Radiology Coding

*Presented by:*
*Ruth Broek, MBA, RT(R), CIRCC, CPC-H, CCS, CHC*

---

Radiology Coding

- **Agenda**
  - Diagnostic Radiology
    - Appropriate coding of problem-prone procedures
    - Use of modifiers in radiology
    - Physician documentation
  - Tips for other modalities
    - Ultrasound
    - Computed Tomography (CT)
    - Magnetic Resonance Imaging (MRI)
Radiology Coding

• Problem prone procedures
  – Fluoroscopy
  – KUBs
  – Extremity imaging
  – Chest X-rays
  – Simple interventions

Radiology Coding

• Fluoroscopy (76000)
  – Designated as a “separate procedure”
  – Bundled into all RS&I procedures
    • Don’t report separately with conventional X-ray of same site
  – Bundled into cardiac catheterizations
Radiology Coding

• Fluoroscopy (76000)
  – Bundled into endoscopies
  – Bundled into most surgical procedures

Radiology Coding

• Fluoroscopy (76000)
  – Don’t use when there is a more specific code (77001, 77002, 72291, etc.)
  – Report RS&I procedures for interventions
Radiology Coding

• Fluoroscopy (76000)
  – Solutions for Radiology Department
    • Transfer staff hours in surgery to surgery department
    • Have line items in RIS for tracking fluoro that don’t bill
    • Don’t report it

Radiology Coding

• When can you code 76000
  – When it is the only imaging performed and not a normal part of the procedure
    • To aid in FB removal/identification
    • To watch diaphragm movement
  – In conjunction with surgical procedures that cross-walk to it
    • Repositioning of a CVC
Radiology Coding

• KUBs
  – Included in gastrointestinal procedures
    • Preliminary KUB included
    • Delayed filming included
  – Included in urinary tract procedures
    • Preliminary KUB included
    • Post-void film included

Radiology Coding

• KUBs
  – Do not use for
    • CT scout films of the abdomen
    • An X-ray following an angiogram to view renal function
Radiology Coding

• Extremity Imaging
  – Do Nots
    • Do not report comparison imaging separately
    • Do not code for additional views
    • Do not need all the finger modifiers
    • Do not need all the toe modifiers

Radiology Coding

• Extremity Imaging
  – Dos
    • Use -52 modifier for 1 view
    • Combine procedures if performed on one “film”
Radiology Coding

• Chest X-ray
  – A PA chest is included in all CVC placements
  – Don’t report an X-ray to confirm location of any tube

Radiology Coding

• Simple Interventions
  – Report both the imaging guidance and intervention performed
    • Instillation of contrast for cystogram (51600)
      – If through an existing catheter append -52
    • Arthrography
      – Report injection procedure separately
        » Wrist is by injection into a compartment
        » Others are unilateral
Radiology Coding

• Simple Interventions
  • Myelography
    – Report injection procedure separately (C1-C2 vs. L4-L5)
    – Report post-myelogram CT as a with contrast study
  • Injection of t-tube for t-tube cholangiogram
  • Injection for hysterosalpingogram/sonohystogram

• Don’ts
  – Report placement of a Foley catheter with a cystogram
  – Report IV infusion or injection services for injecting contrast
  – Code for additional views
Radiology Coding

• Contrast material
  – Specific codes for injectable contrast
    • Separate codes for ionic and non-ionic contrast
    • Codes are designated by iodine content
    • Are to be reported per milliliter of contrast

Radiology Coding

• Documentation
  – Clinical data
    • Reason for the exam
      – ICD-9-CM Diagnosis Coding
        » If there is a finding, code it as principle
        » If it is normal, code presenting symptom(s)
        » If there are incidental findings, code presenting symptom first
        » If there is no presenting symptom use “V” code
Radiology Coding

• Documentation
  – Anatomical area imaged
  – Number of views taken
  – Results
    • If a limited study (-52) why it is limited

Ultrasound Coding

• Ultrasound of transplanted kidney (76776)
  – Includes Duplex Doppler
  – If Doppler not done report limited retroperitoneal (76775) ultrasound
  – Cannot report non-invasive vascular study of pelvic arteries
Ultrasound Coding

- Interventions
  - Report both “surgical” procedure and ultrasound guidance
  - If marking the skin for non-guided aspiration, it is not a guidance

Ultrasound Coding

- Ultrasound Breast
  - Breast screening with US non-covered by Medicare
  - Breast US shouldn’t be routine with mammography
  - Report US CAD with 76999
Computed Tomography (CT) Coding

• Do not report hydration prior to CT separately
• Do not report a TC for images reconstructed from another study
  – Physicians report a PC for reading these reconstructed images

Computed Tomography (CT) Coding

• A code includes all imaging it requires for an anatomical area
  – All vertebrae included in code for that section of the spine
  – Do not report a limited study (76380) as an add-on code
Computed Tomography (CT) Coding

• Report unusual studies as a study of the site imaged
  – CT urogram depends on what is included
• Report “with & without contrast” even if different encounters (same day)

Computed Tomography (CT) Coding

• Imaging of the orbit, sella, posterior fossa or ear are included in head imaging
  – If performed in separate encounters add -59 modifier
• CT guidance for needle placement (77012) is reported once per encounter
Computed Tomography (CT) Coding

• Other Key Rules for CT
  – CT of just the coccyx is a pelvis CT
    • If performed with L/S spine it is included in spine
  – CT of the hip can be CT extremity or CT pelvis
    • Base it on what is being imaged

Computed Tomography (CT) Coding

• Other Key Rules for CT
  – Reporting combined procedures
    • Report the most complex procedure performed
    • With contrast in one area and without contrast in another area is a with & without contrast study
  – CT limited or follow-up study is reported only once
Computed Tomography (CT) Coding

- CT and CTA
  - CT is a “1” NCCI edit with CTA
  - May be reported in special circumstances
    - Performed during separate encounters
    - Two complete distinct studies are performed
  - Append modifier -59 to the CT procedure

Computed Tomography (CT) Coding

- CT and CTA
  - If a single technical study is performed that provides all necessary info for both studies only the CTA should be reported
    - Must have medical necessity for both
    - It should be rare that the two are reported together
  - Same rules apply to MRI and MRA procedures
Magnetic Resonance Imaging (MRI) Coding

- All sequences are included in the base procedure
- Imaging of orbit, face and/or neck (70540 – 70543) includes imaging of one or all
  - Base coding on the contrast utilization in any portion

Magnetic Resonance Imaging (MRI) Coding

- MRI of the TMJ is bilateral
- MRI of internal auditory canals is MRI of the brain
- MRI of the posterior fossa is MRI of the brain
- Report 0159T for CAD of the breast (includes 3-D reconstruction)
Magnetic Resonance Imaging (MRI) Coding

- Report unlisted code 76498 for total body MRI

Magnetic Resonance Imaging (MRI) Coding

- Report MRI joint imaging per joint imaged
- Report non-joint imaging once per extremity imaged
- Joint imaging with intra-articular contrast is a “with contrast”
- Report intra-articular injection of contrast separately
Non-Invasive Vascular

• Noninvasive physiologic studies of upper or lower extremity arteries
  – 93922: 1 - 2 levels bilaterally
    • Unilateral 93922-52
  – 93923: 3 or more levels bilaterally
    • Unilateral : 93923-52

Top Tips

• All imaging to complete the study is included in the procedure – additional codes shouldn’t be reported for additional views/sequences
• CMS rules trump all other guidelines so read the NCCI Manual for Medicare Services
• Use caution when using a -59 modifier to bypass NCCI edits - follow CMS guidelines
• Expect that what we know now, will change next year
Thank You