Radiology Coding
Tips & Traps

Melody W. Mulaik
1-877-6-CODING
melody.mulaik@codingstrategies.com

Copyright

The material contained in this presentation and handout are distributed under copyright by Coding Strategies, Inc.

Audio or video taping the presentation, or copying written handout material is strictly prohibited by this copyright.

Copyright 2010, Coding Strategies, Inc.

Today’s Goal
Answer your questions!
CT Coding Risks

- With and w/o studies must have documentation supporting use of IV contrast and pre-contrast slices.
- With and w/o studies at different sessions on the same day are coded with the combined code.
3-D Rendering – 76376/76377

Codes are for 3D only

- 2-D is considered part of the tomography procedure and is not separately reportable.
- Require concurrent physician supervision of image postprocessing 3D manipulation of volumetric data set and image rendering.
- Reported in conjunction with base exam

3-D Rendering

- Documentation should indicate that 3-D rendering was performed (and how)
- Includes:
  - Maximum intensity projection (MIP)
  - Shaded surface rendering
  - Volume rendering

3-D Rendering

- Codes can only be added to CT or MR codes – NOT CTA or MRA
- Orders are strongly recommended
- Medical necessity is required
- Varying payor policies exist as to requirements and coverage
Trailblazer Policy (4X-48AB-R1)

- No more than 20% of the practice’s CTs and MRs should have 3D
- For non-hospital studies, the 3D rendering must be ordered by the treating physician.
- The radiologist’s report must address the specific clinical questions for which the 3D rendering was ordered.
- If 3D is needed urgently and an order cannot be obtained, specific info must be documented.
- Info gained from 3D must not be a duplicate of info gained from prior tests or from 2D exam.

3-D Documentation

Examples:
“Multiplanar 3D rendered images were created from the volumetric source images. This confirms the presence of the described fractures.”
“..AP, lateral, and multiple oblique projections with 3D rotational angiography and reconstruction on a separate workstation demonstrate ... “

Spinal Reformats

- Q: How should reconstructions of the spine obtained from a reformatted CT of the abdomen be reported?
- A: With regard to the physician services... it is appropriate to code for the additional professional services by reporting the appropriate 70000 series CT codes appended by modifier 26.

For technical services 2D is included in the base procedure and should not be separately coded. Assign code for 3-D if performed.
CTA

- Requires 3-D rendering
- Includes reconstruction post-processing of angiographic images of the vessels and interpretation.
- Additional reconstructions are not separately coded.

Clinical Examples in Radiology Volume 4, Issue 4; Fall 2008
CPT Assistant June 2009

CTA

- Evaluation of blood vessels in itself does not make it CTA.
- Key distinction is image postprocessing
  - 3-Dimensional angiographic rendering

CTA

- 3-D rendering includes
  - Maximum Intensity Projection (MIP)
  - Shaded surface rendering
  - Volume rendering
- Permanent images must be kept of the 3D component as well.
- Maintaining axial data set only is not sufficient.
**CTA Includes:**

- Acquisition of localizing (without contrast) and contrast-enhanced (w/contrast) images — Note: w/o contrast images are not always performed depending on the equipment
- 3-D rendering of those images (image post processing)
- Interpretation of both the axial source images and the reconstruction images

---

**Thorax CTA Includes:**

- Interpretation of:
  - Mediastinum
  - Lungs
  - Other structures viewed

---

**Pulmonary Embolism**

- CT or CTA?
  
  *Depends on your protocol*
CTA & CT on same DOS?

- Findings on anatomic CT raises clinical concerns that require a CTA
- If CTA is medically necessary
- New data acquisition is performed
- Both studies may be billed
- This should not occur frequently
- Commercial payor pre-certification guidelines must be followed.

CT Scanogram

- Q: How is CT scanogram performed for leg measurements coded?
  - If only leg measurement – 77073 (scanogram)
  - If a true CT scan is performed then 73700 (CT lower extremity) should be assigned.

CT of the hip joint

- Q: What is the appropriate code to report for CT of the hip joint?
  - A: If only the hip is studied, then the CT lower extremity codes are appropriate (73700-73702), as the hip joint is right at the junction of the pelvis and lower extremity, and either code set (ie, lower extremity codes or pelvis, 72192-72194) would be appropriate. Occasionally, a hip study includes portions of the pelvis, and because the hip is at the junction of the pelvis and lower extremity, it is not appropriate to report 2 separate studies. In this circumstance, it is appropriate to report the pelvis code.
CT Urogram/Cystography

- Q: How are CT urograms and CT cystography (virtual cystoscopy) procedures reported?
- A: These terms have no universal definition so it is recommended that these terms not be utilized in radiology reports. What will be coded will vary by institution depending on what was performed. For example, if a CT abdomen and CT pelvis are done without contrast, the w/o contrast codes should be reported; if a study is performed w/contrast, bill the w/contrast procedure codes. Also, if 3-D is medically necessary and performed, bill the 3-D rendering code as well...

ACR Radiology Coding Source, January/February 2007

CT Urogram/Cystography

- Contrast inserted via a foley catheter is not considered to be a “with contrast” study.
- Foley catheter insertion would only be billed by physician if he/she actually inserted the catheter.

ACR Radiology Coding Source, January/February 2007

CT Myelography

- Performed after spinal contrast injection
- Coded as a CT “with contrast”
- Should also bill injection and either fluoro or traditional myelogram depending on what was performed.
CT Myelography

Example:
- Under fluoro, contrast is injected in the lumbar spine, following which CT lumbosacral myelogram is performed.
  - 62284 – Injection
  - 77003 – Fluoro guidance for injection
  - 72132 – With contrast lumbar CT

CTA Abdominal/Run-Off

- Procedure code 75635
- Includes abdominal aorta and bilateral iliacs and femoral arteries
- Includes pelvic vessels if examined (internal iliacs)
- Pelvic CTA code 72191 is included (bundled) into 75635 and should not be separately coded when both are performed at the same encounter.
Questions related to CT or CTA?

MRA (MRV)

- Includes 3-D rendering
- Includes reconstruction post-processing of angiographic images of the vessels and interpretation.
- Additional reconstructions are not separately coded.
- Only assigned once even if MRA and MRV performed.
MRI Abdomen w/ MRCP

- MRI of the abdomen
  - 74181, 74182, 74183
- 3D reconstruction (must be documented)
  - 76376, 76377

An additional MRI of the abdomen should NOT be reported.
An additional sequence (or two) is considered part of the base procedure.

MRI of the Pelvis – (72195 – 72197)

- Typically includes evaluation of
  - Bladder, prostate, ovaries, uterus, lower retroperitoneum, and iliac lymph nodes
- ACR Bulletin, February 2001
  - Used to report MRI of the sacrum or sacroiliac joint
- Clinical Examples in Radiology, Fall 2006
  - Used to report MRI exam of a fetus

Q / A

- MRI knee performed same session as w/ MRI of the ankle same extremity
  - Lower extremity twice
  - Medical necessity – separate reports
- MRI performed on both hips same session
  - Lower extremity twice
  - Confirm medical necessity vs comparison
- MRI of the “foot”
  - Intent of the study?
MRA Run-Off Study

Assign
- Abdomen 74185
- Lower Extremity 73725 x 2

*Clinical Examples in Radiology Spring 2006*

MR Arthrography

- Performed after joint contrast injection
- Coded as a MR "with contrast"
- Should also bill injection and either fluoro or traditional arthrogram depending on what was performed.

Example:
- Under fluoro, contrast is injected in the shoulder joint, following which MR arthrogram is performed.
  - 23350 – Injection
  - 77002 – Fluoro guidance for injection
  - 73222 – With contrast Upper Extremity MR
MR Arthrography

Example:

- Under fluoro, contrast is injected in the shoulder joint, following which traditional arthrography is performed and then finally an MR study.
  - 23350 – Injection
  - 73040 – Arthrography
  - 73222 – With contrast Upper Extremity MR, joint

Gadolinium

The facility that performs the MRI can bill separately for any contrast material used during the exam.

CMS has issued the following HCPCS codes for gadolinium:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9576</td>
<td>Injection, gadoteridol, (ProHance Multipack), per ml</td>
</tr>
<tr>
<td>A9577</td>
<td>Injection, gadobenate dimeglumine (Multihance), per ml</td>
</tr>
<tr>
<td>A9578</td>
<td>Injection, gadobenate dimeglumine (Multihance Multipack), per ml</td>
</tr>
<tr>
<td>A9579</td>
<td>Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (nos), per ml</td>
</tr>
</tbody>
</table>

Questions related to MR or MRA?
Doppler

- Evaluation of vascular structures using both color and spectral Doppler is separately reportable. However, color Doppler alone, when performed for anatomic structure identification in conjunction with a real-time ultrasound evaluation, is not reported separately.
  - Scrotal/testicular Doppler – protocol?

Pelvis

76830  Echography, transvaginal
76856  Echography, pelvic (non-OB)
- Should have separate paragraphs to justify the coding of both exams
- Both exams should be ordered/approved by the referring physician
Vascular Ultrasound

Duplex scanning is an ultrasonic scanning procedure with display of both 2-D structure and motion with time and Doppler ultrasonic signal documentation with spectral analysis and/or color flow velocity mapping or imaging.

Copyright 2010, Coding Strategies, Inc.

Color Doppler

- Use of a hand-held or any device that does not create hard-copy is not separately reported.
- When performed alone (without spectral Doppler) – not separately reportable.

Copyright 2010, Coding Strategies, Inc.

Vascular Ultrasound

- Physiological studies produce qualitative and quantitative data but do not produce images
  - Doppler w/o B-mode
  - Ankle-brachial index (ABI)
  - Segmental blood pressure measurements
  - Transcutaneous oxygen tension measurements
  - Plethysmography

Copyright 2010, Coding Strategies, Inc.
ABI Studies

- Involves measurement of the blood pressure in both arms and both legs.
- Some Medicare contractors will not cover 93922 if ABI is the only test performed.
- They consider it part of E/M
- Who is referring these studies to you?

Renal Duplex

- Limited (93976) = arteries only
- Complete (93975) must have documentation of arteries and veins
- This applies to all Duplex studies
- Complete = inflow and outflow of 1+ organs

Questions related to Ultrasound?
Nuclear Medicine

- New cardiac codes for 2010
  - Includes wall motion & ejection fraction; does not require it

Nuclear Medicine

- Parathyroid imaging
  - If SPECT performed code both studies
    (78070 + 78803)
Nuclear Medicine

• Don’t forget radiopharmaceuticals and add on codes when appropriate
• Length of study time does not dictate code assignment

Radiopharmaceuticals

• Per study dose
• Sometimes “up to” amount
• Rest and stress = 2 studies so bill x2

Medications

• J codes per mg (0.1, 1, 10, 250)
• If single use vial ensure wastage is billed
Questions related to Nuclear Medicine?

PET Registry?
- Yes: Virtually all scans you perform should be covered
- No: Expanded coverage but still limitations
Framework

- Applies to all oncologic PET and PET-CT Studies

- Studies are divided into 2 categories:
  - Initial treatment (PI)
  - Subsequent treatment (PS)

Initial Treatment (PI)

Determine the physician’s initial treatment strategy when the pt has a solid tumor that is biopsy proven or strongly suspected based on other diagnostic testing.

Previously Diagnosis or Staging

Initial Treatment

Physician must order the study for 1 of the following purposes:

- To determine whether the pt is a candidate for an invasive procedure
- To determine the optimal anatomic location for an invasive procedure; or
- To determine the anatomic extent of the tumor when the treatment recommendations depend on the extent.
**Initial Treatment**

- Only 1 initial treatment scan will be covered per patient, per tumor.

- Add’l scans for initial treatment strategies of same tumor will NOT be covered.

**Restrictions are still in place for:**

- Cervical cancer
- Breast cancer
- Melanoma

- No coverage for prostate cancer – not even through NOPR.

**Subsequent Treatment (PS)**

Performed to guide the physician’s subsequent treatment strategies after the completion of initial treatment.

*Previously Re-staging or Monitoring*
Modifiers

• In addition to PI and PS any scan submitted to NOPR and covered under CED must also have modifier Q0.
• Q0 – Investigational clinical service provided in a clinical research study than is in an approved clinical research study.
• Hospital claims must include diagnosis code V70.7 and condition code 30.

Questions related to PET?
Mammography Orders

- Medicare patient can self-refer for a screening mammogram
- Diagnostic mammograms must be ordered by the treating physician
- Without an order, only a screening study can be done

Order Exception

- If screening study is interpreted while the patient is in the facility and the radiologist believes diagnostic images are needed, no order is required.
- This relates to same day imaging only.

Both Screening & Diagnostic (Same Day)

The –GG modifier must be appended to the diagnostic mammogram

- The performance of additional images is permissible only when the radiologist notes a suspicious finding on the original screening films.
- The radiologist may not examine the patient and order a diagnostic mammogram.
Common Scenario

• Patient arrives with an “incorrect” order.
• Cannot change screening order to diagnostic based on facility’s protocols.
• Payor guidelines do not always match clinical recommendations.

CAD

• Can be used for either traditional mammography or digital
• Extra quality check of images to identify areas of possible abnormalities
• Patient’s presence is not required.

Screening Mammograms

• 77057  Screening mammography, bilateral
• G0202  Direct digital images
• Unilateral screening exam should be coded 77057-52 or G0202-52
• For CAD, add 77052 to either code above (no 52 req’d)
Diagnostic Mammograms

Per ACR standards and most Medicare payors, diagnostic mammography must be performed under direct supervision. Direct supervision means that the physician must be in the area and immediately available to provide assistance and direction throughout the time a treatment is delivered.

Copyright 2010, Coding Strategies, Inc.

Post Procedure Mammo

A post-procedure mammogram may only be billed after an ultrasound, MR or CT guided procedure.

Copyright 2010, Coding Strategies, Inc.

Questions related to Mammography or Breast Procedures?

Copyright 2010, Coding Strategies, Inc.
What Are The Main Issues?

- Number and/or type of views
- Unbundling
- Use of fluoroscopy

Comparison Views

- Comparison views not billable
- Both sides must be ordered
- Considered medically necessary when bilateral conditions or symptoms exist
**Spot Films (PC)**

- What is the purpose of the images?
- Quality Assurance
  - Contract requirement
  - Requested by performing physician?
- If true interpretation then you can bill
  - Plain films
  - RS&I interpretation – modifier 52

---

**Hospital Fluoro Charges**

- If performed procedure includes fluoro by code definition or CCI edits then no separate charge can be generated.
- If not, then either the rad dept or the OR can charge separately but not both.
- Medicare (and many other payors) package all fluoro services

---

**Hospital Fluoro Charges**

- Purpose of charge capture?
  - Productivity? Look for alternative methods
- Spot films can be separately charged according to the number of views.
  - Same area multiple times = 1 view.
Questions related to plain films or use of fluoroscopy?
Modifiers

- Bundling edits
- Who applies modifiers?
- What information do they utilize?
- How is your department involved?

Interventional Services

- Transcatheter Therapies
- Dialysis Access Maintenance
- Other Services?

Compliance

- Orders (Precertification)
- Supervision
- Advance Beneficiary Notices (ABNs)
- MACs (Medicare)
- RACs, MICs
Other

- Dictation concerns
- Other physician concerns?
- ??

Any Questions about Any Area?

This Concludes The Presentation

Thank You!

Melody W. Mulaik
melody.mulaik@codingstrategies.com