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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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TABLE OF CONTENTS

Chapter IX - Radiology Services (CPT Codes 70000 - 79999)

A. Introduction IX-2
B. Evaluation and Management (E&M) Services IX-2
C. Non-interventional Diagnostic Imaging IX-5
D. Interventional/Invasive Diagnostic Imaging IX-9
E. Nuclear Medicine IX-13
F. Radiation Oncology IX-15
G. Medically Unlikely Edits (MUEs) IX-19
H. General Policy Statements IX-20

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, ZZZ, or MMM. 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. Procedures with a global period of MMM are maternity procedures.

Since NCCI PTP 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 preoperative 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. In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the 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 contains many, but not 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.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for

which the surgical procedure was performed unless related to a complication of surgery may be reported separately on the same day as a surgical procedure with modifier 24 ("Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period").

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 separately reportable for an initial visit at which time a decision is made whether to proceed with the treatment.

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 imaging studies (e.g., radiographs, computerized tomography, magnetic resonance imaging) are repeated during the course of a radiological encounter due to substandard quality or need for additional views, only one unit of service for the appropriate code may 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 *a* comparative *imaging* stud*y is* performed *to assess potential complications or completeness of a procedure*(e.g., post-reduction, post-intubation, post-catheter placement, etc.), the *professional component of the* CPT code for the *post-procedure imaging study is not separately payable and should not be reported. The technical component of the CPT code for the post-procedure imaging study may be reported.*

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.

9. When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. Similarly when an emergency endotracheal intubation procedure (CPT code

31500), chest tube insertion procedure (e.g., CPT codes 32550, 32551, 32554, 32555), or insertion of a central flow directed catheter procedure (e.g., Swan Ganz)(CPT code 93503) is performed, a chest radiologic examination is usually performed to confirm the location and proper positioning of the tube or catheter. The chest radiologic examination is integral to the procedures, and a chest radiologic examination (e.g., CPT codes 71010, 71020) should not be reported separately.

10. CPT code 77075 (Radiologic examination, osseous survey; complete (axial and appendicular skeleton)) includes radiologic examination of all bones. CPT codes for radiologic examination of other bones should not be reported in addition to CPT code 77075. However, if a separate and distinct radiologic examination with additional films of a specific area of the skeleton is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI-associated modifier.

11. CPT code 77073 (bone length studies...) includes radiologic examination of the lower extremities. CPT codes for radiologic examination of lower extremity structures should not be reported in addition to CPT code 77073 for examination of the radiologic films for the bone length studies. However, if a separate and distinct radiologic examination with additional films of a specific area of a lower extremity is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI-associated modifier.

12. CPT code 75635 describes computed tomographic angiography of the abdominal aorta and bilateral iliofemoral lower extremity runoff. This code includes the services described by CPT codes 73706 (computed tomographic angiography, lower extremity...) and 74175 (computed tomographic angiography, abdomen...). CPT codes 73706 and 74175 should not be reported with CPT code 75635 for the same patient encounter. CPT code 73706 plus CPT code 74175 should not be reported in lieu of CPT code 75635.

13. Ultrasound examination of a transplanted kidney and retroperitoneal structures at the same patient encounter may be reported with CPT code 76770 (ultrasound, retroperitoneal...; complete). It should not be reported with CPT code 76776 (ultrasound, transplanted kidney...) plus CPT code 76775 (ultrasound, retroperitoneal...; limited).

14. Computed tomography (CT) of the spine with intrathecal contrast should not be reported with myelography (e.g., CPT codes 72240-72270) unless both studies are medically reasonable and necessary. Radiography after injection of intrathecal contrast to perform a CT of the spine in order to confirm the location of the contrast is not separately reportable as myelography.

15. CPT code 77063 is an add-on code describing screening digital tomosynthesis for mammography. Since this procedure requires performance of a screening mammography producing direct digital images (HCPCS code G0202), CPT code 77063 may be reported with HCPCS code G0202. However, CPT code 77063 should not be reported with CPT code *77067* which describes screening mammography using radiography.

16. Screening and diagnostic mammography are normally not performed on the same date of service. However when the two procedures are performed on the same date of service, Medicare requires that the diagnostic mammography HCPCS/CPT code be reported with modifier GG (performance and payment of a screening and diagnostic mammogram on the same patient, same day) and the screening mammography HCPCS/CPT code be reported with modifier 59.

17. CPT codes 72081-72084 describe radiologic examination of the entire spine, the codes differing based on the number of views. The other codes in the CPT code range 72020-72120 describe radiologic examination of specific regions of the spine differing based on the region of the spine and the number of views. If a physician performs a procedure described by CPT codes 72081-72084 and at the same patient encounter performs a procedure described by one or more other codes in the CPT code range 72020-72120, the physician should sum the total number of views and report the appropriate code in the CPT code range 72081-72084. The physician should not report a code from the CPT code range 72081-72084 plus another code in the CPT code range 72020-72120 for services performed at the same patient encounter.

18. Since the foot includes the toes and calcaneous bone, CPT code 73630 (radiologic examination, foot; complete, minimum of 3 views) includes radiologic examination of the toes and calcaneous. A physician should not report CPT code 73650 (radiologic examination; calcaneus, minimum of 2 views) or 73660 (radiologic examination; toe(s), minimum of 2 views) with CPT code 73630 for the same foot on the same date of service.

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 in addition to modifier 59 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. For lymphangiography procedures, injection of dye into subcutaneous tissue is integral to the procedure. CPT code 96372 (Therapeutic, prophylactic, or diagnostic injection...; subcutaneous or intramuscular) should not be reported separately for this injection of dye.

7. 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.

8. 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.

9. Computed tomography (CT) and computed tomographic angiography (CTA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate CT and CTA reports, only one procedure, either the CT or CTA, for the anatomic region may be reported. Both a CT and CTA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the CT and one for the CTA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

Similarly magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) procedures for the same anatomic location may

be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate MRI and MRA reports, only one procedure, either the MRI or MRA, for the anatomic region may be reported. Both an MRI and MRA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the MRI and one for the MRA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

10. Computed tomography of the heart (CPT codes 75571-75573) and computed tomographic angiography of the heart (CPT code 75574) include electrocardiographic monitoring if performed. CPT codes 93000-93010 (electrocardiogram...) and 93040-93042 (rhythm ECG...) should not be reported separately with CPT codes 75571-75574 for the ECG monitoring integral to these procedures.

11. 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., *77065-77067*, G0202-G0206) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure.

12. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed at multiple vertebral levels that are not contiguous and in different regions of the spine, the physician may report one primary code for each non-contiguous region.

For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment.

CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an add-on code describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code, the one for the first procedure, may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4, the physician may report CPT codes 22532 and 22533.

CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the physician may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not.

13. CPT code 50398 describes change of a nephrostomy or pyelostomy tube. If the tube change occurs in a patient without new symptoms related to the tube, CPT code 50394 (injection procedure for pyelography through a nephrostomy or pyelostomy tube) should not be reported separately for the tube check. However, if the patient has new symptoms related to the tube, the provider may separately report CPT code 50394 with an NCCI-associated modifier for the tube check. (CPT codes 50394 and 50398 were deleted January 1, 2016.)

14. Diagnostic studies of the cervicocerebral arteries (CPT codes 36221-36227) include angiography of the thoracic aortic arch. Physicians should not separately report CPT codes 75600 or 75605 (thoracic aortography) for this examination unless it is medically reasonable and necessary to additionally examine the descending thoracic aorta. A physician should not report CPT codes 75600 or 75605 for the examination of the descending thoracic aorta with the runoff of the dye used to examine the thoracic aortic arch included in the diagnostic studies of the cervicocerebral arteries. Additionally, if an unexpected abnormality of the descending thoracic aorta is identified while examining the dye runoff in the descending aorta, CPT codes 75600 or 75605 should not be reported separately.

15. 3D rendering of an imaging modality (e.g., CPT codes 76376, 76377) should not be reported for mapping the sites of multiple biopsies or other needle placements under radiologic

guidance. For example, a provider performing multiple prostate biopsies under ultrasound guidance (e.g., CPT code 76942) should not report CPT codes 76376 or 76377 for developing a map of the locations of the biopsies.

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 784*51*-784*54*) 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 78012-78999). 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 codes 78451-78452 (myocardial perfusion imaging;... additional quantification...) include 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.

6. Positron emission tomography (PET) imaging requires use of a radiopharmaceutical diagnostic imaging agent. HCPCS codes A9555 (Rubidium Rb-82...) and A9526 (Nitrogen N-13 Ammonia...) may only be reported with PET scan CPT codes 78491 and 78492. HCPCS code A9552 (Fluorodeoxyglucose F-18, FDG,...) may only be reported with PET scan CPT codes 78459, 78608, and 78811-78816.

7. Positron emission tomography (PET) procedures include a finger stick blood glucose level. CPT codes 82948 (glucose; blood, reagent strip) or 82962 (glucose, blood by glucose monitoring device(s)...) should not be reported separately for the measurement of the finger stick blood glucose included in a PET procedure.

8. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic...) describes a radiopharmaceutical utilized for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 should not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if two separate nuclear medicine studies are performed on the same date of service, one with the radiopharmaceutical described by HCPCS code A9512 and one with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported utilizing an NCCI-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be utilized for separate nuclear medicine studies on the same date of service as a nuclear medicine study utilizing the radiopharmaceutical described by HCPCS code A9512.

9. Generally diagnostic nuclear medicine procedures are performed on different dates of service than therapeutic nuclear medicine procedures. However, if a diagnostic nuclear medicine procedure is performed on an organ and the decision to proceed with a therapeutic nuclear medicine procedure on the same organ on the same date of service is based on results of the diagnostic nuclear medicine procedure, both procedures may be reported on the same date of service utilizing an NCCI-associated modifier.

A physician should not report a radiopharmaceutical therapy administration code for the radionuclide administration that is integral to diagnostic nuclear imaging procedures.

10. A three phase bone and/or joint imaging study (CPT code 78315) includes initial vascular flow imaging. CPT code 78445 (non-cardiac vascular flow imaging...) should not be reported separately for the vascular flow imaging integral to CPT code 78315.

11. Non-cardiac vascular flow imaging, when performed, is integral to a nuclear medicine procedure. CPT code 78445 (non-cardiac vascular flow imaging...) should not be reported with any other nuclear medicine procedure code.

12. Supervision and handling of radionuclides is integral to nuclear medicine procedures (e.g., CPT codes 78012-79999.) Physicians should not separately report CPT code 77790 (supervision, handling, and loading of radiation source) for this service.

F. Radiation Oncology

1. Except for an initial visit evaluation and management (E&M) service at which the decision to perform radiation therapy is made, E&M services are not separately reportable with radiation oncology services with one exception as noted below. Effective January 1, 2010, CMS eliminated payment for consultation E&M CPT codes 99241-99255. The initial E&M visit for radiation oncology services may be reported with office/outpatient E&M CPT codes 99201-99215, initial hospital care E&M CPT codes 99221-99223, subsequent hospital care E&M CPT codes 99231-99233, or observation/inpatient hospital care with same day admission and discharge E&M CPT codes 99234-99236.

The only radiation oncology services that may be reported with E&M services in addition to an initial visit E&M service are CPT codes 77770-77772 (remote afterloading high dose rate radionuclide brachytherapy...) E&M services reported with these brachytherapy codes must be significant, separate and distinct from radiation treatment management services.

2. 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, 77301-77318, 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.

3. 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)
90832-90838 (Psychotherapy)
90839-90840 (Psychotherapy)
90846 (Psychotherapy)
90847 (Psychotherapy)
90863, M0064(Pharmacologic management) (HCPCS code M0064 was deleted January 1, 2015.)
97802-97804 (Medical nutrition therapy)
99151-99153 (Anesthesia – Moderate conscious sedation) *(CPT codes 99143-99145 were deleted January 1, 2017.)*
99185 (Regional hypothermia)(CPT code 99185 was deleted January 1, 2010.)
99201-99215 (Evaluation & Management)
99217-99239 (Evaluation & Management)
99281-99498 (Evaluation & Management)

4. 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.

5. The procedure described by CPT code 37204 (transcatheter occlusion or embolization (eg, for tumor destruction)...) includes infusion of the occlusion/embolization agent. It is not appropriate to separately report CPT code 77750 (infusion or instillation of radioelement solution...) if the embolization agent is a radioelement solution. Similarly it is not appropriate to separately report CPT code 77778 (interstitial radiation source application, complex,...) in addition to CPT code 37204 for infusion of the radioelement solution. (CPT code 37204 was deleted January 1, 2014.) (CPT codes 77776 and 77777 were deleted January 1, 2016.)

6. The procedure described by CPT code 77778 (interstitial radiation source application, complex,...) requires that a radiation source be applied interstitially. Reporting a CPT code requires that all essential components of the procedure are performed. These codes should not be reported by a radiation oncologist for intraoperative work with another physician who surgically places catheters interstitially unless the radiation oncologist also applies the radiation source at the same patient encounter. The intraoperative work of the radiation oncologist may be reportable with a non-brachytherapy code. If the radiation source application occurs postoperatively in a different room, the radiation oncologist may report CPT codes 77770-77772(remote afterloading high dose rate radionuclide brachytherapy...) for the radiation source application. (CPT codes 77776 *and* 77777 were deleted January 1, 2016.)

7. Stereotactic radiosurgery (SRS) treatment delivery (CPT codes 77371-77373) includes stereotactic guidance for placement of the radiation therapy fields for treatment delivery. CPT codes 77014 (computed tomography guidance for placement of radiation therapy fields) and 76950 (ultrasonic guidance for placement of radiation therapy fields) should not be reported additionally for guidance for placement of the radiation therapy field for SRS treatment delivery. *(CPT code 76950 was deleted January 1, 2015.)*

8. Since CPT code 0197T (intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy...) includes localization of the radiation field, it should not be reported with other CPT codes describing localization of the radiation field such as CPT codes 76950 (ultrasonic guidance for placement of radiation therapy fields), 77014 (computed tomography guidance for placement of radiation therapy fields), or 77421 (stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy). (CPT codes 0197T*, 76950,* and 77421 were deleted January 1, 2015.)

9. Since CPT code 77387 (guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking when performed) includes localization of the radiation field, it should not be reported with other CPT codes describing localization of the radiation field such as CPT codes 76950 (ultrasonic guidance for placement of radiation therapy fields) or 77014 (computed tomography guidance for placement of radiation therapy fields). *(CPT code 76950 was deleted January 1, 2015.)*

10. Partial breast high dose rate brachytherapy may be performed two times a day. The first therapeutic radiology simulation for the course of therapy may be complex and reported as CPT code 77290. However, subsequent simulations during the course of therapy should be reported as CPT code 77280.

11. Intensity modulated treatment (IMRT) delivery (e.g., CPT codes 77418,77385, 77386) is not normally reported with treatment device design and construction CPT codes 77332-77334. The latter codes are generally reported for treatment device(s) design and construction for external beam radiation therapy. IMRT planning (CPT code 77301) includes many treatment device(s) required for IMRT. Multi-leaf collimator (MLC) device(s) (CPT code 77338) may be reported separately once per IMRT plan. However, patients receiving IMRT occasionally require an additional treatment device at a later date due to decreased tumor volume or patient weight. This device may be reported with CPT codes 77332-77334. (CPT code 77418 was deleted January 1, 2015.)

12. CPT code 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan) should not be reported with CPT code 77385 (Intensity modulated radiation treatment delivery (IMRT),

includes guidance and tracking, when performed; simple) if the IMRT is compensator based. However, if the IMRT is not compensator based, CPT code 77338 may be reported separately.

13. Calculations described by CPT code 77300, if performed, are integral to some clinical brachytherapy procedures (e.g., CPT codes 77767-77772, 77778). CPT code 77300 should not be reported with these clinical brachytherapy procedure codes.

14. Intensity modulated radiotherapy (IMRT) plan (CPT code 77301) includes therapeutic radiology simulation-aided field settings. Simulation-*aided* field settings for IMRT should not be reported separately *using* CPT codes 77280-7729*0*. Although procedure to procedure edits based on this principle exist in NCCI for procedures performed on the same date of service, these edits should not be circumvented by performing the two procedures described by a code pair edit on different dates of service.

15. CPT codes 77280-77290 (simulation-aided field settings) should not be reported for verification of the treatment field during a course of intensity modulated radiotherapy (IMRT) treatment.

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.

4. The MUE values for J0152 (injection, adenosine for diagnostic use, 30 mg...) and J1245 (injection, dipyridamole, per 10 mg) were set for single pharmacologic stress tests. For the unusual patient who requires two different types of pharmacologic stress tests (e.g., myocardial perfusion and echocardiography) on the same date of service, the amount of drug utilized for each stress test should be reported on separate lines of a claim with modifier 59 appended to the code on one of the claim lines. (HCPCS code J0152 was deleted January 1, 2014.)

5. The code descriptor for CPT code 77417 states "Therapeutic radiology port image(s)". The MUE value for this code is one (1) since it includes all port films.

H. General Policy Statements

1. *MUE and NCCI PTP edits are based on services provided by the same physician to the same beneficiary on the same date of service. Physicians should not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.*

2. 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 [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 50 (Payment for Anesthesiology Services)] and Global Surgery Rules [e.g., CMS *Internet-Only Manual*, Publication 100-04 (*Medicare Claims Processing Manual*), Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery)] do not apply to hospitals.

3. Providers reporting services under Medicare's hospital outpatient prospective payment system (OPPS) should report all services in accordance with appropriate Medicare *Internet-Only Manual* (*IOM*) instructions.

4. 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.*

5. 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*.

6. 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.

7. Based on CPT coding instructions xeroradiography (e.g., CPT code 76150) is not separately reportable with mammography studies. (CPT code 76150 was deleted January 1, 2011.)

8. Guidance for placement of radiation fields by computerized tomography or by ultrasound (CPT codes 77014 or 76950) for the same anatomical area is mutually exclusive of one another. *(CPT code 76950 was deleted January 1, 2015.)*

9. *Evaluation of an anatomic region and guidance for a needle placement procedure in that anatomic region by the same radiologic modality at the same or different patient encounter(s) on the same date of service are not separately reportable. For example, a physician should not report a diagnostic ultrasound CPT code and CPT code 76942 (ultrasonic guidance for needle placement...) when performed in the same anatomic region on the same date of service. Physicians should not avoid these edits by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service.*

10. 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.

11. 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 77770-77772) since these procedures include the supervision, handling, and loading of the radioelement.

12. 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.

13. 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.

14. 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.

15. 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.

16. Axial bone density studies may be reported with CPT codes 77078 or 77080. Peripheral site bone density studies may be reported with CPT codes 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 PTP 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.

17. 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.

18. 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. (CPT code 76350 was deleted January 1, 2011.)

19. 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.

20. 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.

21. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI PTP 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.

22. 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.

23. Most NCCI PTP 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 PTP 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.

24. Physicians should not report radiologic supervision and interpretation codes, radiologic guidance codes, or other radiology codes where the radiologic procedure is integral to another procedure being performed at the same patient encounter. Procedure to procedure edits that bundle these radiologic codes into the relevant procedure codes have modifier indicators of “1” allowing use of NCCI-associated modifiers to bypass them. An NCCI-associated modifier may be used to bypass such an edit if and only if the radiologic procedure is performed for a purpose unrelated to the procedure to which it is integral. For example, fluoroscopy is integral to a cardiac catheterization procedure and should not be reported separately with a cardiac catheterization. However, if on the same date of service the physician performs another procedure in addition to the cardiac catheterization, the additional procedure requires fluoroscopy, and fluoroscopy is not integral to the additional procedure, the fluoroscopy procedure may be reported separately with an NCCI-associated modifier.