - 24,25,57
  - 58,76, 77, 79
  - 59

INSURANCE QUIRKS

- Procedures documented as each
  - No laterality modifiers
  - Submit on one line with units

Consulting Radiologists Ltd.

MEDICARE NCCI

Radiology 101

REPEAT IMAGING

"If imaging studies (e.g., radiographs, computerized tomography, magnetic resonance imaging) are repeated during the course of a radiological encounter due to substandard quality or need for additional views, only one unit of service for the appropriate code may be reported. If the radiologist elects to obtain additional views after reviewing initial films in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests must be followed. The **CPT code describing the total service shall be reported**, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptors for many of these services refer to a "minimum" number of views. If more than the minimum number specified is necessary and no other more specific CPT code is available, only that service shall be reported. However, if additional films are necessary due to a change in the patient's condition, separate reporting may be appropriate."

CODE REPORTING

"CPT code descriptors that specify a minimum number of views include additional views if there is no more comprehensive code specifically including the additional views. For example, if 3 views of the shoulder are obtained, CPT code 73030 (Radiologic examination, shoulder; complete, minimum of two views) with 1 unit of service shall be reported rather than CPT code 73020 (Radiologic examination, shoulder; one view) plus CPT code 73030."

COMPARISON IMAGING

"When a comparative imaging study is performed to assess potential complications or completeness of a procedure (e.g., post-reduction, post-intubation, post-catheter placement, etc.), the professional component of the CPT code for the post-procedure imaging study is not separately payable and shall not be reported. The technical component of the CPT code for the post-procedure imaging study may be reported."

COMPARISON IMAGING

"When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. Similarly, when an emergency endotracheal intubation procedure (CPT code 31500), chest tube insertion procedure (e.g., CPT codes 32550, 32551, 32554, 32555), or insertion of a central flow directed catheter procedure (e.g., Swan-Ganz)(CPT code 93503) is performed, a chest radiologic examination is usually performed to confirm the location and proper positioning of the tube or catheter. The chest radiologic examination is integral to the procedures, and the chest radiologic examination (e.g., CPT codes 71045, 71046) shall not be reported separately."

COMPARISON IMAGING

HOWEVER…."this applies only when the procedure and the post-procedure imaging are performed and billed by the same physician or two physicians from the same group. The radiologist can bill for interpreting an x-ray following a procedure by a physician from a different group (different TIN)."

Coding Strategies *Navigator for Diagnostic Imaging*

SCOUT IMAGES

- Preliminary scout films prior to contrast administration or delayed imaging radiographs are not separately reportable

FLUOROSCOPY

"Fluoroscopy is inherent in many radiological supervision and interpretation procedures. Unless specifically noted, fluoroscopy necessary to complete a radiologic procedure and obtain the necessary permanent radiographic record is included in the radiologic procedure and shall not be reported separately."

RS&I

“Radiological supervision and interpretation codes include all radiological services necessary to complete the service. CPT codes for fluoroscopy/fluoroscopic guidance (e.g., 76000, 77002, 77003) or ultrasound/ultrasound guidance (e.g., 76942, 76998) shall not be reported separately. Radiological guidance procedures include all radiological services necessary to complete the procedure. CPT codes for fluoroscopy (e.g., 76000) shall not be reported separately with a fluoroscopic guidance procedure. CPT codes for ultrasound (e.g., 76998) shall not be reported separately with an ultrasound guidance procedure. A limited or localized follow-up computed tomography study (CPT code 76380) shall not be reported separately with a computed tomography guidance procedure. (CPT code 76001 was deleted January 1, 2019.)”

37

RS&I

“Physicians shall not report radiologic supervision and interpretation codes, radiologic guidance codes, or other radiology codes where the radiologic procedure is integral to another procedure being performed at the same patient encounter. PTP edits that bundle these radiologic codes into the relevant procedure codes have modifier indicators of “1” allowing use of NCCI PTP-associated modifiers to bypass them. An NCCI PTP-associated modifier may be used to bypass such an edit if and only if the radiologic procedure is performed for a purpose unrelated to the procedure to which it is integral. For example, fluoroscopy is integral to a cardiac catheterization procedure and shall not be reported separately with a cardiac catheterization. However, if on the same date of service the physician performs another procedure in addition to the cardiac catheterization, the additional procedure requires fluoroscopy, and fluoroscopy is not integral to the additional procedure, the fluoroscopy procedure may be reported separately with an NCCI PTP-associated modifier. “

38

ABDOMINAL RADIOLOGY PROCEDURES

"Any abdominal radiology procedure that has a radiological supervision and interpretation code (e.g., CPT code 75625 for abdominal aortogram) includes abdominal x-rays (e.g., CPT codes 74018-74022) as part of the total service.)"

39

CONTRAST INJECTION SPINE

"Computed tomography (CT) of the spine with intrathecal contrast shall not be reported with myelography (e.g., CPT codes 72240-72270) unless both studies are medically reasonable and necessary. Radiography after injection of intrathecal contrast to perform a CT of the spine in order to confirm the location of the contrast is not separately reportable as myelography.

40

CT/CTA

"Computed tomography (CT) and computed tomographic angiography (CTA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is used to generate images for separate CT and CTA reports, only one procedure, either the CT or CTA, for the anatomic region may be reported. Both a CT and CTA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the CT and one for the CTA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon"

MRI/MRA

"Similarly magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is used to generate images for separate MRI and MRA reports, only one procedure, either the MRI or MRA for the anatomic region may be reported. Both an MRI and MRA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the MRI and one for the MRA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon."

CTA/MRA

- CTA requires documentation image post-processing (3D)
  - Not separately reportable
  - If image post-processing not documented should not be coded w/52 modifier
- MRA includes image post processing but code does not require documentation

CT Runoff Study

"CPT code 75635 describes computed tomographic angiography of the abdominal aorta and bilateral iliofemoral lower extremity runoff. This code includes the services described by CPT codes 73706 (Computed tomographic angiography, lower extremity...) and 74175 (Computed tomographic angiography, abdomen...). CPT codes 73706 and 74175 shall not be reported with CPT code 75635 for the same patient encounter. CPT code 73706 plus CPT code 74175 shall not be reported in lieu of CPT code 75635."

MRI

"CPT codes 70540-70543 are used to report magnetic resonance imaging of the orbit, face, and/or neck. Only 1 code may be reported for an imaging session regardless of whether 1, 2, or 3 areas are evaluated in the imaging session."

"An MRI study of the brain (CPT codes 70551-70553) and MRI study of the orbit (CPT codes 70540-70543) are separately reportable only if they are both medically reasonable and necessary and are performed as distinct studies. An MRI of the orbit is not separately reportable with an MRI of the brain if an incidental abnormality of the orbit is identified during an MRI of the brain since only one MRI study is performed"

SPINE IMAGING

"CPT codes 72081-72084 describe radiologic examination of the entire spine, the codes differing based on the number of views. The other codes in the CPT code range 72020-72120 describe radiologic examination of specific regions of the spine differing based on the region of the spine and the number of views. **If a physician performs a procedure described by CPT codes 72081-72084 and at the same patient encounter performs a procedure described by one or more other codes in the CPT code range 72020-72120, the physician should sum the total number of views and report the appropriate code in the CPT code range 72081-72084.** The physician should not report a code from the CPT code range 72081-72084 plus another code in the CPT code range 72020-72120 for services performed at the same patient encounter"

SPINE

- 72082-72084 “complete spine”= entire thoracic and lumbar spine
  - Cervical/skull/sacrum included if performed thus not coded separately
  - Done for deformity such as scoliosis, kyphoscoliosis
- 72020-72100 series for individual levels may be reported on single encounter if separate levels were ordered and documented
  - Done for disease conditions/trauma

VERTEBROPLASTY/AUGMENTATION

“CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the physician may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not. ”

Bone Length

"CPT code 77073 (Bone length studies...) includes radiologic examination of the lower extremities. CPT codes for radiologic examination of lower extremity structures shall not be reported in addition to CPT code 77073 for examination of the radiologic films for the bone length studies. However, if a separate and distinct radiologic examination with additional films of a specific area of a lower extremity is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI-associated modifier."

- Similar notation for 77075 osseous survey

Foot Imaging

"Since the foot includes the toes and calcaneous bone, CPT code **73630** (radiologic **examination, foot; <u>complete</u>, minimum of 3 views) includes radiologic examination of the toes and calcaneous**. A physician **should not report CPT code 73650** (radiologic examination; calcaneus, minimum of 2 views) **or 73660** (radiologic examination; toe(s), minimum of 2 views) with CPT code 73630 for the same foot **on the same date of service**."

Nuc Med Bone Studies

"Bone studies such as CPT codes 77072-77076 require a series of radiographs. Separate reporting of a bone study and individual radiographs obtained in the course of the bone study is inappropriate."

Breast Biopsy

"If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (e.g., 19281, 19282), the physician shall not separately report a post procedure mammography code (e.g., 77065-77067, G0202-G0206) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure. (HCPCS codes G0202-G0206 were deleted January 1, 2018.)"

MAMMOGRAPHY

“Screening and diagnostic mammography are normally not performed on the same date of service. However when the 2 procedures are performed on the same date of service, Medicare requires that the diagnostic mammography HCPCS/CPT code be reported with modifier GG (Performance and Payment of a Screening and Diagnostic Mammogram on the Same Patient, Same Day) and the screening mammography HCPCS/CPT code be reported with modifier 59 or XU.”

DEXA SCANS

Axial bone density studies may be reported with CPT codes 77078 or 77080. Peripheral site bone density studies may be reported with CPT codes 77081, 76977, or G0130. Although it may be medically reasonable and necessary to report both axial and peripheral bone density studies on the same date of service, NCCI PTP edits prevent the reporting of multiple CPT codes for the axial bone density study or multiple CPT codes for the peripheral site bone density study on the same date of service.

NGS DEXA

- When coding 77080 and 77081 together, attach modifier –XU (Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service) to 77080.

55

ABDOMINAL ULTRASOUND

"Abdominal ultrasound examinations (CPT codes 76700-76775) and abdominal duplex examinations (CPT codes 93975, 93976) are generally performed for different clinical scenarios, although there are some instances where both types of procedures are medically reasonable and necessary. In the latter case, the abdominal ultrasound procedure CPT code should be reported with an NCCI PTP-associated modifier."

56

TRANSPLANTED KIDNEY

- "Ultrasound examination of a transplanted kidney and retroperitoneal structures at the same patient encounter may be reported with CPT code 76770 (Ultrasound, retroperitoneal...; complete). It shall not be reported with CPT code 76776 (Ultrasound, transplanted kidney…) plus CPT code 76775 (Ultrasound, retroperitoneal…; limited)."

GUIDANCE

"Evaluation of an anatomic region and guidance for a needle placement procedure by the same radiologic modality on the same date of service may be reported separately if the 2 procedures are performed in different anatomic regions. For example, a physician may report a diagnostic ultrasound CPT code and CPT code 76942 (Ultrasonic guidance for needle placement...) when performed in different anatomic regions on the same date of service. Physicians shall not avoid edits based on this principle by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits."

GUIDANCE

"CPT codes 76942, 77002, 77003, 77012, and 77021 describe radiologic guidance for needle placement by different modalities. CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations. "

BIOPSY

"Fine needle aspiration (FNA) biopsies (CPT codes 10004-10012, and 10021) shall not be reported with another biopsy procedure code for the same lesion. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the physician shall report only one code, either the biopsy code or the FNA code. (CPT code 10022 was deleted January 1, 2019.)"

PET PET/CT

"Tumor imaging by positron emission tomography (PET) may be reported with CPT codes 78811-78816. If a concurrent computed tomography (CT) scan is performed for attenuation correction and anatomical localization, CPT codes **78814-78816** shall be reported rather than CPT codes 78811-78813. A CT scan for localization shall not be reported separately with CPT codes 78811-78816."

PET PET/CT WITH DIAGNOSTIC CT

- "A medically reasonable and necessary diagnostic CT scan may be separately reportable with an NCCI-associated modifier. If the data set for the diagnostic CT is obtained concurrently on the same PET/CT integrated system where the CT portion of the study is co-registered with the PET images for the purpose of attenuation correction and anatomic localization, the diagnostic CT CPT code may be reported with PET CPT codes 78811-78813 using an NCCI PTP-associated modifier. Under these circumstances, the diagnostic CT CPT code shall not be reported with PET/CT CPT codes 78814-78816".

PET PET/CT WITH DIAGNOSTIC CT

"However, if a data set for the PET/CT for attenuation correction and anatomic localization and a separate data set for the diagnostic CT are **obtained on separate pieces of equipment**, the diagnostic CT CPT code may be reported with CPT codes 78811-78816 using an NCCI PTP-associated modifier."

PET

"Positron emission tomography (PET) imaging requires use of a radiopharmaceutical diagnostic imaging agent. HCPCS codes A9555 (Rubidium Rb-82...) and A9526 (Nitrogen N-13 Ammonia...) may only be reported with PET scan CPT codes 78491 and 78492. HCPCS code A9552 (Fluorodeoxyglucose F-18, FDG,...) may only be reported with PET scan CPT codes 78459, 78608, and 78811-78816."

PET

"Positron emission tomography (PET) procedures include a finger stick blood glucose level. CPT codes 82948 (Glucose; blood, reagent strip) or 82962 (Glucose, blood by glucose monitoring device(s)...) shall not be reported separately for the measurement of the finger stick blood glucose included in a PET procedure."

NUC MED

"CPT codes 76376 and 76377 (3D rendering) are not separately reportable for nuclear medicine procedures (CPT codes 78012-78999). However, CPT code 76376 or 76377 may be separately reported with modifier 59 or XS on the same date of service as a nuclear medicine procedure if the 3D rendering procedure is performed in association with a third procedure (other than nuclear medicine) for which 3D rendering is appropriately reported."

Nuc Med

"Generally, diagnostic nuclear medicine procedures are performed on different dates of service than therapeutic nuclear medicine procedures. However, if a diagnostic nuclear medicine procedure is performed on an organ and the decision to proceed with a therapeutic nuclear medicine procedure on the same organ on the same date of service is based on results of the diagnostic nuclear medicine procedure, both procedures may be reported on the same date of service using an NCCI PTP-associated modifier. A physician shall not report a radiopharmaceutical therapy administration code for the radionuclide administration that is integral to diagnostic nuclear imaging procedures."

Vascular Flow Imaging

"A three-phase bone and/or joint imaging study (CPT code 78315) includes initial vascular flow imaging. CPT code 78445 (Non-cardiac vascular flow imaging...) shall not be reported separately for the vascular flow imaging integral to CPT code 78315."

- "Non-cardiac vascular flow imaging, when performed, is integral to a nuclear medicine procedure. CPT code 78445 (Non-cardiac vascular flow imaging...) shall not be reported with any other nuclear medicine procedure code."

Consulting Radiologists Ltd.

DIAGNOSTIC IMAGING PEARLS

Radiology 101

RADIOLOGY PEARLS

- Bilateral standing AP knees 73565
  - Reported if the only study being performed
    - Supported by both AMA (5.1.15, 2.1.15)and ACR (Fall 2006, Winter 2015)
  - When performed with other views, bill based upon the number of views/knee
  - If performed and reported, must have an interpretation for each knee otherwise it is simply a comparison film which is generally not covered

Consulting Radiologists Ltd.

HIP WITH PELVIS

- 2016 code changes
  - Incorporated pelvis into hip
    - 73501 radiologic examination, hip, *unilateral*, with pelvis **when performed**, 1 view
    - 73502…..2-3 views
    - 73503…..minimum of 4 views
    - 73521 radiologic examination, hip, *bilateral*, with pelvis **when performed**, 2 views
    - 73522….3-4 views
    - 73523….minimum 5 views

HIP WITH PELVIS

- Key is number of views not films
- Pelvis counts as a view
  - Does not have to be done
  - Codes created for consistency, 1 view will never have pelvis done
- Unilateral or bilateral count total number of views NOT views for each side
- When x-rays of pelvis are included, must be documented and should include an interp

HIP WITH PELVIS

- 73501 *radiologic exam hip, unilateral with pelvis when performed, 1 view* is basically misworded
- 73521 *radiologic exam, hips, bilateral with pelvis when performed; 2 views*= bilateral AP OR lateral OR frog lateral, etc. only
- If only x-ray of pelvis done, report pelvis codes 72170 or 72190
- Code descriptions set up to be consistent

HIP WITH PELVIS

- AMA response
- "Q: How is a single view of the hip reported when a view of the pelvis is included?

The correct answer depends simply on counting the number of views performed

If a single view of the hip and a single view of the pelvis are both performed they should be reported with code **73502**, Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views. This is because when a single view of the hip and a single view of the pelvis are performed it consists of 2 views.

HIP WITH PELVIS

AMA response continued

The one view hip code **73501**, Radiologic examination, hip, unilateral, with pelvis when performed; 1 view includes the phrase "with pelvis when performed." Code 73501 is a single view examination and was worded this way to be consistent across the family of hip codes. This service is a single-view hip study that is currently described by both 73500,Radiologic examination, hip, unilateral; 1 view, and 73530, Radiologic examination, hip during operative procedure.

If one were to do a single view of each hip, Code 73521, Radiologic examination, hips, bilateral, with pelvis when performed; 2 views should be reported. If a pelvis view is added, it is now 3 view study, and one should code 73522, Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views."

HIP WITH PELVIS

- "The inclusion of "when performed" in the new hip X-ray (73501-73503 and 73521-73523) code descriptors is included to recognize that some but not all radiographic workups of the hip utilize pelvic X-rays too.
- In the event pelvic X-rays are performed as part of the hip X-ray procedures, separate pelvic X-ray codes (eg.72170, 72190) are not used; rather; the pelvic X-rays are recognized by determining the **total number of views** obtained, which then guides selection of the appropriate hip X-ray CPT code.
- That is, the total number of views is calculated by adding the number of hip views plus the number of pelvis **views**. For example, when one view of a unilateral hip is performed, code 73501 should be reported. However, if the study is performed along with one view of the pelvis, this is a total of two views and, therefore, the correct CPT code to report the study is 73502, Radiologic examinations, hip, unilateral 2-3 views.

HIP WITH PELVIS

- A bilateral hip X-ray study (one view of right hip plus one view of the left hip) with one view of the pelvis is reported with code 73522, Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views.

- Resource: "Clinical Examples In Radiology, Newsletters, 2015-Fall Addition, Article 5, Hip

74022

- Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg. Supine, erect, decubitus), and a single view chest
  - Parenthetical after 71046 For complete acute abdomen series that includes 2 or more views of the abdomen (eg. Supine, erect, decubitus) and a single view chest use 74022)
  - Thoughts driven by views or diagnosis?

Eye for Foreign Body

- 70030 radiologic examination, **eye,** for detection of foreign body
  - Dx Z01.89 encounter for other specified examinations
  - Not scout images
  - ACR believes separately reportable and medically necessary
  - Bilateral yes or no?

Extremity CT

- Question: Is it appropriate to report the upper extremity or lower extremity computed tomography (CT) codes once per joint (ie, codes 73200-73201, 73700-73702)? For example, if CT scans of the right shoulder and elbow joint are performed during the same encounter, is it appropriate to report code 73200 or code 73201 twice on the same date of service?
- Answer: No. When a CT scan of the forearm is performed and then the arm is repositioned to image another joint of the forearm, only one CPT code representing the upper extremity CT scan should be reported. Unlike the magnetic resonance imaging (MRI) codes, the CT code descriptors make no distinction between “extremity joints” and the “extremity other than the joints.” When imaging and documenting three components of the same upper extremity (ie, humerus, radius, or wrist), code 73200, Computed tomography, upper extremity; without contrast material, should be reported only once as only one extremity is imaged. The codes for CT scan of an extremity (codes 73200-73202 or 73700-73702) are unilateral codes; therefore, based on payer requirements, it is appropriate to report the scan code with the appropriate modifier (LT, RT, or -50) appended or with a unit value of 2 when bilateral imaging is performed

Extremity Ultrasound

- 76881 *Ultrasound, **complete** joint (ie. joint space and periarticular soft tissue structures) real-time with image documentation*
  - Muscle, joint, tendons, other soft tissues and any identifiable abnormality in a specific anatomic site of an extremity
- *76882 Ultrasound, **limited,** joint or other nonvascular extremity structure(s) (eg. Joint space, peri-articular tendon(s), muscle(s), nerve(s), other soft tissue structure(s), or soft tissue mass(es), real-time with image documentation*

Extremity Ultrasound

- Require saved images and separate report
- For extremities only
  - Upper=shoulder to fingers includes clavicle and scapula not SC joint
    - Use when only imaging the axilla and not the breast
  - Lower=leg below inguinal ligament
- Cannot bill both complete and limited for same region

EXTREMITY ULTRASOUND

- Bilateral allowed only if pathology in both
- Max 1 complete/joint/extremity/12 months; 4 extremity (limited or complete)/12 months
- Once diagnosis established repetitive studies on the same extremity must be coupled with evidence of the need for treatment decision
- Done by individuals knowledgeable in performance of the test; general supervision by physician
  - Must be able to provide documentation of training

83

ULTRASOUND SOFT TISSUE

Code	Soft Tissue Area
76536	Neck
76882	Extremity
76882	Axilla
76604-52	Chest wall
76604-52	Upper back
76705	Lower back
76705	Abdominal wall
76882	Nerves, peripheral
76857	Pelvic wall
76857	Buttock
76857	Penis
76885	Groin
76857	Perineum
76999	Other soft tissue areas

84

Complete vs Limited Ultrasound

- Complete requires documentation of all of the elements defined in the code or guidelines
  - Documentation or reason for nonvisualization counts
    - Surgically absent
    - Obscured by bowel gas
  - Limited may be billed once per session, not per organ

Appendix Ultrasound

- Depends upon order and clinical circumstances
  - 76705 single quadrant
  - 76700 complete abdomen
  - 76856 pelvic

CRL Consulting Radiologists Ltd.

OB Ultrasound

- When to use it?
  - Done based upon pregnancy assumption going in to the exam
  - Patient is believed to be pregnant by any confirmed method, including a home pregnancy test, considered OB even if no pregnancy seen
  - Retained products of conception is assumed not pregnant and coded as non-OB study
  - Coding is based upon indication not outcome
  - If not known to be pregnant and found to be pregnant it is not an OB US
  - Use non-OB code when indications are not pregnancy related even it patient is pregnant

OB Ultrasound Fetal Anatomic Survey

- 76811 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, **transabdominal** approach; **single or first gestation**
- 76812 … **each additional gestation** (List separately in addition to code for primary procedure)
  - Done for high risk pregnancies
  - Patients at elevated risk of fetal anomalies
  - Generally done by Maternal Fetal specialists
  - If not high risk pregnancy, should be billed as 76805/76810

OB Ultrasound Fetal Anatomic Survey

- Documentation requirements:
  - All elements of 76805 plus detailed fetal anatomy
    - Fetal brain/ventricles
    - Face
    - Heart/outflow tracts and chest anatomy
    - Abdominal organ specific anatomy
    - Number/length architecture of limbs
    - Detailed evaluation of umbilical cord and placenta
    - Other fetal anatomy as clinically indicated
  - All elements must be documented or the reason for non-visualization

OB Ultrasound Biophysical Profile

- 76818 Fetal biophysical profile; with non-stress testing
- 76819 Fetal biophysical profile; without non-stress testing
  - May be assigned in addition to other OB US studies
  - Reported/fetus w/mod 59
  - Required elements:
    - Amniotic fluid
    - Breathing
    - Gross body movement
    - Fine motor movement
      - Each scored from 0-2 for a possible total of 8/8
      - Each element must be documented not just a total score
    - Non-stress testing is done by OB
    - If just AFI report 76815

OB ULTRASOUND FAQ

- When the patient presents with an order for US for bleeding or pain in early pregnancy and no IUP is identified what code should be assigned?
  - 76801 Can I use the OB US codes (positive pregnancy test) when the US identifies an ectopic pregnancy or no pregnancy?
  - Yes
- When a pelvic US is ordered when pregnancy is not known, do I code an OB US or a standard pelvic US if a pregnancy is identified?
  - Based upon the order and the clinical indications

(ACR User's Guide)

DUPLEX

- A vascular ultrasound procedure performed to assess blood flow and the structure of veins and arteries. The term "duplex" refers to two modes of ultrasound: Doppler and B-mode. The B-mode transducer (like a microphone) obtains an image of the blood vessel of interest. The Doppler probe within the transducer measures the velocity and direction of blood flow within the vessel.
- Conventional US views the structure of the blood vessels
- Doppler US views movement and speed through the vessels
- Duplex produces images that can be color coded that shows where blood flow may be blocked

DUPLEX

Per CPT Noninvasive vascular diagnostic Doppler studies (93880-93990) are separately reportable when evaluation of vascular structures is performed using BOTH color and spectral Doppler. When color flow is used only for anatomic structure identification, it is not reported separately but is part of the original study.

DUPLEX

TABLE 1. List of terms that indicate a Doppler examination was performed

Analog velocity	Pulsed Doppler	Spectral Doppler
Bandwidth broadening	Pulsatility	Tardus parvus waveforms
Monophasic	Pulse waveform resistive index	Triphasic
Peak systolic velocity	Spectral analysis	Velocity
Phasicity	Spectral broadening	Duplex Doppler
Power Doppler		

Source: American College of Radiology. 2017 Ultrasound Coding User's Guide.

Resistive Index
Waveform analysis

DUPLEX DOPPLER AND TEST ORDERS

- Should not be added routinely to every ultrasound performed
- Must be medically necessary based upon clinical presentation
- Test design exception
- When there is an order from the referring physician, a detailed explanation by the radiologist in his or her report as to why the Doppler was medically necessary should be documented

Clinical Examples of Radiology Volume 9 Issue 1, Winter 2002

DUPLEX VS PHYSIOLOGIC IMAGING

- Duplex = Imaging
- Physiologic vascular measurements may be performed in conjunction with duplex
- Code both when performed
  - Not all health plans will allow or consider medically necessary
- When coding for a physiologic study it is important that all services listed in the parentheses (eg.) section are performed

NONINVASIVE PHYSIOLOGIC STUDIES

- 93922-93924
  - Bilateral studies
  - Upper or lower 93922-93923
    - Complete/limited
      - Complete 3 or more levels
      - Limited 1-2 levels
  - 93924 lower at rest and treadmill stress

WHAT IF JUST TRANSCUTANEOUS OXYGEN?

CPT Assistant January **2014**

- ***Question:*** *What is the appropriate CPT code to report noninvasive vascular testing performed without an ankle-brachial index (ABI)?*
- **Answer:** CPT guidelines list ankle/brachial indices as a requirement to report codes 93922, 93923, and 93924 when noninvasive vascular diagnostic studies are performed. Therefore, if the testing is performed without an ABI, the unlisted code 93998, Unlisted noninvasive vascular diagnostic study, should be reported.

CPT Assistant June **2012**

- ***Question:*** *When transcutaneous oxygen tension measurement (TCOM) is performed, but no ankle-brachial indices (ABI) are performed, may code 93922 or 93923 be reported?*
- **Answer:** No. CPT guidelines list ankle/brachial indices as a requirement to report codes 93922, 93923, and 93924. Therefore, if no ABI is performed in addition to the TCOM, the unlisted CPT code 99199, *Unlisted special service, procedure or report,* should be reported.
  - Also the response from Dr. Z listserve

Breast Ultrasound

- 76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
  - Requires documentation of all 4 quadrants
  - Axilla alone 76882
- 76642 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited

Stereotactic Guidance

- Considered to be a form of mammography
- If biopsy done with stereotactic guidance, post-procedure mammogram may only be billed if performed on a different machine

Consulting Radiologists Ltd.

PREVENTATIVE SERVICES RADIOLOGY

Radiology 101

LOW DOSE LUNG CANCER SCREENING

- NCD 210.14
- 71271 Low dose CT scan (LCDT) for lung cancer screening
  - Maximum once/year
  - Requires physician order
  - If previous cancer diagnosis must be in remission for 5 years or greater
  - Medicare coverage:
    - Age 50-77 (50-80 for most commercial plans) **AND**
    - Asymptomatic **AND**
    - Tobacco smoking history of at least 20 pack years **AND**
      - Tobacco for Medicare is only cigarettes
    - Current smoker OR quit smoking within the last 15 years

Consulting Radiologists Ltd.

Low Dose Lung Cancer Screening

- 1st scan requires lung cancer screening counseling and shared decision making
- Order must include (Medicare):
  - DOB
  - Actual pack year smoking history
  - Current smoking status OR
  - If former smoker, number of years since quit smoking
  - Statement beneficiary is asymptomatic (no S&S of lung cancer)
  - Ordering provider NPI
- Subsequent order must be furnished during an appropriate visit with a physician or other QHP
- Requires specific radiologist and facility requirements and data reporting

LDCT Lung Cancer Screening

Screening:
- COPD
- Asthma
- Emphysema
- Dyspnea that worsens when laying down
- Shortness of breath without exercise
- Chronic smokers cough
- > 5 years post cancer treatement
- Prior LDLC with Lung-RADS 1-4A
- Cancer diagnosis > 5 years in remission unless ordered by the oncologist, then check with Rad

Diagnostic:
- Any neoplasm/cancer within the past 5 years
- Fever
- Extreme shortness of breath
- Persistent cough
- Coughing up blood (Hemoptysis)
- Acute congestion
- Specific chest pain
- Recurring lung infections(i.e. bronchitis or pneumonia)
- Undergoing cancer treatment
- Prior LDLC with Lung-RADS 4B
- Cancer diagnosis or in remission within past 5 years NOT ordered by an oncologist

SCREENING ABDOMINAL AORTIC ANEURYSM

- 76706
  - Once/lifetime
  - Requires referral for screening from attending physician/PA/NP
  - Must be performed by an authorized provider
  - Under at least one of the following risk categories
    - Family history of AAA male or female, no age requirement
    - Man age 65-76 who as smoked at least 100 cigarettes in his lifetime
    - Manifests other risk factors according to the USPSF (none exist)

SCREENING ABDOMINAL AORTIC ANEURYSM

- Diagnosis
  - Z13.6 encounter for screening for cardiovascular disorders and either
  - The most appropriate tobacco usage code F17.21- **OR**
    - F17.210 Nicotine dependence, cigarettes, uncomplicated
    - F17.211 Nicotine dependence, cigarettes, in remission
    - F17.213 Nicotine dependence, cigarettes, with withdrawal
    - F17.218 Nicotine dependence, cigarettes, w/other nicotine-induced disorders
    - F17.219 Nicotine dependence, cigarettes, w/unspecified nicotine-induced disorders
  - Z84.89 Family history of other specified conditions

DEXA SCANS

- Woman determined to be estrogen-deficient and at clinical risk for osteoporosis based upon medical history and other findings
- An individual w/vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass) or vertebral fracture
- An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to ≥5mg/day of prednisone, for > 3 months
- An individual w/primary hyperparathyroidism
- An individual being monitored to assess the response to or efficacy of an FDA approved osteoporosis drug

DEXA SCANS

- Covered once every 2 years (at least 23 months between)
- May be covered more frequently (11+ months) if:
  - Monitoring for long-term glucocorticoid therapy
  - Confirming baseline BMM to permit monitoring in the future
    - Only covered when performed w/a dual-energy x-ray system on the axial skeleton
  - To assess response to FDA-approved osteoporosis drug therapy until a response has been documented over time
    - Covered only if performed on a dual-energy system

MEDICARE NCD

Radiology 101

RADIOLOGY NCDS

- PET
  - 220.6.13 FDG PET for Dementia and Neurodegenerative Diseases
  - 220.6.17 PET (FDG) for Oncologic Conditions
  - 220.6.19 PET (NaF-18) to Identify Bone Metastasis of Cancer
  - 220.6.20 Beta Amyloid PET in Dementia and Neurodegenerative Disease

PET FDG FOR ONCOLOGIC CONDITIONS

- 1 Initial, 3 subsequent covered for the same cancer dx
  - PI modifier on initial
  - PS modifier on subsequent
  - Additional beyond 3 add KX modifier if meet medical necessity
- Cervix non-covered for initial diagnosis related to initial anti-tumor treatment strategy
- Breast non-covered for initial diagnosis and/or staging of axillary lymph nodes
  - Covered for staging of metastatic disease
  - Covered for all other indications
- Melanoma non-covered for initial staging of regional lymph nodes. All other indications covered

PET FDG FOR ONCOLOGIC CONDITIONS

Tumor Type	Initial Treatment Strategy	Subsequent Treatment Strategy
Colorectal	Cover	Cover
Esophagus	Cover	Cover
Head and Neck (not thyroid, CNS)	Cover	Cover
Lymphoma	Cover	Cover
Non-small cell lung	Cover	Cover
Ovary	Cover	Cover
Brain	Cover	Cover
Cervix	Cover with exceptions *	Cover
Small cell lung	Cover	Cover
Soft tissue sarcoma	Cover	Cover
Pancreas	Cover	Cover
Testes	Cover	Cover
Prostate	Non-cover	Cover
Thyroid	Cover	Cover
Breast (male and female)	Cover with exceptions *	Cover
Melanoma	Cover with exceptions *	Cover
All other solid tumors	Cover	Cover
Myeloma	Cover	Cover
All other cancers not listed	Cover	Cover

Consulting Radiologists Ltd.

MEDICARE LCD

Radiology 101

113

LCD

- Chest x-ray
  - Noridian
- MRI and CT of the head and neck
  - Noridian
  - Palmetto
- MRI lumbar
  - Noridian
- Cardiac Nuc Med
  - CGS
  - First Coast
  - NGS
  - Novitas
  - Palmetto
- Non-invasive vascular studies
  - CGS
  - First Coast
  - NGS
  - Novitas
  - WPS
- Non-vascular Ultrasound
  - NGS
  - Noridian
  - Novitas
  - WPS
- Breast MRI/US
  - CGS
  - NGS

Consulting Radiologists Ltd.

114

LCD Spinal Procedures

- Verbebroplasty/Kyphoplasty
  - CGS
  - First Coast
  - NGS
  - Novitas
  - Palmetto
  - WPS
- Lumbar Epidural
  - NGS
  - Noridian
  - Novitas
  - Palmetto
  - WPS
- Transforaminal
  - First Coast
  - Noridian
  - Novitas
- Facet Injection/Medial Branch Block
  - CGS
  - First Coast
  - NGS
  - Noridian
  - Novitas
  - Palmetto
  - WPS
- Peripheral Nerve Blocks
  - CGS
  - First Coast
  - NGS
  - Noridian
  - Palmetto
  - WPS

115

LCD Therapeutic Injections

- Trigger Point
  - First Coast
  - NGS
  - Noridian
  - Novitas
  - Palmetto
  - WPS
- SI Joint
  - NGS
  - Noridian
- Tendon sheath/ligament
  - NGS
  - Noridian

116

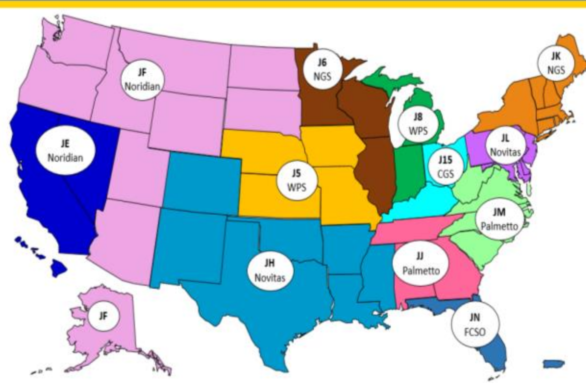
LCD Miscellaneous Radiology

- 3D Reconstruction
  - First Coast
  - Novitas

LCD

- LCD covers frequency, provider qualifications, medical necessity
- Articles provide covered diagnoses, modifiers, documentation

A/B MAC Jurisdictions
as of June 2021



119

RESOURCES

- cms.gov/medicare
- https://www.cms.gov/medicare/national-correct-coding-initiative-edits/ncci-policy-manual-medicare
- AMA CPT ®

120


02/15/2022
Radiology
Consulting Radiologists Ltd.
121

121


Thank You
luvfeet53@gmail.com
Radiology

122