Coding Companion for Radiology

A comprehensive illustrated guide to coding and reimbursement
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## Getting Started with Coding Companion

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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 sulphur 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.

**Anesthesia**
N/A

**ICD-9-CM Procedural**

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

571.5 Hepatic glucoin test
571.9 Test of liver, other than glucoin test

571.00 Hepatic glucoin test
571.09 Test of liver, other than glucoin test

571.10 Malignant neoplasm of liver, primary
571.11 Malignant neoplasm of intrahepatic bile ducts
571.12 Malignant neoplasm of liver, not specified as primary or secondary

571.2 Secondary malignant neoplasm of liver
571.3 Secondary malignant neoplasm of other digestive organs and spleen
571.4 Secondary malignant neoplasm of bile duct
571.5 Secondary malignant neoplasm of liver, not specified as primary or secondary

572.0 Abcess of liver
573.0 Chronic passive congestion of liver
573.1 Other specified disorders of liver
573.2 Acute virus hepatitis (acute) (chronic), without mention of obstruction
573.3 Acute hepatic failure without mention of obstruction

573.4 Other specified disorders of liver
573.5 Unspecified alcoholic liver disease without mention of obstruction
573.6 Unspecified chronic hepatitis
573.7 Unspecified hepatic disease, unspecified
573.8 Unspecified hepatic disease, unspecified without mention of obstruction

573.9 Unspecified liver disease, unspecified without mention of obstruction
573.90 Unspecified liver disease, unspecified without mention of obstruction, alcoholic
573.91 Unspecified liver disease, unspecified without mention of obstruction, chronic
573.92 Unspecified liver disease, unspecified without mention of obstruction, not alcoholic
573.99 Unspecified liver disease, unspecified without mention of obstruction, other

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
574.40 Calculus of gallbladder with acute cholecystitis, without mention of obstruction
574.41 Calculus of gallbladder with acute cholecystitis and obstruction
574.50 Calculus of bile duct with acute cholecystitis, without mention of obstruction
574.51 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 and obstruction
574.70 Calculus of gallbladder and bile duct with chronic cholecystitis, without mention of obstruction
574.71 Calculus of gallbladder and bile duct with chronic cholecystitis and obstruction
575.00 Acute cholecystitis
575.12 Acute and chronic cholecystitis
575.60 Unspecified congenital anomaly of gallbladder, bile ducts, and liver
578.4 Jaundice, unspecified, not of newborn
578.91 Hepatomegaly
902.11 Hepatic vein injury
902.22 Hepatic artery injury

**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 Hemangiomata 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 and 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
574.90 Calculus of gallbladder, bile duct, and liver
575.00 Acute cholecystitis
575.12 Acute and chronic cholecystitis
575.60 Unspecified congenital anomaly of gallbladder, bile ducts, and liver
578.4 Jaundice, unspecified, not of newborn
578.91 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, 77750-77779, 77789-77790, 78201-78202, J1642

Also not with 78206, 78201-78205

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

**Medicare Edits**

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</tbody>
</table>

**MUE**

| 78205 | 1 | N/A | N/A | N/A | 80* |
| 78206 | 1 | N/A | N/A | N/A | 80* |

* with documentation

**Medicare References:** None
Appendix to assist in locating the lump. Fine needle aspiration is performed without imaging guidance; the needle is withdrawn and a small guidance allows computer-assisted targeting of the needle insertions are usually required to ensure that and out needle motions are performed. Several of the lesion, a vacuum is created and multiple in guidance. After the needle is placed into the region 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 19021 if fine needle aspiration is performed without imaging guidance. Report 19022 if imaging guidance is used to assist in locating the lump.

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 19021 if fine needle aspiration is performed without imaging guidance. Report 19022 if imaging guidance is used to assist in locating the lump.

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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 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 privileging (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 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