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Straight-Up Radiology Coding

Professional vs. Technical Component

The majority of radiology procedures are comprised of two components – technical and professional

- The technical component includes the provision of the equipment, supplies, personnel and the costs related to the performance of the exam
  - *Technical Modifier – TC*
- The professional component encompasses the physician work in providing supervision and the dictated report
  - *Professional Modifier – 26*

Global Service

- The term "global" service pertains to owning the service – providing both the technical and professional component
  - Global services are seen in a private office setting
  - A technical/professional split is seen in a hospital setting
  - Examples:
    - *Global Billing* *71020*
    - *Professional Billing* *71020-26*
    - *Technical Billing* *71020-TC*

Diagnostic Radiology Coding Rules

- Medical Necessity:
  - The referring physician should provide the Radiologist with a clinical indication why a study is being ordered
  - Examples include: pain, injury, cough, fever, etc.
    - *Pain—Per body part (ankle pain/foot pain)*
    - *Injury—Per body part (ankle injury/foot injury)*
  - The symptoms are appropriate for ordering a diagnostic procedure – These indications should be dictated in the report under a sub-heading of "Clinical Indication"

Diagnostic Radiology Coding Rules…

continued

- Medical Necessity:
  - The Radiologist will interpret a study and dictate his/her findings into the Radiology report
  - The coders will code all positive findings to the highest level of specificity for billing purposes
    - They will be listed from highest degree of severity to lowest
  - If the examination is "negative" or "normal", then the symptoms under the clinical information heading will be coded for the "medical necessity"

Diagnostic Radiology Coding Rules…

continued

- Radiology Coding Issues – Documentation:
  - The same rule holds true for a Radiologist that applies to a Primary Care Physician:

    If its not documented it didn't happen
  - Do *not* code what is *not* documented
  - Radiologists have to realize that the dictated report is the same as a primary care physicians office notes

Diagnostic Radiology Coding Rules…

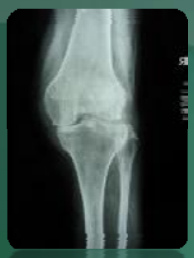
continued

- It is the responsibility of the Radiologist and his/her staff to validate that the clinical indication for the procedure requested is appropriate
- If it is not, the Radiologist should contact the referring physician to verify the test ordered and the clinical indication for the study – he/she should make recommendations for changes if the study is not the appropriate study done based on the clinical indication
- If the referring physician can not be reached, the Radiologist should perform the correct examination and document in his/her report that they tried to reach the office

Diagnostic Radiology Coding Rules…

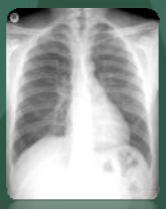
continued

- The number of views, either a number such as a three view or four view study was done, or the name of the actual views performed must be dictated (AP, lateral, oblique, etc.) – the coder can then count the views and attach the appropriate CPT® code to the bill
- Examples:
  - Knee, one or two view
    73560
  - Knee, three views
    73562
  - Knee, Complete 4 or more views
    73564
  - Both Knees – AP Standing
    *73565 – (CCI edit 73565 is bundled into 73564)



Diagnostic Radiology Coding Rules…

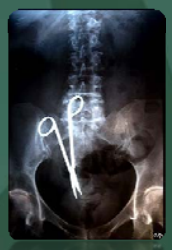
continued



- Chest Single view 71010
- Chest two view – AP and lateral 71020
  - with apical lordotic view 71021
  - with oblique views 71022
  - with fluoroscopy 71023
- Chest 4 views 71030
- Chest Special views 71035

Diagnostic Radiology Coding Rules…

continued



- Abdomen Single view
  74000
- Abdomen, AP and oblique view
  74010
- Abdomen, Comp Inc decubitus and/or erect views
  74020
- Abdomen, comp Inc. supine, erect and/or decubitus, chest single view
  74022

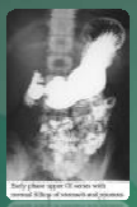
Diagnostic Radiology Coding Rules…

continued

- Spine Lumbosacral, two or three views
  72100
- Minimum of four views
  72110
- Complete including bending views
  72114
- Wrist, two views
  73100
- Complete, minimum of three views
  73110

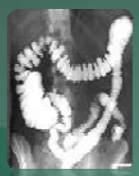
Gastrointestinal Tract

- Contrast -Barium-HD Barium-Air
  - Upper G.I. Series--Single contrast—Barium
    - Generally Includes a Cervical Esophagus study 74210
    - Upper G.I. w/wo delayed films, w/o KUB 74240
    - Upper G.I. w/wo delayed films, with KUB 74241
      with small intestine, multiple serial films 74245
  - Upper G.I. Series – Double Contrast – Barium/Air
    - Double Contrast UGI w/wo delayed w/o KUB 74246
    - Double Contrast UGI w/wo delayed with KUB 74247
      with small intestine follow-through 74249



Barium Enema – Colon studies

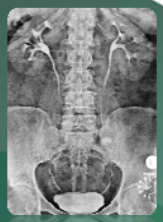
- Contrast—Barium-HD Barium-Air
  - Colon, barium enema, w/wo KUB 74270
  - Colon, Air contrast, with HD Barium 74280
    - w/wo glucagon



Urinary Tract

Urogram or Pyelogram are interchangeable-imaging of the urinary system

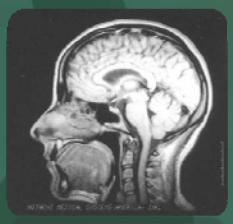
- Urography, IV w/wo KUB, w/wo tomography 74400
- Urography, Infusion, drip and/or bolus inject. 74410
  with nephrotomography 74415
- Urethrocystography (supervision and interpretation requires a modifier 52 because the radiologist is only performing the interpretation part of the exam – modifier 52 shows a reduction for billing)

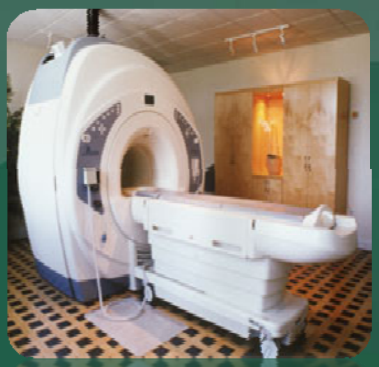


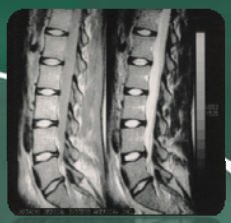
MRI/CT " With or Without Contrast"

- *MRI/CT reports should document whether contrast (dye) was injected.*
  - Site of the I.V. (intravenous) injection,
  - Amount of contrast (# of cc's) injected
  - Name or type of contrast used.
  - Document (I.V. Contrast only for billing)
- Some carriers are unbundling the contrast and paying it separately

MRI IMAGING



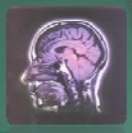




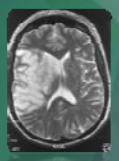
Magnetic Resonance Imaging (MRI)

"With and Without Contrast"

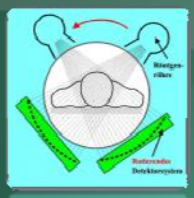
- Examples:
  - Head MRI –Without contrast 70551
  - Head MRI—with Contrast 70552
  - Head MRI—W/O—with Contrast 70553



  - MRA Head W/O Contrast 70544
  - MRA Head With Contrast 70545
  - MRA Head WO/With Contrast 70546



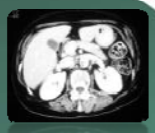
Computed Tomography



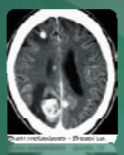
Computed Axial Tomography (CT)

"With or Without Contrast"

- Examples:
  - CT Abdomen w/o Contrast 74150
  - CT Abdomen with Contrast 74160
  - CT Abdomen w/o –with Contrast 74170



  - Head CT w/o contrast 70450
  - Head CT with Contrast 70460
  - Head CT w/o –with Contrast 70470

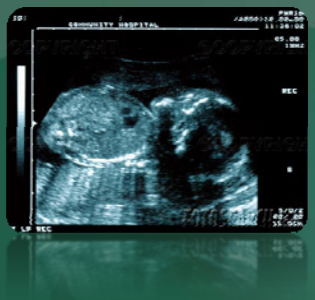


Computed Tomography Angiography (CTA)

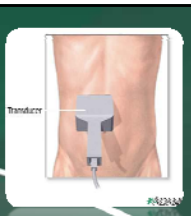
- Example: CPT 71275
  - Computed tomography angiography, chest, with contrast material(s), including non-contrast images, if performed, and image post processing

Note: The dictated technique should document: 3-D reconstructions or image post processing

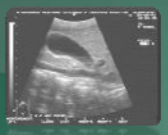
Diagnostic Ultrasound

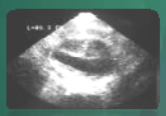


Diagnostic Ultrasound



- All diagnostic studies require a permanent image and/or measurements if clinically indicated
- Examples:
  - Abdomen, complete 76700
  - Abdomen, Limited 76705
  - Retroperitoneum, complete 76770
  - Retroperitoneum, limited 76775
  - Breast, Unilateral and/or Bilateral 76645





Abdominal Ultrasound, Complete

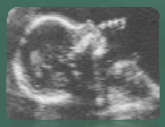
- ***CPT® – 76700***
- Abdomen, Complete – Consists of B-Mode Scans of: liver, gall bladder, common bile duct, pancreas, spleen, kidneys and the upper abdominal aorta and inferior vena cava
- Note: All anatomy listed above must be documented in the report, otherwise, the procedure must coded as "limited" (76705)

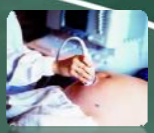
Retroperitoneum, Complete (CPT - 76770)

- Consists of B-mode scans of: kidneys, abdominal aorta, common iliac artery origins and inferior vena cava
- Alternatively, if clinical history suggests urinary tract pathology, complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound
- *If not complete, code as a limited study (76775)*

Diagnostic Ultrasound-Continued

- Examples:



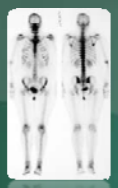


  - Ultrasound, Pregnant uterus, 1st trimester 76801
    - Each additional gestation 76802
  - Ultrasound, Pregnant uterus, after 1st trimester 76805
    - Each additional gestation 76810

Doppler Studies

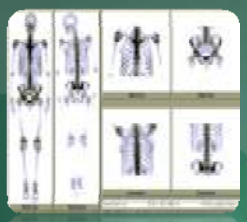
- Vascular Diagnostic Studies (Noninvasive)
  93875 – 93982
- Technique: The following phrase should be included under the technique section of the report – this phrase documents the Doppler part of the study to the payers and/or auditor:
- Spectral Analysis with color flow imaging

Diagnostic Nuclear Medicine



Diagnostic Nuclear Medicine

- These studies do not include the provision of radium or radioelements.
  - Examples:
  - Bone and/or joint, limited 78300
    - multiple areas 78305
    - whole body 78306
    - 3-phase 78315
    - tomographic SPECT 78320



Diagnostic Nuclear Medicine-Continued

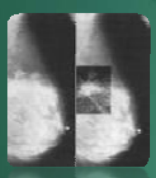
- Kidney imaging, static only 78700
  - with vascular flow 78701
  - with function study (renogram) 78704
- Kidney, with flow, w/o drug intervention 78707
  - with drug intervention 78708

Positron Emission Tomography PET/CT

- CPT® codes 78811- 78816
- Example:
- 78815 Positron emission tomography(PET) with concurrently acquired
- Computed tomography (CT) for attenuation correction and anatomical localization imaging: skull base to mid thigh
- Note: A separate, diagnostic CT scan that is deemed necessary may be reported with a modifier 59

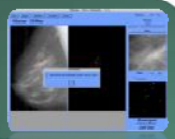
Mammography

- Screening Bilateral Mammography
  - Code 77052 (two views of each breast)
- Diagnostic Bilateral – Code 77056
  - (patient with suspected disease)
- Diagnostic Unilateral – Code 77055

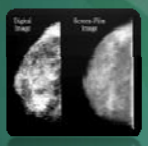


Mammography - Continued

- Computer Aided Detection (CAD)
  - add on code - 77051 Diagnostic Mammography
  - add on code - 77052 Screening Mammography



- Digital Screening Mammo, Bilateral G0202
- Digital Diagnostic Mammo, Bilateral G0204
- Digital Diagnostic Mammo, Unilateral G0206



Modifiers

- 22 – Unusual procedure services - more than CPT® minimum requirement
- 26 - Professional component - S/I Supervision and Interpretation
- 50 - Bilateral services – 70,000 S/I codes only
- 51 - Multiple procedures-same day
- 52 - Reduced services - less that CPT® description
- 53 – Discontinued Services

Modifiers - Continued

- 59 – Distinct/Separate identifiable Procedure-two like procedures – identify separate vascular families
- 76 – Repeat procedure – same doctor, only used on 70,000 S/I codes
- 77 – Repeat procedure – different doctor (same day), only used on 70,000 S/I codes
- Right & Left may be used with 70,000 S/I codes as a descriptor

Billing Rules for the New Coder

- Reminder!!
  - * Submit Correct Claims – Know your Payer
  - * Give them what they want.
  - * Can they see more than one modifier???
- Assign ICD-9-CM code(s)
  - * Code Positive Results to the highest level
  - * Use clinical signs and symptoms if a normal or negative study

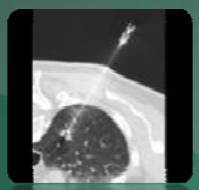
Fine Needle Aspirations

- Fine needle aspiration (FNA) is a percutaneous needle stick thru the skin, usually with a 22 or 25 gauge needle and a syringe, to sample some fluid from a cyst or some cells from a solid mass.

  - Code 10021 FNA w/o Imaging Guidance
  - Code 10022 FNA with Imaging Guidance

Percutaneous Biopsy

- A percutaneous biopsy is when tissue is removed thru a needle (cutting needles) or by a biopsy gun for analysis
  - Examples:
    - Liver 47000
    - Lung 32405
    - Kidney 50200
    - Abdominal 49180



Percutaneous Biopsy - Continued

- Generally, Biopsies will have Imaging Guidance: The Imaging code is added in addition to the biopsy code for billing:
  - Ultrasound Guidance 76942
  - CT Guidance 77012
  - Fluoroscopic Guidance 77002

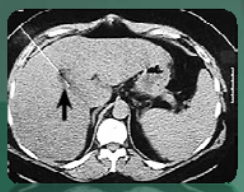
Percutaneous Abscess Drainage

- A drainage catheter is placed thru the skin percutaneously into the abscess with the catheter open to external drainage

- The catheter usually remains in place until the drainage has stopped or until the cavity is gone

Percutaneous Abscess Drainages

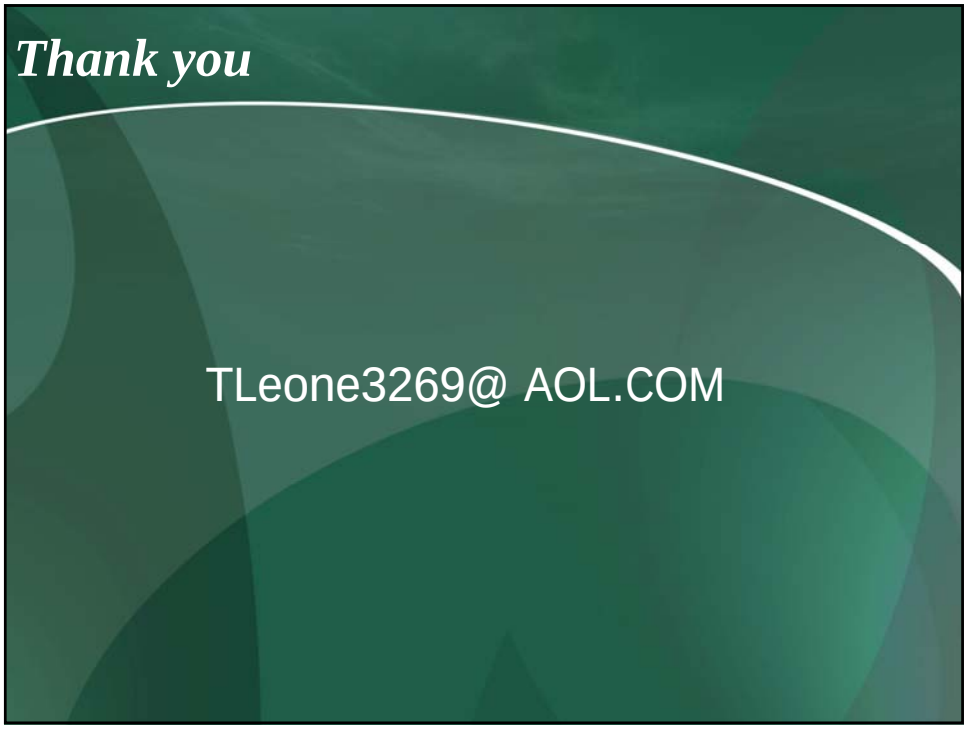
- Examples by site:
  - Abscess Drainage, Lung 32201
  - Abscess Drainage, Appendiceal 44901
  - Abscess Drainage, Peritoneal 49021
  - Abscess Drainage, Subdiaphramatic 49041
  - Abscess Drainage, Retroperitoneal 49061
  - Abscess Drainage, Renal/Perirenal 50021



  - Reminder – Imaging code 75989 would be billed in addition to the above procedures

Percutaneous Abscess - Continued

- Most abscesses are drained under CT guidance – The following rule applies for Imaging Guidance of Abscess drainages:
  - Coding Rule – CPT® 75989 Radiological Guidance is applied whether Fluoroscopy, Ultrasound or CT is used for percutaneous drainage, with placement of catheter, radiological supervision and interpretation


Thank you
TLeone3269@ AOL.COM