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

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Chapter IX
Radiology Services
CPT Codes 70000 - 79999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 70000-79999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

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 may be reported.

In radiation oncology, evaluation and management CPT codes are not separately reportable except for an initial consultation at which time a decision is made whether to proceed with the

treatment. Subsequent evaluation and management services are included in the radiation treatment management CPT codes.

C. Non-interventional Diagnostic Imaging

Non-invasive/interventional diagnostic imaging includes but is not limited to 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 should be reported. Because the number of views necessary to obtain medically useful information may vary, a complete review of CPT coding options for a given radiographic session is important to assure accurate coding with the most comprehensive code describing the services performed rather than billing multiple codes to describe the service.

1. If 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. If the radiologist elects to obtain additional views after reviewing initial films in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests must be followed. The CPT code describing the total service should be reported, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptors for many of these services refer to a “minimum” number of views. If more than the minimum number specified is necessary and no other more specific CPT code is available, only that service should be reported. However, if additional films are necessary due to a change in the patient’s condition, separate reporting may be appropriate.

2. CPT code descriptors that specify a minimum number of views include additional views if there is no more comprehensive code specifically including the additional views. For example, if three views of the shoulder are obtained, CPT code 73030 (Radiologic examination, shoulder; complete, minimum of two views) with one unit of service should be reported rather than CPT code 73020 (Radiologic examination, shoulder; one view) plus CPT code 73030.

3. When limited comparative radiographic studies are performed (e.g., post-reduction, post-intubation, post-catheter placement, etc.), the CPT code for the radiographic series should be reported with modifier 52 indicating that a reduced level of interpretive service was provided. This requirement does not apply to OPPS services reported by hospitals.

4. Some studies may be performed without contrast, with contrast, or both with and without contrast. There are separate codes to describe all of these combinations of contrast usage. When studies require contrast, the number of radiographs obtained varies between patients. All radiographs necessary to complete a study are included in the CPT code description.

5. Fluoroscopy is inherent in many radiological supervision and interpretation procedures. Unless specifically noted, fluoroscopy necessary to complete a radiologic procedure and obtain the necessary permanent radiographic record is included in the radiologic procedure and should not be reported separately.

6. Preliminary "scout" radiographs prior to contrast administration or delayed imaging radiographs are not separately reportable.

7. *CPT Manual* instructions state that in the presence of a clinical history suggesting urinary tract pathology complete ultrasound evaluation of the kidneys and urinary bladder constitutes a complete retroperitoneal ultrasound study (CPT code 76770). A limited retroperitoneal ultrasound (CPT code 76775) plus limited pelvic ultrasound (CPT code 76857) should not be reported in lieu of the complete retroperitoneal ultrasound (CPT code 76770).

8. CPT code 76380 (computer tomography, limited or localized follow-up study) should not be reported with other computed tomography (CT), computed tomography angiography (CTA), or computed tomography guidance codes for the same patient encounter.

D. Interventional/Invasive Diagnostic Imaging

1. If a radiologic procedure requires that contrast be administered orally (e.g., upper GI series) or rectally (e.g., barium enema), the administration is integral to the radiologic procedure, and the administration service is not separately reportable. If a radiologic procedure requires that contrast material be administered parenterally (e.g., IVP, CT, MRI), the vascular access (e.g., CPT codes 36000, 36406, 36410) and contrast administration (e.g., CPT codes 96360-96376) are integral to the procedure and are not separately reportable.

2. Many services utilizing contrast are composed of a procedural component (CPT codes outside the 70000 section) and a radiologic supervision and interpretation component (CPT code in the 70000 section). If a single physician performs both components of the service, the physician may report both codes. However, if different physicians perform the different components, each physician reports the CPT code corresponding to that component.

3. Many interventional procedures require contrast injections for localization and/or guidance. Unless there are CPT instructions directing the physician to report specific CPT codes for the localization or guidance, the localization or guidance is integral to the interventional procedure and is not separately reportable.

4. 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 (fluoroscopic or computed tomographic) 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 modifier 59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier 52 to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed tomographic) was complete, the provider should not report a second angiogram for

the dye injections necessary to perform the percutaneous intravascular interventional procedure.

5. The individual CPT codes in the 70000 section identify which injection or administration code, if any, is appropriate for a given procedure. In the absence of a parenthetical CPT note, the injection or administration service is integral to the procedure and is not separately reportable. If an intravenous line is inserted (e.g., CPT code 36000) for access in the event of a problem with the procedure or for administration of contrast, it is integral to the procedure and is not separately reportable. CPT code 36005 describes the injection procedure for contrast venography of an extremity and includes the introduction of a needle or an intracatheter (e.g., CPT code 36000). CPT code 36005 should not be reported for injections for arteriography or venography of sites other than an extremity.

6. When urologic radiologic procedures require insertion of a urethral catheter (e.g., CPT code 51701-51703), this insertion is integral to the procedure and is not separately reportable.

7. Fluoroscopy reported as CPT codes 76000 or 76001 is integral to many procedures including, but not limited, to most spinal, endoscopic, and injection procedures and should not be reported separately. For some of these procedures, there are separate fluoroscopic guidance codes which may be reported separately.

E. Nuclear Medicine

The general policies described above apply to nuclear medicine as well as standard diagnostic imaging.

1. The injection of a radiopharmaceutical is an integral component of a nuclear medicine procedure. CPT codes for vascular access (e.g., CPT code 36000) and injection of the radiopharmaceutical (e.g., CPT codes 96360-96376) are not separately reportable.

2. 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, a SPECT study of a limited area is not separately reportable with a planar study of the same area. 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 size of the scanned area (e.g., bone imaging), both planar and SPECT scans may be necessary and reported separately.

3. Myocardial perfusion imaging (CPT codes 78460-78465) is not reportable with cardiac blood pool imaging by gated equilibrium (CPT codes 78472-78473) because the two types of tests utilize different radiopharmaceuticals.

4. CPT codes 76376 and 76377 (3D rendering) are not separately reportable for nuclear medicine procedures (CPT codes 78000-78999). However, CPT code 76376 or 76377 may be separately reported with modifier 59 on the same date of service as a nuclear medicine procedure if the 3D rendering procedure is performed in association with a third procedure (other than nuclear medicine) for which 3D rendering is appropriately reported.

5. CPT code 78465 (myocardial perfusion imaging; tomographic (SPECT)... with or without quantification) includes calculation of the heart-lung ratio if obtained. CPT code 78580 (pulmonary perfusion imaging, particulate) should not be reported for calculation of the heart-lung ratio during the processing of a SPECT myocardial perfusion procedure.

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 are reported on the same date of service.

2. The *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 13, Section 70.2 (Services Bundled Into Treatment Management Codes) defines services that may not be reported separately with radiation oncology procedures. Based on these requirements, the NCCI contains edits bundling the following CPT codes into all radiation therapy services:

11920-11921 (Tattooing)
16000-16030 (Treatment of burns)
36000, 36410, 36425 (Venipuncture or Introduction of catheter)
51701-51703 (Urinary bladder catheterization)
96360-96368 (Intravenous infusion)
90804-90822 (Psychotherapy)
90846 (Psychotherapy)
90847 (Psychotherapy)
90862, M0064 (Pharmacologic management)
97802-97804 (Medical nutrition therapy)
99143-99144 (Anesthesia – Moderate conscious sedation)
99185 (Regional hypothermia)
99201-99215 (Evaluation & Management)
99217-99239 (Evaluation & Management)
99281-99480 (Evaluation & Management)

3. Brachytherapy (CPT codes 77750-77790) includes radiation treatment management (CPT codes 77427 and 77431) and continuing medical physics consultation (CPT code 77336). CPT codes 77427, 77431, and 77336 should not in general be reported separately with brachytherapy services. However, if a patient receives external beam radiation treatment and brachytherapy treatment during the same time period, radiation treatment management and continuing medical physics consultation may be reported for the external beam radiation treatments. Additionally, if a patient has multi-step brachytherapy, it may be appropriate to separately report continuing medical physics consultation with the brachytherapy.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. CPT codes 76942, 77002, 77003, 77012, and 77021 describe radiologic guidance for needle placement by different modalities. CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

3. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

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

5. Based on CPT coding instructions xeroradiography (e.g., CPT code 76150) is not separately reportable with mammography studies.

6. Guidance for placement of radiation fields by computerized tomography or by ultrasound (CPT codes 77014 or 76950) for the same anatomical area are mutually exclusive of one another.

7. Ultrasound guidance and diagnostic ultrasound (echography) procedures may be reported separately only if each service is distinct and separate. If a diagnostic ultrasound study identifies a previously unknown abnormality that requires a therapeutic procedure with ultrasound guidance at the same patient encounter, both the diagnostic ultrasound and ultrasound guidance procedure codes may be reported separately. However, a previously unknown abnormality identified during ultrasound guidance for a procedure should not be reported separately as a diagnostic ultrasound procedure.

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

9. CPT code 77790 (supervision, handling, loading of radiation source) is not separately reportable with any of the remote afterloading brachytherapy codes (e.g., CPT codes 77785-77787) since these procedures include the supervision, handling, and loading of the radioelement.

10. Bone studies such as CPT codes 77072-77076 require a series of radiographs. Separate reporting of a bone study and individual radiographs obtained in the course of the bone study is inappropriate.

11. Radiological supervision and interpretation codes include all radiological services necessary to complete the service. CPT codes for fluoroscopy/fluoroscopic guidance (e.g., 76000, 76001, 77002, 77003) or ultrasound/ultrasound guidance (e.g., 76942, 76998) should not be reported separately.

Radiological guidance procedures include all radiological services necessary to complete the procedure. CPT codes for fluoroscopy (e.g., 76000, 76001) should not be reported separately with a fluoroscopic guidance procedure. CPT codes for ultrasound (e.g., 76998) should not be reported separately with an ultrasound guidance procedure. A limited or localized follow-up computed tomography study (CPT code 76380) should not be reported separately with a computed tomography guidance procedure.

12. Abdominal ultrasound examinations (CPT codes 76700-76775) and abdominal duplex examinations (CPT codes 93975, 93976) are generally performed for different clinical scenarios although there are some instances where both types of procedures are medically reasonable and necessary. In the latter case, the abdominal ultrasound procedure CPT code should be reported with an NCCI-associated modifier.

13. Tumor imaging by positron emission tomography (PET) may be reported with CPT codes 78811-78816. If a concurrent computed tomography (CT) scan is performed for attenuation correction and anatomical localization, CPT codes 78814-78816 should be reported rather than CPT codes 78811-78813. A CT scan for localization should not be reported separately with CPT codes 78811-78816. However, a medically reasonable and necessary diagnostic CT scan may be separately reportable with an NCCI-associated modifier.

14. Axial bone density studies may be reported with CPT codes 77078 or 77080. Peripheral site bone density studies may be reported with CPT codes 77079, 77081, 76977, or G0130. Although it may be medically reasonable and necessary to report both axial and peripheral bone density studies on the same date of service, NCCI edits prevent the reporting of multiple CPT codes for the axial bone density study or multiple CPT codes for the peripheral site bone density study on the same date of service.

15. When existing vascular access lines or selectively placed catheters are used to procure arterial or venous samples, reporting sample collection separately is inappropriate. CPT codes 36500 (venous catheterization for selective organ blood sampling) or 75893 (venous sampling through catheter with or without angiography...) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling with or without venography. CPT code 75893 includes concomitant venography. If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 should not be reported for blood sampling during an arterial procedure.

16. Radiologic studies with contrast (e.g., CT, CTA, MRI, MRA, angiography) utilize subtraction techniques as a standard of

practice. CPT code 76350 (subtraction in conjunction with contrast studies) should not be reported with procedures that typically utilize contrast.

17. CPT codes 70540-70543 are utilized to report magnetic resonance imaging of the orbit, face, and/or neck. Only one code may be reported for an imaging session regardless of whether one, two, or three areas are evaluated in the imaging session.

18. An MRI study of the brain (CPT codes 70551-70553) and MRI study of the orbit (CPT codes 70540-70543) are separately reportable only if they are both medically reasonable and necessary and are performed as distinct studies. An MRI of the orbit is not separately reportable with an MRI of the brain if an incidental abnormality of the orbit is identified during an MRI of the brain since only one MRI study is performed.

19. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

20. CPT code 36005 (injection procedure for extremity venography (including introduction of needle or intracatheter)) should not be utilized to report venous catheterization unless it is for the purpose of an injection procedure for extremity venography. Some physicians have misused this code to report any type of venous catheterization.

21. Most NCCI edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate

patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.