Coding Companion for Radiology

A comprehensive illustrated guide to coding and reimbursement
Contents

Getting Started with Coding Companion ................................................. i

Diagnostic Radiology
Head/Neck ................................................................................................. 1
Chest ............................................................................................................... 38
Spine/Pelvis ............................................................................................... 51
Upper Extremities ..................................................................................... 78
Lower Extremities .................................................................................... 92
Abdomen ................................................................................................... 104
GI Tract .................................................................................................... 112
Urinary Tract .......................................................................................... 132
Ob/Gyn .................................................................................................... 144
Heart ......................................................................................................... 148
Vascular .................................................................................................. 152
Other Procedures ...................................................................................... 208

Diagnostic Ultrasound
Head/Neck ............................................................................................... 217
Chest ......................................................................................................... 226
Abdomen/Retroperitoneum ..................................................................... 228
Pelvis ........................................................................................................ 231
Genitalia ................................................................................................. 244
Extremities ............................................................................................. 246
Ultrasonic Guidance .............................................................................. 248
Other Procedures ...................................................................................... 257
Radiologic Guidance .............................................................................. 260
Breast, Mammography ............................................................................ 271
Bone/Joint Studies .................................................................................... 275
Nuclear Medicine — Diagnostic .............................................................. 284
Nuclear Medicine — Therapeutic ............................................................ 364
Noninvasive Vascular Diagnostic Studies ............................................. 366
Appendix .................................................................................................. 379
Evaluation and Management ................................................................. 405
Index ........................................................................................................ 425
Explanation
The physician performs a radiographic study on the veins of a left or right extremity, upper or lower, in 75820 and both the left and right legs or arms in 75822. This type of study is most often performed on the lower extremities as opposed to the arms and commonly involves the femoral vein, described here. A local anesthetic is applied over the site where the catheter is to be introduced. The vein is percutaneously punctured with a needle and a guidewire is fed through the vein to the point where dye will be injected. A catheter is threaded over the guidewire and the guidewire is removed. Contrast medium is injected and a series of x-rays performed to visualize the vessels and evaluate any abnormalities. In venography, contrast medium is injected into the catheter that has traveled to an area upstream of the site under investigation. These codes report the radiological supervision and interpretation only. Use a separately reportable code for the catheterization.

Coding Tips
Procedures 75820 and 75822 have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. For injection procedures, see 36000–36015 or 36400–36510. Contrast media may be reported with Q9955–Q9957. Check with the specific payer to determine coverage.

ICD-9-CM Procedural
88.66 Phlebiotry of femoral and other lower extremity veins using contrast material

Anesthesia
N/A

ICD-9-CM Diagnostic
447.0 Arteriovenous fistula, acquired
451.0 Phlebitis and thrombophlebitis of superficial vessels of lower extremities — (Use additional E code to identify drug, if drug-induced)
451.11 Phlebitis and thrombophlebitis of femoral vein (deep) (superficial) — (Use additional E code to identify drug, if drug-induced)
451.19 Phlebitis and thrombophlebitis of other deep vessels of lower extremities — (Use additional E code to identify drug, if drug-induced)
451.2 Phlebitis and thrombophlebitis of lower extremities, unspecified — (Use additional E code to identify drug, if drug-induced)
451.81 Phlebitis and thrombophlebitis of iliac vein — (Use additional E code to identify drug, if drug-induced)
451.82 Phlebitis and thrombophlebitis of superficial veins of upper extremities — (Use additional E code to identify drug, if drug-induced)
451.83 Phlebitis and thrombophlebitis of deep veins of upper extremities — (Use additional E code to identify drug, if drug-induced)
453.40 Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity
453.41 Acute venous embolism and thrombosis of deep vessels of proximal lower extremity
453.42 Acute venous embolism and thrombosis of deep vessels of distal lower extremity
453.50 Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity — (Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61))
453.51 Chronic venous embolism and thrombosis of deep vessels of proximal lower extremity — (Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61))
453.52 Chronic venous embolism and thrombosis of deep vessels of distal lower extremity — (Use additional code, if applicable, for associated long-term (current) use of anticoagulants (V58.61))
453.89 Acute venous embolism and thrombosis of other specified veins
454.0 Varicose veins of lower extremities with ulcer
454.1 Varicose veins of lower extremities with inflammation
454.2 Varicose veins of lower extremities with ulcer and inflammation
459.2 Compression of vein
729.81 Swelling of limb
996.1 Mechanical complication of other vascular device, implant, and graft
996.62 Infection and inflammatory reaction due to other vascular device, implant, and graft — (Use additional code to identify specified infections)

CCI Version 17.3
01916, 01924-01926, 35201-35206, 35226, 35261-35266, 35286, 36000, 36410, 36500, 75896, 76000-76001, 76942, 76998, 77002, 96360, 96365, 96372, 96374-96376
Also not with 75820: 78456-78458
Also not with 75822: 75820
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

<table>
<thead>
<tr>
<th>Code</th>
<th>Fac RVU</th>
<th>Non-Fac RVU</th>
<th>FUD</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>75820</td>
<td>3.78</td>
<td>3.78</td>
<td>N/A</td>
<td>A</td>
</tr>
<tr>
<td>75822</td>
<td>4.65</td>
<td>4.65</td>
<td>N/A</td>
<td>A</td>
</tr>
</tbody>
</table>

MUE

<table>
<thead>
<tr>
<th>Code</th>
<th>Fac RVU</th>
<th>Non-Fac RVU</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>75820</td>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>75822</td>
<td>1</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

MUE Modifiers

* with documentation

Medicare References: None
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 cleaned. 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 non-palpable 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 radionuclide application following partial mastectomy, includes imaging guidance;
19297 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 radionuclide 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
Evaluation and Management

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 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.

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's office, the outpatient area, or any 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 within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including written orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99222).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported if the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician