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CHAPTER IX
RADIOLOGY SERVICES
CPT CODES 70000 - 79999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter IX
Radiology Services
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A. Introduction

The *CPT Manual* includes codes related to diagnostic radiology (imaging), ultrasound, radiation oncology and nuclear medicine. The diagnostic imaging section includes non-invasive and invasive diagnostic and therapeutic (interventional) procedures, as well as computerized tomography and magnetic resonance imaging. Most correct coding issues are defined by CPT coding convention.

B. Non-interventional Diagnostic Imaging

Non-invasive/interventional diagnostic imaging includes standard radiographs, single or multiple views, contrast studies, computerized tomography and magnetic resonance imaging. The *CPT Manual* allows for various combinations of codes to address the number and type of radiographic views. For a given radiographic series, the procedure code that most accurately describes what was performed is appropriate. Because of the number of combinations of views necessary to obtain medically useful information, a complete review of CPT coding options for a given radiographic session is important to assure accurate coding with the most comprehensive code that describes the services performed rather than billing multiple codes to describe the service.

In the event that radiographs have to be repeated in the course of a radiographic encounter due to substandard quality, only one unit of service for the code can be reported. Additionally, if after reviewing initial films, the radiologist elects to obtain additional views in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests should be followed and the CPT code describing the total service is reported, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptor for many of these services refers to a "minimum" number of views. Accordingly, if more than the minimum number specified is necessary, and no other more specific CPT code is available, only that service should be billed. On the other hand, if additional films are necessary due to a change in the patient's condition, separate billing would be appropriate.

CPT code descriptors which specify a minimum number of views should be reported when the minimum number of views or if more than the minimum number of views must be obtained in order to satisfactorily complete the radiographic study. For example, if three views of the shoulder are obtained, CPT code 73030, one unit of service, should be reported, not 73020 and 73030.

When limited comparative radiographic studies are performed (e.g. post-reduction radiographs, post-intubation, post-catheter placement, etc.), the CPT code for a comprehensive radiographic series should be reported with modifier -52, indicating that a reduced level of interpretive service was provided.

Studies may be performed without contrast, with contrast or both with and without contrast. There are separate codes available to describe all of these combinations of contrast usage. When studies require contrast, there is not generally an established number of radiographs to be obtained because of patient variation. Accordingly, all radiographs necessary to complete a study are included in the CPT code description. Unless specifically noted, fluoroscopy necessary to complete a procedure and obtain the necessary permanent radiographic record is included in the major procedure performed.

Preliminary "scout" radiographs obtained prior to contrast administration or delayed imaging radiographs are often performed; when a separate CPT code is available to include these radiographs, it should be used. If there is no separate CPT code including additional views, it is assumed that these are included in the basic procedure.

C. Interventional/Invasive Diagnostic Imaging

When contrast can be administered orally (upper GI) or rectally (barium enema), the administration is included as part of the procedure and no administration service is reported. When contrast material is parenterally administered, whether the timing of the injection has to correlate with the procedure or not (e.g. IVP, CT scans, gadolinium), the administration and the injection (e.g. HCPCS/CPT codes 36000, 36406, 36410 and 90782-90784) are included in the contrast studies.

When a contrast study is performed in which there is direct correlation of the timing of the study to the injection or

administration (e.g. angiography), and different providers perform separate parts of the procedure, each provider would bill the service he/she rendered. The procedural aspect of the service is coded from outside the CPT 70000 series and the radiographic supervision and interpretation (S & I) service is coded from the 70000 series of codes.

Diagnostic angiography (arteriogram/venogram) performed on the same date of service by the same provider as a percutaneous intravascular interventional procedure should be reported with modifier -59. If a diagnostic angiogram was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifiers -52 and -59. If the prior diagnostic angiogram was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.

The individual CPT codes in the 70000 section identify which injection or administration code is appropriate for a given procedure. In the absence of a parenthetical CPT note, it is not appropriate to submit an administration component. When an intravenous line is placed (e.g. CPT code 36000) simply for access in the event of a problem with the procedure or for administration of contrast, it is considered part of the procedure. A separate code (e.g. CPT code 36005), is available for the injection procedure for contrast venography and includes the introduction of a needle or an intracatheter (e.g. CPT code 36000).

In the case of urologic procedures and other surgeries, insertion of a urethral catheter (e.g. CPT code 51701-51702) is part of the procedure and is not to be separately reported.

The CPT codes 90783 and 90784 are for intra-arterial and intravenous therapeutic or diagnostic injections. Injections for contrast procedures are included in the procedure. CPT codes 90783 and 90784 cannot be separately reported with radiographic, CT, MRI, or nuclear imaging codes to represent part of the injection procedure. CPT codes 90783 and 90784 are status "T" codes on the Medicare Physician Fee Schedule indicating that they

are not separately payable if any other service on the Medicare Physician Fee Schedule is payable on that date of service.

D. Evaluation and Management

When physician interaction with a patient is necessary to accomplish a radiographic procedure, typically occurring in invasive or interventional radiology, the interaction generally involves limited pertinent historical inquiry about reasons for the examination, the presence of allergies, acquisition of informed consent, discussion of follow-up, and the review of the medical record. In this setting, a separate evaluation and management service is not reported. As a rule, if the medical decision making that evolves from the procurement of the information from the patient is limited to whether or not the procedure should be performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, an evaluation/management code is not reported separately. If a significant, separately identifiable service is rendered, involving taking a history, performing an exam, and making medical decisions distinct from the procedure, the appropriate evaluation and management service can be reported. The appropriate evaluation and management service code is chosen based on the type of service rendered which satisfies the Evaluation and Management guidelines developed by the AMA and CMS.

In radiation oncology, evaluation and management services would not be separately reported with the exception of an initial consultation at which time a decision is made whether to proceed with the treatment. Radiation oncology includes clinical treatment planning, simulation, medical radiation physics, dosimetry treatment devices, special services, and clinical treatment management procedures in teletherapy and brachytherapy.

The categories of procedures in this subsection are well-defined according to levels of intensity for clinical treatment planning, devices, delivery and management.

E. Nuclear Medicine

The general policies promulgated above apply to nuclear medicine as well as standard diagnostic imaging. Several issues specific to the practice of nuclear medicine require comment.

The injection of the radionuclide is included as part of the procedure; separate injection codes (e.g. 36000, 90783) should not be reported.

Single photon emission computed tomography (SPECT) studies represent an enhanced methodology over standard planar nuclear imaging. When a limited anatomic area is studied, there is no additional information procured by obtaining both planar and SPECT studies. While both represent medically acceptable imaging studies, when a SPECT study of a limited area is performed, a planar study is not to be separately reported. When vascular flow studies are obtained using planar technology in addition to SPECT studies, the appropriate CPT code for the vascular flow study should be reported, not the flow, planar and SPECT studies. In cases where planar images must be procured because of the extent of the scanned area (e.g. bone imaging), both planar and SPECT scans may be necessary and reported separately.

F. Radiation Oncology

1. Continuing medical physics consultation (CPT code 77336) is reported "per week of therapy". It may be reported after every five radiation treatments. (It may also be reported if the total number of radiation treatments in a course of radiation therapy is less than five.) Since radiation planning procedures (CPT codes 77261-77334) are generally performed before radiation treatment commences, the NCCI contains edits preventing payment of CPT code 77336 with CPT codes 77261-77295, 77301-77328, and 77332-77334. Because radiation planning procedures may occasionally be repeated during a course of radiation treatment, the edits allow modifier -59 to be appended to CPT code 77336 when the radiation planning procedure and continuing medical physics consultation occur on the same date of service.

G. General Policy Statements

1. Any abdominal radiology procedure that has a radiological supervision and interpretation code (e.g. CPT code 75625 for abdominal aortogram), would also include abdominal x-rays (e.g. CPT codes 74000-74022) as part of the total service.

2. Xeroradiography (e.g. CPT code 76150) is not to be reported with any mammography studies based on CPT coding instruction.

3. Guidance for placement of radiation fields by computerized tomography or ultrasound (CPT codes 76370 or 76950) for the same anatomical area are mutually exclusive of one another.

4. Ultrasound guidance services and diagnostic echography should be reported only when both procedures are performed. Ultrasound guidance services alone do not represent diagnostic echography.

5. CPT code 76970 (ultrasound study, follow-up) cannot be reported with any other echocardiographic or ultrasound guidance procedures because it represents a follow-up procedure on the same day.

6. CPT code 77790 (supervision, handling, loading of radiation source) is not to be reported with any of the remote afterloading brachytherapy codes (e.g. CPT codes 77781-77784) since these procedures inherently include the supervision of the radioelement.

7. Bone studies such as CPT codes 76020-76065 require a series of radiographs; billing separately for bone studies and individual radiographs obtained in the course of the bone study is inappropriate.

8. Radiologic supervision and interpretation codes for specific procedures include all the radiologic services necessary for that procedure. For example, do not additionally report fluoroscopy (e.g., CPT codes 76000, 76001, 76003, 76005) or ultrasound guidance (e.g., CPT codes 76942, 76986).