Coding Companion for Radiology

A comprehensive illustrated guide to coding and reimbursement
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78205-78206

78205 Liver imaging (SPECT); 78206 with vascular flow

Explaination

Tomographic SPECT (single photon emission computed tomography) imaging permits an in-depth evaluation of the complex anatomy and functional activity of the liver by introducing a radiolabeled sulfur colloid through an injection into a peripheral vein and then detecting the distribution of gamma radiation emitted from the radiopharmaceutical taken up by the reticuloendothelial cells of the liver. SPECT imaging differs from the usual planar scans of the gamma camera by rotating a single or multiple-head camera mounted on a gantry around the patient to give three-dimensional computer reconstructed views of cross-sectional slices of the liver. For imaging done with a vascular flow test, red blood cells are labeled to enable imaging of the blood flow through the liver. Report 78205 for SPECT imaging of the liver without vascular flow and 78206 for SPECT imaging with vascular flow.

Coding Tips

Procedures 78205 and 78206 have both a technical and professional component. To report only the professional component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. For liver imaging with vascular flow, see 78202. According to CPT guidelines, 76376 and 76377 may not be additionally reported when 3D rendering is performed. Contrast media may be reported with 9503, 9510, 9537, 9541 and 9582. Check with the specific payer to determine coverage.

ICD-9-CM Procedural

92.02 Liver scan and radioisotope function study
92.05 Cardiovascular and hematopoietic scan and radioisotope function study

Anesthesia

N/A

ICD-9-CM Diagnostic

155.0 Malignant neoplasm of liver, primary
155.1 Malignant neoplasm of intrahepatic bile ducts
155.2 Malignant neoplasm of liver, not specified as primary or secondary
197.7 Secondary malignant neoplasm of liver
197.8 Secondary malignant neoplasm of other digestive organs and spleen
209.72 Secondary neuroendocrine tumor of liver
211.5 Benign neoplasm of liver and biliary passages
228.04 Hemangioma of intra-abdominal structures
230.8 Carcinoma in situ of liver and biliary system
235.3 Neoplasm of uncertain behavior of liver and biliary passages
239.0 Neoplasm of unspecified nature of digestive system
289.52 Splenic sequestration — (Code first sickle-cell disease in crisis: 282.42, 282.62, 282.64, 282.69)
571.1 Acute alcoholic hepatitis
571.3 Unspecified alcoholic liver damage
571.40 Unspecified chronic hepatitis
571.41 Chronic persistent hepatitis
571.5 Cirrhosis of liver without mention of alcohol — (Code first, if applicable, viral hepatitis (acute) (chronic): 070.0-070.9)
571.9 Unspecified chronic liver disease without mention of alcohol
572.0 Abscess of liver
573.0 Chronic passive congestion of liver
573.3 Unspecified hepatitis — (Use additional E code to identify cause)
573.8 Other specified disorders of liver
574.00 Calculus of gallbladder with acute cholecystitis, without mention of obstruction
574.01 Calculus of gallbladder with acute cholecystitis and obstruction
574.30 Calculus of bile duct with acute cholecystitis without mention of obstruction
574.31 Calculus of bile duct with acute cholecystitis and obstruction
574.60 Calculus of gallbladder and bile duct with acute cholecystitis, without mention of obstruction
574.61 Calculus of gallbladder and bile duct with acute cholecystitis, with obstruction
574.80 Calculus of gallbladder and bile duct with acute and chronic cholecystitis, without mention of obstruction
574.81 Calculus of gallbladder and bile duct with acute and chronic cholecystitis, with obstruction
575.0 Acute cholecystitis
575.12 Acute and chronic cholecystitis
751.60 Unspecified congenital anomaly of gallbladder, bile ducts, and liver
782.4 Jaundice, unspecified, not of newborn
789.1 Hepatomegaly
902.11 Hepatic vein injury
902.22 Hepatic artery injury

CCI Version 18.3

36000, 36005, 36410, 76000-76001, 76376-76377, 76942, 76998, 77001-77002, 78215-78216, 78445, 96360, 96365, 96372, 96374-96376

Also not with 78205: 77750-77778#, 77789-77790#, 78201-78202#, J1642

Also not with 78206: 78201-78202#

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

<table>
<thead>
<tr>
<th>Facility</th>
<th>Non-Fac</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVU</td>
<td>RVU</td>
</tr>
<tr>
<td>78205</td>
<td>6.47</td>
</tr>
<tr>
<td>78206</td>
<td>10.34</td>
</tr>
</tbody>
</table>

MUE | Modifiers

78205 | 1 | N/A | N/A | 80* | with documentation

78206 | 1 | N/A | N/A | 80* |

Medicare References: None

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Appendix

10021-10022
10021 Fine needle aspiration; without imaging guidance
10022 with imaging guidance

Explanation
Fine needle aspiration (FNA) is a percutaneous procedure that uses a fine gauge needle (22 or 25 gauge) and a syringe to sample fluid from a cyst or remove clusters of cells from a solid mass. First, the skin is cleansed. If a lump can be felt, the radiologist or surgeon guides a needle into the area by palpating the lump. If the lump is non-palpable, the FNA procedure is performed under image guidance using fluoroscopy, ultrasound, or computed tomography (CT), with the patient positioned according to the area of concern. In fluoroscopic guidance, intermittent fluoroscopy guides the advancement of the needle. Ultrasonography-guided aspiration biopsy involves inserting an aspiration catheter needle device through the accessory channel port of the echoendoscope; the needle is placed into the area to be sampled under endoscopic ultrasonographic guidance. After the needle is placed into the region of the lesion, a vacuum is created and multiple in and out needle motions are performed. Several needle insertions are usually required to ensure that an adequate tissue sample is taken. CT image guidance allows computer-assisted targeting of the area to be sampled. At the completion of the procedure, the needle is withdrawn and a small bandage is placed over the area. Report 10021 if fine needle aspiration is performed without imaging guidance. Report 10022 if imaging guidance is used to assist in locating the lump.

19030
19030 Injection procedure only for mammary ductogram or galactogram

Explanation
The physician performs an injection procedure for mammary ductogram or galactogram. A cannula or needle is inserted into the duct of the breast. Contrast media is introduced into the breast duct for the purpose of radiographic study. A dissecting microscope may be used to aid in placing the cannula. The needle or cannula is removed once the study has been completed.

19102-19103
19102 Biopsy of breast; percutaneous, needle core, using imaging guidance
19103 percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

Explanation
The physician performs a breast biopsy with image guidance using a percutaneous needle core in 19102, and an automated vacuum assisted or rotating biopsy device, in 19103. In 19102, under image guidance, the physician inserts a large gauge (e.g., 14 gauge), hollow core biopsy needle through the skin of the breast and into the suspicious breast tissue. The physician takes five or more cores of tissue to obtain a sufficient amount of tissue for diagnosis. In 19103, under image guidance, an automated vacuum assisted or rotating biopsy device is inserted through the skin into the suspicious breast tissue and a core of suspect tissue is removed for biopsy. The needle or automated vacuum assisted or rotating biopsy device is withdrawn. Pressure and bandages are applied to the puncture site.

19290-19291
19290 Preoperative placement of needle localization wire, breast;
19291 each additional lesion (List separately in addition to code for primary procedure)

Explanation
Placement of a needle localization wire into a breast lesion is performed to assist in operative identification of the suspect tissue. The physician punctures the skin overlying a breast mass and inserts a needle threaded with a guide wire. Using radiological guidance to facilitate placement, the physician inserts the wire into the mass. Sometimes dye is also injected into the suspect tissue. The wire will help identify a nonpalpable mass that is to be removed from the patient during a separate operative session. Report 19291 for each additional lesion localization wire placed.

19295
19295 Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)

Explanation
The physician places a metallic clip prior to a breast biopsy or aspiration. Using image guidance, the physician places a metallic clip adjacent to a breast lesion to mark the site for a separately reportable breast biopsy or aspiration.

19296-19297
19296 Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy concurrent with partial mastectomy (List separately in addition to code for primary procedure)

Explanation
A remote single or multichannel afterloading expandable catheter for interstitial radiotherapy treatment is placed in the breast following partial mastectomy. A catheter is placed at a later date, separate from the lumpectomy surgery in 19296, and concurrently with the lumpectomy in 19297. This is a single catheter with an expandable balloon tip that holds the radioactive seed or treatment source, which is loaded and removed for each session. The catheter can be single or multichannel, depending on the treatment delivery requirements. During the lumpectomy surgery, an uninflated balloon catheter is inserted into the recently created tumor cavity and positioned under imaging with a portion of the catheter remaining outside of the body. If a separate procedure is done after surgery, a small incision is first made and the uninflated balloon catheter is guided into position under imaging. After correct placement is determined, the balloon is inflated with saline to fit snugly into the lumpectomy cavity, and the breast is bandaged. The catheter remains until radiotherapy treatment sessions are complete.

19298
19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance

Explanation
Using imaging guidance, at the time of a partial mastectomy, or subsequent to a partial mastectomy having been performed, remote afterloading catheters are placed into the breast for interstitial radiotherapy application. The lumpectomy site is identified. A template with pre-drilled holes that function as coordinates for catheter placement around the surgical area may be applied for imaging. Brachytherapy needles are first inserted into the chosen coordinates. The brachytherapy catheters are fed into position through the needles, which are then removed. A catheter button is positioned to hold each catheter in place and imaging confirms their position. These remain in place until the actual loading of the radioactive material for treatment. This code reports only the placement of the catheters.

20220-20225
20220 Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)
20225 deep (eg, vertebral body, femur)

Explanation
The physician usually performs a biopsy on bone to confirm a suspected growth, disease, or infection. The physician normally uses local anesthesia; however, general anesthesia may be used. The
This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $32 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient, presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under “Instructions for Use of the CPT Codebook” on page x of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase “physician or other qualified health care professional” (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privilege (when applicable)” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient’s encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient’s attending physician or other qualified health care provider may not bill a new