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Coding  
Diagnostic Radiology
**Professional versus 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**

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**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, while a technical/professional split is seen in a hospital setting

**Examples**

- 71020-26  **Professional Billing**
- 71020-TC  **Technical Billing**
- 71020     **Global Billing**
Diagnostic Radiology Coding Rules

- Medical Necessity:
  - The referring physician should provide the Radiologist a clinical indication why a study is being ordered: i.e.: pain, injury, cough, fever, etc.
  - Pain - Per body part (i.e: ankle pain/foot pain)
  - Injury - Per body part (i.e: ankle injury/foot injury)

  - The symptoms are appropriate for ordering a diagnostic procedure: These indications should be dictated in the report under the heading under a sub-heading of “Clinical Indication”

Diagnostic Radiology Coding Rules - Continued

- Medical Necessity, continued...
  - 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, from highest degree of severity to lowest
  - If the examination is “negative” or “normal” the symptoms under the clinical information heading will be coded for the “medical necessity”
Radiology Coding Issues
“Documentation”

- The same rule holds true for a Radiologist that applies to a Primary Care Physician - **If it’s not documented it didn’t happen**
- Don’t 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 to be 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 (AP, lateral, oblique, etc.) – must be dictated
  - The coder counts the views and attaches the appropriate CPT code to the bill

Examples:

- Knee; complete, 4 or more views 73564
- ...one or two view 73560
- ...three views 73562
- ...both knees, standing anteroposterior *73565

*CCI edit: 73565 is bundled into 73564

Diagnostic Radiology Coding Rules - Continued

- Chest; single view 71010
- ...two view – AP and lateral 71020
  - with apical lordotic view 71021
  - with oblique views 71022
  - with fluoroscopy 71023
- ...4 views (min.) 71030
- ...special views 71035
Diagnostic Radiology Coding Rules - Continued

Abdomen; single AP view 74000
...AP and oblique/cone views 74010
...complete w/ decubitus and
and/or erect views 74020
...complete w/ supine, erect,
and/or decubitus, chest single view 74022

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

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Gastrointestinal Tract

- Contrast - Barium-HD Barium-Air
  - Upper G.I. Series—Single contrast—Barium
    - Generally includes 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 (reduced services) because the radiologist performs only the interpretation

2/10/2011

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

2/10/2011
Magnetic Resonance Imaging (MRI) “With and Without Contrast”

- Examples:
  - Head MRI - w/o contrast
  - Head MRI - with contrast
  - Head MRI - w/o and with contrast
  - MRA Head w/o contrast
  - MRA Head with contrast
  - MRA Head w/o and with contrast
Computed Tomography

The injection of intravenous contrast is the major factor in the code set, as shown above.

- Head CT w/o Contrast: 70450
- Head CT with Contrast: 70460
- Head CT w/o and with Contrast: 70470

The injection of intravenous contrast is the major factor in the code set, as shown above.
Computed Axial Tomography (CT) “with or without contrast”

Examples:
- CT Abdomen w/o Contrast  74150
- CT Abdomen with Contrast  74160
- CT Abdomen w/o and with Contrast  74170
- CT Pelvis w/o contrast  72192
- CT Pelvis with contrast  72193
- CT Pelvis w/o and with contrast  72194

As of 2011, the above abdomen/pelvis codes stand alone (see the new abdomen/pelvis combination codes)

2011 Combination
CT Abomen and Pelvis Codes

- Abdomen/Pelvis w/o contrast  74176
- Abdomen/Pelvis with contrast  74177
- Abdomen/Pelvis w/o and with contrast  74178

The CPT codes shown above are to be billed when a CT Abomen/Pelvis are performed together
Computed Tomography Angiography (CTA)

Example: 71275

Computed tomography angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image post processing.

Note: The dictated technique should document 3-D reconstructions or image post processing.
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 or bilateral 76645

Abdominal Ultrasound, Complete (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 (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
New Extremity Codes for 2011

- 76881 - Ultrasound; extremity, non-vascular, real-time with image documentation, complete
- 76882 - ...limited, anatomic specific

CPT® 76880 has been deleted.
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

Diagnostic Ultrasound
Female Pelvis

- 76856 - Ultrasound, pelvis (non-obstetrical), real time with image documentation; complete
- 76857  ...limited or follow-up
- 76830 Ultrasound, transvaginal
Doppler Studies

Vascular Diagnostic Studies (Noninvasive)
93875 - 93982

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

- 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

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
  - 77057 (two views of each breast)

- Diagnostic Bilateral
  - 77056 (patient with suspected disease)

- Diagnostic Unilateral
  - 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 (Supervision and Interpretation)
- 50 - Bilateral services (70000 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, e.g., identify separate vascular families)
- 76 - Repeat procedure, same doctor (only used on 70000 S/I codes)
- 77 - Repeat procedure, different doctor, same day (only used on 70,000 S/I codes)
- Right & Left may be used with 70000 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 code(s)
* Code positive results to the highest level
* Use clinical signs and symptoms if a normal or negative study
Thank you

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