ACR Radiology Coding Source™

May-June 2017 Q and A

Q: What is the appropriate code to report a urologic examination when Digital X-Ray Tomosynthesis (DTS) is used? Several manufacturers produce DTS systems that integrate into fixed or mobile radiographic units or into combination radiographic and fluoroscopic systems to enable tomosynthesis imaging in supine/prone or erect patient positions.

A: It is appropriate to report CPT® code 74400 (Urography (pyelography), intravenous, with or without KUB, with or without tomography) when an intravenous contrast excretion exam using a digital X-ray tomosynthesis (DTS) system is performed. DTS is a series of low-dose projections acquired during a linear sweep of the x-ray tube along the indicated anatomy, while the digital detector remains stationary. Acquired projection data are reconstructed into an array of successive thin-slice images throughout the entire anatomy's depth as compared to a linear tomography sweep which produces a single thick-slice image. DTS thin-slice images are comparable to standard radiography images, but without any overlapping structures from out-of-plane anatomy that impair interpretation on conventional projection images.1

1GE Healthcare

Q: The ACR published in the March/April 2014 ACR Radiology Coding Source that it was appropriate to report 73550 with modifier -52 to describe a one-view evaluation of the femur for an atypical femur fracture assessment that delivers dual-energy bone density measurements in a single-sweep. How should this be reported now that code 73550 has been deleted?

A: A one-view evaluation of the femur for an atypical femur fracture assessment that delivers dual-energy bone density measurements in a single-sweep, as of 2016, is appropriately reported with code 73551 Radiologic examination, femur; one view. In 2016, the femur code 73550, previously recommended, was deleted and replaced by two codes that describe the number of views: 73551 a one-view study, and 73552 a two-view study.

July-Aug 2015 Q and A

Q: MRI always involves "localizer" scans to prescribe any scans, contrast or not. These are generally of limited diagnostic value although usually archived and reviewed as part of the exam. Consequently, no MRI or MRA scans are ever truly done "with contrast" only as they all have at least these (noncontrast) localizers built in. If only localizer scans are done precontrast and the bulk of the diagnostic imaging is done only after contrast administration, would that constitute a "contrast only" MRI/MRA scan? In other words, would a "non-contrast followed by contrast scan" code only apply if additional imaging beyond localizers was done after contrast?

A: It is not appropriate to report a non-contrast study of any type (CT or MR) based on localizer images only. Counting the localizer noncontrast images as sufficient for coding purposes as a noncontrast portion of a "without and with contrast" exam would be inappropriate in the absence of diagnostic sequences performed prior to contrast administration. Specifically, the localizer images are not meant to be used as a noncontrast portion of the examination and should not be coded as such.

Q: Do beneficiary coinsurance and deductible apply to claim lines with 77063 (Screening digital breast tomosynthesis, bilateral [List separately in addition to code for primary procedure])?

A: No, beneficiary coinsurance and deductible do not apply to claim lines with 77063 (Screening digital breast tomosynthesis, bilateral [List separately in addition to code for primary procedure]). The Centers for Medicare & Medicaid Services (CMS) looks at code 77063 only in terms of it being a screening mammogram procedure. In addition, code 77063 is an add-on code to the primary procedure. Therefore, 77063 must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only). In accordance with that policy, beneficiary coinsurance and deductible do not apply to claim lines with code 77063.

Q: Assuming that the reading physician provides all of the necessary documentation criteria, can we charge 76376 or 76377 in addition to the primary procedure for 3-D reconstruction of AP and Lateral X-ray images? All reconstruction performed 100 percent of the time on-site.

A: It is appropriate to report the CPT X-ray code for the body part being examined.

CPT codes 76376 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post-processing on an independent workstation) or 76377(3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation) by their definition require that the original imaging be performed via computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality. The two-view planar x-ray image acquisition as described does not fit into any of these categories and thus the reporting of either of these CPT codes is not appropriate. It would be appropriate, however, to report the increased procedural services modifier (-22) for the additional work of generating and interpreting the reconstructions, if the site wishes to do so.

Q: Does ACR have a recommendation for coding of percutaneous core biopsy of an ovary?

A: It is the consensus of the Economics Committees on Coding and Nomenclature and Interventional Radiology that it is appropriate to use CPT code 49180 (Biopsy, abdominal or retroperitoneal mass, percutaneous needle) plus the appropriate guidance code for the reporting of a percutaneous core biopsy of an ovary.

Nov-Dec 2014 Q and A

Q: Is breast tomosynthesis 3D?

A: Although vendors describe breast tomosynthesis as 3D, 3D is a misnomer. Breast tomosynthesis is not truly 3-D in any sense, and is not the 3D imaging as is done for CT and MR. The ACR has gone to great lengths at the CPT® Editorial Panel and the Relative Value Scale Unit Update Committee meetings to NOT use the terms 2D or 3D for that reason. Breast tomosynthesis is essentially the same as doing a group of tomograms from conventional tomography, which was historically performed as part of an IVP exam, and looking at the individual tomograms in a stacked set. That is not 3-D in the way most of us think about 3D.

Q: Must I use the new XE, XP, XS and XU modifiers in place of modifier 59 as of January 1, 2015?

A: No, you may continue to use modifier 59 during the transitional period that begins on 1/1/2015. CMS will not require the use of the new modifiers until such time as it publishes additional guidance.

As noted in July/August 2014 (https://www.acr.org/Advocacy/Economics-Health-Policy/Billing-Coding/Coding-Source-List/2014/Jul-Aug-2014/New-Specific-HCPCS-Modifiers-to-Define Distinct-Procedural-Services) ACR Radiology Coding Source and as CMS notified the ACR, it will be implementing CR#8863 (Specific Modifiers for Distinct Procedural Services) on January 5, 2015, effective January 1, 2015. CR 8863 states that four new more selective modifiers are available and describes the general situations in which they can be used. However, CR#8863 also noted that, at the present time, modifier -59 may continue to be used. The CR system instructions specify that Medicare edits will initially consider the –X{EPSU} modifiers to be equivalent (interchangeable from an edit perspective) with modifier -59, a situation which will also allow providers time to slowly adjust to the new modifiers. CMS wrote these instructions in order to allow a transition period as additional coding advice and educational programs are developed. As with all codes and modifiers, until such time as additional coding advice is published, providers should take the new modifiers at face value. The –XE modifier, for example, defines a separate encounter, so it should only be used when services provided

at multiple encounters are reported. CMS intends to promote transparency and consistent coding by pairing additional education and guidance with any future edit changes that depend on these new modifiers, so additional guidance on their appropriate use with specific codes and specific situations will be forthcoming.

Q: Is a written order required for tomosynthesis now that there is a billable service?

A: An order for breast tomosynthesis, as described by the new breast tomosynthesis add-on codes, is not required and would fall within the Ordering of Diagnostic Tests Rule exception. However, when breast tomosynthesis is used, the breast tomosynthesis procedure should be documented in the report. The breast tomosynthesis add-on codes fall within the test design exception described in Medicare Benefit Policy Manual, Chapter 15, – Covered Medical and Other Health Services (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf). See section 80.6 for the latest guidelines on the Ordering of Diagnostic Tests Rule.

Q: Is the use of the new breast tomosynthesis codes dependent on the type of equipment used?

A: No, use of the new digital breast tomosynthesis (DBT) codes is not dependent on the type of equipment used.

When the ACR, American Roentgen Ray Society, and Radiological Society of North America's CPT advisors worked with the AMA's CPT Editorial Panel to create the new codes for screening and diagnostic tomosynthesis, the codes were specifically designed to be vendor neutral. If a screening or diagnostic tomosynthesis is performed, it should be reported with the new CPT codes (77061, 77062, 77063) or the new Medicare HCPCS Level II G-code (G0279) for diagnostic tomosynthesis, regardless of which vendor's equipment was used to perform the exam.

In an effort to reduce patient exposure further, each of the manufacturers with current approval of their DBT systems has designed a system that allows the full-field digital mammography (FFDM) planar images to be generated from the multiple small exposures of the DBT system rather than necessitating an additional exposure to acquire a FFDM planar image. Whether a FFDM planar image is derived from a single larger exposure or a series of smaller exposures, it is still a planar mammogram and should be coded as such.

Questions have also arisen regarding the combination of planar mammography and tomosynthesis. When a planar mammogram and a tomosynthesis exam are performed, both the planar mammogram and the tomosynthesis exam should be coded. This is true for both screening and diagnostic exams and is again vendor neutral.

Jan-Feb 2014 Q and A

Q: With the bundling of imaging guidance, specimen and clip placement into the 2014 breast biopsy codes, how do you report a procedure when a radiologist confirms the imaging guidance, specimen and clip placement and the surgeon does the actual biopsy?

A: Bundled codes were not structured to be reported by more than one physician. In 2014 the breast biopsy procedures are to be reported with only a single CPT code now that the surgery, radiological supervision and interpretation, specimen, and clip placement codes are bundled into the new codes. Therefore, only a single provider (National Provider Identifier) can be reported on the CMS-1500 claim form and submitted to the carrier. Per the claim form instructions, the physician submitting the 1500 form certifies that he or she performed the entire service.

If more than one physician submits a bill for the same service, the first claim into the payer is the one that is reimbursed and the second claim is usually denied.

If a radiologist or radiology practice is approached to participate in an arrangement whereby the surgeon does the breast biopsy and the radiologist provides the interpretation, documentation of the arrangement, as well as advice by corporate legal counsel and a malpractice insurer, is critical to ensure the billing arrangement complies with federal and applicable state laws.

Q: Please provide advice regarding the reporting of post-biopsy mammogram, if a biopsy is performed under ultrasound guidance (19083). Following the biopsy, a post-procedure unilateral mammogram is performed in a digital room (G0206). Can I now bill separately for both the ultrasound-guided biopsy and the digital post-procedure mammogram?

A: When a breast biopsy is performed under ultrasound guidance (19083), and the post-procedure mammogram is done in a digital room (G0206), it is appropriate to bill separately for both, the ultrasound-guided biopsy and the digital post-procedure mammogram as different modalities were used for the biopsy guidance and the post-procedural film.

The wording in the 2014 National Correct Coding Initiative (NCCI) narrative now allows the coding of the postprocedural mammogram when a different modality is used for the breast biopsy.as noted in the following:

If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (e.g., 19281, 19282), the physician should not separately report a post procedure mammography code (e.g., 77051, 77052, 77055-77057, G0202-G0206) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure.

Q: How do the Centers for Medicare and Medicaid recommend that breast tomosynthesis procedures be reported for Medicare beneficiaries?

A: As previously noted on the ACR Economics & Health Policy eNews page*, the Centers for Medicare and Medicaid Services (CMS) posted a November 6 FAQ stating that breast tomosynthesis produces direct digital images and, therefore, is appropriately reported using one of the three existing HCPCS codes that describe digital mammography services. They state breast tomosynthesis, and all other types of digital mammography, are described using G0202, G0204, and G0206.

The date practices were notified by their Medicare Administrative Contractor (MAC) is the effective date. We assume that all physicians have now received notice from Medicare contractors indicating they should ONLY report one of the G020X mammography codes when breast tomosynthesis is furnished.

Radiology practices do not need to go back and refund breast tomosynthesis payments prior to the CMS notification. Prior to the posting of the CMS FAQ and its communication to physicians, a decision on coverage and payment was reached by payers, including Medicare contractors, since miscellaneous codes generally require manual adjudication.

Medicare issues an FAQ as the fastest way to get information out to MACs and providers. As Medicare has published this, MACs should be following, and you must bill Medicare according to that guideline.

The ACR strongly disagrees with the CMS recommendation to report only a digital mammography code. The digital mammography codes do not accurately describe the procedure performed or take into consideration the additional work and associated practice expense involved with breast tomosynthesis. Coverage varies from payer to payer based on contracts. As long as your third-party payers maintain it is as a non-covered service you can continue to bill the patient. For example, a few payers cover CT colonography while others don't (including Medicare) so some patients have a screening colonography by CT while most patients have
conventional colonoscopy since that is what is covered.

Note that the ACR, American Roentgen Ray Society, and Radiological Society of North America proposed the designation of specific CPT codes for breast tomosynthesis at the American Medical Association's February 2014 CPT Editorial Panel meeting in Phoenix. If approved by the panel, breast tomosynthesis codes will be available for use by the 2015 CPT code cycle.

*Reference:

ACR Maintains Its Coding Recommendation for Breast Tomosynthesis, ACR Economics & Health Policy eNews, November 14, 2013
Inappropriate to Balance Bill Medicare Patients for Breast Tomosynthesis, ACR Economics & Health Policy eNews, November 26, 2013

Nov-Dec 2013 Q and A

Q: Prior to 2014, there were separate codes for a spring-loaded biopsy device and for a vacuum-assisted or mechanical rotating device. How and why have these been bundled into the new breast biopsy codes?

A: With the Centers for Medicare and Medicaid Services (CMS) requirement for bundling, we were requested by the CPT/Relative Value Scale Update Committee (RUC) Workgroup to collapse the breast biopsy procedures and devices into a single code. When presenting the data to the RUC for valuation, the ACR was required to present the time, intensity, and practice expense for the "typical patient" for those procedures. Because the vacuum biopsy needles have become so common and, in fact, are the most typical biopsy devices used for image-guided breast biopsies, the ACR asserted that those needles were in fact "typical" and all the work, time, and practice inputs that were presented to the RUC to develop the RVUs for these new codes are based on the vacuum needles rather than the spring needles.

The new global reimbursement rate for the biopsy codes is less than the sum of the prior individual code reimbursements. This is the problem with all of the bundling that is being required of all specialties. The ACR and other radiology specialty societies are doing our best to maintain appropriate reimbursement for these procedures in this difficult climate.

Q: If a patient had breast cancer identified several years ago, but the imaging is now negative, are we still required to address the malignancy by using the Physician Quality Reporting System CPT Category II code 3350F, Mammogram assessment category of "known biopsy proven malignancy," documented (RAD)5, in addition to or in place of the 3341F, Mammogram assessment category of "negative," documented (RAD)5 ?

A: According to the ACR's Breast Imaging-Reporting and Data System (BI-RADS®) guidelines, if the current breast exam is negative, a BI-RADS® 1 (negative) code should be assigned, as this study is independent of the previous cancer history. The appropriate CPT II quality data code to report, therefore, is 3341F, Mammogram assessment category of "negative," documented (RAD) 5.

Sept-Oct 2013 Q and A

Q: A urologist utilizes a workstation independent of the ultrasound system when performing a prostate biopsy to create a three-dimensional (3D) model of the prostate from the ultrasound images. This is used to assist with biopsy locations and also to

generate a report noting the location within the prostate for each biopsy taken. The system also stores information for future procedures if necessary. Is code 76377 the appropriate code to report the use of this system in addition to ultrasound code 76942?

A: No, code 76377, 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post processing under concurrent supervision; requiring image postprocessing on an independent workstation, should not be reported in addition to 76942, Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation, to describe the use of a separate workstation to create a three-dimensional (3D) model of the prostate from the ultrasound images.

Three-dimensional reformats from sectional imaging modalities, such as computed tomography and magnetic resonance imaging are created off-line and after the image acquisition. Conceivably, two-dimensional (2D) ultrasound images could be transferred off-line for 3D reformats, but this would require a mechanical rather than a hand-held scanner for positional image registration. Codes 76376 and 76377 describe 3D complex reformatting, which includes shaded-surface rendering, volumetric rendering, maximum intensity projections, fusion of images from other modalities, and quantitative analysis.

Q: The bundled code 37210 for uterine fibroid embolization (UFE) is to be deleted in 2014. What code should be reported in 2014 to describe an elective UFE procedure?

A: Code 37243, (Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction) will replace 37210 in 2014 to describe an elective embolization of the uterine arteries to treat uterine fibroids.

Key to determining the appropriate embolization code is the indication for the study. As noted in the CPT® 2014 guidelines, Code 37243 is used to report embolization for the purpose of tissue ablation and organ infarction or ischemia. This can be performed in many clinical circumstances, including embolization of benign or malignant tumors of the liver, kidney, uterus, or other organs.

There may be overlapping indications for an embolization procedure. The code for the immediate indication for the embolization should be used. For instance, if the immediate cause for embolization is bleeding in a patient with an aneurysm, report 37244. Therefore, in an emergency situation to control uterine artery hemorrhage, it is appropriate to report 37244. Note that the codes for catheter placement, ultrasound for vascular access, and imaging for diagnostic studies may be reported separately with the appropriate modifier (eg, 59) to designate separate

and distinct procedures.

May-Jun 2013 Q and A

Q: Would you please provide coding guidance for the performance of screening and diagnostic breast tomosynthesis studies using the Hologic C-View for reconstruction of a two-dimensional tomosynthesis dataset?

A: The Hologic C-view is new technology that can be used for screening or for diagnostic mammography. When a screening breast tomosynthesis study is performed using the Hologic C-view for reconstruction of a two-dimensional tomosynthesis dataset, it is appropriate to report the unlisted diagnostic procedure code 76499 to describe the breast tomosynthesis study and HCPCS Level II "G" code G0202, Screening Mammography, producing direct digital image, bilateral, all views to describe the reconstruction of the two-dimensional tomosynthesis dataset.

When a diagnostic breast tomosynthesis study is performed using the Hologic C-view for reconstruction of a two-dimensional image set, it is appropriate to report the unlisted diagnostic procedure code 76499 to describe the breast tomosynthesis study and HCPCS Level II "G" code G0204, Diagnostic Mammography, producing direct digital image, bilateral, all views or G0206, unilateral, to describe the reconstruction of the two-dimensional image set.

Computer-aided detection (CAD) can only be applied to full images, not spot films or magnification views. CAD is not yet available for synthetic planar images or for tomosynthesis.

Q: What is the appropriate diagnostic imaging exam for a male >30 y.o. presenting with a clinical abnormality? Our practice routinely performs a bilateral diagnostic exam including bilateral CC, MLO, and unilateral ML or LM for the affected breast. This has been called into question by our coding staff. Similarly, how should an exam for a unilateral diagnostic indication (e.g., breast lump) be coded? Historically, we have coded as a bilateral diagnostic exam, but have recently been asked to change to a unilateral screening for the unaffected breast and unilateral diagnostic for the affected breast coding scheme.

A: When a patient presents with signs and symptoms of breast disease, a diagnostic mammogram of both breasts should be performed and reported. The ACR published a breast imaging FAQ in the July/August 2008 issue of the ACR Radiology Coding Source. As noted in this issue, the Centers for Medicare & Medicaid Services (CMS) National Coverage Determination notes the following definitions for screening and diagnostic mammography:

"A diagnostic mammogram is a radiologic procedure furnished to a man or woman with signs and symptoms of breast disease, or a personal history of breast cancer, or a

personal history of biopsy - proven benign breast disease, and includes a physician's interpretation of the results of the procedure."

"A screening mammogram is a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure. A screening mammogram has limitations as it must be, at a minimum a two-view exposure (cranio-caudal and a medial lateral oblique view) of each breast."

The ACR Practice Guidelines, Section IV, Patient Selection, notes the following.

Diagnostic mammography may be appropriate for patients:

1. With a specific focus of clinical concern including, but not limited to, mass, induration, axillary lymphadenopathy, some types of nipple discharge, skin changes or persistent focal areas of pain or tenderness
2. With a possible radiographic abnormality detected on screening mammography
3. Recommended for short-interval follow-up (e.g., less than one year) for probably benign radiographic concerns as defined by the ACR Breast Imaging Reporting and Data System (BI-RADS®)
4. Whose examination requires direct involvement of the radiologist for special views, breast physical examination, or consultation
5. Who have been treated for breast cancer. At the discretion of the facility, asymptomatic women may undergo screening or diagnostic mammography.

Therefore, whenever a diagnostic study is indicated, it is appropriate to do a diagnostic mammogram on one or both breasts as indicated. It is not appropriate to do a screen of one breast and a diagnostic of the other. In the specific case of a 30-year-old male who presents with a clinical abnormality of the breast, a diagnostic study should be performed. If a patient presents for their annual screen and a breast lump is felt, that is an indication for a bilateral diagnostic study. For biopsy-proven benign breast disease, a diagnostic or screening study may be performed. CMS expanded its definition of diagnostic mammography to include a personal
history of biopsy-proven benign breast disease, thereby allowing the attending physician and the patient the opportunity to determine whether a screening mammogram or a diagnostic mammogram is performed.

Q: Are code(s) available to report a nuclear medicine myocardial sympathetic innervation imaging study?

A: Two Category III CPT codes were developed and are available for reporting myocardial sympathetic innervation imaging as of July 1, 2013. Code 00331T, Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment describes a planar study, and code 0332T, Myocardial sympathetic innervation imaging, planar qualitative

and quantitative assessment; with tomographic SPECT, describes a planar and SPECT study. The quantitative assessment of the heart to mediastinum (H/M) ratio is included in codes 0331T and 0332T and is not reported separately.

The radiopharmaceutical I-123 mIBG, used to perform a myocardial sympathetic innervation imaging study, should be reported with the Healthcare Common Procedure Coding System (HCPCS) Level II code A9582 Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries. It is important to report the radiopharmaceutical codes separately even though there may be no reimbursement. The reporting of radiopharmaceuticals is used in the hospital outpatient prospective payment system and by other payers to set future payments for radiopharmaceuticals.

May-Jun 2012 Q and A

Q: Where can I find the most current evaluation and management guidelines?

A: The latest evaluation and management (E/M) guidelines are posted on the Centers for Medicare and Medicaid Services website under the Medicare Learning Network, Documentation Guidelines for Evaluation and Management (E/M) Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html). Note that providers may use either the 1995 or 1997 version of the documentation guidelines, but not a combination of the two, for a patient encounter.

Q: Can a radiologist in an office setting bill an evaluation and management service in conjunction with a breast MRI procedure (77058, 77059) when the radiologist reviews the findings with the patient?

A: No, a radiologist should not report an evaluation and management (E/M) code when the findings of a breast MRI procedure are discussed with the patient, whether it be in an office or any other setting. Discussing the findings of a diagnostic procedure with the referring physician and/or patient is considered part of the diagnostic procedure.

Radiation oncology and nuclear medicine practices commonly report E/M services, while the vast majority of E/M services in diagnostic radiology occur within the area of interventional procedures. See the January/February 2008 ACR Radiology Coding Source (http://gm.acr.org/Hidden/Economics/FeaturedCategories/Pubs/coding_source/archives/JanFeb08/EvaluationandManagementServicesinRad.aspx) for a discussion of the reporting of E/M services in interventional radiology.

Nov-Dec 2011 Q and A

Q: To report the complete abdominal ultrasound CPT code 76700, CPT requires documentation of eight specific elements, or the reason for nonvisualization. Are

there specific elements which must be documented in a radiology report to report a complete abdominal CT scan?

A: No, unlike abdominal ultrasound, no specific elements have to be described to report a complete CT study of the abdomen. In many, if not most practices, requests for CT examinations are protocoled and tailored to specific clinical indications. Protocols stipulate what anatomical areas need to be imaged in order to answer the clinical question.

As stated in the ACR Practice Guidelines for the Performance of Computed Tomography (CT) of the Abdomen and Computed Tomography (CT) of the Pelvis (http://gm.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/dx/gastro/ct_abdomen_pelvis.aspx), "In general, a CT examination of the abdomen includes transaxial images from just above the dome of the diaphragm to the upper margin of the sacroiliac joints with 5 mm or less slice thickness. In certain cases, it may be appropriate to limit the area exposed and focus only on the area or organs of concern in order to limit the radiation dose. This is especially advised in patients with multiple CT studies and follow-up examinations. The written or electronic request for a CT of the abdomen should provide sufficient information to demonstrate the medical necessity of the examination and allow for its proper performance and interpretation. The accompanying clinical information should be provided by a physician or other appropriately licensed health care provider familiar with the patient's clinical problem or question and consistent with the state's scope of practice requirements."

The same principles apply to CT imaging of other anatomic areas (e.g., chest, pelvis, etc).

Q: How is a DaTscan coded?

A: A DaTscan® is the trademark name for I-123 Ioflupane. This radiopharmaceutical agent (approved by the FDA on January 14, 2011) is used in conjunction with Single Photon Emission Computed Tomography (SPECT) imaging to evaluate patients with suspected Parkinsonian syndromes. I-123 Ioflupane is used to determine the location and concentration of dopamine transporters (DaTs) in the synapses of striatal dopaminergic neurons. It is effective in detecting degeneration of the dopaminergic nigrostriatal pathway, thus differentiating patients with essential tremor from those with presynaptic Parkinsonian syndromes. In some cases, it may assist in distinguishing between some causes of Parkinsonism. I-123 Ioflupane is administered intravenously and SPECT images of the brain are obtained 3-6 hours after injection.

CPT code 78607 [Brain imaging, tomographic (SPECT)] is used to report the SPECT images of the brain, and the HCPCS Level II code A9584 (Iodine I-123 Ioflupane, diagnostic, per study dose, up to 5 millicuries) is used to report the I-123 radiopharmaceutical administered.

Q: A 3-view C-spine study has been ordered and anteroposterior, odontoid, and lateral views were taken. The tip of the odontoid process could not be visualized on the odontoid view, therefore the technologist repeated the view, but this time a Fuch's view to show the tip of the odontoid process was obtained. Now, we have a complete series showing all the anatomy. What is the correct code to report the study described above?

A: The appropriate code to report anteroposterior, odontoid, lateral and Fuch's views is CPT code 72050 (Radiological examination, spine, cervical; minimum of four views), as the Fuch's view is a uniquely different view and not simply a repetition of the odontoid view. A Fuch's, also called the occipito-mental view, is a modified frontal view for imaging the tip of the dens (odontoid process).

Sept-Oct 2011 Q and A

Q: What CPT code should be used to report a lumbar CT performed after discography? Is a CT scan post-discography considered a "with contrast" study?

A: The correct CPT code to report a post-discography lumbar CT study is 72131 (Computed tomography, lumbar spine; without contrast material. The CPT®code book introductory guidelines, p. 361 of the professional edition, Administration of Contrast Material(s), states The phrase "with contrast" used in the codes for procedures performed using contrast for imaging enhancement represents contrast material administered intravascularly, intra-articularly or intrathecally." Therefore, intradiscal administration of contrast does not meet the requirement to report a "with contrast" CT study.

Q: Is it appropriate to report the intra-operative ultrasound CPT® code 76998 in conjunction with a renal angioplasty when the physician uses ultrasound guidance in the OR to access the vessel?

A: No, it is not appropriate to report CPT® code 76998 (Ultrasound guidance, intra-operative) to report the ultrasound guidance used for vascular access when the guidance is performed in the operating room (OR). The appropriate code to report ultrasound guidance to achieve vascular access is 76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure).

Per the ACR's Ultrasound Coding User's Guide 2010, code 76998 is used when ultrasound is utilized in the operating room by the surgeon or ultrasonologist. It is appropriate to report 76998 once, when all the imaging is in the same operative field. If there are several

operative fields, report the code per operative field. Providers should recognize that individual payers may limit coverage in such circumstances.

July-Aug 2011 Q and A

Q: What code(s) should be reported to describe a NaF PET/CT whole body bone scan performed on a PET/CT machine to identify bone metastasis? Will Medicare cover this procedure?

A: The appropriate CPT® code to report a sodium fluoride-18 (NaF) PET/CT whole body bone scan performed on a PET/CT scanner to identify bone metastasis is 78816, Positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization imaging; whole body. Additionally, the appropriate Healthcare Common Procedural Coding System (HCPCS) Level II radiopharmaceutical code A9580, Sodium fluoride F-18, diagnostic, per study dose, up to 30 millicuries, must be reported.

For Medicare reimbursement, under the Centers for Medicare and Medicaid Services (CMS) "coverage with evidence development" through the National Oncologic PET Registry (NOPR) program, the following must be included on the claim:

- Appropriate PET or PET/CT CPT code for the study performed (78811-78816)
- Oncology PET modifier PI (initial treatment strategy) or PS (subsequent treatment strategy)
- Modifier Q0 (Q zero) to identify a facility providing an investigational clinical service in a clinical research study
- Modifier KX with modifier 26 to denote the professional component only. Use of modifier KX confirms that the requirements specified in the medical policy have been met and allows the Medicare administrative contractor to differentiate the study as PET with sodium fluoride-18 (NaF) rather than PET with F-18 fluorodeoxyglucose (FDG).
- Modifier KX is not required for hospital claims, billing globally or billing only the technical component
- Appropriate ICD-9 cancer diagnosis code. Hospital Outpatient Prospective Payment System claims must include diagnosis code V70.7 (examination of participant in clinical trial) in the second diagnosis position and condition code 30 (qualifying clinical trials non-research services provided to all patients, including managed care enrollees enrolled in a qualified clinical trial)
- Radiopharmaceutical HCPCS Level II code A9580

The NOPR program was established in response to CMS' proposal to expand coverage for PET with F-18 FDG to include cancers and indications not currently eligible for Medicare reimbursement. Under CMS's "coverage with evidence development", Medicare reimbursement can be obtained if the patient's referring physician and provider submit

data to a clinical registry managed by the NOPR to assess the impact of FDG-PET imaging on cancer management.

Recently, CMS expanded coverage through the NOPR to include NaF-PET to identify bone metastases and improved health outcomes under "coverage with evidence development." The NOPR launched a registry for NaF-PET similar to the FDG-PET registry and began accepting patients on January 31, 2011.

The NOPR is sponsored by the Academy of Molecular Imaging (AMI) and managed by the American College of Radiology (ACR) through the American College of Radiology Imaging Network (ACRIN).

For more information on PET reporting and the NOPR, go to
www.cms.gov/transmittals/downloads/R2096CP.pdf
(http://www.cms.gov/transmittals/downloads/R2096CP.pdf)
www.cancerpetregistry.org/ (http://www.cancerpetregistry.org/)

Q: Our radiology group would like to know how long they are required to keep radiologic films in the office setting. Are there any special rules for Medicare?

A: Currently, there is no mandate from Medicare regarding film retention in the office setting. As part of Medicare's Conditions of Participation (CoP (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=26ca5672f121461b630071cf6cb6f570&rgn=div8&view=text&node=42:5.0.1.1.1.3.4.6&idno=42)), hospitals are required to retain medical records, which include radiology films, scans and other image records, as well as copies of reports and printouts for a minimum of five years. Conversely, some States may require a longer period for maintaining medical records and radiology films. Although Medicare's CoP apply to hospitals, many outpatient offices and clinics follow the five-year rule unless their State requires a longer retention period. In addition, health care facilities that perform mammograms must follow FDA regulations (http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/ucm110906.ht #s90012), which state mammography films and reports must be maintained a minimum of five years, ten years if no additional mammograms of the patient are performed at the facility, or longer if mandated by the State or local law.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (http://www.hhs.gov/ocr/privacy/hipaa/faq/safeguards/580.html) does not specify a record retention period. However, HIPAA requires covered entities to apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other health information for the period of time the information is maintained.

ACR members are urged to contact their State regarding radiology film and medical record retention requirements.

For more information see Hospital Conditions of Participation, medical record and radiology film retention (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl).

Q: How should a percutaneous breast biopsy procedure be reported if a radiologist provides the guidance and the surgeon places the needle? Should the co-surgeon modifier "62" be used?

A: No, the co-surgeon modifier "62" should not be used if a percutaneous breast biopsy procedure is performed by a surgeon and radiologist. A percutaneous breast biopsy procedure using imaging guidance is reported with either 19102 (Breast biopsy; percutaneous, needle core, using imaging guidance) or 19103 (Breast biopsy; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance) and one of the imaging guidance codes (76942, 77012, 77021, 77031, 77032). Neither 19102 nor 19103 permits the use of a co-surgeon modifier according to the Medicare Physician Fee Schedule (http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage). If the radiologist provides the imaging guidance and the surgeon is providing the needle placement, they should bill the codes accordingly, i.e., the radiologist bills the guidance code, and the surgeon bills the needle placement code.

The Medicare Physician Fee Schedule (http://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage) provides guidance on when the co-surgeon, assistant surgeon, and team surgeon codes can be used. For codes 19102 and 19103 a modifier indicator of 0 (zero) is listed, which indicates a co-surgeon is not permitted for these procedures.

May-June 2011 Q and A

Q: Where can I find additional coding tips on how to assign the appropriate CPT code?

A: All coders are instructed to carefully read the Introduction section and specific guidelines provided within each section of the CPT code book. These sections of the CPT code book provide important information on how to appropriately assign a code, and too many coders fail to review these notes.

Experienced coders, as well as new coders, are advised to review these basic guidelines yearly, as these guidelines change periodically. For example, in 2002 the Instructions for Use of the CPT Codebook section was updated to specify that coders are to select the name of the procedure or service that "accurately" identifies the service performed and not to select a CPT code that merely approximates the service provided. This was a change

to the long-standing practice that advised a coder to choose a code that "most accurately" identifies the procedure performed.

Specific guidelines at the beginning of each section of the CPT code book (eg, Evaluation & Management, Surgery, Radiology, Medicine) help to define when to use the codes within that section. For example, the radiology guidelines (prior to the 70000 series codes) provide additional information on the definition of separate procedures, unlisted services, supervision and interpretation codes, reports, and the administration of contrast. In addition, prior to the listing of the specific codes within the radiology section, additional clarification is given (eg, cardiac magnetic resonance imaging and computed tomography guidelines are provided prior to the 75557-75574 codes; diagnostic ultrasound coding guidelines are provided prior to the 76000 series of ultrasound codes). These guidelines provide important coding details that help the coder determine the appropriate code(s) to choose to describe a particular procedure or service.

Parenthetical statements following a code and descriptor also are provided to prevent errors, but they are not all inclusive. As noted in the CPT 2010 code book, when reporting codes for services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including CPT Assistant and other publications resulting from collaborative efforts of the American Medical Association with medical specialty societies (eg, *Clinical Examples in Radiology*).

The AMA CPT code books are updated yearly and available for purchase in October. Implementation of the new codes and guidelines is effective January 1 of the following year. Be sure not to overlook these important sections of the CPT code book when reviewing the changes for the year, as they offer important coding tips to both the new and veteran coder.

Q: Have the Centers for Medicare and Medicaid Services (CMS) changed their guidelines on the chiropractor exemption for plain film xrays that allows radiologists to order diagnostic tests?

A: Yes, as noted in the January/February 2008 ACR Radiology Coding Source (http://gm.acr.org/Hidden/Economics/FeaturedCategories/Pubs/coding_source/archives/JanFeb08/CMSScrapsChiropractorException.aspx), CMS no longer has a "chiropractor exception" that allows non-treating physicians, such as radiologists, to order diagnostic tests at a chiropractor's request to identify a subluxation of the spine.

Prior to January 1, 2000, the law required that an x-ray confirm the subluxation diagnosis for Medicare to reimburse for chiropractic adjustments to correct subluxations. Radiologists, however, did not qualify under Medicare rules as a treating physician, and chiropractors are not permitted to order x-rays. Therefore, the regulations provided a

"chiropractor" exception. In 2000, the law eliminated the requirement for x-ray confirmation of spinal subluxations; however, the chiropractor exception remained in Medicare rules for eight years. In 2008, CMS acted to align its reimbursement policies with the 2000 statutory change. Consequently, CMS no longer pays for x-rays or other diagnostic tests ordered by a nontreating physician to be used by chiropractors to demonstrate subluxation.

The following language is stated in the Medicare Benefit Policy Manual, Chapter 15 §240.1

"Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of the hands. No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but Medicare coverage and payment are not available for those services."

Jan-Feb 2011 Q and A

Q: The Food & Drug Administration recently approved equipment used for digital breast tomosynthesis. How is digital breast tomosynthesis coded?

A: Currently, there is no CPT code that accurately describes a digital breast tomosynthesis study. Until a code is created, it would be appropriate to report the unlisted diagnostic procedure code 76499. It is not appropriate to report a three-dimensional reconstruction code in conjunction with a full-field digital mammography code.

Q: What code should be reported as the primary code during multiple interventions in the same vascular territory when performing lower extremity arterial endovascular procedures? Is it based on chronology of when interventions are performed, increasing order in the CPT codebook, or intensity as determined by work relative value units (RVU)? For example, in the tibial/peroneal artery, the atherectomy code has a higher RVU than the stent code. So if atherectomy is performed in one vessel and stent in another, which is the primary code?

A: For lower extremity arterial revascularization, the choice of the primary code involving multiple interventions in the same vascular territory should be based on the intensity as determined by the relative value units (RVUs). One should report the highest valued RVU code as the primary code. For example, if a stent is placed in the anterior tibial and an atherectomy performed in the posterior tibial, the atherectomy (37229 – RVU value 14.05) would be the primary code and the stent (37230 – RVU value 13.80)* would be the add-on code.

The introductory notes of the 2011 CPT® codebook, p.208, provide the following coding guidance:

These lower extremity codes are built on progressive hierarchies with more intensive services inclusive of lesser intensive services. The code inclusive of all of the services provided for that vessel should be reported (i.e. use the code inclusive of the most intensive services provided).

The "intensity concept" translates to the RUC value of work and not to the numerical order of the base code in the CPT® codebook. Therefore, the increasing order of intensity for lower extremity arterial endovascular interventions is percutaneous transluminal angioplasty, stent, atherectomy, and stent/atherectomy based on the RUC survey data and the final Centers for Medicare and Medicaid Services work RVU content.

*Errata – The above incorrectly listed the stent add-on code as 37230 with an RVU value of 13.80. The correct stent add-on code is 37234 at an RVU value of 5.50. [Updated 3/10/11]

Q: Is the imaging of the thoracic spine in AP, lateral, and swimmer's views considered a two-view or three-view study?

A: Imaging of the thoracic spine in anteroposterior (AP), lateral, and swimmer's views is considered a three-view study and is appropriately reported by code 72072 (Radiologic examination, spine, thoracic; three views).

Prior to 2001, 72072 described a radiologic examination, spine; thoracic, AP and lateral, including swimmer's view of the cervicothoracic junction. In 2001, code 72072 was editorially revised to specify the number of views versus the types of views to allow greater flexibility in reporting. Code 72072 was revised to describe a three-view study.

The swimmer's view is considered a unique view and not simply an additional lateral view. The main difference between the swimmer's view and other plain views is the way the technologist positions the patient, as both the upper and lower thoracic vertebrae cannot be adequately viewed on the lateral projection. Due to overlying anatomy in the lateral projection (the shoulders), an additional projection (swimmer's view) with different exposure factors must be done to evaluate the upper thoracic spine.

It should be noted that when more than one exposure is necessary to obtain complete coverage for a particular view, it is not appropriate to code for more than the single view.

Nov-Dec 2010 Q and A

Q: The radiology department performed a diagnostic solid lesion biopsy using a smaller gauge needle. A small semisolid specimen was obtained. The pathology department processed this as an "aspirate," as there was not enough solid tissue to make a block. Is the radiology department required to report the aspiration biopsy code based upon the pathologist's processing of the specimen?

A: No, the radiology department is not required to report a biopsy procedure code based upon the way the specimen is evaluated by the pathologist. The selected biopsy code reported by the radiologist should reflect the biopsy technique used for the procedure. Ideally, radiology and pathology should be using consistent terminology; however, there may be circumstances when a core biopsy specimen is sent to pathology for histological evaluation and it may not be possible to process the specimen as intended. As stated in the introductory section of the CPT 2011 codebook, Select the name of the procedure or service that accurately describes the procedure performed, do not select a CPT code that merely approximates the services provided.

Core needle biopsies acquire a core of tissue and are intended for histological evaluation. The core of tissue may be obtained with a needle of any size, such as a small caliber needle or a larger gauge "cutting" needle. Aspiration biopsies may be performed with fine needles or with needles of a larger gauge, but the intent is to obtain only cytologic specimens. Aspirations are usually performed when a fluid-containing structure is sampled, or after the instillation of sterile fluid to facilitate obtaining a specimen.

Q: Can you tell me the supervision level required for CPT® code 74230 (Swallowing function, cineradiography/videoradiography). According to the Centers for Medicare and Medicaid Services' Medicare Physician Fee Schedule, it lists a supervision level of 09 – concept does not apply, as well as a level of 03 - personal supervision. What is the correct supervision level?

A: Supervision levels, as defined in the Medicare Physician Fee Schedule (MPFS), apply to the technical component only. Therefore, be sure to read the technical component (TC) line in determining the type of supervision level required to perform a study. For example, the following is an excerpt from the MPFS listing of supervision levels for 74230:

CPT/MODIFIER/DESCRIPTION	PHYSICIAN SUPERVISION OF DIAGNOSTIC PROCEDURES
74230 Cine/vid x-ray, throat/esoph	09 [Global]
74230 TC Cine/vid x-ray, throat/esoph	03 [Technical]
74230 26 Cine/vid x-ray, throat/esoph	09 [Professional]

As noted above, the MPFS lists the supervision level for three billing line items: global, technical component, and professional component. A supervision level of "03" for the technical component designates that a personal level of supervision is required for code 74230. According to the Centers for Medicare and Medicaid Services, personal supervision

requires the supervising physician to be in attendance in the room during the performance of the procedure. Note that a "09," concept does not apply, is assigned to the global (no modifier) and professional (modifier 26) components.

Q: What supervision level is required for CT and MRI studies?

A: The Centers for Medicare and Medicaid Services require that contrast-enhanced (with contrast) computed tomography (CT) and magnetic resonance imaging (MRI) studies be performed under the direct supervision of a physician. Direct supervision requires that the supervising physician be present in the office suite or facility and immediately available to furnish assistance and direction throughout the performance of the procedure.

The supervision levels for all services are listed in the Medicare Physician Fee Schedule Relative Value Unit file. Supervision levels, as defined in the Medicare Physician Fee Schedule (MPFS), apply to the technical component only.

See the 2011 listing of supervision levels on the CMS website under RVU11A download.

Q: How is a percutaneous cholecystostomy reported as of January 1, 2011?

A: As of January 1, 2011, the radiological supervision and interpretation (imaging) performed in conjunction with a percutaneous cholecystostomy procedure is bundled into code 47490. Therefore, it is not appropriate to report 75989 separately. The AMA CPT 2011 Errata notes that the cross-reference (For radiological supervision and interpretation, use 75989) is listed in error in the CPT 2011 codebook.

Click here for a listing of the AMA's CPT 2011 codebook errata.

July-Aug 2010 Q and A

Q: Is it appropriate to report an MRI brain code for the axial images acquired as part of an MRA study? If not, when is it appropriate to report both brain MRI and brain MRA codes?

A: No, it is not appropriate to report a magnetic resonance imaging (MRI) brain code for the axial source images acquired as part of a magnetic resonance angiography (MRA) study. The axial source images are an integral portion of the MRA examination. While some lesions may be visible on the MRA axial source images, these images are specifically designed to minimize brain parenchymal resolution in order to optimize visualization of the vasculature.

Only when a full and complete brain MRI is performed separate from a full and complete MRA examination (separate data set acquisition) would it be appropriate to report both an MRI and MRA code. When medically necessary, MRI and MRA exams can be

complementary. MRI and MRA of the brain represent separate procedures, each with a distinct anatomic target - the nervous system (extra-vascular) and its vascular system (intra-vascular). The two procedures employ distinctly different imaging protocols, and separate reports are generated. In this instance, the use of modifier 59 is appropriate, even though the distinct anatomic targets are both intracranial in location. As noted in the AMA's Coding with Modifiers guide, in order to use modifier 59, documentation needs to be specific to the distinct procedure or service and be clearly identified in the medical record.1

1Coding with Modifiers: A Guide to Correct CPT® and HCPCS Level II Modifier Usage, Second Edition, Copyright 2006, AMA, p. 173.

Q: We performed discography injections of the lumbar spine at the L1- L2 and L3-L4 levels. What CPT® code(s) is used to report this study? Is it appropriate to report the fluoroscopic guidance code 77003 for the needle injection as well?

A: Injections at the L1-L2 and L3-L4 levels of the lumbar spine for discography are appropriately reported with code 62290 (Injection procedure for discography, each level; lumbar). The associated imaging code 72295 (Discography, lumbar, radiological supervision and interpretation) also should be reported. Both the surgical (62290) and radiological supervision and interpretation (72295) codes should be reported twice – once for each level injected and studied.

No, it is not appropriate to report the fluoroscopic guidance code 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, Transforaminal epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction), as the work for fluoroscopy has been valued into the discography imaging codes 72285 and 77295.

For cervical and thoracic discography, see codes 62291 and 72285.

References:
CPT Assistant, Nov 99:35, 40; Apr 03:27
CPT Changes: An Insider's View 2000
ACR Radiology Coding Source, March/April 2006

Mar-Apr 2010 Q and A
Q: How is an MRI of only the brachial plexus reported?

A: As noted in a coding Q&A in the February 2001 ACR Bulletin, the consensus of the Economics Committee on Coding & Nomenclature is that the choice of the appropriate CPT code for a magnetic resonance imaging (MRI) study of the brachial plexus depends

significantly on the clinical indications. For example, an MRI of the chest, focusing on the brachial plexus, is most commonly used in cases of apical lung cancers (Pancoast tumors), while an MRI of the orbit, face and neck may be used to identify head and neck cancers to the level of the thyroid, including the brachial plexus. In the evaluation of a tumor of the shoulder girdle or axilla, including the brachial plexus region, or in the evaluation of a patient with a brachial plexopathy (a non-specific symptom related to the nerve itself that might require imaging), an MRI of the upper extremity would be appropriate.

Q: The physician diagnosed and treated two different obstructions through two separate arteriovenous accesses, one at the arterial anastomosis and one in the subclavian vein. Is this reported with two percutaneous transluminal angioplasties (PTAs), one arterial and one venous, or only a venous PTA?

A: All balloon angioplasty of the arteriovenous (AV) dialysis access is coded with one set of angioplasty codes, no matter how many focal stenoses are treated within the AV dialysis circuit. The majority of the time, this is a venous angioplasty code, and would be reported using 35476 and 75978. However, as in this case, if the stenosis in the AV fistula or graft that is treated is at the arterial anastomosis, it may be coded with arterial angioplasty codes 35475 and 75962. This code would then apply to all other stenoses treated within the AV dialysis "vessel." In other words, all angioplasty within the AV dialysis circuit (considered from the peri-anastomotic vessels near the arterial anastomosis through the axillary vein), would be coded with either 35475 and 75962 or 35476 and 75978. The appropriate code is chosen dependent upon whether a true arterial anastomotic stenosis is treated. Removal of the arterial "plug" occlusion is never coded with a PTA as it is considered to be part of the thrombectomy (coded 36870), not as treatment of an arterial stenosis with angioplasty.

In addition, in this case the angioplasty of a separate subclavian vein stenosis, is reported using CPT codes 35476 and 75978. All lesions treated in the central veins beyond the axillary venous segment would be coded as a single venous angioplasty, indeterminate of how many focal lesions are treated. For therapeutic purposes, the fistula or graft "vessel" is defined as from the arterial anastomosis through the venous anastomosis, as well as the outflow vein, but not including the subclavian vein. Therefore, the venous angioplasty of a central vessel (e.g., the subclavian vein) is appropriately reported in addition to the angioplasty of the fistula graft itself. The clinical indication for treatment of these lesions should be clearly documented in the medical record.

Please note that there are National Correct Coding Initiative (NCCI) edits for the reporting of CPT codes 35475 and 35476 for procedures performed on the same day of service. A modifier (-59) must be used to ensure appropriate reimbursement

Jan-Feb 2010 Q and A

Q: Can you please explain the difference between CPT codes 36147, 36148 and 75791? The code descriptors are similar and it is difficult to understand the appropriate use of each code.

A: Code 36147 is reported when the physician performs a fistulagram to evaluate a dialysis arteriovenous fistula or graft. This code includes all components of the fistulagram, including the work of the initial puncture into the graft or fistula and all of the necessary imaging from the arterial anastomosis through the entire venous outflow – including the central veins and superior or inferior vena cava. This code also includes all of the catheter manipulation to perform the diagnostic examination, including advancement of the catheter to the cava if necessary to fully visualize the central veins.

Code 36148 was established to describe the placement of a second (additional) access that may be necessary to perform a therapeutic procedure (e.g., percutaneous transluminal angioplasty, thrombolysis). Please note that code 36148 is an add-on code that is reported only in conjunction with code 36147.

Code 75791 is reported to describe the imaging of the arteriovenous dialysis fistula or graft performed through an existing access (e.g., patient presents from the dialysis suite with needles placed into the graft or fistula, or from a remote access such as the femoral artery that is not a direct puncture to the graft, or images from an operative angiogram that are submitted for interpretation only). The imaging includes the entire length of the graft or fistula and all of the outflow veins through the central veins, including the vena cava.

Q: The physician diagnosed and treated two different obstructions through two separate accesses — one at the venous anastomosis and one in the subclavian vein. Is this reported with two percutaneous transluminal venous angioplasties (PTAs) or only one?

A: All balloon angioplasties performed to the arteriovenous (AV) dialysis fistula or graft are coded with one set of angioplasty codes (35476, 75978), no matter how many focal stenoses are treated within the AV dialysis circuit. All lesions treated in the central veins beyond the axillary vein are coded as a separate venous angioplasty, regardless of how many focal lesions are treated.

For therapeutic purposes, the fistula or graft "vessel" is defined as extending from the arterial anastomosis, through the venous anastomosis, and including the outflow veins to the junction of the axillary or cephalic vein and subclavian vein. Therefore, the venous angioplasty of a central vessel (e.g., the subclavian vein) is appropriately reported separately in addition to the angioplasty of the fistula itself. The clinical indication for treatment of these lesions should be clearly documented in the medical record.

Q: If a physician places an access to the dialysis arteriovenous fistula or graft and advances the catheter for selective catheterization into a venous collateral of the extremity, does code 36147 include the selective catheter placement or should the selective catheterization be reported separately?

A: The new bundled code 36147 (Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access…) includes all catheterization within the circuit; however, selective catheterization within branch draining veins off the circuit is NOT bundled into code 36147 and is separately reportable. If the collateral vein is subselected for a clinical purpose (described in the operative report), it may be reported separately. In this case, the selective venous catheterization and the imaging are reported using CPT codes 36011 [Selective catheter placement, venous system; first order branch (e.g., renal vein, jugular vein)] and 75791 (Angiography, arteriovenous shunt (e.g., dialysis patient fistula/graft) complete evaluation of dialysis access…). Because a more selective catheterization code (36011) is reported, one no longer reports 36147.

Q: When a patient comes to the Interventional Radiology suite for radiological evaluation of the fistula or graft with an existing access (e.g., needles placed in dialysis unit), and based on the findings a second access is necessary to perform a therapeutic procedure, what are the correct code(s) to report?

A: When a patient comes to the Interventional Radiology suite for radiological evaluation of the fistula or graft with an existing access in place and, based on the findings, a second access is necessary to perform a therapeutic procedure, the correct code to report for the access to the dialysis fistula graft is 36147 (Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access…). This is considered a single new access, not an additional access. Because CPT code 36147 includes all of the necessary imaging for the diagnostic radiological evaluation of the fistula graft, the initial imaging performed to the existing access is not reported separately. In this scenario, it is inappropriate to report add-on code 36148 (Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention…) as this code is reported only in
conjunction with code 36147.

Nov-Dec 2009 Q and A

Q: An orthopedic surgeon ordered an MRI of the knee for use in prosthetic design and for the design of custom cutting jigs. An interpretation is not necessary. However, the hospital requires that the radiologist render an interpretation. Is it appropriate for the radiologist to report the professional component of the MRI study when an interpretation is rendered?

A: When magnetic resonance imaging (MRI) scans of the knee are performed and exported for prosthesis design and/or for the design of custom cutting jigs without a request for an

interpretation, it would be appropriate for the entity that owns the equipment to report only the technical component of CPT code 73721, 73722, or 73723 (Magnetic Resonance Imaging, any joint of the lower extremity) based on whether or not contrast was administered. In this scenario, no professional component (PC) should be charged. If, however, an interpretation of the study is requested, and the medical necessity of the procedure is substantiated with an order from the referring physician, then the professional component of the appropriate CPT code (73721-73723) should be reported by the radiologist that renders the interpretation.

Q: What HCPCS Level II code is used to report the contrast agent Eovist® used for an MRI study of the liver?

A: As of January 1, 2010, the Centers for Medicare and Medicaid Services (CMS) has established A9581 (Injection, gadoxetate disodium, 1 ml) to report the gadolinium-based contrast agent Eovist® used in the performance of a contrast-enhanced MRI study of the liver to detect and characterize lesions in adults with known or suspected focal liver disease.

The Healthcare Common Procedure Coding System (HCPCS) Level II code A9581 should be reported in both the hospital and nonhospital settings. Eovist® (gadoxetate disodium) has been identified as a new drug and is, therefore, on the Hospital Outpatient Prospective Payment System (HOPPS) pass-through list until 2013. Under HOPPS, codes that appear on the pass-through list are paid separately and not bundled into the ambulatory payment classification (APC) code. Once a code is taken off the pass-through list, payment under HOPPS is bundled into the APC payment for the procedure code and is not paid separately.

Because payment for drugs and radiopharmaceuticals under HOPPS is bundled into the procedure code for those items not on the pass-through list, it is extremely important to report and charge separately for drugs and radiopharmaceuticals even though they may not trigger additional payment, as this charge data is used by the HOPPS and by other payers to determine and set current and future payments. Potential loss of this valuable charge data could jeopardize future appropriate bundled payments.

Q: In the September/October ACR Radiology Coding Source it was noted that it would not be known whether or not the HCPCS codes G0392 (AV fistula or graft arterial) and G0393 (AV fistula or graft venous) would be deleted. Have these codes been deleted for 2010?

A: Yes, the Centers for Medicare and Medicaid Services (CMS) verified in the Hospital Outpatient Prospective Payment System (HOPPS) Final Rule the deletion of percutaneous transluminal angioplasty codes G0392 (AV fistula or graft arterial) and G0393 (AV fistula or graft venous). In place of these HCPCS “G” codes, CPT code 35475 (Repair arterial blockage) and code 35476 (Repair, venous blockage) should be reported. These

procedures will be covered surgical procedures in the Ambulatory Surgical Center (ASC) setting for CY 2010.

A percutaneous transluminal angioplasty of an arterial AV fistula or graft should be reported with 35475 for the procedure and 75962 for the imaging. For a venous AV fistula or graft angioplasty, report code 35476 for the procedure and 75978 for the imaging.

Clarification of May/June 2009 ACR Radiology Coding Source on MRCP

Please note that a magnetic resonance cholangiopancreatography (MRCP) study uses maximum intensity projection (MIP) images to better delineate the bile duct and/or pancreatic duct anatomy as part of the study. In the May/June 2009 ACR Radiology Coding Source Q&A only the bile duct was specified.

Sept-Oct 2009 Q and A

Q: As of January 1, 2010, will HCPCS Level II codes G0392 and G0393 be used to report arterial and venous percutaneous transluminal angioplasty for maintenance of a hemodialysis access, arteriovenous fistula or graft? It is my understanding that the Centers for Medicare and Medicaid Services are proposing to delete these two codes.

A: The Centers for Medicare and Medicaid Services, through the Hospital Outpatient Prospective Payment System Proposed Rule, is recommending the deletion of HCPCS Level II percutaneous transluminal angioplasty codes G0392 (AV fistula or graft arterial) and G0393 (AV fistula or graft venous) and the designation of CPT code 35475 (Repair arterial blockage) and 35476 (Repair, venous blockage) as covered surgical procedures in the Ambulatory Surgical Center (ASC) setting for CY 2010. If approved, ASCs will be able to use CPT 35475 and 35476 to report the AV fistula or graft angioplasty procedures currently reported by G0392 and G0393.

Prior to the establishment of the G codes in 2007, a percutaneous transluminal angioplasty of an arterial AV fistula or graft was reported with 35475 for the procedure and 75962 for the imaging. When a venous AV fistula or graft angioplasty was performed it was reported with code 35476 for the procedure and 75978 for the imaging. It will not be known until the final rule is published in early November 2009 whether these proposed changes will be made. The ACR will be posting comments on the Final Rule in November to keep its members up to date.

Q: There are CCI edits on the MR with contrast code pairs 70552 (MRI, brain with contrast) and 70553 (MRI, brain without contrast, followed by with contrast material) reported in conjunction with the injection codes 36000 and 96372. However, a modifier indicator of "1" is listed, which denotes a modifier can be used to override the edit. Would it be appropriate to append a modifier -59 to code 36000 or 96372 in order to designate a separate encounter, as this portion of the procedure is performed

10-15 minutes before the actual with contrast study (70552 or 70553) procedure is performed?

A: No, it is not appropriate to add modifier 59 to code 36000 (Introduction of needle or intracatheter, vein) or 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) to override the Correct Coding Initiative (CCI) edits in order to report an injection for a contrast-enhanced magnetic resonance imaging (MRI) study that is given 10-15 minutes prior to the study. The injection performed 10-15 minutes prior to the study is part of the same study. A contrast-enhanced magnetic resonance imaging (MRI) study includes the professional component for injecting contrast, and reporting a separate code for the injection is unwarranted. It is only appropriate to add the 59 modifier to one of these codes when the with contrast code is reported on the same day by the same physician for the same patient when the injection is performed for a separate procedure, i.e., the injection code
is not reported for the injection of contrast for the MRI study.

As noted in the Radiology Business Management Association Bulletin, September 1993:

Diagnostic procedures that are specified with contrast are assigned higher professional relative values than those that are specified without contrast (e.g., MRI, CT). These differences in the professional relative values reflect differences in the amount of professional work performed by the radiologist. The higher relative values assigned to the procedures with contrast were intended to cover the extra effort and time taken by the radiologist to administer the contrast materials and interpret the enhanced images. The injection should not be billed separately for CT, MRI, IVP or nuclear medicine studies, since the value of the work is already built into the RVUs for radiology.

May-June 2009 Q and A

Q: A Q & A in Clinical Examples in Radiology (Fall 2008, p. 11) states that 3D rendering must be performed in order to assign a CTA code. However, prior guidance from the ACR (e.g., July 2001 ACR Bulletin) has indicated that either 2D or 3Drendering is acceptable. The CPT code description specifies "images post processing," but it is not clear if this is referring to 2D or 3D. Please clarify if 2D rendering is still acceptable for CTA. If not, why has this changed?

A: Two-dimensional (2D) postprocessing does not constitute a computed tomographic angiography (CTA) study. When CT scanning is performed using contrast enhanced dynamic-timed imaging and 2D reformatted axial images are obtained or multiplanar reconstructions (MPR) (e.g., coronal, sagittal, or even an off-axis view) are done, this should be reported with a standard CT with contrast code that identifies the anatomic area studied. None of these 2D planar reconstructions qualify as "angiographic" reconstruction.

As noted in the Fall 2008 issue of Clinical Examples in Radiology, Computed Tomography Angiography is a distinct type of service that includes postprocessing for angiographic reconstructions. In order to report "angiographic reconstructions" the physician needs to use different techniques which can all broadly be classified as 3D techniques. These include maximum intensity pixel (MIP) reconstruction, volume-rendered images, or other 3D techniques. If a referring physician orders a CT study for a vascular indication and the radiologist feels a CTA study is clinically indicated, appropriate documentation of the medical necessity for the CTA is strongly recommended.

Some historical background may help to understand why different information was provided by ACR in 2001. When 2D reformatting and 3D rendering were reported using code 76375 (Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality) the ACR and AMA issued advice that CTA required "angiographic reconstruction" imaging.

The deletion of code 76375 and the introduction of 76376 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post-processing on an independent workstation) and 76377(3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image post-processing on an independent workstation), raised the bar for CTA studies, and "angiographic reconstruction" was gradually redefined as requiring 3D rendering. With the evolution of scanner capabilities to produce 2D reformatting virtually in real time, it was felt that the 2D reformats should be included in the base procedure code and not separately reported. On the other hand, complex 3D image rendering often requires extensive independent workstation processing by a supervising physician and specially trained technologist.

The CPT codes for CTA have always required angiographic reconstruction. However,"angiographic reconstruction" has not been explicitly defined in CPT. The ACR has interpreted this to parallel CPT definitions of the independent reconstruction code. Previously, the now deleted CPT code 76375 could be used for 2D and/or 3D reconstruction imaging, and that was used as the basis of the definition of angiographic reconstruction imaging. Since CPT codes 76376 and 76377 have been introduced, and have restricted the reporting of reconstruction imaging to 3D, such 3D imaging now serves as the basis of defining angiographic reconstruction imaging.

Q: Is it necessary to have a permanent archive of 3D images acquired on a CTA study?

A: Yes, the ACR believes that it is necessary to have a permanent archive of 3D images acquired on a CTA study. The axial data set from which 3D images are created is insufficient for the reporting of a CTA study. When reformatted images are acquired and

interpreted in addition to the CT axial images, the reformatted images are a part of the study and should be permanently archived. Just as it is required that a permanent hardcopy image be maintained for a plain film study, permanent CTA reformatted images should be permanently archived.

Q: How should a magnetic resonance cholangiopancreatography (MRCP) be reported?

A: There has been confusion recently after publication of a recent CPT Assistant Q&A regarding the reporting of a magnetic resonance cholangiopancreatography (MRCP) study. The ACR is in the process of working with the AMA to provide clarification.

Note that when an MRCP study is performed alone, it is appropriate to report one of the MRI of the abdomen codes (74181, 74182 or 74183 depending on whether contrast is administered) and a three-dimensional (3-D) reconstruction code (76376 or 76377). These codes accurately describe the procedure performed. An MRCP study includes a standard MR of the abdomen, along with maximum intensity projection (MIP) images to better delineate the bile duct anatomy. Therefore, because there are codes that accurately describe the procedure performed, those codes should be reported to describe an MRCP study.

As noted in the July/August 2006 ACR Radiology Coding Source Q&A, if imaging of the abdomen is performed concurrently with an MRCP study, it is appropriate to report one of the MRI of the abdomen codes (74181, 74182, or 74183) plus a 3-D reconstruction code (76376 or 76377). An additional MRI of the abdomen code should not be reported, as performance of an additional sequence or two would be considered part of the base procedure code.

Look for clarification to appear in the August CPT Assistant.

Mar-Apr 2009 Q and A

Q: A patient with Kaposi's sarcoma has an electron plan for nine separate areas. Should the isodose plan code be reported once or per area treated?

A: If the treatment team believes an isodose plan is required, it is appropriately coded as 77321, Special teletherapy port plan, particles, hemibody, total body. To correctly report 77321, a separate electron distribution must be performed for each volume. Code 77321 should be reported only once even thoughmultiple plans may be created.

In the absence of an isodose plan, code 77300, Basic radiation dosimetry calculation, central axis depth dose calculation, TDF [time, dose, fractionation parameter], NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician, could be reported for each lesion (if treated

separately). This is done to ensure that the monitor units used are correct for the prescription dose for each lesion. Most electron fields with a relatively simple geometry can be adequately treated with just the 77300 calculation.

Q: We currently report on Measure #145 – Exposure Time Reported for Procedures Using Fluoroscopy as part of the Physician Quality Reporting Initiative (PQRI) program. However, we have noticed there are some codes listed in the denominator for this measure that do not include fluoroscopy. How should these non-fluoroscopy codes be reported?

A: The Centers for Medicare and Medicaid Services (CMS) has issued clarification on the Physician Quality Reporting Initiative (PQRI) Measure #145, Exposure Time Reported for Procedures Using Fluoroscopy. CMS and the measure developer recommend that you do not change how you have been reporting Measure #145 and that you continue to report in the manner in which you have been reporting for the 2009 reporting period.

If you have been reporting the quality-data code (QDC) 6045F with the 8P modifier (action not performed, reason not otherwise specified) for any of the 22 non-fluoroscopy procedures, you should continue to report the 8P modifier for those procedures. If you have NOT reported any QDC codes for the 22 non-fluoroscopy procedures, DO NOT START reporting QDCs codes now. CMS will calculate two different reporting rates for each individual National Provider Identifier (NPI) for this measure and will use the most favorable reporting rate. The performance rate will exclude the 22 non-fluoroscopy codes.

The specifications provided to CMS inadvertently included 22 CPT codes for non-fluoroscopy radiology procedures in the denominator. The 22 non-fluoroscopy codes identified are: 36597, 64510, 64520, 64622, 64626, 74400, 74410, 74415, 74420, 75820, 75822, 76100, 76101, 76102, 76150, 77031, 77053, 77054, 77071, G0259, G0260, and G0365. Because the PQRI measure specifications are final as posted on the CMS PQRI Web site, CMS is providing an analytic fix for this measure so as not to disadvantage eligible professionals.

This information was posted on the CMS PQRI FAQ Web site on March 31, 2009, as FAQ #9675. Please contact P4Pquestions@acr.org with questions.

Jan-Feb 2009 Q and A

Q: How should intrafraction localization used during the delivery of radiation therapy be reported?

A: If a CT scanogram or topogram of the lower extremities is all that is performed for leg measurement, then this is simply a radiograph performed on a CT scanner and Current Procedural Terminology® (CPT®) code 77073 (Bone length studies, orthoroentgenogram, scanogram) should be reported. In some circumstances, however, a CT examination may

be appropriate; for example, when there are flexion contractures that would distort anteroposterior images, and when lateral images from a CT can provide bone leg measurement in patients with leg inequalities (e.g., ununited fracture). These CT studies are performed to determine whether there are rotational components, not to determine whether or how much leg length discrepancy is present.

When a bilateral CT study of the lower extremities is medically necessary and performed on patients with leg length inequalities, CPT® code 73700 (Computer tomography lower extremity; without contrast material) should be reported once. The contralateral leg is usually studied for comparison purposes and should not be reported separately.

Q: What code should be used to report a sacroplasty procedure?

A: New Category III codes 0200T (Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device (if utilized), one or more needles) and 0201T (Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device (if utilized), two or more needles) were posted on the American Medical Association (AMA) Web site in January and will be available for use on July 1, 2009. Until that time, it is recommended that code 22899 (Unlisted procedure, spine) be reported.

As noted on the AMA Web site, if fluoroscopic or CT guidance is performed in conjunction with sacroplasty, it is appropriate to report 72291 or 72292, as these codes accurately describe the guidance used. According to the AMA, "When reporting codes for services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources."1

1 "Instructions for Use of the CPT® Codebook." In CPT® 2009 Codebook, Professional Edition, p. xiv, American Medical Association, 2009.

Q: What is the appropriate coding for a nasogastric placement of an enteroclysis tube?

A: A small bowel enteroclysis exam, typically, is performed using a tube that is placed into the small intestine either through the nose or through the mouth. Code 44500 (Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)) describes this exam. Fluoroscopy, the imaging technique used to guide and confirm the placement of the tube, is reported with code 74340 (Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation). When the tube is determined to be in the correct position, contrast (barium) is administered through the tube

and into the small intestine. Radiographic images are taken to examine the small intestine for abnormalities. These images are separately reported by code 74251 (Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube).

Note that code 74355 (Percutaneous placement of enteroclysis tube, radiological supervision and interpretation) describes a percutaneous placement of an enteroclysis tube and should not be reported for a nasogastric placement of an enteric tube.

For additional information on the coding and performance of an enteroclysis exam, see Clinical Examples in Radiology, Volume 2, Issue 4, Fall 2006; and the ACR Practice Guideline for the Performance of an Enteroclysis Examination in Adults (http://gm.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/dx/gastro/enteroclysis.aspx).

Q: How should intrafraction localization used during the delivery of radiation therapy be reported?

A: Category III code 0197T (Intrafraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3D positional tracking, gating, 3D surface tracking), each fraction of treatment) was posted on the American Medical Association Web site in July 2008 with implementation on January 1, 2009. As noted in the descriptor, this code is used to track the target or patient motion during conformal radiation delivery.

As noted in the CPT® 2009 Codebook, "Select the name of the procedure or service that accurately identifies the service performed." Because a Category III code has been established to describe this procedure, it must be reported as it accurately describes the procedure performed.

Q: Are radiologists required to dictate separate reports when abdominal and pelvic computed tomography scans are performed at the same setting? Does the ACR reference this in the Practice Guideline for Communication of Diagnostic Imaging Findings?

A: A small bowel enteroclysis exam, typically, is performed using a tube that is placed into the small intestine either through the nose or through the mouth. Code 44500 (Introduction of long gastrointestinal tube (eg, Miller-Abbott) (separate procedure)) describes this exam. Fluoroscopy, the imaging technique used to guide and confirm the placement of the tube, is reported with code 74340 (Introduction of long gastrointestinal tube (eg, Miller-Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation). When the tube is determined to be in the correct position, contrast (barium) is administered through the tube and into the small intestine. Radiographic images are taken to examine the small intestine for abnormalities. These images are separately reported by

code 74251 (Radiologic examination, small intestine, includes multiple serial films; via enteroclysis tube).

Note that code 74355 (Percutaneous placement of enteroclysis tube, radiological supervision and interpretation) describes a percutaneous placement of an enteroclysis tube and should not be reported for a nasogastric placement of an enteric tube.

For additional information on the coding and performance of an enteroclysis exam, see Clinical Examples in Radiology, Volume 2, Issue 4, Fall 2006; and the ACR Practice Guideline for the Performance of an Enteroclysis Examination in Adults (http://gm.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/dx/gastro/enteroclysis.aspx).

Nov-Dec 2008 Q and A

Q: How should a gastrostomy tube button change that is performed through a mature tract without fluoroscopic guidance be reported?

A: A gastrostomy tube button change that is performed through a mature tract without fluoroscopic guidance should be reported with code 43760 (Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance). When fluoroscopic guidance is used, it is appropriate to report the enteral access code 49450 (Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report) established in 2008.

Q: A referring physician wants to verify that a jejunostomy tube is properly positioned. An unenhanced CT of the abdomen (diaphragm to the crest) is performed, followed by the injection of 50 mL of air and a repeat non-enhanced CT scan of the abdomen (using the same parameters). What is the appropriate coding for this examination?

A: A noncontrast (un-enhanced) computed tomography of the abdomen, followed by the injection of 50 mL of air, and repeated noncontrast CT imaging of the abdomen is appropriately
reported with CPT code 74150 (Computed tomography, abdomen; without contrast material). It is not appropriate to code for a contrast enhanced CT scan because the air injection is not considered sufficient to fulfill the requirements for a contrast study. As always, there needs to be an appropriate medical indication for this examination and an order from the referring physician.

More commonly, evaluation for position of an enteral catheter is done under fluoroscopic guidance and is reported with CPT code 49465 (Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or

cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report) which includes the imaging guidance.

Q: How is a real-time duplex and color imaging study of the groin to look for a pseudoaneurysm, arteriovenous (A-V) fistula or hematoma reported?

A: Duplex and color imaging of the groin is appropriately reported with code 93926 (Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited). If a duplex and color imaging study is performed as a part of an ultrasound-guided compression repair, report 76936 [Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (including diagnostic ultrasound evaluation, compression of lesion and imaging)].

Q: Must you have an order from the referring physician that specifically asks for wall motion and ejection fraction in order to perform and report them when only a cardiac stress SPECT or thallium stress SPECT is listed on the order?

A: No, an order that specifically requests the performance of wall motion and ejection fraction studies is not required in addition to a request for a cardiac stress SPECT or thallium stress SPECT study. The performance of wall motion and ejection fraction is part of the test design exception, as codified in the Medicare Carriers Manual Internet Only Manual, Section 80.6.5, which states:

Test Design

Unless specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).

Jan-Feb 2008 Q and A

Q: Should 71035 be reported once or twice when right and left decubitus views of the chest are performed?

A: CPT® code 71035 (Radiologic examination, chest, special views [eg, lateral decubitus, Bucky studies]) should be reported twice when both right and left lateral decubitus views of the chest are performed. To indicate to the payer that these are two separate and distinct studies, it would be appropriate to add a modifier to designate that a bilateral procedure (eg, RT, LT, 50) was performed and that this is not a duplicate charge submitted in error. Verify with your payers the appropriate modifier to use.

This code for a special view is not included in any of the other chest codes; therefore, when special views are performed, it is appropriate to report it in addition to other chest-imaging

codes. It was developed to describe a special projection of the chest (eg, decubitus view, Bucky view).

The long-standing ACR position is as follows:

Unlike most other plain film chest procedures which have their own unique CPT-4 code, decubitus views (projections taken while the patient is lying on his side) and other special views (eg, Bucky studies) are categorized under a single code (ie, 71035), as it applies to decubitus views, represents a single anteroposterior view; much like a one view chest study (71010). To put it another way, code 71035 symbolizes a single anteroposterior view of the chest taken while the patient is lying on either side. The analogy to a one-view chest exam is also reflected by the professional relative values assigned to each code. Therefore, given the nature of the procedure and the relative values assigned to it, code 71035 should be reported once for each decubitus view taken. (RBMA Bulletin, September 1992, p 22)

Q: Does the ACR have a recommendation for coding when an axillary view is done with a breast ultrasound? Would the axillary ultrasound be coded separately with 76880, or would it be included in the breast ultrasound?

A: Axillary views taken during an ultrasound study of the breast are not reported separately, as they would be considered included in the breast ultrasound study. Code 76645 (Ultrasound, breast[s] [unilateral or bilateral], B-scan and/or real time with image documentation) is used when evaluating one or both breasts for cysts or solid masses. Breast ultrasonography is typically performed with high-frequency transducers and often in conjunction with mammography.

CPT code 76880 (Ultrasound, extremity nonvascular, B-scan and/or real time with image documentation) refers to an examination of an extremity (eg, shoulder, knee) that would be performed primarily for evaluation of muscles, tendons, joints, and soft tissues. Because the axillary area is considered to be part of the upper extremity, it is appropriate to report CPT 76880 for circumstances in which the axillary study is performed to evaluate a soft tissue mass that may be present in the upper extremity where knowledge of its cystic or solid characteristic is needed.

Q: How is digital motion fluoroscopy reported? Is it appropriate to report the video radiography code 76120?

A: Yes, digital motion fluoroscopy should be reported using CPT code 76120 (Cineradiography/ videoradiography, except where specifically included). Because the study is recorded digitally does not negate the use of code 76120. As noted in the American Medical Association's September 2000 CPT Assistant (p 4), both videofluorography and cineradiography are used to record motion at fluoroscopy.

Video fluorography is the recording of motion on videotape or on a digital disk from a television monitor mounted on the output port of a fluoroscopic image intensifier. Cineradiography is a motion picture recording produced by a camera attached to the output port of a fluoroscopic image intensifier. Both are methodologies for recording moving events as seen by a physician at fluoroscopy.

Q: Are there new Healthcare Common Procedure Coding System codes for 2008 to describe the use of gadolinium?

A: The Healthcare Common Procedure Coding System (HCPCS) codes for payment of gadolinium were updated and became effective as of January 1, 2008. Codes A9576 to A9579 replace code Q9952 (Injection, gadolinium-based magnetic resonance contrast agent, per ml), which has been deleted. Codes for gadoteridol (A9576); gadobenate dimeglumine (A9577); gadobenate dimeglumine (multipack) (A9578); and gadolinium based magnetic resonance contrast agent, not otherwise specified (A9579) should be used to report these paramagnetic contrast agents. As of January 1, 2007, contrast media and paramagnetic contrast agents are paid separately when used in magnetic resonance imaging and other various imaging procedures. However, it should be noted that contractors still have the authority to specify the payment guidelines of contrast materials by placing it on their local coverage determination policies. It should also be noted that as of January 1, 2008, contrast and paramagnetic imaging agents are bundled into the base procedure code under the Hospital Outpatient Prospective Payment System and will not be reimbursed separately.

Sept-Oct 2007 Q and A

Q: Measure #10 of the Physician Quality Reporting Initiative (PQRI) is used to identify patients who have had computed tomography (CT) or magnetic resonance imaging (MRI) studies of the brain performed with a diagnosis of transient ischemic attack (TIA) or intracranial hemorrhage that includes documentation of the presence or absence of hemorrhage, mass lesion, and acute infarction. When the radiologist's final impression is normal or not TIA, can the ICD-9 code for TIA (435.9) be reported if the referring physician lists a clinical diagnosis of TIA?

A: Per the American Hospital Association's Central Office, if a patient is seen with signs and symptoms that are an integral part of a TIA or the referring physician makes a clinical diagnosis of TIA, the radiologist may code TIA even though the CT or MRI study is found to be normal. The Central Office refers to the ICD-9-CM Official Guidelines for Coding & Reporting (October 2007), B. General Coding Guidelines, items #6 and #7 that clarify this point (p. 10).

#6. Signs and symptoms:
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established

(confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-Defined Conditions (codes 780.0–799.9) contain many, but not all, codes for symptoms.

#7. Conditions that are an integral part of a disease process:
Signs and symptoms that are associated routinely with a [October 2007 change] disease process [such as TIA] should not be assigned as additional codes, unless otherwise instructed by the classification.

Therefore, it would be appropriate to report 435.9 as the primary diagnosis to describe a TIA if the clinical history provided by the referring physician is TIA and the CT or MRI study is normal.

Clearly, the least problematic way to code for a TIA is for the referring physician to use that code without qualifiers such as "rule out, possible, probable, consistent with, etc." when ordering the study. The diagnosis of TIA can certainly be made on clinical criteria similar to a diagnosis of pneumonia prior to the performance of an imaging study. This clinical diagnosis of TIA provided by the referring physician can be reported as the ICD-9 code for the CT or MRI of the brain study when a more specific diagnosis is not derived from the imaging study (eg, intracerebral hemorrhage).

However, if all that is given by the referring physician are signs and symptoms as an indication for the CT or MRI examination, then these codes must be carried forward if nothing more specific is derived from the imaging examination (ie, the study is normal).

The list of eligible codes currently included in Measure #10 will be reviewed by the Centers for Medicare and Medicaid Services and the American Medical Association Consortium Stroke Workgroup for possible expansion in the 2008 PQRI program.

Q: How should an order for an ultrasound of the kidneys be performed and coded?

A: Unless the referring physician specifically asks for a renal size assessment only, we evaluate for an intrarenal or postrenal cause of the patient's symptoms. Our standard scanning protocol involves images of the kidneys and bladder and often evaluation for ureteral jets within the bladder. This leads me to believe, therefore, that we should actually bill for a complete retroperitoneal ultrasound.

Radiologists should always tailor their examinations on the basis of the clinical information received, and services should be coded on the basis of both medical necessity and the details of the examination performed.

According to Current Procedural Terminology® (CPT) guidelines, p. 248 of the standard version of the CPT code book: A complete ultrasound examination of the retroperitoneum (76770) consists of real-time scans of the kidneys, abdominal aorta, common iliac artery

origins, and inferior vena cava, including any demonstrated retroperitoneal abnormality. Alternatively, if clinical history suggests urinary tract pathology, complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound.

Therefore, if only the kidneys are medically indicated and evaluated, then a limited retroperitoneal code, 76775, should be reported.

Q: We are able to provide a detailed 5-mm MRI scan with three different sequences that cover the head to the feet. This study is used to evaluate patients with metastases or lymphoma. How should this study be reported?

A: A whole-body diagnostic MRI study is rare, and there is no CPT code that accurately describes this procedure. When medically necessary and performed, the unlisted MRI code 76498 (Unlisted magnetic resonance procedure [eg, diagnostic, interventional]) should be reported. When only one or a few discrete anatomical areas are targeted for MRI evaluation, then those specific anatomical regions should be coded.

Q: When should CPT code 77084 (Magnetic resonance [eg, proton] imaging, bone marrow blood supply) be reported? Can it be reported in conjunction with joint and spine imaging when FAT suppression techniques (eg, chemical FAT SAT or STIR) are used? For example, if an ankle (73721) study is performed with multiple extra FAT SAT and STIR sequences, can 77084 also be billed?

A: Code 77084 (Magnetic resonance [eg, proton] imaging, bone marrow blood supply) is a stand-alone code used for a bone marrow survey. It should not be used as an add-on code to describe extra sequences, such as for multiple extra FAT SAT (specialized technique that selectively saturates fat protons prior to acquiring data as in standard sequences) and STIR (short inversion time inversion recovery) sequences. Extra sequences are part of some exam protocols and do not justify an additional CPT code.

July-Aug 2007 Q and A

Q: How should the use of computer-aided detection software be reported for breast sonography services?

A: Computer-aided detection (CAD) performed in conjunction with breast sonography is reported with Current Procedural Terminology (CPT) code 76999 (unlisted ultrasound procedure (e.g., diagnostic, interventional) to describe the CAD analysis and CPT code 76645 (ultrasound, breast(s) (unilateral or bilateral), real time with image documentation) to describe the breast ultrasound study. Although CAD codes have been established to be used in conjunction with diagnostic and screening mammography (77051, 77052) and breast magnetic resonance imaging (MRI) (0159T), no code is available to be used in conjunction with breast ultrasound; therefore, the unlisted procedure code should be used to report this service.

Q: Is an order required for the use of CAD? Must the use of CAD be dictated in the report?

A: The add-on procedure code for CAD is exempt from the Ordering Diagnostic Tests rule and, therefore, does not require a separate order from the referring physician.

The Centers for Medicare and Medicaid Services (CMS) informed the ACR that the Ordering of Diagnostic Tests rule (42 CFR 410.32) allows for performance of computer-aided detection in conjunction with mammography without a written order from the referring (treating) physician. Since there is no medical necessity prerequisite for the use of CAD with mammography procedures, and if all aspects of CAD are performed in conjunction with mammography, the radiologist may determine whether or not CAD should be performed. The use of CAD in conjunction with mammography is covered under the Radiologist Exception as noted in Medicare Transmittal #1725:

15021 (E)(1) Test Design - Unless specified in the order, the radiologist may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or nonuse of contrast media).

When CAD is used in addition to a mammography procedure, it should be documented in the report.

Q: In a freestanding office or independent diagnostic testing facility (IDTF) setting, is a separate order required for the breast ultrasound study recommended by the radiologist to further evaluate a suspicious finding on screening mammography?

A: Yes, a separate order is required in the freestanding office and IDTF settings for the addition of a breast ultrasound study following a screening mammography procedure to further evaluate a suspicious finding. The rationale that allows for the performance of a diagnostic mammogram following a screening mammogram without an order from the referring physician does not apply to additional diagnostic testing such as ultrasound or MRI. The National Office of the Centers for Medicare and Medicaid Services (formerly known as the Healthcare Financing Administration [HCFA]) notified the ACR that Medicare proposed and adopted the diagnostic mammography exception to the Ordering of Diagnostic Tests rule because Congress made the Food and Drug Administration, rather than HCFA, responsible for the conditions under which mammograms are covered. In addition, the screening mammography benefit contains no requirement for a physician's order. Thus, a beneficiary could receive the screening mammogram on a walk-in basis, with no treating physician to order the subsequent diagnostic procedure.

If a diagnostic breast ultrasound study is required after a screening mammogram, the radiologist must obtain a separate order from the referring physician in the freestanding office and IDTF settings.

Mar-April 2007 Q and A

Q: If a radiologist reviews previous images obtained from another (outside) facility in order to provide an interpretation for a current imaging study, can a separate charge be billed? The previous studies are reviewed for comparative purposes to evaluate any change in the patient's condition.

A: When a radiologist reviews prior images performed either at the same institution or from an "outside" facility at the time he or she interprets an "inside" study, it is not appropriate to code separately for the review of the previous examination. The review of an outside institutional examination is no different from reviewing old inside studies at the time of the interpretation of the new inside service. A comparison with old studies, when available, is an integral part of the interpretation of any study, regardless of where they were performed.

Q: Is it appropriate to report a diagnostic breast MRI twice when a diagnostic breast MRI is performed on one day, followed by an MRI-guided breast biopsy procedure on the following day?

A: No, it is not appropriate to report a diagnostic MRI study code twice when a diagnostic MRI study is performed on one day, followed by an MRI-guided biopsy study on another day. CPT® codes 77058 and 77059 (formerly 76093 and 76094) are diagnostic MRI breast study codes. The diagnostic MRI code should be reported only once on the day it was performed. Code 77021 (formerly 76393) should be used to report the MRI guidance used for placement of a needle during a breast biopsy procedure. If a diagnostic MRI breast study is performed on the same day as the MRI-guided breast biopsy, it is appropriate to report the diagnostic MRI code and the MRI guidance code, as well as the appropriate surgical code for the breast biopsy.

Q: Is the selective catheterization and embolization of the ovarian arteries performed during a uterine fibroid embolization (UFE) procedure coded separately?

A: The selective catheterization and embolization of an ovarian artery during UFE is not coded separately, as it is included in the all-inclusive UFE code 37210.

According to the AMA's CPT® Changes 2007: An Insider's View (p. 114) the following describes the physician work of a UFE procedure:

> Local anesthesia is applied to the entry site. The femoral artery is punctured and the sheath placed. A guidewire is advanced over the branch of the aorta into the contralateral uterine artery (or from a second puncture of the contralateral femoral

artery, again advancing over the branch of the aorta). An arteriography is performed to provide a road map of the blood supply to the uterus and fibroids. The technical personnel are directed throughout the procedure. An interpretation is prepared of the imaging of all views necessary of the vessels traversed and treated, including the ovarian arteries. The diagnostic catheter is removed, the hydrophilic wire is advanced, and the selective catheter is placed. Under continuous fluoroscopic imaging, particles of embolic material are injected slowly into the flow in the vessel(s) feeding the fibroid. A conformational arteriography is performed and reviewed to ensure that the vessel is blocked with an assessment of the maintenance of the flow to the normal portions of the uterus. Once one side is completed, the other side is embolized. The guiding sheath/catheter is removed from the pelvic arteries. The guiding sheath/catheter is removed from the puncture site. Compression is applied to the puncture site for closure.

CPT® code 37210 (effective January 1, 2007) is inclusive of all services occurring on the day of the procedure as noted in the descriptor.

37210 Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure. (37210 includes all catheterizations and intraprocedural imaging
required for a UFE procedure to confirm the presence of previously known fibroids and to roadmap vascular anatomy to enable appropriate therapy)

(Do not report 37210 in conjunction with 36200, 36245-36248, 37204, 75894, 75898) (For all other non-central nervous system (CNS) embolization procedures, use 37204)

Q: In the November/December 2006 ACR Radiology Coding Source and in the March 2007 ACR Bulletin, it states that it is appropriate to report 3-D rendered angiography images using codes 76376 and 76377 when performed in addition to the base angiography procedure code. Please clarify this statement as this appears to be contradictory to what has been published previously by the ACR and AMA.

A: The statement that it is appropriate to report the 3-D angiography reconstruction images using codes 76376 or 76377 in addition to the base angiography procedure code is not contradictory to prior coding guidance published by the ACR and AMA. This statement is referring to the reporting of 3-D imaging when performed in conjunction with catheter angiography. It does not refer to the reporting of 3-D with computed tomography or magnetic resonance angiography, where the 3-D rendering is incorporated into the base CTA and MRA codes.

Q: What is the correct way to bill for a mammography examination on a mastectomy patient when one or two additional films are taken of the axillary region on the mastectomy side? Is it still correct to bill as a bilateral examination even though there is no breast tissue? Is this considered a screening or diagnostic exam?

A: Yes, it is correct to bill a bilateral examination even though there is no obvious breast tissue because both the side of the remaining breast and the mastectomy side are being imaged. This is analogous to a male mammogram, where there is little breast tissue. If there is enough clinical concern to warrant imaging, there is probably clinical concern that a tiny amount of breast tissue remains. This should, therefore, be billed as a diagnostic mammogram.

It is important to note the differences between diagnostic and screening mammography in order to code this procedure correctly. Diagnostic mammography serves a specific clinical purpose in that it is used to diagnose or followup on disease of the breast and to provide additional information about patients who have signs and/or symptoms of breast disease. Screening mammography is used to detect breast cancer in patients who lack signs and symptoms.

A diagnostic mammogram usually includes MLO and CC views as well as other views necessary
based on concurrent interpretation to answer the clinical question. Additional views include spot compression, spot compression with magnification, medial-lateral, and tangential views as required. A diagnostic mammogram includes whatever views are needed to evaluate an area of clinical concern. The number and types of views should be identified within the report.1

1 AMA/ACR Clinical Examples in Radiology, vol.1: 4, Fall 2005.

July-Aug 2006 Q and A

Q: When a CT angiography of the abdominal aorta and bilateral iliofemoral lower extremity runoff study (75635) is performed, must the radiologist mention in his or her report the evaluation of the entire abdominal aorta (not just the distal portion), as well as the bilateral femoral vessels (not just the external iliac arteries)?

A: When a CT angiography of the abdominal aorta and bilateral iliofemoral lower extremity runoff study (75635) is performed, the entire abdominal aorta, which means up to the diaphragm, need not be reported. The CTA of the abdominal aorta, like conventional angiography, should be tailored to the individual patient and clinical indication. In most circumstances, this includes imaging of the abdominal aorta just above the level of the renal arteries and imaging inferiorly. It would be quite unusual to include the abdominal aorta up through the diaphragmatic hiatus.

When an abdominal aorta and bilateral iliofemoral lower extremity runoff study is performed,
the evaluation also should include both the iliac and femoral arteries in the lower extremities at least to the level of the knees and usually to the level of the ankles.

Q: How do you code for ankle/brachial indices with a duplex scan of the lower extremity arterial bilateral blood flow study? Can both studies be coded when performed at the same time? Can color flow velocity mapping also be charged if performed?

A: When a duplex Doppler of the lower extremities is performed with the addition of ankle/brachial (A/B) indices, it is appropriate to code 93925 (Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study) for the duplex scan and 93922 (Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement) for the A/B indices.

Code 93922 is for a limited noninvasive physiologic arterial study that covers one level only of each leg (eg, ankle brachial indices with ankle waveforms).1 It is not appropriate to code 93922 in conjunction with 93923 (Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethsmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia) as 93922 is a limited version of 93923. Code 93923 includes segmental pressures and tracings and is used to report bilateral complex noninvasive physiologic testing procedures.

Duplex scanning (such as 93925) describes an ultrasonic scanning procedure for characterizing
the pattern and direction of blood flow in the arteries in a single display of real time images integrating 2-D vascular structure with spectral and color flow Doppler mapping or imaging.

As noted in the CPT 2006 codebook, the noninvasive physiologic studies are performed using equipment separate and distinct from the duplex scanner. Codes 93875, 93965, 93922, 93923, and 93924 describe the evaluation of nonimaging physiologic recordings such as ankle/brachial indices, Doppler analysis of bidirectional blood flow, plethysmography, and/or oxygen tension measurements appropriate for the anatomic area studied.

Q: How should an MRI of the abdomen performed in conjunction with an MRCP study be reported?

A: If imaging of the abdomen is performed concurrently with a magnetic resonance cholangiopancreatography (MRCP) study, it is appropriate to report one of the MRI of the abdomen codes (74181, 74182, or 74183) plus a 3-D reconstruction code (76376 or 76377). An additional MRI of the abdomen code should not be reported, as performance of an additional sequence or two would be considered part of the base procedure code.

A magnetic resonance cholangiopancreatography (MRCP) study includes MIP cholangiographic
images, as well as any axial and/or coronal abdominal MR cross-sectional images.

Q: We perform 5 mm cuts of the abdomen and of the pelvis using CT without contrast to diagnose kidney stones and ureteral stones. How should this be reported?

A: If CT without contrast studies of the abdomen and pelvis are performed to detect kidney stones or ureteral stones, it is appropriate to report both a CT of the Abdomen code (74150) and a CT of the Pelvis code (72192) as these codes accurately describe the procedure performed. Please refer to the December 1996 ACR Bulletin coding article and CT Practice Guideline on Performance of CT Abdomen and CT Pelvis for a discussion on the appropriateness of performing and reporting a CT abdomen and CT pelvis studies.

May-June 2006 Q and A

Q: Please clarify whether a screening mammogram or a diagnostic mammogram should be performed on an asymptomatic patient with augmented breasts (eg, breast implants).

A: According to the ACR's Standard for Diagnostic Mammography, a diagnostic mammogram
should be performed on patients with augmented breasts. However, the Centers for Medicare and Medicaid Service's (CMS, formerly known as HCFA) payment policy for a diagnostic mammogram does not recognize asymptomatic patients with augmented breasts as diagnostic. Medicare will only pay for a screening mammogram for an asymptomatic woman with breast implants.

Since Medicare denies the necessity of a diagnostic mammogram for an asymptomatic patient with augmented breasts, an advance beneficiary notice (ABN) should be obtained from the patient if the radiologist plans to bill the patient for a diagnostic mammogram. If the patient and referring physician decide that a screening mammogram should be performed, then the patient would receive a screening mammogram.

Q: What type of mammogram should a patient receive who has a personal history of biopsy-proven benign breast disease?

A: According to the ACR Standard for Diagnostic Mammography, a diagnostic mammogram is appropriate for patients with a personal history of biopsy-proven benign breast disease. Also, as noted in the Dec. 8, 1995 Federal Register, CMS expanded its definition of diagnostic mammography to include a personal history of biopsy-proven benign breast disease, thereby allowing the attending physician and the patient the opportunity to determine whether a screening mammogram or diagnostic mammogram is performed.

Q: Is there a guideline that states that patients with a history of mastectomy must revert to a screening mammography study after a set number of negative diagnostic studies or after a specified number of years postmastectomy?

A: The ACR considers patients who have been treated for breast cancer (either with breast conservation or mastectomy) high-risk patients, an indication for a diagnostic mammogram for the rest of their lives. However, as stated above, CMS allows the attending physician and the patient the flexibility to choose whether they want to continue with a diagnostic mammogram or revert back to the screening process.

Q: If a physical exam is performed in conjunction with a diagnostic mammogram or breast ultrasound and the results are discussed with the patient, is it appropriate to bill for an office visit, 99212, if performed in a private office setting?

A: It is only appropriate to bill for a consultation or other evaluation and management (E/M) service when the service is provided and documented according to established E/M guidelines. For breast interventional procedures, a brief review of history and physical exam and obtaining informed consent is not a separately reportable E/M service. This service is considered bundled into the surgical procedure code.

Click here for a copy of the documentation guidelines. The E/M guidelines are currently under review. Until the E/M documentation guidelines are finalized, it is up to the provider to use either the 1995 or 1997 published guidelines. It is recommended, however, that for auditing purposes a radiology practice use one set of guidelines, ie, either 1995 or 1997.

Q: Is a consent form by the patient required for breast cyst aspiration or core biopsy?

A: Yes. The requirements for an informed consent for breast cyst aspiration or core biopsy are no different than obtaining consent for any other invasive or interventional procedure.

Mar-April 2006 Q and A

Q: Is it appropriate to code a CTA of the Chest (71275) if only 2-D reconstructions are performed?

A: Yes, it is appropriate to code a CTA of the chest for the detection of pulmonary embolism (PE) if only 2-D reconstructions are performed. CTA includes 2-D or 3-D reconstructions. For nonvascular CT (ie, non CTA services), 2-D reconstructions are included in the base CT code, however, 3-D renderings are separately coded using 76376 or 76377.

As noted in the June 2002 ACR Bulletin coding article, "...the acquisition of CTA image data includes skeletal anatomy, soft tissues and vessels. In CTA, typically, a few unenhanced images are taken to calibrate the scanner and localize the anatomic region to be evaluated during the contrast-enhanced scan. The patient is then given a rapid injection of intravenous contrast to enhance the blood vessels. A full set of enhanced CT data is then obtained, which includes all of the anatomy in the area to be examined; an enhanced CT of that region and field-of-view is included in the CTA. Following the imaging, 2-D or 3-D reformatted images are typically performed. The 2-D reformatted images can be created in multiple planes, then interpreted, annotated and archived as hard copy, electronic files or both. The 3-D or volume-rendered reconstructions are typically evaluated in multiple projections. The work of 3-D reformatting is quite extensive, usually performed on a separate work station. Vessels are highlighted and featured for viewing and noncritical areas, such as bony structure and surrounding soft tissues, are eliminated in order to provide a focused evaluation of the vasculature. The entire process, including the acquisition of localizing images and contrast-enhanced data, the reformatting of those images and the interpretation of both the source images and the reconstructions that defines the work of a CTA study and is included in the respective CPT codes."

ACR Bulletin Coding Article, June 2002.

Q: Is it appropriate to report the fluoroscopic guidance code 76003 with code 20982 when fluoroscopy is used for radiofrequency ablation of a bone tumor code?

A: When the radiofrequency ablation (RFA) of bone tumors was reviewed and presented at the CPT Editorial Panel, it was noted that RFA of bone tumors always was performed with CT guidance. That is why CT guidance was then included in the final code descriptor and used in the Relative (Value) Update Committee (RUC) evaluation and recommendation.

It is because this code is described and valued as being performed with CT guidance that the ACR recommends that the unlisted musculoskeletal procedure code (20999) and fluoroscopic guidance code (76003) be reported when a bone RFA study with fluoroscopic guidance is performed. The rationale is that 20982 (Ablation, bone tumors [eg, osteoid osteoma, metastasis], radiofrequency percutaneous, including computed tomographic guidance) is accurate only for bone RFA with CT guidance. If a significant use of

fluoroscopic or other guidance for this procedure develops (which is believed to be unlikely), then additional codes would have to be created.

Q: Would the administration of Xanax or chloral hydrate be reported by the new moderate (conscious) sedation codes?

A: It would not be appropriate to report the new moderate (conscious) sedation codes for the administration of Xanax or chloral hydrate. The use of drugs to reduce anxiety or tension is not included in or reported by the new moderate sedation codes. Although oral, rectal and intranasal are listed as possible routes of administration (CPT Changes: An Insider's View 2006, page 272), it would be rare that these routes of administration would be used alone to induce moderate sedation. There may be instances, however, in the pediatric population when an oral medication (such as Versed lollipops) may be used as the sole method to induce moderate sedation. In this case, it would be appropriate to report the new moderate sedation codes if all the other CPT requirements for reporting moderate sedation are met, ie, physician in attendance during the intraservice period of sedation and the presence of an independent trained observer.

Q: When does the intraservice time begin and end for the new moderate (conscious) sedation codes (99143, 99144, 99145, 99148, 99149, and 99150)?

A: According to the CPT Guidelines, "Intraservice time starts with the administration of the sedating agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation." The new CPT codes for moderate sedation and the corresponding Relative (Value) Update Committee recommended work values require that the physician be in attendance during the intraservice period of sedation. If a drug is administered to accomplish "moderate sedation," then the time claimed by the physician for the moderate sedation codes submitted must correspond to the documented personal attendance by the physician providing the sedation. Note that a physician cannot order that a drug be given and then leave the patient. For example, a radiologist cannot order a medication be given to induce moderate sedation for an MRI study and then leave the patient with a nurse in attendance to monitor the patient status. This does not meet the requirement of continuous face-to-face attendance by the physician.

Jan-Feb 2006 Q and A

Q: How do I code for the use of computer-aided detection (CAD) performed in conjunction with an MRI of the breast?

A: At this time, the unlisted procedure code 76498 should be used to describe CAD when performed in conjunction with an MRI of the breast. The MRI of the breast is reported separately using code 76093 (unilateral) or 76094 (bilateral).

Note that 3-dimensional reconstructions, subtraction and angiodynamic assessment performed in
conjunction with CAD are included in the CAD procedure base code and are not coded separately. The 3-D imaging is an inherent and intrinsic part of the CAD software and is thus included in the unlisted procedure code 76498. In this setting, 3D imaging should not be separately reported by CPT® codes 76376 (3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation) or 76377 (3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation).

A category III add-on code (+0159T) was recently approved by the CPT Editorial Panel to describe the use of CAD for MRI of the breast which will become effective for use July 1, 2006. This new code will similarly include all inherent 3-D imaging (which should not be reported separately with 76376 or 76377). Until July 1, however, the unlisted CPT code should be assigned to describe this additional work.

Q: How do you code for diffusion-tensor imaging and diffusion-weighted imaging when performed with MRI brain imaging? Are there specific codes to describe this imaging?

A: When diffusion tensor imaging (DTI) is performed at the same setting as a routine brain MRI, the brain MRI code should be coded only once. However, in the unusual circumstance in which a patient had a routine brain MRI performed and a request is then later received to specifically perform DTI at a separately distinct imaging session, then it would be appropriate to report each study using a brain MRI code since this took place at two separate scanning sessions. DTI involves scanning the patient and a large amount of post-processing.

Unlike DTI, diffusion-weighted imaging (DWI) is considered a routine sequence of MRI, such as fluid-attenuated inversion recovery (FLAIR), and should not be coded separately. A DWI sequence typically adds minimal additional time to both image acquisition and physician interpretation and, when performed, should be considered an inherent part of the base MRI study.

Q: How do you code for a nuchal translucency measurement when performed in conjunction with a complete first trimester OB ultrasound exam?

A: If performed during the same session, it would be appropriate to report 76801 for the complete first trimester OB ultrasound and 76999 for the nuchal translucency measurement.

The American College of Obstetrics & Gynecology submitted a request to establish a new code for 2007 to describe a nuchal translucency measurement. This measurement is a method for detecting fetal chromosomal abnormalities (eg, Downs syndrome) in the first trimester. The ACR commented during the CPT discussion of this new code that it felt that a limited OB code 76815 would appropriately describe this procedure. However, the CPT Editorial Panel felt a separate code was warranted and established a code for 2007. Because the editorial panel feels that a nuchal translucency measurement should be described by a separate and distinct code (which means that currently it is not accurately described by an existing code), the ACR recommends the use of the unlisted procedure code until the new Category I code approved for 2007 is
released.

Nov-Dec 2005 Q and A

Q: How do you code for low osmolar contrast media (LOCM), high osmolar contrast media (HOCM), and paramagnetic contrast agents (i.e., gadolinium)?

A: Low Osmolar Contrast Media and High Osmolar Contrast Media

Effective January 1, 2006, Low osmolar contrast media (LOCM) should be coded by using Q9945-Q9951 and High Osmolar Contrast Media (HOCM) should be coded by using Q9958-Q9964, respectively, in hospital and free-standing settings. Based on the 2006 Medicare Physician Fee Schedule (MPFS) Final Rule, separate payment for HOCM given in a free-standing setting will be delayed until a time when direct practice expense collected through the Practice Expense Advisory Committee can be used to determine the practice expense values in the MPFS. However, LOCM and HOCM are reimbursed separately in the hospital setting, as per the 2006 Hospital Outpatient Prospective Payment System (HOPPS) Final Rule, with the exception of HOCM code Q9959. CMS announced that they are packaging this code under HOPPS as they did not have sufficient pricing data available at this time. If Average Sales Price (ASP) data become available for this code, then CMS will reimburse separately based on the appropriate payment rate.

Over the last year, there have been numerous changes in coding and coverage that included the following:

1. Elimination of the restrictive criteria for payment of LOCM (January 1, 2005), allowing payment of LOCM for all patients;
2. Establishment of HOCM HCPCS Level II "Q" codes for tracking purposes without separate payment in the non-hospital setting (July 1, 2005); and
3. Changes in payment for HOCM on the hospital outpatient side as of January 1, 2006.

Gadolinium:

Coding for paramagnetic contrast agents,ie, gadolinium, have changed and, similar to LOCM and HOCM, new "Q" codes have been established and implemented in the hospital and free-standing settings. Effective January 1, 2006, codes Q9952-Q9954 should be used for gadolinium in all settings. In the free-standing setting, gadolinium is not separately payable. CMS specifies that gadolinium is generally bundled into the MRI procedures because the TC RVUs for MRI procedures that specify "with contrast" include payment for paramagnetic contrast media. Medicare carriers may pay for the contrast material given for the third MRI procedure through the respective supplies code but understand that this example is rare.

Specifically, when an MRI of the brain or spine is performed without contrast material, then another MRI is performed with a standard (0.1mmol/kg) dose of contrast material, and based on the need to achieve a better image, a third MR is performed with an additional double dosage (0.2mmol/kg) of contrast material, the contrast should be reimbursed for that third MRI procedure. If you are being denied for gadolinium given under these rare circumstances, please contact your local Medicare carrier.

Note: According to officials at the national CMS office, the gadolinium codes Q9952-Q9954 are paid under the 2006 MPFS as described above (ie, third MRI) and separately payable under HOPPS Final Rule. CMS is planning to correct an error within the 2006 MPFS Final Rule, Addendum H that incorrectly identifies these Q codes being effective on January 1, 2007.

Use this link to identify the codes to use and when to expect payment for the use of LOCM, HOCM and MR contrast agents under Medicare (https://www.acr.org/~/media/ACR/Documents/PDF/Economics/Coding-Source/2005-Nov-Dec/Codes-to-Use-and-When-to-Expect-Payment-for-the-use-of-LOCM-HOCM-and-MRcontrast-agents-under-Medicare.pdf?la=en). (Note that separate payment of supplies by other third party payers is based on individual contracts.)

References:

Retroactive Payment for LOCM, ACR Radiology Coding Source , Sept/Oct 2005

CMS Publishes Transmittal Removing LOCM Restrictive Coverage Criteria, ACR Radiology Coding Source, Jul/Aug 2005

ACR Presses CMS to Update Low Osmolar Contrast Material Coverage;
New HCPCS Codes for HOCM Tracking, ACR Radiology Coding Source , May/June 2005

Payment for Low Osmolar Contrast Media (Transmittal 627)
(http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2005-

Transmittals-Items/CMS043690.html?DLPage=1&DLFilter=627&DLSort=2&DLSortDir=descending)

Payment Conditions for Radiology Services: Technical Component Payment of Magnetic Resonance Imaging Procedures, 15022(B)(6)

Radiology Services: CMS Manual System, Pub 100-4 Medicare Claims Processing (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf)(includes appeals, contractor interface with CWF, and MSN), Chapter 13, Section 40

Q: Is an order from the referring physician required for 3D rendering procedures in the non-hospital setting?

A: In the past, the ACR maintained that an order for 2D and 3D reconstruction imaging was not necessary as this was covered under the Ordering of Diagnostic Tests rule design exception. However, based on the exponential rise in the use of 76375 and in the number of practice investigations evolving out of overutilization (routine use), the ACR strongly encourages radiology practices to obtain an order from the referring physician in the nonhospital setting. In the hospital setting, radiologists may generate their own order, but they are strongly encouraged to justify medical necessity for the use of 3D rendering in a separate dictation.

The 3D rendering should be done at the request of or in consultation with the referring physician when there is medical necessity. Referring physicians should be educated as to the need for an order and when 3D rendering would be beneficial. The 3D codes should be reserved for situations where additional imaging is necessary for surgical planning or for complete depiction of an abnormality from the two-dimensional study. Those practices that routinely provider 3D rendering may prompt an investigation by the Office of the Inspector General.

May-June 2005 Q and A

Q: Before performing an MR study, a plain film of the orbits is performed to detect any metallic foreign bodies that may be present which would cause eye damage to the patient during an MRI procedure. Is the performance of a plain film in this instance considered a scout film which is not reported or is it considered a screening diagnostic study and separately reportable?

A: It is the consensus of the American College of Radiology's Committee on Coding and Nomenclature that a plain film of the orbits (to detect a foreign body) which is performed prior to an MRI procedure is not considered a scout film. A scout film is an inherent part of an imaging study typically performed on the same modality. The plain film or digital image on PACS is reported using CPT® code 70030 – Radiological examination, eye, for detection

of foreign body. Orbit studies are ordered for patients prior to an MRI when medically necessary (i.e. history of sheet metal work, prior history of intraocular foreign body).

May-June 2005 Q and A

Q: In the Jan/Feb 2005 ACR Radiology Coding Source™ feature article, the ACR recommended use of the unlisted CT code (76497) to report coronary CT angiography. Others have recommended using the CT Angiography Chest code for coronary CTA (71275). Do I risk being considered noncompliant if I use 71275?

A: Pending creation of a new code, the ACR's position is that, unless a specific payer has advised otherwise (some private payers are requesting use of the temporary HCPCS code S8093), the new work of coronary CT angiography should be reported using the unlisted computed tomography procedure code (76497).

According to the CPT coding guidelines (p. xiii, CPT 2005 code book) you should "select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such service exists, then report the appropriate unlisted procedure/service code."

As noted in the Jan/Feb 2005 ACR Radiology Coding Source™, the typical acquisition and postprocessing protocols used for CTA of the chest are for pulmonary embolism or aortic dissection, which do not supply the information needed for exclusion of coronary artery occlusive disease. Acquisition and postprocessing algorithms dedicated to evaluation of coronary vessels are used instead of those employed for a conventional CTA of the chest examination. The CT techniques for high-quality coronary CTA are vastly different from the examinations described by 71275 with respect to field of view, slice thickness, gating requirements, reconstruction algorithms, and even scanner requirements. Therefore, since the coronary CTA is not accurately described by CTA of the chest, it would not be appropriate to report code 71275.

New Category III codes will take effect in January of 2006. Look for updates to the coding of coronary CTA in the July/August ACR Radiology Coding Source™.

Q: Should the telemedicine codes be used alone or in conjunction with radiology codes to report radiology services performed via tele-imaging or teleradiology?

A: No, telemedicine codes should not be used as stand-alone codes or in conjunction with radiology codes to report any teleradiology or tele-imaging service performed.

Formal complete imaging interpretation and reporting services are excluded from any telemedicine services. When formal imaging interpretation and reporting services are provided either on-site or remotely (the latter using established tele-imaging standards), such services are appropriately described by the existing radiology CPT® codes. For

example, the formal interpretation of any chest x-ray is appropriately reported by one of the radiologic examination codes 71010, 71015, 71020, etc.

The Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services,
Section 270.2 identifies telemedicine services as:

- Consultations – CPT® codes 99241-99275
- Office or other outpatient visits – CPT® codes 99201-99215
- Individual psychotherapy - CPT® codes 90804-90809
- Pharmacologic management - CPT® code 90862
- Psychiatric diagnostic interview examination – CPT® code 90801
- End stage renal disease related services - HCPCS codes G0308, G0309, G0312, G0314,G0315, G0317, and G0318

Q: One of the components required for reporting a complete OB ultrasound for gestational age less than 14 weeks (76801) is a "survey of placental anatomic structure." However, the placenta cannot be distinguished on ultrasound until around the tenth week of gestation. Would documentation of measurement and shape of the gestational sac serve as the requirement for "survey of placental anatomic structure" performed at 9 weeks or should the limited procedure code 76815 be assigned?

A: It is appropriate to code for the complete OB ultrasound study (76801) even though a survey of the placental anatomic structure was not performed. However, the radiologist must note in his dictation that a survey of placental anatomic structure could not be performed because of gestational age. As noted in the CPT 2005 code book introductory notes prior to the diagnostic ultrasound codes: "For those anatomic regions that have 'complete' and 'limited' ultrasound codes, note the elements that comprise a 'complete' exam. The report should contain a description of these elements or the reason that an element could not be visualized (eg, obscured by bowel gas, surgically absent, etc.)."

May-Jun 2004 Q and A

Q: When digital subtraction is used in conjunction with a breast MRI with contrast study, is it appropriate to report code 76350 (subtraction in conjunction with contrast studies)?

A: No, the subtraction code 76350 (subtraction in conjunction with contrast studies) was developed prior to digitization when the creation of plain film subtraction images was done in the darkroom. Code 76350 should not be reported in addition to the code for a breast MRI with contrast study or any other MRI study.

Digital subtraction is a scanner-performed function that generates another set of images. This is not dissimilar to another pulse sequence in MR or another set of windows in CT.

Therefore, the digital subtraction would be inherent to the MR breast procedure. It is not a postprocessing function on a separate workstation.

Q: How would an MRA of both the right and left subclavian arteries be reported?

A: When an MRA of the right and left subclavian arteries is performed, with the subclavian artery ending at the axilla, which is coincidentally at the lateral margin of the chest, it is appropriate to report an MRA of the chest (71555) once, even if both right and left subclavian arteries are examined. However, if the requested diagnostic imaging extends into the right and/or left axillary arteries and beyond to include the upper extremity(ies), then it would be appropriate to code for the MRA of the upper extremity (73225) in addition to the MRA of the chest. If an MRA study of an upper extremity includes the ipsilateral subclavian artery, this should be coded as an MRA of the upper extremity only (73225).

Q: What is the appropriate CPT® code for reporting an MRI of a pregnant uterus?

A: To report an MRI of a pregnant uterus (fetus) use the unlisted MRI procedure code 76498 [unlisted magnetic resonance procedure (eg, diagnostic, interventional)]. The MRI evaluation of a pregnant uterus requires additional physician work relative to the MRI of the pelvis (not dissimilar from the difference between ultrasound of the pelvis and ultrasound of the pregnant uterus). For example, an MRI of the pelvis would include evaluation of the uterus, ovaries, and adnexa, where the evaluation of a pregnant uterus (fetus) includes evaluation of the fetus for viability, placental position and anatomy, qualitative assessment of amniotic fluid, etc., in addition to the examination of the maternal uterus and adnexa.

Nov-Dec 2004 Q and A

Q: How do you code for the brachytherapy seeds in the office (freestanding) setting as of January 1, 2005 when CPT code 79900 is deleted?

A: With the deletion of CPT® code 79900 (Provision of therapeutic radiopharmaceutical(s)), it is appropriate to report HCPCS code Q3001 (Radioelements for brachytherapy, any type, each). CMS announced in the Medicare Physician Fee Schedule 2005 Final rule that it is reinstating HCPCS code Q3001 under the physician fee schedule and that it will be carrier priced (Reference. Nov. 15, 2004, Federal Register, Vol. 69, No. 219, p. 66370). In the hospital outpatient setting, the appropriate HCPCS Level II C code should be used.

Q: **What is the correct code to use for a standing film that includes both legs from hips to ankles as AP legs on a 14X36 cassette for such indications as Legg Perthes disease and leg length discrepancies? Is it appropriate to use 76040 (bone length study) even though the study is performed standing and no ruler is used, or should 73565 be reported instead?**

A: The appropriate code to use to describe a study performed for such indications as Legg Perthes disease (a disease of bone growth) is 76040 (Bone length studies (orthoroentgenogram, scanogram)). The bone length study, performed for bone length or growth discrepancy, does not require a quantitative assessment of length, and the fact that the patient is standing and a ruler is not used should not deter from the use of this code. Assuming that the standing view is obtained at 6' rather than at 40", it is possible to make direct measurements on the film without a ruler to correct for magnification.

Code 73565 (Radiologic examination, both knees, standing, AP) is used for a standing view of both knees from which morphology (form and structure) is reported. If both studies are medically necessary and are both performed, it is appropriate to code for both.

Q: How do you code for a "midline catheter" (similar to a PICC line) when it terminates in the subclavian vein?

A: A central venous access device is described in the Current Procedural Terminology (CPT) book as a catheter or device terminating in the subclavian, innominate or iliac vein, the superior or inferior vena cava, or the right atrium. Accordingly, a peripherally inserted catheter terminating in the subclavian vein fulfills these strict criteria and would be appropriately coded using one of the central venous access procedure codes described as Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump. Depending upon the patient's age, this service should be coded as 36568 (under 5 years of age) or 36569 (age 5 or older).

"Midline catheter" is used by many different individuals to describe different types of peripheral lines, some terminating in the chest, and some in a peripheral vein. More important than the title given to the catheter is the exact anatomic position of the catheter, which can only be determined from careful review of a well-dictated report.

The structure of the CVA surgical codes is organized by: the type of procedure performed (i.e., insertion, repair, partial replacement, complete replacement or removal of a central venous device), the type of device employed in the procedure (e.g., non-tunneled central venous catheter, tunneled central venous catheter), the method of insertion [centrally inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or peripherally inserted (e.g., basilic or cephalic vein)], and device access, i.e., via the use of a port or pump or via an exposed catheter. It should be noted that no distinction is made between how venous access is achieved (percutaneously or by cutdown), and no distinction is made based on catheter size.

The patient's age is used to differentiate some of the procedures, because pediatric patients less than five years old require additional work. For the more complex venous access insertion procedures in the premature infant (body weight less than 4 kg), a –63

modifier should be assigned with the appropriate CVA (30000 series) code. A –63 is not to be reported with radiology 70000 series code.

For additional information on the central venous access device codes, please refer to the November/December 2003 edition of the ACR Radiology Coding Source™ online or the March 2004 edition of the Journal of the American College of Radiology.

Sept-Oct 2004 Q and A

Q: What code(s) should be reported for the evaluation of a patient and administration of an initial treatment dose of I-131 for hyperthyroidism?

A: Currently, CPT® code 79000 (Radiopharmaceutical therapy, hyperthyroidism; initial, including evaluation of patient) is used to report the initial therapeutic dose of I-131 in the treatment of hyperthyroidism. As noted in the descriptor, evaluation of the patient is included in the procedure and is not coded separately. However, the type of radiopharmaceutical supply used is reported separately with a HCPCS Level II code (e.g., A9517, A9530) or CPT® code 79900 (Provision of therapeutic radiopharmaceutical(s)).

As of January 1, 2005, submit code 79005 (Radiopharmaceutical therapy, by oral administration) to report the treatment of hyperthyroidism with an orally administered dose of I-131 sodium iodide. Note that unlike 79000 (Radiopharmaceutical therapy, hyperthyroidism; initial, including evaluation of patient), which includes the evaluation of the patient, neither 79005 nor any of the other therapeutic codes include evaluation and management services. Although dose calculation and a discussion of risks and benefits of radiotherapy are included in CPT® code 79005, it is appropriate to report an evaluation and management code when additional services are provided and documented related to the clinical workup of the patient and the decision to treat with radioiodine. Evaluation and management code selection should be in compliance with CPT® requirements. In 2005, a HCPCS Level II code should be submitted to all payers to report the radiopharmaceutical supply used since the CPT® codes 78990 and 79900 have been deleted from the CPT® book. Check Medicare and other third-party payer notifications on their guidelines for the use of these codes.

Note that if a second treatment dose of I-131 for hyperthyroidism needs to be given, there is no code to describe an additional dose, as previously described by 79001 (subsequent, each therapy); therefore, reporting of 79005 (Radiopharmaceutical therapy, by oral administration) for the second therapeutic dose of I-131 would be appropriate.

Q: My carrier has informed me to use the old codes in place of the new Category III codes 0066T and 0067T to report CT colonography. Should I be concerned about compliance?

A: If your carrier's system is not set up as yet to accept the new category III codes implemented in July 2004 to identify screening (0066T) and diagnostic (0067T) CT colonography studies, ask the carrier to provide something to you in writing stating the appropriate codes to use until their system is updated. As of January 1, 2005, however, all radiology practices and payers will need to have their systems updated to send and receive the appropriate codes on the date the codes become valid, as noted in the Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rules. There will no longer be a 90-day grace period. Reference the Mar/Apr 2004 ACR Radiology Coding Source™ for further discussion of this change in policy.

Q: Is it appropriate to report the fluoroscopic guidance and injection codes used when performed in conjunction with a nuclear medicine therapeutic synovectomy?

A: Yes, it is appropriate to report one of the injection codes (20600-20610) and fluoroscopic guidance for needle placement code (76003) when performed in conjunction with intra-articular radiopharmaceutical therapy (79440). The introductory language to the Nuclear Medicine Therapeutic section of the CPT® 2005 book has been updated to note the appropriateness of separately reporting these services. It states "For intra-arterial, intra-cavitary, and intra-articular administrations, also use the appropriate injection and/or procedure codes, as well as imaging guidance and radiological supervision and interpretation codes, when appropriate."

July-Aug 2004 Q and A

Q: What is the appropriate code to report for a translabial ultrasound when the probe is different from that used for a transvaginal ultrasound, and the probe does not enter the vagina?

A: A translabial ultrasound performed using a probe that is different from that used for a transvaginal ultrasound and that does not enter the vagina is appropriately coded using either a nonobstetrical pelvic or obstetrical ultrasound code.

Translabial or transperineal ultrasound is occasionally performed for determining cervical effacement in a late third trimester pregnancy to check the inferior placental margin without resorting to a transvaginal probe, or to evaluate a labial or perineal mass. Since these indications are all part of a nontransvaginal ultrasound evaluation of the pelvis or a pregnancy, the appropriate pelvic (eg, 76856) or obstetrical ultrasound code (eg, 76805) should be used. If the study is limited to translabial or transperineal scans, and a complete transabdominal study is not performed, the appropriate limited pelvic (eg, 76857) or other limited obstetrical ultrasound code (eg, 76815) should be used. If a complete transabdominal ultrasound of the pelvis or transabdominal obstetrical ultrasound study is also performed, then the respective translabial examination is included and not coded separately.

Q: Is it appropriate to code 76986 (ultrasonic guidance, intraoperative) when a duplex scan is performed to verify intraoperatively the functioning of a newly created graft or fistula for dialysis?

A: It is not appropriate to report code 76986 (ultrasonic guidance, intraoperative) when a duplex scan is performed to verify intraoperatively the functioning of a newly created graft or fistula for dialysis. Code 76986 describes an intraoperative ultrasound guidance procedure, not final verification. This is a code intended to be used for localization. It is not intended to be used to show that something works, such as a newly created graft or fistula for dialysis.

If a full and complete duplex study were performed, it would be appropriate to report 93990 (duplex scan of hemodialysis access including arterial inflow, body of access, and venous outflow). If a duplex scan were performed for patency only, report 93990 with the –52 modifier to indicate the study was limited.

Mar-Apr 2004 Q and A

Q: With the implementation of new Category III codes as of July 1, 2004, how should a CTC be coded when it is performed following a failed screening colonoscopy due to obstructing lesion? Should this be reported as a screening or diagnostic procedure?

A: Although the indication for the colonoscopy was for screening purposes, the indication for CT colonography is for a known obstructing lesion and, therefore, should be coded as a diagnostic CT colonography study. As of July 1, 2004, the code used to describe a diagnostic CTC is 0067T.

If the indication for CT colonography were for screening purposes, the screening CTC code (0066T) should be reported even if a positive finding may be found on CTC. The positive finding may be reported as a secondary diagnosis.

Section IV, Diagnostic Coding and Reporting Guidelines for Outpatient Services, of the ICD-9-CM Official Guidelines for Coding & Reporting (http://www.cdc.gov/nchs (http://www.cdc.gov/nchs)), as provided by the Centers for Medicare and Medicaid Services and National Center for Health Statistics (developed and approved by the American Hospital Association, the American Health Information Management Association, CMS and NCHS), has been clarified in Program Memorandum AB-01-144 (E),

When a diagnostic test is ordered in the absence of signs/symptoms or other evidence of illness or injury, the physician interpreting the diagnostic test should report the reason for the test (e.g., screening) as the primary ICD-9-CM diagnosis code. The results of the test, if reported, may be recorded as additional diagnoses.

Q: Is it appropriate to use code 76937 (ultrasound guidance for vascular access) with a –52 modifier if permanent images are not recorded?

A: No, it is not appropriate to report 76937 (ultrasound guidance for vascular access…) with a –52 (reduced services) modifier if permanent images are not recorded. The descriptor specifies "…with permanent recording and reporting…". As noted in the ACR Radiology Coding Source™ Nov/Dec 2003 issue, "A permanently recorded image for guidance (U/S and/or fluoroscopy) is required."

The AMA's CPT® Changes – An Insider's View, 2004, also notes: "…Use of code 76937 requires a permanent recorded image(s) of the vascular access site to be included in the patient record, as well as a documented description of the process either separately or within the procedure report."

Q: What are the appropriate codes to use for two PA chest x-rays performed on inspiration and expiration postlung biopsy, or for trauma cases?

A: When two PA chest x-rays are performed, one on inspiration and one on expiration, it is appropriate to code 71010 (chest, single view) for the single, frontal chest inspiration view, and 71035 (chest, special views [e.g., lateral, decubitus, Bucky studies]) for the expiration view. The expiration view of the chest is considered a special view.

If a PA and lateral chest x-ray were performed on inspiration and expiration, it would be appropriate to report 71020 for the two views of the chest on inspiration, and 71035 for the two views of the chest on expiration.

Jan-Feb 2004 Q and A

Q: Is it appropriate to code for a mammogram following a vacuum assisted, image-guided biopsy and tissue marker placement?

A: The coding for a mammogram following a vacuum-assisted, image-guided breast biopsy and tissue marker placement would depend on the modality used, as well as the number of physicians involved. The biopsy is appropriately coded 19103 for the percutaneous vacuum-assisted breast biopsy using imaging guidance, 76095 for the stereotactic localization, and 19125 for the placement of the tissue marker.

If all of the imaging takes place on a stereotactic machine and is performed by the same physician, the post procedure mammogram is included in code 76095. Code 76095 includes all of the imaging and work involved by a physician to perform this procedure. Therefore, it is not appropriate to code for the follow-up mammogram.

There are instances, however, when it would be appropriate to code separately for a mammogram post vacuum-assisted breast biopsy. The rationale for this is that the

mammogram is a separate procedure using a different imaging modality and it is not essential to the successful completion of the ultrasound guidance procedure.

Another instance when it would be appropriate to code separately for the follow-up mammogram is when a surgeon does the stereotactic procedure and clip placement, and then refers the patient to radiology for a follow-up mammogram or ultrasound. In this instance, it is appropriate for the radiologist to code for the mammogram or ultrasound study performed. This is one of many examples where coding is dependent on whether there is one or multiple physicians involved in the steps of the procedure.

Q: How is a magnetic resonance angiography of the aorta with runoff coded? How far do you have to go for it to be considered iliofemoral?

A: Unlike CTA of the abdominal aorta with iliofemoral runoffs of the lower extremity (75635) there is no specific MRA code to describe this study. MRA of the abdominal aorta with iliofemoral runoffs of the lower extremity is appropriately coded using CPTâ code 74185 [Magnetic resonance angiography, abdomen, with or without contrast material(s)] and 73725 [Magnetic resonance angiography, lower extremity, with or without contrast material(s)]. To be considered an iliofemoral runoff procedure, the femoral artery should be included, at least, to the level of the knees.

When a bilateral study of the lower extremities is performed, it is appropriate to submit code 73725 twice. However, you will need to identify for your carrier and other third-party payers that this is not a duplicate charge by assigning a modifier (e.g. –RT, –LT, or –59) to identify that a bilateral procedure was performed.

Q: Is it appropriate to code 72080 for two views of the thoracolumbar spine produced on a DEXA machine?

A: It is the opinion of the ACR's Committee on Coding & Nomenclature that it is not appropriate to code for 72080 for the two views of the thoracolumbar spine or for any number of spine views when obtained on a DEXA unit in conjunction with a bone scan. The rationale is that CPT code 72080 is intended for plain film radiography, and the views obtained on a DEXA unit are not plain film radiography. Code 72080 is specifically for two plain film views of the thoracolumbar spine.

Nov-Dec 2003 Q and A

Q: How do you code for a radiofrequency ablation of a varicose veins procedure using ultrasound imaging for guidance and monitoring?

A: Currently there is no code that accurately describes the performance of endovenous radiofrequency ablation therapy using imaging for guidance and monitoring of the ablation. At this time, the appropriate codes to report this procedure are 37799 (Unlisted procedure, vascular surgery) for the endovenous RFA and 76999 [(Unlisted ultrasound procedure (e.g.,

diagnostic, interventional)] for the guidance and monitoring of the procedure, unless otherwise instructed by your carrier or payer.

Q: A post-operative lung transplant patient has a conventional CT scan without contrast performed to evaluate bronchial anastamosis, the parenchyma, and lymph nodes. During the same session, an inspiration/expiration high-resolution CT scan is performed to look for air trapping and to better evaluate the parenchyma. Is it appropriate to charge for the high-resolution scan separately?

A: If a high-resolution CT of the chest without contrast that consists of more than just a few extra sections (e.g. supine and prone studies in inspiration and expiration at multiple levels) is performed to better evaluate the parenchyma, report code 71250 (CT thorax, without contrast) and append a –22 modifier (services provided are greater than those usually required). It is recommended that a report be submitted to justify the use of the –22 modifier. It is not appropriate to code for the high resolution separately as all three acquisitions are "unenhanced" chest CT exams.

When a few additional sections are obtained as part of a CT of a particular anatomical region, they are included in the initial examination and not coded separately. However, if two studies are performed at two separate sessions and based on two separate orders, it would be appropriate to report both studies. In this case, one of the studies would require a modifier to indicate separate and distinct studies.

Q: How should a study of an MRI of the brain and of the pituitary gland be reported?

A: If both an MRI of the brain and an MRI of the pituitary gland are separately requested and performed with a full series of specialized pulse sequences, specifically of the pituitary
gland, then an MRI of the brain should be reported two times with a modifier (e.g. –59) appended to the second study. Note that clear, separate and distinct indications for two complete studies must be documented. If just an additional pulse sequence or two, focused on the pituitary gland, are added to the MRI of the brain, the extra sequences would be considered part of the base study, and an MRI of the brain reported only once.

This is similar to the reporting of an MRI of brain and the internal auditory canal. Reference the March/April 2003 feature article of the ACR Radiology Coding Source™ for further discussion.

Sept-Oct 2003 Q and A

Q: How do you code for CT-guided radiofrequency ablation of a kidney tumor?

A: Currently, there is no CPT® code to describe a radiofrequency ablation of a kidney tumor; therefore, it is recommended that the unlisted procedure code 53899 be used. The

CT guidance associated with the kidney tumor ablation would be coded 76362 (CT guidance for, and monitoring of, tissue ablation). CPT® codes are also available to describe guidance for, and monitoring of, tissue ablation when performed with MR (76394) and ultrasound (76490).

Please note that in the CPT® 2004 manual there is a revision to the descriptors of the ablation guidance codes. The descriptors have been updated to specify "...guidance for and monitoring of visceral tissue ablation." Also new for 2004 is a CPT® code to describe radiofrequency ablation of bone tumors. See the November/ December ACR Radiology Coding Source™ for a more detailed discussion of the new 2004 codes.

Q: How do you code for a CTA of the coronary arteries and CT for heart wall thickness, ejection fractions and stroke volumes? Essentially, we perform two different studies: 1) a CTA of the coronary arteries; and 2) a CT heart for wall thickness, ejection fractions, and stroke volumes, as well as other information. Each test is separate and distinct from the other and can be performed alone or at the same time. If performed at the same time, we scan them once and use the same data set for both parts. However, they will be ordered and performed together the majority of the time. How should this be coded?

A: When a study of the coronary arteries and imaging of the heart for wall thickness, including ejection fractions and stroke volumes, is performed, it would be appropriate to code for a CTA of the chest (71275) with the addition of a –22 modifier to indicate unusual procedural services above and beyond that which is ordinarily performed. A CT of the thorax should not be coded. Just as a dedicated splenic CTA would be a CTA of the abdomen, a targeted CTA of the coronaries would be CTA of the chest. Likewise, interpretation of a CTA of the abdomen includes interpretation of the axial data set, and the same is true for CTA of the thorax. It is not appropriate to code for a 76375 for reconstruction, because the 3-D work is included in the CTA code. Currently a code does not exist for the ejection fraction work of this procedure; therefore, it is recommended that the –22 be used in addition to the CTA code, with an appropriate increase in charges to reflect the extra work.

Please reference the May/June ACR Radiology Coding Source™ for a discussion of CTA and when it is appropriate to code for both CT and CTA.

Q: Are there any qualifiers to the use of the CPT code 76010 (Radiologic examination from nose to rectum for foreign body, single view, child)? How do you define a child when coding for this procedure?

A: The definition of "child" for the purpose of CPT code 76010 is an operational one, i.e., can the procedure be done on one film? Any child who measures less than 17 inches from nose to rectum and, thereby, fits on a single 14 x 17 inch film would fit the definition of

"child" for this study. Since the descriptor specifically states "one view," one could argue that the entire study should be able to fit on one film. Hence, any child requiring two or more films to evaluate from nose to rectum for a foreign body would be coded as separate one-view chest and abdomen studies.

Mar-Apr 2003 Q and A

Q: Is it appropriate to use one of the new urinary catheterization codes (51701, 51702 or 51703) in conjunction with the nuclear medicine ureteral reflux study code (78740)?

A: Yes, it is appropriate to use code 51701, 51702, or 51703 in conjunction with the nuclear medicine code 78740 [Ureteral reflux study (radiopharmaceutical voiding cystogram)] when a physician performs the catheterization.

Urinary catheterization, as described by the newly created 2003 CPT® codes 51701, 51702, and 51703, is not part of a ureteral reflux study. These new codes replace urethra catheterization codes 53670 (simple) and 53675 (complicated) and HCPCS code G0002 [Office procedure, insertion of temporary indwelling catheter, Foley type (separate procedure)]. The codes are broken down into three types of bladder catheterization procedures: insertion of a non-indwelling catheter (e.g. for residual urine); insertion of a temporary indwelling catheter, simple (e.g. a Foley catheter); and insertion of an indwelling catheter, complicated (e.g. possible complications such as altered anatomy, fractured catheter/balloon). These urinary catheterization procedures would be performed prior to a radiopharmaceutical voiding cystogram (78740). The radiopharmaceutical voiding cystogram (ureteral reflux study) is a separate and distinct study and is performed for the detection of vesicoureteral reflux with dynamic imaging during filling and emptying of the urinary bladder.

Note: it would not be appropriate to code 51701, 51702, or 51703 if urinary catheterization is performed as a small component of a larger surgical procedure. Note also that urinary catheterization should only be coded separately if it is done by a physician - not by a nurse or technologist.

Q: If a vascular study (with or without color doppler) is performed in conjunction with ultrasound of the liver, is it appropriate to report both CPT code 76705 (Abdominal ultrasound, limited) and CPT code 93975 (Duplex scan of arterial inflow and venous outflow of abdominal, pelvic and/or retroperitoneal organs; complete study)?

A: Yes, if an ultrasound of the liver is performed, and there is a clinical need for further evaluation by duplex scanning, then it is appropriate to code for both 76705 and 93975.

A vascular study (with or without color flow) may be reported in addition to ultrasound studies when it is clinically indicated (medically necessary). The radiology codes for ultrasound (e.g. abdomen, retroperitoneal, etc.) generally represent two-dimensional

(gray-scale) imaging. For example, CPT-4 code 76700 includes gray-scale real-time or static images of the entire abdomen from the diaphragm to the level of the umbilicus. If the study includes anything less than the all-inclusive code 76700, then the limited code 76705 should be billed.

Sometimes a vascular study is added to the basic gray-scale study when enhancement of suspect areas or more detailed analysis is needed. CPT code 93975 describes evaluation of arterial inflow and venous outflow of abdomen, retroperitoneum, scrotal contents and/or pelvic organs. This code can be used whether single or multiple organs are studied. It is a "complete" procedure in that all major vessels supplying blood flow (inflow and outflow, with or without color flow mapping) to the organ are evaluated. If the study is only a partial evaluation, then the limited code (93976) is billed. Therefore, in cases where it is necessary to perform a vascular study in conjunction with ultrasound of an organ, it would be appropriate to report the vascular study separately.

In order to code an abdominal duplex study, true vascular analysis needs to be performed. Abdominal duplex should not be coded when color is just turned on to determine if a structure is vascular (e.g. distinguishing hepatic artery from the common bile duct).

Note that since January 1997, Medicare Correct Coding Initiative (CCI) edits have been in place for the vascular study codes (93975/93976) when used in conjunction with the pelvic ultrasound codes (76856/76857). Medicare considers these pairs to be mutually exclusive, that is, they should not be performed by the same physician, for the same patient, on the same date of service. The code pair edits do list a modifier indicator of "1" with the vascular study codes (939751, 939761); therefore, it would be appropriate to submit these codes together with a modifier attached to the vascular study code (e.g. 93975 –59 or 93976 –59). For example, a patient comes in with pelvic pain, and the US of the pelvis demonstrates an enlarged ovary. The differential diagnosis includes torsion of the ovary. A vascular study is requested to establish the arterial inflow and venous drainage of the ovary and determine torsion or infarction. In this scenario, it would be appropriate to code 76856 for the pelvic ultrasound and 93976-59 for the limited vascular study of the ovary.

Jan-Feb 2003 Q and A

Q: What is the correct CPT® radiology code to describe an ultrasound of a pregnant uterus with multiple gestations when no maternal evaluation is provided?

A: It is the consensus of the ACR's Committee on Coding & Nomenclature that if an ultrasound of a pregnant uterus with multiple gestations is performed without maternal evaluation, it would be appropriate to code either 76801 for the first gestation and 76802 for each additional gestation if performed during the first trimester (< 14 weeks 0 days), or 76805 for the first gestation and 76810 for each additional gestation if performed after the first trimester (= or > 14 weeks 0 days) as long as reason for nonvisualization is

documented. As noted in the introductory notes of the CPT® 2003 Manual, all elements must be evaluated and documented in the report or the reason for non-visualization.

Q: How do you code for treatment aids using multi-leaf collimation (MLC) when it substitutes for the use of blocks? Would you code one treatment aid charge for each gantry angle?

A: It is appropriate to report one treatment device code per (77332-77334) gantry angle.

Q: How should a CT virtual colonoscopy be coded?

A: It is the opinion of the ACR's Committee on Coding & Nomenclature that CT of the abdomen, CT of the pelvis and 3-D reconstruction (76375) codes are appropriate to describe a fly-through exam of the colon (sometimes called "virtual colonoscopy").

May-June 2016 Q and A

Q: Previous National Correct Coding Initiative (NCCI) edits and SIR/ACR guidance indicate that when venous sampling is performed, it is reported "once per organ sampled." Since adequate pituitary venous sampling requires selective catheterization and aspiration of bilateral petrosal venous sinuses, what is the correct coding for this procedure?

A: It is the consensus of the Economics Committees on Coding and Nomenclature and Interventional Radiology that it is appropriate to report codes 36500, 36500-59.

Venous catheterization for selective organ blood sampling), 75893, and 75893-59 (Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation) when a single organ such as the pituitary is sampled from separate, selective catheterizations of the right and left inferior petrosal sinuses. Use modifier 59 Distinct Procedural Service) or modifier XS (Separate Structure: A service that is distinct because it was performed on a separate organ/structure) in lieu of modifier 59 to distinguish the procedures are separate and distinct. As modifiers are payer specific, check with your third-party payers to determine how you should report these procedures.

May-June 2016 Q and A

Q: An ultrasound of the liver is performed using the newly FDA–approved contrast agent Lumason. How should this be reported? [CLARIFIED 7/12/16*]

A: The Ultrasound contrast agent known as Lumason has been approved by the Food and Drug Administration for use in ultrasonography of the liver for characterization of focal liver lesions in adult and pediatric patients. The temporary Healthcare Common Procedure Coding System (HCPCS) Level II code C9457 (Lumason contrast agent) was replaced by a

permanent HCPCS Level II code Q9950 (Injection, sulfur hexafluoride lipid microspheres, per ml), effective January 1, 2016.

Given that there are no dedicated ultrasound with contrast codes, when a contrast enhanced ultrasound study of the liver is performed using Lumason, the ultrasound procedure may be reported with CPT code 76705; Ultrasound, abdominal, real time with image documentation; limited, and the injection of contrast reported with code 96374; Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug. The reporting of 96374 is similar to the long-standing coding guidance regarding the use of contrast agents for echocardiography. As noted in the January 2010, CPT Assistant, p. 8, the use of 96374 is appropriate for the administration of contrast material used during performance of a resting echocardiography (codes 93306, 93307, and 93308). For the injection of contrast media for imaging, code 96374, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug, may be reported. The ultrasound contrast agent Lumason should be reported separately using HCPCS Level II supply code Q9950 based on the number of milliliters administered.

*96374 is identified as an Incident to Code and cannot be coded by the radiologist in the in patient and out-patient hospital place of service for Medicare patients. As noted in the National Physician Fee Schedule Relative Value File Calendar Year 2016 PC/TC Indicator, 5, = Incident To Codes--This indicator identifies codes that describe services covered incident to a physician's service when they are provided by auxiliary personnel employed by the physician and working under his or her direct personal supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes.

May-June 2019 Q and A

Q: How is a voiding urosonography (ultrasound voiding cystourethrography) reported?

A: A voiding urosonography (ultrasound voiding cystourethrography) is reported with codes 51600, *Injection procedure for cystography or voiding urethrocystography*, and 74455, *Urethrocystography, voiding, radiological supervision and interpretation*. These codes are used to report the injection of the contrast material and the radiological supervision and interpretation of the exam regardless of the type of imaging or contrast material used for the procedure. Similarly, if performing ultrasound cystography (eg, for evaluation for suspected or known enterovesical fistula in a patient with inflammatory bowel disease), it is appropriate to report the exam with codes 51600 and 74430, *Cystography, minimum of 3 views, radiological supervision and interpretation*.

May – June 2015 Q and A

Q: How do you code for additional volume quantification following magnetic resonance imaging (MRI)? Is CPT code 76377, 3D rendering with interpretation and reporting of CT, MRI, US or other tomographic modality with image post-processing under concurrent supervision; requiring imaging post-processing on an independent workstation, the appropriate code to use?

A: It is appropriate to report CPT code 76377 if it meets the requirements for CPT 76377, 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image post-processing on an independent workstation.

However, it is not appropriate to report CPT code 76377 if MRI data is loaded onto a vendor's computer system at an off-site location for post-processing and a summary report is generated that is then used by the physician treating the patient as part of an evaluation and management service. In this scenario, this additional volume quantification following magnetic resonance imaging (MRI) does not involve separate identifiable physician work and is included in the base MRI code. The 3D rendering code 76377 is not separately reportable because there is no concurrent physician supervision.

Q: How do we code for a single planar imaging session alone or planar with SPECT imaging using 99mTc PYP looking for cardiac amyloidosis? Since the procedure is similar to infarct avid CPT 78469, should we use that CPT code?

A: The ACR and Society of Nuclear Medicine and Molecular Imaging do not recommend reporting CPT 78469, Myocardial imaging, infarct avid, planar; tomographic SPECT with or without quantification, to describe a single planar imaging session alone or planar with SPECT imaging using 99mTc PYP looking for cardiac amyloidosis. CPT code 78469 was established for a different purpose, and cardiac amyloidosis is not an infarct procedure. As per CPT instructions, “Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided.”

After reviewing the CPT options, the ACR and SNMMI recommend CPT 78800, Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); limited area, for a single planar imaging session alone (without a SPECT study), and CPT 78803, Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); tomographic (SPECT), for planar imaging with SPECT, as these CPT codes accurately describe the services. When reporting CPT 78803, limited or multiple planar imaging would be included with the SPECT, therefore, this CPT code reflects the service performed. Report HCPCS Level II code A9538, Technetium Tc-99M pyrophosphate, diagnostic, per study dose, up to 25 millicuries, to describe the radiopharmaceutical used.

Mar-April 2014 Q and A

Q: We have a new system that delivers dual-energy bone density measurements in a single-sweep. One of the system's clinical applications is for Atypical Femur Fracture (AFF) assessment. It provides images of the entire femur for assessment of potential atypical femur fractures to monitor the effects of bisphosphonate therapy over time. The FDA says that any patient on bisphosphonates who presents with thigh or groin pain must be evaluated to rule out femoral fracture. In this case, the one-view evaluation is for patients that present with thigh or groin pain. How should this study be reported?

A: It is appropriate to report CPT code 73550 (Radiologic examination, femur, 2 views) as the service provided is a diagnostic evaluation of the femur. Modifier 52 should be used in conjunction with 73550 to indicate that the procedure performed was altered, i.e., only a one-view evaluation of the femur was provided vs two views. As noted in the CPT 2014 codebook, Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service."

July-Aug 2020 Q and A

Q: What are the appropriate codes to report a percutaneous renal access for an antegrade pyelogram study?

A: Reporting a percutaneous antegrade pyelogram (nephrostogram) depends on whether a new access is required, or whether an existing access is in place. For a patient requiring a new access, the procedure is performed under imaging guidance by percutaneous placement of a needle or catheter into the renal pelvis under imaging guidance. Contrast medium is injected and a series of images are performed to observe the flow of contrast material as it passes from the renal collecting system through the urinary tract. This is appropriately reported with CPT® code 50430, *Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access*. Additionally, instructional guidelines in the CPT codebook under the O*ther Introduction (Injection/Change/Removal) Procedures* states, "Code 50430 also includes accessing the collecting system and/or associated ureter with a needle and/or catheter."

For a patient with an existing access, contrast medium is introduced through an existing tube, catheter, or stoma. This procedure is reported with CPT code 50431, *Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated*

radiological supervision and interpretation; existing access. It is important to note that antegrade nephrostogram/ureterogram is included in all of the percutaneous genitourinary procedures (50432, 50433, 50434, 50435, 50693, 50694, 50695).

Nov-Dec 2020 Q and A

Q: ACR has previously clarified in the December 2018 issue of Coding Source that it is appropriate to code a "with contrast" spine when the spine is reconstructed from a body computed tomography (CT) acquisition that was performed with contrast. For example, original scan such as CT Chest w/contrast (71260 and CT Abdomen & Pelvis w/contrast 74177. A question has been raised if this is still correct when only the bone windows of the reconstructed spine are interpreted, since the IV contrast is not evident as in the soft tissues window. The reconstructed spine will be interpreted by a neuroradiologist. The soft tissues with contrast on the original body CT scans are interpreted by another radiologist. I would like to confirm that 72129 CT Thoracic Spine with contrast and 72132 CT Lumbar Spine with contrast is appropriate for the professional component (-26 modifier).

A: The window and level settings used to review the CT images do not determine the CPT code selection. When the base body CT code is performed with IV contrast (eg, 71260), then the respective reconstructed spine CT with IV contrast (72129 with -26 modifier) should be reported. Similarly, when the base body CT code is performed without IV contrast (eg, 71250), then the respective reconstructed spine CT without IV contrast (72128 with -26 modifier) should be reported.

The anatomic area scanned and whether the scan is performed without, with, or with and without intravenous contrast, should all be clearly described in the dictated report. Based on the report provided, it is not possible to assign a CPT code correctly. Specifically, the dictation does not specify whether contrast was used. This information is necessary for the selection of the correct CPT code for the reconstructed CT and should be included in the reports for both the base CT procedure and reconstructed spine CT.

Breast Imaging Frequently Asked Questions Update 2019

Q: How should the use of computer-aided detection software be reported in conjunction with breast sonography services?

A: No code is available to describe computer-aided detection (CAD) performed in conjunction with breast ultrasound. CAD performed in conjunction with breast sonography is reported with the unlisted CPT code 76999 (Unlisted ultrasound procedure (e.g., diagnostic, interventional)) to describe the CAD analysis and CPT code 76641 (Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete) or 76642 (Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited) to describe the breast ultrasound study.

Mar-April 2012 Q and A

Q: How does concurrent supervision apply to the radiologist that is performing the interpretation only for 3D reconstruction of images? If the 3D acquisition is the result of a computer program which generates the images, may the radiologist report the interpretation using one of the 3D codes, 76376 or 76377? How should the "concurrent supervision" be documented in the dictated report?

A: It is not appropriate to report the technical component (TC) or the professional component (PC) of CPT codes 76376 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image post-processing on an independent workstation) or 76377(3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image post-processing on an independent workstation) when the reconstruction of images is performed without concurrent physician supervision.

As stated in the Q&A published in the November-December 2006 issue of the ACR Radiology Coding Source™, the Winter 2006 issue of Clinical Examples in Radiology, and on page 370 of the CPT 2012, Professional Edition code book, concurrent physician supervision is required for the reporting of the three-dimensional (3D) codes 76376 and 76377. It is not required to document physician involvement; however, the College recommends that it is best to document the physician's supervision or participation in the 3D reconstruction of images in case of an audit, and to distinguish from those cases where the physician is not involved.

Per the AMA/ACR Clinical Examples in Radiology, Concurrent physician supervision, as noted in the new 3D codes 76376 and 76377, defines a temporal relationship to creating the 3D volume rendered images. Concurrent means active participation in and monitoring of the reconstruction process that includes: design of the anatomic region that is to be reconstructed; determination of the tissue types and actual structures to be displayed (eg, bone, organs, and vessels); determination of the images or cine loops that are to be archived; and monitoring and adjustment of the 3D work product.

Concurrent does not relate to the definitions for general, direct, and personal supervision that have been established by the Centers for Medicare and Medicaid Services, which relate to the physical location of the physician with respect to the patient and would apply to the computed tomography acquisition base procedure code.

Breast Imaging Frequently Asked Questions Update 2019

Q: Should a screening mammogram or a diagnostic mammogram be performed on an asymptomatic patient with augmented breasts (e.g., breast implants)?

A: According to the ACR Practice Parameter for Performance of Screening and Diagnostic Mammography, the facility and/or interpreting physician can determine whether a woman with augmented breasts (breast implants) is imaged as a screening or a diagnostic patient. The practice parameter notes the following screening mammography indications for a woman with breast augmentation:

6. Woman with breast augmentation
a. Asymptomatic women with breast implants may undergo screening mammography.
b. Facilities must have procedures in place to inquire whether patients have breast implants before a mammogram is performed.
c. If a facility does not provide implant imaging services, it should refer the patient to other facilities that provide such services.

However, the Centers for Medicare and Medicaid Services' (CMS) payment policy for a diagnostic mammogram does not recognize asymptomatic patients with augmented breasts as diagnostic. Medicare will pay only for a screening mammogram for an asymptomatic woman with breast implants.

Because Medicare denies the necessity of a diagnostic mammogram for an asymptomatic patient with augmented breasts, it is recommended that the physician have the patient sign an advance beneficiary notice form so that the radiologist may bill the patient for the procedure. If the patient and referring physician decide that a screening mammogram should be performed, then the patient would receive a screening mammogram.

The ACR practice parameters are an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care.3

3ACR Practice Parameter for the Performance of Screening and Diagnostic Mammography, Res. 35 - 2018)*.

Breast Imaging Frequently Asked Questions Update 2019
Q: What CPT code(s) should be used to report a percutaneous breast biopsy?

A: Percutaneous breast biopsy procedures are reported with CPT codes 19081-19086 and 19100 based on whether the procedure performed is with or without imaging guidance. When percutaneous placement of a localization device is performed without the performance a breast biopsy, see codes 19281-19288.

Table 1 below provides a summary of the breast biopsy and placement of breast localization device codes. For detailed guidelines on the reporting of these codes, please reference the AMA's CPT 2019 introductory notes, which state the following:

- *When more than one biopsy or localization device placement is performed using the same imaging modality, use an add-on code whether the additional service(s) is on the same or contra-lateral breast.*
- *If additional biopsies or localization device placements are performed using different imaging modalities, report another primary code for each additional biopsy or localization device placement performed using a different image guidance modality.*
- *When more than one breast biopsy is performed using the same imaging modality, use an add-on code whether the additional service(s) is on the same or contra-lateral breast.*
- *If additional biopsies are performed using different imaging modalities, report another primary code for each additional modality.*
- *To report bilateral image-guided breast biopsies, report 19081, 19083, or 19085 for the initial biopsy.*
- *The contra-lateral and each additional breast image guided biopsy are then reported with code 19082, 19084 or 19086*
- The biopsy procedure code is submitted per lesion and NOT per sample.

Breast biopsy includes: imaging, placement of localization device(s), and imaging of biopsy specimen, when performed

Table 1: Reporting of Breast Biopsy and Placement of Location Devices

BREAST NEEDLE BIOPSY	**CPT**
Breast biopsy w/o imaging guidance, percutaneous	19100
Stereotactic guidance, 1st lesion	19081
Stereotactic guidance, each additional lesion	19082
Ultrasound guidance, 1st lesion	19083
Ultrasound guidance, each additional lesion	19084
Magnetic resonance guidance, 1st lesion	19085

Magnetic resonance guidance, each additional lesion	19086
Tomosynthesis guidance w/o stereotactic	19499

BREAST LOCALIZATION DEVICE(S) W/O BREAST BIOPSY	**CPT**
Mammographic guidance, 1st lesion	19281
Mammographic guidance, each additional lesion	19282
Stereotactic guidance, 1st lesion	19283
Stereotactic guidance, each additional lesion	19284
Ultrasound guidance, 1st lesion	19285
Ultrasound guidance, each additional lesion	19286
Magnetic resonance guidance, 1st lesion	19287
Magnetic resonance guidance, each additional lesion	19288
Surgical specimen radiography	76098

Breast Imaging Frequently Asked Questions Update 2019

Q: What is the correct way to code for a mammography examination on a mastectomy patient when one or two additional images are taken of the axillary region on the mastectomy side? Is it correct to report a bilateral mammography code even though there is no breast tissue? Would this be considered a screening or diagnostic study?

A: Yes, it is correct to code a bilateral mammography examination code even though there is no obvious breast tissue because both the side of the remaining breast and the mastectomy side are being imaged. This is analogous to a mammogram of a man, where there is little breast tissue. Depending on the type of mastectomy performed, there may be residual breast tissue left behind, usually in the axillary tail. If there is enough clinical concern to warrant imaging, there is probably clinical concern that a small amount of breast tissue remains. This should, therefore, be billed as a bilateral diagnostic mammogram (77066).

Breast Imaging Frequently Asked Questions Update 2019

Q: In a freestanding office or independent diagnostic testing facility (IDTF) setting, is a separate order required for a breast ultrasound study recommended by a radiologist to further evaluate a suspicious finding on screening mammography?

A: Yes, in freestanding office and IDTF settings a separate order is required for the addition of a breast ultrasound study following a screening mammography procedure to further evaluate a suspicious finding. The rationale that allows for the performance of a diagnostic mammogram following a screening mammogram without an order from the referring physician does not apply to additional diagnostic testing such as ultrasound or MRI (see Terrence Kay letter to American College of Radiology).

The national office of the Health Care Financing Administration (HCFA) notified the ACR that Medicare proposed and adopted the diagnostic mammography exception to the Ordering of Diagnostic Tests Rule (see Medicare Benefit Policy Manual, Chapter 15, Section 80.6) because Congress made the Food and Drug Administration, rather than HCFA, responsible for the conditions under which mammograms are covered. In addition, the screening mammography benefit contains no requirement for a physician's order. Thus, a beneficiary could receive the screening mammogram on a walk-in basis, with no treating physician to order the subsequent diagnostic procedure. Note that the Ordering of Diagnostic Test Rule does not apply in the hospital setting (see Thomas Scully letter to American Hospital Association, Response #1).

For more information on the Ordering of Diagnostic Test Rule, reference Further Clarification on the Ordering of Diagnostic Tests Rule in the July- Aug 2003 ACR Radiology Coding Source

Breast Frequently Asked Questions Update 2019

Q: When I do breast biopsies or localize breast lesions using metallic pellets, radioactive seeds, radio-frequency identification (RFID) devices or other localization devices instead of traditional clips or localization wires, how are these markers reported?

A: Metallic pellets, radioactive seeds, RFID devices or any other localization devices used during breast biopsy or breast localization are all included in codes 19081-19086 and 19281-19288. Note that these codes are used once per lesion localized, regardless of the number of localization devices placed in or around the lesion (i.e., if mammographically-guided needle localization is performed using two radioactive seeds to designate the margins prior to surgical excision, code 19281 is still only reported one time).

Breast Frequently Asked Questions Update 2019

Q: What differentiates a diagnostic from a screening mammography procedure?

A: Medicare's definitions of screening and diagnostic mammography, as noted in the Centers for Medicare and Medicaid's (CMS') National Coverage Determination database, and the American College of Radiology's (ACR's) definitions, as stated in the ACR Practice Parameter of Screening and Diagnostic Mammography, are provided as a means of differentiating diagnostic from screening mammography procedures. Although Medicare's definitions are consistent with those from the ACR, the ACR's definitions of screening and diagnostic mammography offer additional insight into what may be included in these procedures. Please go to the CMS and ACR Web site links noted below for detailed comments about these studies.

Medicare Definitions (CMS National Coverage Determination for Mammograms 220.4)

Per the CMS National Coverage Determination , the following definitions for screening and diagnostic mammography are provided:

"A diagnostic mammogram is a radiologic procedure furnished to a man or woman with signs and symptoms of breast disease, or a personal history of breast cancer, or a personal history of biopsy - proven benign breast disease, and includes a physician's interpretation of the results of the procedure."

"A screening mammogram is a radiologic procedure furnished to a woman without signs or symptoms of breast disease, for the purpose of early detection of breast cancer, and includes a physician's interpretation of the results of the procedure. A screening mammogram has limitations as it must be, at a minimum a two-view exposure (cranio-caudal and a medial lateral oblique view) of each breast."

Medicare will not pay for a screening mammogram performed on a woman under the age of 35. Medicare will pay for only one screening mammography procedure performed on a woman over age 34 but under age 40. For an asymptomatic woman over age 39, payment may be made for a screening mammography performed after at least 11 months have passed following the month in which the last screening mammography was performed.

As noted in the Medicare Benefit Policy Manual, Chapter 15 — Covered Medical and Other Health (Section 280.3) "the term 'screening mammography' means a radiologic procedure provided to an asymptomatic woman for the purpose of early detection of breast cancer…" Therefore, Medicare does not cover screening mammography for a man.*

Medicare will pay for a diagnostic mammogram when one of the following conditions is met:

- A patient has distinct signs and symptoms for which a mammogram is indicated
- A patient has a history of breast cancer

- A patient is asymptomatic but, on the basis of the patient's history and other factors the physician considers significant, the physician's judgment is that a [diagnostic] mammogram is appropriate

*Information on the use of modifier KX on claims for transgender patients

ACR Definitions (as defined in the ACR Practice Parameter of Screening and Diagnostic Mammography)

Screening mammography is a radiological examination to detect unsuspected breast cancer in asymptomatic women. Standard views are obtained, and thus the interpreting physician does not need to be present at the facility to monitor the examination when the patient is imaged.

The examination should ordinarily be limited to craniocaudal (CC) and mediolateral oblique (MLO) views of each breast. On occasion, supplementary views may be required to visualize breast tissue completely or optimally, but such views are not ordinarily part of the routine screening examination except for women with implants. Views may be modified to accommodate patient positioning limitations.

Diagnostic mammography is a radiologic examination performed to evaluate patients who have signs and/or symptoms of breast disease, imaging findings of concern, or prior imaging findings requiring specific follow-up. Diagnostic mammography requires direct supervision.1 A diagnostic mammogram may include MLO, CC, and/or additional views to evaluate an area of clinical or radiographic concern. Additional mammographic views might include spot compression, spot compression with magnification, tangential views, or other special views. When selecting a view, the proximity of the area of concern to the image receptor should be considered.

The written or electronic request for a diagnostic mammography examination should provide sufficient information to demonstrate the medical necessity for the examination and allow for its proper performance and interpretation.

As noted in Section II. Indications, B. Diagnostic Mammography, of the ACR Practice Parameter of Screening and Diagnostic Mammography, indications for diagnostic mammography includes:

1. To assess certain clinical findings that may include a palpable abnormality, persistent focal area of pain or tenderness, bloody or clear nipple discharge, or skin changes.
2. A finding detected on screening mammography that requires further imaging evaluation. This could either be a call-back examination following an abnormal screening mammogram, or conversion of a screening mammogram to a diagnostic mammogram when an abnormality is detected at the time of the screening visit.

3. Short-interval follow-up for probably benign radiographic findings as defined by the ACR Breast Imaging Reporting and Data System (BI-RADS®).
4. Asymptomatic patients previously treated for breast cancer may undergo screening or diagnostic mammography at the discretion of the facility.
5. Determination that a patient scheduled for screening mammography has a clinical problem, as noted above in section II.B.1. The facility should have a process whereby screening mammography can be converted to diagnostic mammography. mammography can be converted to diagnostic mammography.

When billing for a Medicare patient who has had a mammogram, one must be cautious to follow the Centers for Medicare and Medicaid Services' definition. One should consult the local Medicare carrier or Medicare Administrative Contractor to determine how to code for some scenarios. Note that non-Medicare third-party payers should be contacted as they may handle coverage of screening and diagnostic mammograms differently.

1Direct supervision is defined as the physician being present and immediately available to furnish assistance and direction throughout the performance of the procedure. Direct supervision may also be accomplished via telemammography as long as the interpreting physician is immediately available.

Breast Imaging Frequently Asked Questions Update 2019

Q: How is computer-aided detection (CAD) coded when performed in addition to mammography?

A: As of January 1, 2017, three Category I codes were created to describe mammography (both digital and analog) with computer-aided detection (CAD) when performed. These bundled codes (77065, 77066, 77067) replaced CPT CAD codes 77051 and 77052, and mammography codes 77055, 77056, 77057. For dates of service on or after January 1, 2018, the Centers for Medicare & Medicaid Services (CMS) has operationalized these CPT codes, and deleted the HCPCS Level II G codes G0202, G0204, and G0206 that used to mirror the CPT codes 77065, 77066, 77067. It is recommended that providers check with their third-party payers for their specific payer requirements.

Breast Imaging Frequently Asked Questions Update 2019

Q: How should breast MRI with the use of computer-aided detection software be reported?

A: Prior to January 1, 2019, breast MRI with CAD was reported with Codes 77058, 77059, and 0159T, these codes have been deleted and replaced with new codes 77046-77049. The ACR presented a code proposal at the June 2017 CPT Editorial Panel meeting that requested the MRI breast codes bundle in the performance of CAD, when performed. The new CPT codes were approved for use beginning January 1, 2019.

Table 1 CPT Description	CPT Codes
MRI, breast, without contrast; unilateral	77046
MRI, breast, without contrast; bilateral	77047
MRI, breast, without and with contrast, including CAD, when performed; unilateral	77048
MRI, breast, without and with contrast, including CAD, when performed; bilateral	77049

Breast Imaging Frequently Asked Questions Update 2019

Q: Is it appropriate to combine the interpretation of a screening and a diagnostic study into one report or must two separate reports be issued?

A: Yes, it is appropriate to combine the interpretation of a screening and a diagnostic study into one report. According to the ACR Breast Imaging Reporting and Data System (BIRADS®)* frequently asked questions (see Multiple Procedures section):

The facility has the option of issuing either separate reports or one combined report. If two reports are issued, each must contain its own overall final assessment (21 CFR 900.12(c)(1)(iv)). In either case, the facility can report the exam(s) on the same piece of paper.

If the facility decides to issue a single combined report, the facility needs to be aware of the following:

1. *A combined report must contain a single overall final assessment for the two exams (21 CFR 900.12(c)(1)(iv)).*
2. *The combined report should make it clear that it is combining the results of the screening and diagnostic studies. This is especially important if questions arise about whether the exams were billed correctly.*
3. *Issuing a single combined report with a single final assessment may skew the facility's medical audit results.*
4. *Though some computerized reporting systems may consider this a single exam (rather than two), the FDA [Food & Drug Administration] would still allow facilities to count both exams toward meeting the continuing experience requirement.*

*BI-RADS® was developed by the ACR to standardize mammographic reporting, improve communication, reduce confusion regarding mammographic findings, aid research, and facilitate outcomes monitoring.

Breast Imaging Frequently Asked Questions Update 2019

Q: Is it appropriate to report the 3-D rendering code 76376 when the referring physician did not include 3-D in the order?

A: In the past, the ACR maintained that an order for 2D and 3D reconstruction imaging was not necessary because this was covered under the Ordering of Diagnostic Tests Rule test design exception (Chapter 15, Medicare Benefit Policy Manual, Section 80.6.4). However, based on the exponential rise in the use of 3D rendering codes 76376 (not requiring image post-processing on an independent workstation) and 76377 (requiring image post-processing on an independent workstation) and in the number of practice investigations evolving out of overutilization (routine use), the ACR strongly encourages radiology practices to obtain an order from the referring physician in the non-hospital setting. In the hospital setting, radiologists may generate their own order, but they are strongly encouraged to justify medical necessity for the use of 3D rendering in a separate dictation.

For more information on the Ordering of Diagnostic Test Rule, reference Further Clarification on the Ordering of Diagnostic Tests Rule in the July- Aug 2003 ACR Radiology Coding Source

Breast Imaging Frequently Asked Questions Update 2019

Q: How are additional views reported when performed during a screening mammography procedure to better visualize breast tissue?

A: Additional views performed to better visualize breast tissue are considered part of the base procedure performed and not reported separately. Although a screening examination should ordinarily be limited to craniocaudal (CC) and mediolateral oblique (MLO) views of each breast, on occasion, supplemental views may be required to visualize breast tissue completely or optimally, but such views are not ordinarily part of the routine screening examination except for women with implants.2 When pathology is suspected, a recommendation for additional imaging studies, diagnostic mammography, or biopsy may be warranted.

[2]ACR Practice Parameter for the Performance of Screening and Diagnostic Mammography

Breast Imaging Frequently Asked Questions Update 2019Q: How do I code for breast marker placement in the absence of performing a biopsy?

A: Codes 19281-19288 were specifically created to describe breast marker placement in the absence of performing a biopsy. To report bilateral image-guided placement of localization devices see codes 19281, 19283, 19285, or 19287 for the initial lesion localized, depending on the modality used for imaging guidance. The contra-lateral and each additional breast image-guided localization device placement(s) is reported with codes 19282, 19284, 19286, and 19288. For example, when a breast localization device is placed using stereotactic guidance, code 19283 is reported for the first lesion and add-on

code 19284 for each additional lesion. If the patient subsequently goes on to surgical excision the same day, it is appropriate to report the radiograph of the surgical specimen using code 76098, Radiological examination, surgical specimen.

May-June 2014 Q and A

Q: A payer is requiring preauthorization for radiation therapy treatments. Many of us are having a hard time getting IMRT (77301) authorized for left breast cancer. The payer is trying to redefine 77301 and has the following statement on the request form: Are you delivering adjuvant therapy to the whole breast or chest wall using two gantry angles and 3D conformal treatment planning, and with(or without) an electron or photon boost? How is forward-planned Intensity Modulated Radiation Therapy (IMRT) reported? The CPT® 2014 codebook does not mention how this should be reported.

A: The field-in-field techniques that are now often called Intensity Modulated Radiation Therapy (IMRT) did not exist when IMRT and three-dimensional (3D) conformal procedures were initially described. The delivery codes for 2015 will make it explicitly clear that field-in-field techniques, which are often misnamed forward-planned IMRT, are to be reported as 3D conformal with code 77295 3-dimensional radiotherapy plan, including dose-volume histograms).

Jan-Feb 2020 Q and A

Q: Do you have to document velocity measurements of blood flow in order to assign one of the duplex codes (93880-93990)?

A: Duplex Doppler studies should only be reported when medically necessary, ordered, and appropriately documented. All Doppler studies should describe that both spectral and color Doppler were performed. While velocities are relevant in some duplex Doppler examinations depending on the clinical scenario and are routinely reported for carotid ultrasounds, documentation of velocity is not a required component to report in all duplex studies. In general, information in the report on specific flow parameters (eg. waveforms, velocities, resistive indices) may be included, according to the relevance determined by the interpreting radiologist.

The ACR 2020 Ultrasound Coding User's Guide lists the following terms that indicate a Doppler study was performed:

Analog velocity	Resistive index
Bandwidth broadening	Spectral analysis
Duplex Doppler	Spectral broadening
Monophasic	Spectral Doppler
Peak systolic velocity	Tardus parvus waveforms
Phasicity	Triphasic
Pulsatility	Velocity

Pulsed Doppler

April 2015 Q and A

Q: What distinguishes the two forms of elastography as described by CPT codes 91200 and 0346T?

A: The distinguishing characteristic between the two forms of elastography (91200 Liver elastography; 0346T Ultrasound, elastography) is imaging.

There are ultrasound imaging systems that have built-in shear wave, as well as regular ultrasound imaging. When imaging-based shear wave elastography or acoustic force imaging is done using one of these systems, one should report the add-on Category III code 0346T in addition to the anatomy based primary ultrasound code. These systems use imaging guidance to define the shear wave or acoustic radiation force region of interest. The result is in the form of a parametric mapping of numeric values, therefore, an image.

To our knowledge there is only one FDA-approved system that does non-imaging elastography. The purpose is to examine the liver and determine the amount of fibrosis, not to evaluate lesion characteristics. The result is a value not an image. Category I code 91200 should be reported to describe this type of non-imaging liver elastography. It is incorrect to report 91200 to describe imaging-based elastography.

Both 91200 and 0346T could be done either before or after a formal liver ultrasound. However, when non-imaging shear-wave elastography testing is performed in conjunction with a formal liver ultrasound, it is recommended that a modifier (e.g., 59) be used to designate this as a separate and distinct procedure.

Breast Imaging Frequently Asked Questions Update 2019

Q: Now that there are two new breast ultrasound codes (Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete (76641), and limited (76642)), should referring physicians be asked to specify on the order whether they want limited or complete, or should the radiologist do what they think is appropriate no matter what is on the order?

A: The referring physician does not need to specify in an order if a complete or limited breast ultrasound is required. The type of ultrasound performed may be determined by the radiologist under the Ordering of Diagnostic Test Rule exemption, similar to the decision to perform a CT with or without contrast. For example, if the order is for breast ultrasound, the radiologist may determine if it should be a complete or limited ultrasound based on the medical necessity. However, if the referring physician specifies that a complete or limited ultrasound should be performed, the radiologist should speak with the referring physician if the radiologist disagrees with the type of study requested.

As noted above, the determination of whether a complete or limited study is performed falls under the Ordering of Diagnostic Tests Rule exemption, i.e., Unless specified in the order, set the protocol for a given diagnostic, interventional, or therapeutic procedure ordered (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media) (see Section 80.6, Chapter 15, Pub. 100-02 of the internet-only Medicare Benefit Policy Manual (http://www.cms.gov/Regulations-and-Recommend Bookmark® Guidance/Guidance/Manuals/downloads/bp102c15.pdf)).

Q: What makes up a limited and a complete breast ultrasound?

A: Per the CPT 2015 codebook, Professional Edition, p. 428, code 76641 represents a complete ultrasound examination of the breast. Code 76641 consists of an ultrasound examination of all four quadrants of the breast and the retro-areolar region. It also includes ultrasound examination of the axilla, if performed.

Code 76642 consists of a focused ultrasound examination of the breast limited to the assessment of one or more, but not all of the elements listed in code 76641. It also includes ultrasound examination of the axilla, if performed.

Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final written report, is not separately reportable.

Breast Imaging Frequently Asked Questions Update 2019

Q: If the same breast ultrasound study is performed on both breasts, how should that be coded?

A: The newly created breast ultrasound codes are unilateral procedures. When the same type of breast ultrasound study is performed on both breasts, it is appropriate to report the code twice – once with an RT modifier and once with an LT modifier to designate a bilateral procedure was performed. For example, a complete breast ultrasound of both the right breast and left breast would be reported as 76641-RT and 76641-LT. As modifiers are payer specific, check with
your third-party payers to determine how you should report these procedures.

Jan-Feb 2016 Q and A

Q: What CPT code should be used for a computed tomography (CT)-guided breast wire localization. Should code 10035 Placement of soft-tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion or code 19499 Unlisted procedure, breast be reported?

A: For CT-guided placement of breast localization devices, it is recommended that providers use CPT code 10035 (Placement of soft-tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging

guidance; first lesion). The CPT 2016 introductory note prior to 10035 states that Soft-tissue marker placement with imaging guidance is reported with 10035 and 10036. If a more specific site descriptor than soft-tissue is applicable (eg, breast,) use the site-specific codes for marker placement at that site. Report 10035 and 10036 only once per target, regardless of how many markers (eg, clips, wires, pellets, radioactive seeds) are used to mark that target. Since there is no site-specific breast code for wire localization including CT guidance, the implied option is to use 10035. Code 10035 and add-on code 10036 bundle in the radiological guidance, therefore, it is inappropriate to report CPT® codes 76942, 77002, 77012, or 77021 in conjunction with codes 10035 and 10036. Soft-tissue marker placement is typically performed with some type of imaging guidance - most commonly ultrasound, but fluoroscopy, computed tomography, or magnetic resonance imaging may also be used.

Nov-Dec 2016 Q and A

Q: If a bilateral mammography study is performed, would both sides need to be documented regardless of findings? If one side is negative, should that be included?

A: When the study performed is a bilateral screening or diagnostic mammogram, both the left and right side should be documented as having been performed or evaluated - either in the technique, findings, or assessment section of the report, regardless of the findings. Note that just providing the procedure performed in the title of the report or in the "procedure requested" does not constitute proper documentation. The AMA/ACR's Clinical Examples in Radiology has noted multiple times the need to document the procedures performed within the report. For example, the Spring 2006 Documentation Challenge states: If the procedure performed is not discussed or mentioned in the radiology report, then coders will not be able to code for that procedure and auditors may not be able to confirm that the procedure was performed.

References

Clinical Examples in Radiology Volume 2, Issue 2; Spring 2006
Clinical Examples in Radiology Volume 4, Issue 4; Fall 2008
Clinical Examples in Radiology Volume 8, Issue 1; Winter 2012

Sept-Oct 2018 Q and A

Q: If a LDCT repeat scan is completed within the 3-6 month recommended timeline for patients with Lung-RADS categories 3 and 4, is it appropriate to bill CPT code 71250 CT chest without contrast and follow the low-dose protocol? The idea is to limit the radiation these patients are receiving and thus repeat LDCT scans should be completed. The concern is that we are billing for 71250 regular CT without contrast and patients are receiving low-dose scans.

A: The proper coding for 3-6 months follow up LDCT for Lung-RADS categories 3 or 4 result is to report CPT code 71250, Computed tomography, thorax; without contrast material. The

imaging technique that is utilized (LDCT vs standard diagnostic CT dose technique) is at the discretion of the radiologist who protocols the study. The imaging technique that the radiologist determines is appropriate for the scan does not change the CPT code reported.

Sept-Oct 2016 Q and A

Q: Can I report code G0297 (Low dose CT scan (LDCT) for lung cancer screening) in conjunction with codes 71250-71270 (computed tomography of the thorax) if both are performed on the same day?

It is appropriate to report a low dose computed tomography (CT) scan code G0297 in conjunction with a diagnostic contrast-enhanced CT of the thorax (71260). Since the low dose screening exam is a non-contrast exam, there will be times where findings found on that non-contrast screening exam will need to be characterized with a diagnostic contrast-enhanced CT exam.

If a low dose CT for lung cancer screening on an asymptomatic patient demonstrates an unexpected but important finding, it might be very reasonable and necessary to follow up with a diagnostic contrast-enhanced CT of the thorax later the same day to fully define the abnormality identified on the non-contrast screening exam. Findings such as enlarged lymph nodes, mediastinal or hilar mass, esophageal mass, or even an obvious lung cancer requiring further staging are all possible reasons why a radiologist might perform a contrast-enhanced exam after a non-contrast screening study later in the same day.

Note that as of October 2016, there are column one and column two CPT code edits for LDCT screening and computed tomography procedures of the thorax. There is a CCI edit in place with a modifier indicator of "1" for the code pair G0297/712601. An NCCI-associated modifier will be allowed where a finding on the screening study, described by Healthcare Common Procedure Coding System (HCPCS) code G0297, leads to an additional CT of the thorax with contrast study, described by CPT code 71260 to define that finding when performed on the same day. However, procedure-to-procedure code pair edits G0297/712500 (CT thorax without contrast) and G0297/712700 (CT thorax without and with contrast) do not allow the use of an NCCI-associated modifier to bypass the edits.

May-June 2018 Q and A

Q: What is the appropriate code to report an ultrasound (liver) elastography when it was not preceded by an abdominal ultrasound?

A: To report ultrasound elastography (USE), it is necessary to perform at least a limited or targeted diagnostic ultrasound to determine the exact location in order to perform the USE. If an ultrasound was performed with documentation of all elements required for coding of a complete abdominal ultrasound, it is appropriate to report CPT codes 76700, *Ultrasound, abdominal, real time with image documentation, complete* and 0346T,

Ultrasound, elastography. If fewer than all of the elements required for coding of a complete ultrasound are imaged and documented, it is appropriate to report codes 76705, *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)* and 0346T.

However, if you do not document that you performed a diagnostic ultrasound in conjunction with USE, it is appropriate to report code 76999 *Unlisted ultrasound procedure (eg, diagnostic, interventional)*. It is not appropriate to report 0346T with 76999 as there is a defined list of codes that may be reported with 0346T in the CPT manual.

Finally, if liver elastography is performed without imaging, it is appropriate to report code 91200, *Liver elastography, mechanically-induced shear wave (eg, vibration), without imaging, with interpretation and report*.

For 2019, Category III code 0346T will be replaced with three new ultrasound elastography Category I codes. There will be stand-alone codes that allow USE to be reported without reporting an additional ultrasound code. Therefore, the above advice will change for 2019.

May-June 2011 Q and A

Q: In the January/February 2011 ACR Radiology Coding Source it stated that it is appropriate to use the unlisted code 76499 to describe digital breast tomosynthesis. Would you clarify if the full-field digital mammography code is reported separately or is it included in the unlisted code?

A: Breast tomosynthesis performed in conjunction with digital mammography is appropriately reported with the unlisted diagnostic procedure code 76499 to describe breast tomosynthesis and one of the HCPCS Level II "G" codes (G0202, G0204, or G0206) to describe the full-field digital mammography performed. If computer-aided detection (CAD) also is performed, it should be reported separately using one of the mammography CAD codes, 77051 (CAD performed in conjunction with diagnostic mammography) or 77052 (CAD performed in conjunction with screening mammography). It is not appropriate to report a three-dimensional reconstruction code in conjunction with the full-field digital mammography code.

Jan-Feb 2013 Q and A

Q: What Is (Are) the Appropriate CPT Code(s) to Report a Cardiac CT Stress Perfusion Study?

A: A cardiac CT stress perfusion study should be reported using CPT code 75574 (Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image post-processing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed) and one of the appropriate cardiac stress test codes

(93015-93018). The total volume of contrast given for stress and rest imaging (if performed) and the stress test agent should be reported as well.

If rest perfusion imaging is performed in addition to stress perfusion imaging, it is not appropriate to report a second cardiac CT study code. Only one cardiac CT code should be reported.

Nov-Dec 2016 Q and A

Q: How should chest tomosynthesis and tomosynthesis of fracture(s) of the upper extremity, lower extremity and spine be reported. Do they have their own CPT code similar to the digital breast tomosynthesis codes 77061-77063?

A: It is the opinion of the ACR's Economics Committee on Coding & Nomenclature that chest and musculoskeletal (e.g., upper extremity, lower extremity or spine) tomosynthesis studies be reported with the existing CPT 76100, Radiologic examination, single plane body section (e.g. tomography), other than with urography.

Nov-Dec 2008 Q and A

Q: A referring physician wants to verify that a jejunostomy tube is properly positioned. An un-enhanced CT of the abdomen (diaphragm to the crest) is performed, followed by the injection of 50 mL of air and a repeat non-enhanced CT scan of the abdomen (using the same parameters). What is the appropriate coding for this examination?

A: A noncontrast (un-enhanced) computed tomography of the abdomen, followed by the injection of 50 mL of air, and repeated noncontrast CT imaging of the abdomen is appropriately reported with CPT code 74150 (Computed tomography, abdomen; without contrast material). It is not appropriate to code for a contrast enhanced CT scan because the air injection is not considered sufficient to fulfill the requirements for a contrast study. As always, there needs to be an appropriate medical indication for this examination and an order from the referring physician.

More commonly, evaluation for position of an enteral catheter is done under fluoroscopic guidance and is reported with CPT code 49465 (Contrast injection(s) for radiological evaluation of existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, from a percutaneous approach including image documentation and report) which includes the imaging guidance.

Sept-Oct 2016 Q and A

Q: How is the contrast agent used for contrast-enhanced ultrasound reported?

A: The Centers for Medicare and Medicaid have established the Healthcare Common Procedure Coding System (HCPCS) Level II code Q9950, Injection, sulfur hexafluoride lipid microspheres, per ml, to report the contrast used for contrast-enhanced ultrasound.

Code Q9950 is a Hospital Outpatient Prospective Payment System (HOPPS) transition pass-through code, which is available for use through December 31, 2017. CMS will state how they propose to cover Q9950 in 2018 and going forward when they release the 2018 HOPPS Proposed Rule, i.e., whether they will leave as a pass-through code, move the drug to a regular Ambulatory Payment Classification or consider it bundled.

Note: Effective January 1, 2017, all claims reporting unused drugs or biologicals from single use vials and packages appropriately discarded must make use of the JW modifier. The JW modifier identifies Drug amount discarded/Not administered to any patient. In addition to the use of the modifier, providers will be required to document appropriate disposal of each single-use drug or biological in the patient's medical record when submitting claims. The JW modifier is not used on claims for drugs in the Competitive Acquisition Program. Readers may reference the May/June 2016 ACR Radiology Coding Source and MLN Matters MM9603 for additional information on reporting of the JW modifier.

Nov-Dec 2018 Q and A

Q: A trauma patient is seen in the emergency department (ED). The provider orders CT studies of the chest, abdomen, and pelvis with intravenous contrast. The CT studies are performed and the patient is then admitted to the hospital. Later the same day, the trauma service orders CT scans of the thoracic and lumbar spine. These are performed by reconstructing the CT scan data from the previously acquired CT scans of the chest, abdomen and pelvis. How should the technical and professional components of the T-spine and L-spine reconstructed images be reported?

A: If CT studies of the chest, abdomen and pelvis with intravenous contrast are ordered and performed, it is appropriate to report for both the technical (TC) and professional component (26) for CT scans of the chest (71260 Computed tomography, chest; with contrast material) and CT of the abdomen and pelvis (74177 Computed tomography, abdomen and pelvis; with contrast material). If reconstructions of the thoracic and lumbar spine are ordered and the images reconstructed from the original CT data sets, it is appropriate to report the professional components for interpretations of the spine CT scans; the technical component is not reported, as it is considered included in the initial CT procedure. For example, in this scenario it is appropriate to report code 72129 Computed tomography, thoracic spine; with contrast material and code 72132 Computed tomography, lumbar spine; with contrast material with -26 modifiers to designate that only the professional components are being reported.

Mar-Apr 2019 Q and A

Q: If the physician documents the use of ultrasound but does not provide enough documentation to meet the CPT requirements of "*documentation of evaluation of the potential puncture sites, patency of the entry vein, and real-time ultrasound*

***visualization of needle entry into the vein*, would it be more appropriate to assign the bundled peripherally inserted central catheters (PICC) code with a modifier 52 or assign the "without imaging" PICC code?**

A: As of January 1, 2019, PICC placed using a guidance system that does not include imaging (eg, ultrasound, fluoroscopy) or sufficient image documentation should be reported with code 36568 *Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age or code 36569 Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older*.

If the PICC placement was performed with only fluoroscopic guidance, only ultrasound guidance, or both fluoroscopic and ultrasound guidance, it is appropriate to report codes 36572 *Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age or 36573 Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older*. Documentation should include imaging guidance and final central position of the catheter.

When ultrasound guidance for PICC placement is performed, the procedure report should include documentation of evaluation of the potential access site(s), the patency of the vein entered, and real-time ultrasound visualization of needle entry into the vein; in addition, a permanent recording and reporting of the guidance must be recorded. In the circumstance of a PICC line placed with only ultrasound guidance (no fluoroscopy) and all of the documentation requirements for ultrasound guidance are not satisfied, then code 36568 or 36569 should be reported.

Mar-Apr 2016 Q and A

Q: For PQRS Measure #145 (Exposure Time Reported for Procedures Using Fluoroscopy), there is inconsistency between the Numerator Statement and the Code Descriptor for codes G9500 and G9501. Is it "radiation exposure indices, or exposure time and number of fluorographic images" or "radiation exposure indices, exposure time or number of fluorographic images?"

A: The Centers for Medicare & Medicaid Services' guidance for the Physician Quality Reporting System (PQRS) Measure #145 is to report G9500 or G9501 if the final report either contains radiation exposure indices or exposure time AND number of fluorographic images. Because the wording of the final measure cannot be revised at this time, CMS published an FAQ that states: For 2016 PQRS, the final report would need to include radiation exposure indices, or exposure time AND number of fluorographic images in order

to meet performance for Measure #145. The Numerator Statement found with the measure: Final reports for procedures using fluoroscopy that include radiation exposure indices or exposure time and number of fluorographic images (if radiation exposure indices are not available) correctly describes what should be reported. It is appropriate to report G9500 if the final report either contains radiation exposure indices or exposure time AND number of fluorographic images. Additionally, the definition for image count includes only images that require additional exposure to ionizing radiation, not those that are captured electronically from the imaging chain without additional exposure.

Mar-Apr 2016 Q and A

Q: Does PQRS Measure #405 (Appropriate Follow-up Imaging for Incidental Abdominal Lesions) apply to CT, MRI, and ultrasound as listed in the denominator or only to CT as indicated in the Code Descriptor for G9547, Incidental CT finding: Liver lesion ≤ 0.5 cm, Cystic kidney lesion < 1.0 cm or Adrenal lesion ≤ 1.0 cm?

A: The Physician Quality Reporting System (PQRS) Measure #405 (Appropriate Follow-up Imaging for Incidental Abdominal Lesions) applies to computed tomography, magnetic resonance imaging and ultrasound modalities as listed in the Denominator and denoted by codes 74150, 74160, 74170, 74176, 74177, 74178, 74181, 74182, 74183, 76700, 76705, 76770, 76775. For more information, see CMS PQRS Measure 405 FAQ.

Jul-Aug 2013 Q and A

Q: Sacroiliac Joint injection procedure note states "ultrasound was used to identify the sacroiliac region including the posterior superior iliac spine, the sacrum, the sacral hiatus, the sacroiliac ligaments and the iliolumbar ligament bilaterally. Once identifying these structures a 22-gauge needle towards the SI joint was advanced. Once reaching the joint, under ultrasound guidance 5 cc of a combination of 0.25% Marcaine with 6 mg of Betamethasone was injected slowly after a negative aspiration. There was no evidence of intravascular puncture or cerebrospinal fluid or any paraesthesias."Is it appropriate, given this procedure note, to bill CPT code 20610 and 76942 in conjunction with CPT 76881?

A: It is not appropriate to report code 76881 (Ultrasound, extremity, nonvascular, real-time with image documentation; complete) or 76882 (Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific) as the documentation provided in the note above does not support a diagnostic evaluation. The following information can be found on page 398 of the 2013 CPT® codebook, “A complete ultrasound examination of an extremity (76881) consists of real time scans of a specific joint that includes examination of the muscles, tendons, joint, other soft tissue structures, and any identifiable abnormality.”

Furthermore, there is no CPT code to describe a sacroiliac joint injection performed with ultrasound guidance, therefore, it is appropriate to report this procedure with code 22899

(Unlisted procedure, spine) and 76942 (Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation).

Jul-Aug 2012 Q and A

Q: A patient was seen for sclerotherapy treatment of a recalcitrant lymphocele. A sclerosing agent of 95 percent ethyl alcohol was used. How should this be reported? Does the coding change based upon the sclerosing agent used?

A: The appropriate codes to report sclerotherapy of nonvascular structures, such as a lymphocele, are 20500, Injection of sinus tract; therapeutic (separate procedure), and 76080, Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation. The ACR and Society of Interventional Radiology agree that these CPT codes should be reported for all non-vascular sclerosis procedures (e.g., seroma, cyst, lymphocele, abscess) and that the use of different agents (e.g., alcohol, tetracycline, betadine) does not limit or alter the reporting of these codes.

If the patient is being seen for new or worsening symptoms and evaluation and management services are provided by the interventionalist to evaluate those symptoms, evaluation and management (E&M) services should be separately documented and coded. This E&M service may need to be reported with the use of an appropriate modifier (e.g., 24, 25) as the patient's
recent operative history demands.

Moderate (conscious) sedation is not included in the 20500 code, therefore, it also may be reported separately when performed (e.g., 99144, 99145).

Sept-Oct 2014 Q &A

Q: The state of Indiana has recently passed a law for women with dense breasts. It states that we are to notify them of this and their higher risk of breast cancer plus it states insurance will have to now provide coverage for screening ultrasounds. Can you please tell me how we should code the screening breast ultrasound exams? Unfortunately, the law does not give us this information.

A: For the remainder of 2014 the appropriate CPT® code to report an ultrasound examination of the breast is 76645 (Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation). For 2015, there will be new breast ultrasound codes to replace 76645. Code 76645 will be deleted.

The CPT 2015 codebook reads:

Code 76641 represents a complete ultrasound examination of the breast. Code 76641 consists of an ultrasound examination of all four quadrants of the breast and the retroareolar region. It also includes ultrasound examination of the axilla, if performed.

Code 76642 consists of a focused ultrasound examination of the breast limited to the assessment of one or more, but not all of the elements listed in code 76641. It also includes ultrasound examination of the axilla, if performed.

Therefore, beginning on January 1, 2015, the complete examination is reported with code 76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete, with the appropriate modifier (e.g., RT, LT) when bilateral studies are performed. It should be noted that unlike the deleted code 76645, the 2015 codes 76641 and 76642 describe unilateral procedures.

Whenever a screening examination is performed, the ICD-9 screening diagnosis code is the first-listed, regardless of the findings or any procedure that may be performed as a result of the findings. An ultrasound screening examination of the breast should be reported with ICD-9 code V76.19 (Special screening for malignant neoplasm, other screening breast examination). It is recommended that a secondary diagnosis be reported (e.g., 793.82, Inconclusive mammogram – dense breasts NOS) to communicate to the payer that the study was performed to a high-risk patient.

Jul-Aug 2015 Q and A

Q: Do beneficiary coinsurance and deductible apply to claim lines with 77063 (Screening digital breast tomosynthesis, bilateral [List separately in addition to code for primary procedure])?

A: No, beneficiary coinsurance and deductible do not apply to claim lines with 77063 (Screening digital breast tomosynthesis, bilateral [List separately in addition to code for primary procedure]). The Centers for Medicare & Medicaid Services (CMS) looks at code 77063 only in terms of it being a screening mammogram procedure. In addition, code 77063 is an add-on code to the primary procedure. Therefore, 77063 must be billed in conjunction with the screening mammography HCPCS code G0202 (Screening mammography, producing direct digital image, bilateral, all views, 2D imaging only). In accordance with that policy, beneficiary coinsurance and deductible do not apply to claim lines with code 77063.

Sept-Oct 2016 Q and A

Q: Is the new HCPCS Level II code C9744 used for billing of the professional component in the hospital setting?

A: No, the Healthcare Common Procedure Coding System (HCPCS) Level II code C9744, Ultrasound, abdominal, with contrast (effective October 1, 2016), was created by the Centers for Medicare and Medicaid Services to report the technical component (TC) of hospital outpatient procedures for Medicare patients. This change affects the hospital TC reporting only. The professional component billing remains unchanged and will continue to

be reported with CPT code 76705 Ultrasound, abdominal, real-time with image documentation; limited (e.g., single organ, quadrant, follow-up). See the September 30, 2016 Advocacy in Action for more details on the current recommended coding of contrast-enhanced ultrasound.

Nov-Dec 2007 Q and A

Q: Can you submit an evaluation and management code for a clinical breast exam performed in conjunction with a screening mammography study?

A: Only the screening mammography code 77057 (*Screening mammography, bilateral* [*2-view film study of each breast*]) should be reported. A clinical breast exam performed in conjunction with a screening mammography study would be considered part of the screening mammography procedure. As noted in the *ACR Practice Guideline for the Performance of Screening Mammography* specifications: "The examination should ordinarily be limited to craniocaudal (CC) and mediolateral oblique (MLO) views of each breast. On occasion, supplemental views may be required to visualize breast tissue completely or optimally, but such views are not ordinarily part of the routine screening examination. When pathology is suspected, a recommendation for additional imaging studies, diagnostic mammography, or biopsy may be warranted. Evaluation of the augmented breast should include, when possible, standard CC and MLO or lateral views as well as implant displacement views. Women should be informed that a clinical breast examination is a complementary and recommended procedure.*"*

Nov-Dec 2016 Q and A

Q: How do you code for a second opinion or reread of a film request?

A: When a physician's opinion or advice regarding a specific imaging examination is requested by another physician, and on examination of the imaging examination the consulting physician provides his or her opinion or advice to the requesting physician in a written report, the specific procedure code with a 26 modifier (professional component only) should be reported. Some Medicare carriers require that a 77 modifier also be used to indicate that a basic procedure or service performed by another physician had to be repeated. Please check with your local Medicare carrier for their guidelines. Other carriers and third-party payers may have different guidelines and may recommend the use of CPT code 76140 (Consultation on X-ray exam made elsewhere, written report). As noted in the American Medical Association's Principles of CPT Coding, if a patient comes to an office for a new or established visit and brings the physician his or her medical records, including X-rays, the review or reread of the X-rays would be considered part of the face-to-face evaluation and management (E&M) service provided to the patient and would not be reported separately. While the second interpretation excerpt from Section 100.1 of the Medicare Claims Processing Manual, Chapter 13, Radiology Services and Other Diagnostic Procedures applies to emergency room patients, the ACR was informed by the CMS National Office (via telephone) that the use of the -77 modifier would apply to other second

interpretations as well. For more information on second opinions, please reference Dr. Richard Duszak's article Another Unpaid Second Opinion, JACR , Volume 2, Issue 9, Pages 793-794 (September 2005), other than with urography.

Sept-Oct 2015 Q and A

Q: How is a single view of the hip reported when a view of the pelvis is included?

A: The correct answer depends simply on counting the number of views performed.

If a single view of the hip and a single view of the pelvis are both performed, they should be reported with code 73502, Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views. This is because when a single view of the hip and a single view of the pelvis are performed it consists of 2 views.

The one view hip code 73501, Radiologic examination, hip, unilateral, with pelvis when performed; 1 view includes the phrase "with pelvis when performed." Code 73501 is a single view examination and was worded this way to be consistent across the family of hip codes. This service is a single-view hip study that is currently described by both 73500, Radiologic examination, hip, unilateral; 1 view, and 73530, Radiologic examination, hip during operative procedure.

If one were to do a single view of each hip, code 73521, Radiologic examination, hips, bilateral, with pelvis when performed; 2 views should be reported. If a pelvis view is added, it is now 3 view study, and one should code 73522, Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views

Jan-Feb 2005 Q and A

Q: Does the ultrasound guidance clarification provided in CPT require that the radiologist state within the report that "permanent images are stored"?

A: No, the ultrasound guidance clarification provided in CPT 2005 does not require that the radiologist state within the report that "permanent images are stored." The guidelines state "Ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized." According to these guidelines, the radiologist is required to dictate a statement about the localization process, eg, ultrasound guidance was used for needle placement, NOT that permanent images are stored. These "permanent images" should be retrievable in the event of a practice audit.

Note that the CPT® descriptor for ultrasound guidance used during vascular access (code 76937) specifically lists the requirements for using this code. The descriptor notes that this code requires ultrasound evaluation of the potential access sites, documentation of

selected vessel patency, and concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting.

All radiologists should follow CPT® guidelines, and coders should make sure the radiologists are informed of the guidelines. While some radiologists may choose to dictate that permanent images were obtained, it is not required by CPT® coding guidelines. As noted previously in this newsletter, original source documentation (AMA, CMS, CDC, specialty society publications, etc.) should be used when determining what is or is not appropriate coding.

Sept-Oct 2005 Q and A

Q: When seeing a patient for an ordered ultrasound-guided thoracentesis or paracentesis, is it appropriate to also charge for a limited diagnostic ultrasound of the abdomen or a limited diagnostic ultrasound of the chest, in addition to the charges for the guidance and thoracentesis or paracentesis procedures?

A: Our protocol is to first have the technologist scan all patients to evaluate how much fluid (if any) is present and in which location. The case is presented to the radiologist, who decides on the approach for the procedure ordered. The radiologist then obtains consent from the patient, rescans the patient to confirm safe needle/catheter access, and then performs the procedure. No, it is not appropriate to charge for a limited diagnostic ultrasound of the abdomen or a limited diagnostic ultrasound of the chest in addition to the charges for ultrasound guidance during thoracentesis or paracentesis procedures when performed to determine the amount and location of the fluid.

Limited sonography is a necessary component of any ultrasound guidance procedure, just as localizing CT images are a necessary component of CT guidance for CT-guided biopsy. As a reference to what is considered inclusive in imaging guidance, refer to the CPT instructions for new code 76937 (older codes such as 76942 have not yet been updated with this explicit language). Limited sonography of the target area is clearly included in such imaging guidance codes. The introductory language to the ultrasound section in CPT 2005 clearly states that permanent images of the target area are required when imaging guidance is utilized. The practice of coding for both a limited diagnostic ultrasound and for ultrasound guidance in this instance would constitute unbundling.

There are 2 issues that need to be addressed in the above question: (1) Is this correct coding? (2) Is this, in the eyes of the payer, "medically necessary?"

Is this correct coding?
When image-guided fluid aspiration is requested (eg, for paracentesis or for thoracentesis), and the ultrasound localizing images demonstrate no fluid, then it would be appropriate to code for the localizing limited ultrasound—and only the limited ultrasound—that resulted in the decision to discontinue the requested procedure. For

example, because a full chest ultrasound is a fluid search, ultrasound localizing images of the chest would be reported with the ultrasound of the chest code (76604). There is no reason to image all elements required for a full and complete abdomen, therefore, ultrasound localization images of the abdomen would be reported with the limited ultrasound of the abdomen code (76705).

This is analogous to the CMS directive that any medically necessary preliminary or scout studies performed prior to the cancelled order should be coded. For example, as clarified in section 15021 (E) of the Medicare Carrier's Manual, if a barium enema cannot be performed because of residual stool in the colon as identified on scout KUB. The scout KUB is payable by Medicare. When one attempts to perform a service and is unsuccessful, but in the attempt has performed a lesser service, then the lesser service should be reported. (1) In the scenario where ultrasound guidance is commenced and the thoracentesis or paracentesis is prematurely discontinued (eg, the patient goes into shock), the ultrasound guidance should be coded as 76942 and the thoracentesis (32000-53) or paracentesis (49080-53) should be reported with the discontinued modifier (53).

Is this, in the eyes of the payer, "medically necessary?"
Depending upon the site of service (hospital vs nonhospital), additional nonordered imaging cannot be performed unless it falls into very specific and explicit safe harbors. For example, reference Medicare's Ordering of Diagnostic Tests rule (Medicare Carriers Manual 15021, Transmittal 1725) [LINK]. The performance and coding of an additional limited diagnostic ultrasound study clearly does not meet those criteria in a nonhospital setting. In a hospital setting, the answer is less clear, but a conservative interpretation would indicate that this is problematic as well.

Although the specific clinical service is different, it is felt that these 2 issues (performance of additional procedures and medical necessity) are fundamental ones used by the U.S. Department of Justice in its legal proceedings against a large practice in Florida. The details of that case are sealed, but what the DOJ has released to the public indicates that issues of "unbundling" and "churning" will not be tolerated. That group settled the suit for $2.4 million!

If a radiology practice discovers that it has inadvertently submitted claims with incorrect coding, the practice is encouraged to work with their compliance officers and counsel to determine what funds need to be returned to patients and payers. The Department of Justice and defense counsel in several health care fraud cases tend to look favorably upon honest mistakes when prompt restitution is made.

These types of fundamental questions suggest that a group may benefit from internal or outsourced coding expertise. If radiology certified coders (RCCs) are not employed or contracted, the radiology group is strongly encouraged to do so. An audit of coding

practices by an expert in these matters might be of value, as well as ensuring full compliance with coding rules and regulations.

(1)Interventional Radiology Coding User's Guide 2005, Frequently Asked Questions, p.230.
Important Links
Radiology Business Management Association (RBMA)
Radiology Coding Certification Board (RCCB)
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Duszak R. Up to code: RCCB's new certification exam recognizes deserving radiology coders. ACR Bulletin. January 2003;59(1):5-6,16

Mar-April 2016 Q and A

Q: Code 50393, *Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous*, has been deleted. How do you code for the radiologist doing percutaneous catheter placement through the renal pelvis and down into the bladder prior to the patient going for lithotripsy? In the past, we used 50393, but not sure since the replacement codes state placement of ureteral stent.

A: According to the parenthetical in the CPT 2016 code book, Professional Edition, p. 322 (50393 has been deleted. To report ureteral catheter placement, see 50693, 50694, 50695). The historic term 'ureteral stent' is a catheter - not a metallic body, and therefore appropriate to use for a catheter placement. Codes 50693, 50694 and 50695 are therapeutic procedure codes describing percutaneous placement of ureteral stents that include access, drainage, catheter manipulations, diagnostic nephrostogram and/or ureterogram, when performed, imaging guidance (eg, ultrasonography and/or fluoroscopy), and all associated radiological supervision and interpretation. Please note that code 50693 should be used if a pre-existing access to the kidney is present; code 50694 should be used if new renal access is acquired; and code 50695 should be used if a new renal access is acquired and a separate nephrostomy tube is also placed.

Jan-Feb 2015 Q and A

Q: What distinguishes the two forms of elastography as described by CPT® codes 91200 and 0346T?

A: The distinguishing characteristic between the two forms of elastography (91200 Liver elastography; 0346T Ultrasound, elastography) is imaging. There are ultrasound imaging systems that have built-in shear wave, as well as regular ultrasound imaging. When imaging-based shear wave elastography or acoustic force imaging is done using one of these systems, one should report the add-on Category III code 0346T in addition to the

anatomy based primary ultrasound code. These systems use imaging guidance to define the shear wave or acoustic radiation force region of interest. The result is in the form of a parametric mapping of numeric values, therefore, an image.

To our knowledge there is only one FDA-approved system that does non-imaging elastography. The purpose is to examine the liver and determine the amount of fibrosis, not to evaluate lesion characteristics. The result is a value not an image. Category I code 91200 should be reported to describe this type of non-imaging liver elastography. It is incorrect to report 91200 to describe imaging-based elastography.

Both 91200 and 0346T could be done either before or after a formal liver ultrasound. However, when non-imaging shear-wave elastography testing is performed in conjunction with a formal liver ultrasound, it is recommended that a modifier (e.g., 59) be used to designate this as a separate and distinct procedure.

Breast Imaging Frequently Asked Questions Update 2019

Q: Is it appropriate to separately report a specimen radiograph performed after a breast localization procedure?

Yes, it is appropriate to report radiographs of a surgical specimen (76098) performed after breast localization (19281-19288). However, radiographs of the specimen samples obtained at the time of biopsies are included in the breast biopsy codes (19081-19086).

Breast Imaging Frequently Asked Questions Update 2019

Q: Is an order required for the use of computer-aided detection (CAD) with breast imaging procedures, such as mammography, magnetic resonance imaging (MRI) and ultrasound? Must the use of CAD be dictated in the report?

A: No, an order is not required for the use of CAD performed in conjunction with breast imaging procedures, such as mammography, MRI, and ultrasound. When CAD is performed, a statement such as “CAD software was used” should be inserted into the report.1

As noted in the Winter 2007 issue of the AMA/ACR *Clinical Examples in Radiology*, an order is not required for the performance of CAD because CAD is covered under the Ordering of Diagnostic Tests design exemption (Section 80.6.4).

The Centers for Medicare and Medicaid Services informed the ACR that the Ordering of Diagnostic Tests Rule allows for performance of CAD in conjunction with mammography without a written order from the referring (treating) physician. Because there is no medical necessity prerequisite for the use of CAD with mammography procedures, and if all aspects of CAD are performed in conjunction with mammography, the radiologist may

determine whether or not CAD should be performed. The use of CAD is covered under the Radiologist Exception as noted in Medicare Transmittal #1725:

15021 (E)(1) Test Design [see Internet Only Medicare Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services 80.6.2 .]

Test Design

Unless specified in the order, the interpreting physician may determine, without notifying the treating physician/practitioner, the parameters of the diagnostic test (e.g., number of radiographic views obtained, thickness of tomographic sections acquired, use or non-use of contrast media).

1AMA/ACR Clinical Examples in Radiology Volume 1, Issue 4; Fall 2005, p. 13.

For more information on the Ordering of Diagnostic Test Rule, reference Further Clarification on the Ordering of Diagnostic Tests Rule in the July- Aug 2003 ACR Radiology Coding Source ACR Radiology Coding Source July-August 2003

Breast Imaging Frequently Asked Questions Update 2019

Q: What code(s) should be reported to describe a screening mammogram when additional magnification views are required for a suspected abnormality? May I code both a diagnostic mammogram and a screening mammogram and is an order required?

A: If a screening mammogram is performed and, after review of the images, pathology is suspected, the interpreting physician is allowed to order additional images. When additional views are obtained, Medicare states that it is appropriate to charge for both a screening mammogram and a diagnostic mammogram whether the studies are performed on the same or different days. If the additional views are done on the same day as the screening mammogram, the diagnostic study should be reported with the GG modifier, which Medicare uses for tracking purposes. This modifier designates the performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day.

In March 2015, CMS responded to an appeal from the ACR regarding a newly implemented National Correct Coding Initiative (NCCI) edit for screening mammography and diagnostic mammography performed on the same patient on the same date of service. CMS elected to retain these NCCI edits. Per CMS, if a provider performs both screening and diagnostic mammography on the same patient on the same date of service, CMS instructions require that a provider report modifier GG with the diagnostic mammography code (77065 or 77066,). However, because modifier GG is not an NCCI-associated modifier and will not

bypass the NCCI edit, providers are instructed to additionally append modifier 59 (Distinct Procedural Service) to the screening mammography (77067) to bypass the NCCI edits.

When a patient has a screening mammogram performed on one day and returns on another day for the additional diagnostic mammogram, both the screening mammogram and diagnostic mammogram services should be coded separately. In this scenario, no GG modifier would be required.

See Medicare Claims Processing Manual, Chapter 18, Preventive and Screening Services, Section 20.2 — HCPCS and Diagnosis Codes for Mammography Services for additional information on the reporting of a screening and diagnostic mammogram performed on the same day.

Breast Imaging Frequently Asked Questions Update 2019

Q: Is it appropriate to separately code for the review of prior mammographic images when those images are not available for comparison at the time of the current mammogram interpretation?

A: No, it is not appropriate to separately code for the review of prior mammographic images when they are not available for comparison at the time of interpretation of the current images. The comparison of prior images, which may be an important part of diagnostic mammography, is considered part of the mammography procedure. Radiology practices should work to ensure images are available for comparison at the time of the current mammography interpretation.

Breast Imaging Frequently Asked Questions Update 2019

Q: How do you code for a unilateral screening mammogram in a patient who has had one of her breasts removed? The code descriptor for a screening mammogram specifies that it is a bilateral study.

A: When a screening mammography study is ordered and performed on a patient who has only one breast, it is appropriate to report 77067 (Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed. Because the CPT code descriptor for 77067 states “bilateral,” it would be appropriate to use a 52 modifier (reduced level of service) to designate a screening procedure of only one breast. However, radiology practices should check with their local carrier and other third-party payers regarding the use of the 52 modifier in this situation, because some payers have stated that a 52 modifier is not necessary for reporting a unilateral screening mammogram.