Radiology Coding

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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)

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Radiology Coding

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

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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

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Radiology Coding

- Fluoroscopy (76000)
  - Bundled into endoscopies
  - Bundled into most surgical procedures

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Radiology Coding

- Fluoroscopy (76000)
  - Don't use when there is a more specific code (77001, 77002, 72291, etc.)
  - Report RS&I procedures for interventions

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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

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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

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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

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Radiology Coding

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

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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

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Radiology Coding

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

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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

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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

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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

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Radiology Coding

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

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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

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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

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Radiology Coding

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

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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

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Ultrasound Coding

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

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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

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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

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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

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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)

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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

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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

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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

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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

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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

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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

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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)

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Magnetic Resonance Imaging (MRI) Coding

- Report unlisted code 76498 for total body MRI

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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

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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

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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

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Thank You