Ensure Your Ultrasound and Fluoroscopy Claims Stand Up To Auditor Scrutiny

Marvel J. Hammer
RN CPC CCS-P ACS-PM CPCO

Radiology Services: Global Versus Components

- CMS Physician Fee Schedule has designated CPT Radiology codes with a PC/TC indicator of 1 = Diagnostic Tests for Radiology Services
  - Identifies codes that describe diagnostic tests; examples are pulmonary function tests or therapeutic radiology procedures, e.g., radiation therapy
  - These codes have both a professional and technical component; modifiers -26 and -TC can be used with these codes…

Global Services (no modifier) = Professional Component (26) + Technical Component (TC)

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Global Radiology Services

- Provider owns/leases equipment and staff for radiology service
- The global procedure code should be reported when both the professional and technical components of a given service are performed by a single provider or entity
- NO modifier reported with radiology code
- Typically office site of service (11)
- Reimbursement based on global RVU; include values for physician work, full practice expense & malpractice expense

Professional Component

- Relative value includes the physician work, associated overhead and professional liability insurance costs of human involvement of radiology service
- Correct coding guidelines require that modifier -26 Professional component be used when the professional component of a global service is the only service provided by the provider or entity
- Typically used to report physician services when procedures performed at facility site of service, i.e. ASC (24), outpatient hospital (22), or inpatient hospital (21)
- Reimbursement based on RVU for professional component only; includes values for physician work, limited practice expense & malpractice expense
Technical Component

- Relative value includes the cost of equipment and supplies to perform the radiology service
- Correct coding guidelines require that modifier -TC (Technical component) be used when the service provided represents only the equipment or facility component of a global service and not the professional component of that same service
- Reimbursement based on RVU for technical component only; include values for majority of practice expense and malpractice expense only, no physician work
  - Payer may not separately reimburse technical component; instead include it into the facility payment for the procedure, i.e. Medicare in ASC site of service

Radiology Modifier Example

- Caudal epidural injection performed under fluoroscopic guidance
  - Place of Service: physician office (POS 11)
    62310 x 1
    77003 x 1 (guidance billed with no modifier)
  - Place of service: Ambulatory Surgery Center (POS 24)
    - Physician services billing:
      62310 x 1
      77003 -26 x 1
    - ASC facility billing:
      62310 x 1
      77003 –TC x 1 (separately billable will depend upon payer policy)
Potential Issue: Facility Place of Service

- Some payers will only reimburse provider for professional component of services (modifier -26) when diagnostic study/image guidance is performed in a facility site of service, i.e. 21, 22, 24, etc.

- Facility is reimbursed for the technical component of the radiologic service via a grouper payment, regardless of who actually owns the machine & performs the technical portion of the service.

- Provider may be required to bill with modifier -26 only for the professional component.

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Potential Issue: Facility Place of Service

- Medicare Claims Processing Manual Chapter 13 20.2.1
  - Carriers may not pay for the technical component (TC) of radiology services furnished to hospital patients. Payment for physicians’ radiological services to the hospital, e.g., administrative or supervisory services, and for provider services needed to produce the radiology service, is made by the fiscal intermediary (FI)/AB MAC to the hospital as a provider service.

  - FIs/AB MACs include the TC of radiology services for hospital inpatients, except Critical Access Hospitals (CAHs), in the prospective payment system (PPS) payment to hospitals.

  - Hospital bundling rules exclude payment to suppliers of the TC of a radiology service for beneficiaries in a hospital inpatient stay.

http://tinyurl.com/MCR-CLM-Chpt13
Potential Issue: Facility Place of Service

- Medicare Claims Processing Manual Chapter 14
  - ASC services for which payment is included in the ASC payment for a covered surgical procedure under 42CFR416.65 include, but are not limited to:
    a) Included facility services: …
    11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;
  - Contractors shall deny the technical component for all ancillary services on the ASCFS list billed by specialties other than 49 provided in an ASC setting (POS 24)

http://tinyurl.com/MCR-CLM-Chpt14

Radiology Modifier Example

- Right femoral nerve block with ultrasound guidance on a Medicare beneficiary for acute postoperative pain
  - Place of service: hospital inpatient (POS 21)
  - Anesthesiologist uses his own ultrasound machine & personally performs the image guidance
    - 64447 – RT x 1
    - 76492 – 26 x 1
Instructions for Use of the CPT Codebook

Results, Testing, Interpretation and Report
- Results are the technical component of a service
- Testing leads to results
- Results leads to interpretation
- Reports are the work product of the interpretation of test results

- Certain procedures or services described in CPT involve a technical component (eg, tests) which produce “results” (eg, data, images, slides). For clinical use, some of these results require interpretation. Some CPT descriptors specifically require interpretation and reporting to report that code.

Diagnostic Study Requirements

- Radiology CPT section guidelines: “A written report, signed by the interpreting physician, should be considered an integral part of a radiologic procedure or interpretation.”

- CMS Claims Processing Manual Chpt 13 Radiology Services: “…The interpretation of a diagnostic procedure includes a written report…An “interpretation and report” should address the findings, relevant clinical issues, and comparative data (when available)…”

- Requires permanent image(s)
  (hard copy and/or electronically stored)
Diagnostic Study Documentation

- Injection of contrast does not equate to a diagnostic study
- Interpretive report needs to include more than verification of needle placement and/or “good flow of contrast”
- Formal radiographic report documents…
  - Number and type of views reviewed
  - Radiographic findings with an impression
    - For example, extent of contrast dispersal, filling defects, stenosis and/or adhesions, if appropriate, contrast pattern(s) visualized

American College of Radiology “Practice Guideline for Communication of Diagnostic Imaging Findings”
- The final report is the definitive documentation of the results of an imaging examination or procedure …

3. Body of the report
   a. Procedures and materials: The report should include a description of the studies and/or procedures performed and any contrast media and/or radiopharmaceuticals (including specific administered activities, concentration, volume, and route of administration when applicable), medications, catheters, or devices used, if not recorded elsewhere. Any known significant patient reaction or complication should be recorded.

http://tinyurl.com/ACR-Documentation
Diagnostic Study Documentation

- American College of Radiology “Practice Guideline for Communication of Diagnostic Imaging Findings”

3. Body of the report …
   
   b. Findings: The report should use appropriate anatomic, pathologic, and radiologic terminology to describe the findings
   
   c. Potential limitations: The report should, when appropriate, identify factors that may compromise the sensitivity and specificity of the examinations.
   
   d. Clinical issues: The report should address or answer any specific clinical questions. If there are factors that prevent the answering of the clinical question, this should be stated explicitly
   
   e. Comparison studies and reports: Comparison with relevant examinations and reports should be part of the radiologic consultation and report when appropriate and available

Diagnostic Study Documentation

- American College of Radiology “Practice Guideline for Communication of Diagnostic Imaging Findings”

4. Impression (conclusion or diagnosis)
   
   a. Unless the report is brief, each report should contain an “impression” section
   
   b. A specific diagnosis should be given when possible.
   
   c. A differential diagnosis should be rendered when appropriate
   
   d. Follow-up or additional diagnostic studies to clarify or confirm the impression should be suggested when appropriate
   
   e. Any significant patient reaction should be reported. …
Ultrasound:
Diagnostic Studies & Image Guidance

CPT Diagnostic Ultrasound Section Guidelines

- All diagnostic ultrasound examinations require permanently recorded images with measurements, when such measurements are clinically indicated.
- A final, written report should be issued for inclusion in the patient's medical record.
- For those anatomic regions that have "complete" and "limited" ultrasound codes, note the elements that comprise a "complete" exam. The report should contain a description of these elements or the reason that an element could not be visualized (eg, obscured by bowel gas, surgically absent).
CPT Diagnostic Ultrasound Section Guidelines

- If less than the required elements for a "complete" exam are reported (e.g., limited number of organs or limited portion of region evaluated), the "limited" code for that anatomic region should be used once per patient exam session.

- A "limited" exam of an anatomic region should not be reported for the same exam session as a "complete" exam of that same region.

Ultrasound guidance procedures also require...

- Permanently recorded images of the site to be localized, as well as

- Documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized

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

76800 Ultrasound, spinal canal and contents

- Global RVU (2014): 2.74
  - Professional component (-26): 0.43
  - Technical component (-TC): 2.31

- April 1998 CPT Assistant

**Q:** Can code 76800 be used to report each area of the spine, or is this code used for the entire spinal canal?

**A:** It is inappropriate to report this code for each area of the spine. From a CPT coding perspective, code 76800 includes the entire spinal canal.

- Best to check payer coverage: limited or noncovered by many payers

First Coast J9 L30353: Ultrasound of the Spine

- Ultrasound of the spine is an accurate and cost-effective examination for the detection of congenital or acquired abnormalities in the newborn and infant. It may also be useful post-operative for neonates and young infants in the evaluation of cord retethering and associated defects.

- Indications: will consider ultrasound of the spine medically reasonable and necessary when used intra-operatively for adults; and for the newborn and infant in the diagnostic evaluation of the spinal cord and canal.

- Limitations: considers non-operational adult ultrasound of the spine and paraspinal tissues for the evaluation of neuromuscular conditions and all other indications (for example, to assist in lumbar puncture or to assist with interventional pain injections) non-covered
CPT Diagnostic Ultrasound - Extremity Guidelines

- A complete ultrasound examination of an extremity (76881) consists of real time scans of a specific joint that includes examination of the muscles, tendons, joint, other soft tissue structures, and any identifiable abnormality.

- Code 76882 refers to an examination of an extremity that would be performed primarily for evaluation of muscles, tendons, joints, and/or soft tissues. This is a limited examination of the extremity where a specific anatomic structure such as a tendon or muscle is assessed. In addition, the code would be used to evaluate a soft-tissue mass that may be present in an extremity where knowledge of its cystic or solid characteristics is needed.

Diagnostic Ultrasound: Extremity

*Ultrasound, extremity, nonvascular, real-time with image documentation;…*

- **76881 …; complete**
  - Global RVU (2014): 2.67
    - Professional component (-26): 0.23
    - Technical component (-TC): 2.44

- **76882 …; limited, anatomic specific**
  - Global RVU (2014): 0.47
    - Professional component (-26): 0.17
    - Technical component (-TC): 0.30

- Codes were created to differentiate between a complete and a focused anatomic-specific exam
Novitas JL L30271: Nonvascular Extremity Ultrasound

- A complete ultrasound examination of an extremity (76881) is a real time scan of a specific joint to include all of the following: muscles, tendons, joints, other soft tissues structures, any other abnormality
  - Medical record documentation **must** include a report of the study findings that indicates all of the above structures were examined and the findings for each.

- A limited ultrasound examination of an extremity (76882) is a scan in which a specific anatomic structure (e.g., soft-tissue mass) is examined

NGS JK L28178 & Novitas JL L30271: Nonvascular Extremity Ultrasound

- Extremity ultrasound is **indicated** for the following conditions:
  - To detect cysts, abscesses, tumors (including evaluation of size of tumors) and effusion;
  - To distinguish solid tumors from fluid-filled cysts;
  - To evaluate tendons (including tears, tendonitis and tenosynovitis), joints, plantar fascia, ligaments, soft tissue masses, ganglion cysts, intermetatarsal neuroma and stress fractures of the metatarsals;
  - To aid in the diagnosis of and surgical removal of foreign bodies
NGS JK L28178 & Novitas JL L30271: Nonvascular Extremity Ultrasound

- **Limitations**: Bilateral studies are allowed only if there is pathology of both extremities dictating medical necessity for two distinct examinations. It is not reasonable and necessary to perform the contralateral extremity as a "control."

- **Documentation requirements**: permanent record of the ultrasound and its interpretation should be kept on file in the patient's record.

- The record should include all of the following:
  - Images of all appropriate areas, labeled with exam date, patient identification, and image orientation; and
  - Documentation of the variations from normal, accompanied by measurements;
  - Formal interpretation

First Coast J9 Billing & Coding Procedure Code 76942 Bulletin 12/2013

- Of note, diagnostic musculoskeletal ultrasound has unique codes. CPT® codes 76881 (Ultrasound, extremity,…; complete) and 76882 (Ultrasound, extremity, …; limited, anatomic specific) describe an ultrasound imaging procedure for the evaluation of muscles, tendons, joints, and/or soft tissue structures generally after a standard radiograph does not determine the diagnosis and other imaging is not indicated (MRI, etc.).

- Use of these procedures codes with aspiration and/or injection procedures **would not** be expected unless a separate musculoskeletal diagnostic evaluation is indicated and documented as reasonable and necessary.
Image Guidance: Ultrasound

76942 Ultrasound guidance for needle placement (eg biopsy, aspiration, injection, localization device), imaging supervision and interpretation

- Used for:
  - Primarily, peripheral nerve, soft-tissue, intra-articular joint injections
  - Spinal injections, not as common, i.e. paravertebral facet, transforaminal, intralaminar and caudal epidural

2014 Medicare Physician RVU Changes

<table>
<thead>
<tr>
<th>Non-facility Total RVU</th>
<th>76942</th>
<th>76942-26</th>
<th>76942-TC (75% decrease)</th>
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<tr>
<td>2014</td>
<td>2.07</td>
<td>0.95</td>
<td>1.12</td>
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<td>2013</td>
<td>6.13</td>
<td>0.96</td>
<td>5.17</td>
</tr>
<tr>
<td>RVU Difference</td>
<td>-4.06 (-$134.41)</td>
<td>-0.01 ($1.37)</td>
<td>-4.05 (-$135.78)</td>
</tr>
<tr>
<td>RVU Change:</td>
<td>Primarily, due to decrease in Non-facility Practice Expense RVU</td>
<td></td>
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</tr>
</tbody>
</table>

$ difference calculated with 2014 1st Quarter Medicare conversion factor: $35.8228
Image Guidance: Ultrasound

- CPT Parenthetical notes
  - Do not report 76942 in conjunction with 10030, 19083, 19285, 27096, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975, 0213T-0218T, 0228T-0231T, 0232T, 0249T, 0301T

  - For injection(s) of platelet rich plasma, use 0232T

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Image Guidance: Ultrasound

- Included in code descriptions of following procedures and not separately billable:
  
  **0213T – 0218T** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) *with ultrasound guidance*;

  **0228T – 0231T** Injection(s), anesthetic agent and/or or steroid, transforaminal epidural, *with ultrasound guidance*;

  **0232T** Injection(s), platelet rich plasma, any site, *including image guidance*, harvesting and preparation when performed

- Potential payer coverage limitations for spinal procedures performed with ultrasound guidance – Best to check
Image Guidance: Ultrasound

- CPT code 27096 not billable when performed with ultrasound guidance
  - Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
  - Medicare NCCI edits: 76942 is a column 2 component of 27096

- CPT parenthetical notes:
  - 27096 is to be used only with CT or fluoroscopic imaging confirmation of intra-articular needle position
  - If CT or fluoroscopy is not performed, use 20552
    - No longer report 20610 if performed without imaging guidance
    - If ultrasound is used for guidance, report injection with 20552

April 2013

CPT Assistant

Q: Can you report the CPT codes for destruction of paravertebral joint nerves with imaging guidance (fluoroscopy or CT) codes 64633-64636, if ultrasound guidance is used instead of CT or fluoroscopic guidance?

A: No. If CT or fluoroscopic guidance is not used when performing a procedure otherwise described by codes 64633-64636 this service would be reported with the unlisted code 64999, Unlisted procedure, nervous system.

- CPT parenthetical note: If CT or fluoroscopic imaging is not used, report 64999
March 2011 CPT Assistant

Q: To report code 76942 correctly, is it required that the ultrasound guide the actual “needle puncture”?

A: Yes. Code 76942, Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation, requires that the ultrasound is used to guide the needle such as for a needle biopsy or fine needle aspiration (FNA) of an organ or body area. It is not required that the ultrasound guidance be used specifically for the insertion of the needle through the skin but the imaging must be used to guide the needle placement in order to report the code.

February 2011 CPT Assistant

- If ultrasound is used to guide the transforaminal injections, a code from the category III code set should be used instead of a code from the 64479-64484 code series. Therefore, parenthetical notes instruct users to report Category III codes 0228T, 0229T, 0230T, and 0231T for ultrasound-guided transforaminal epidural procedures.

- Additionally ultrasound guidance procedure code 76942, *Ultrasound guidance for needle placement (eg biopsy, aspiration, injection, localization device), imaging supervision and interpretation*, has been revised to clarify that it may not be used as guidance for 64479-64495 injections.
April 2005 CPT Assistant

**Q:** Would it be appropriate to report code 76942, Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation, twice when there is more than one lesion in the breast?

**A:** From a CPT coding perspective, code 76942 should be reported per distinct lesion that requires separate needle placement. Therefore, if several passes are made into two separate lesions in the same organ (ie, two lesions in same breast), then code 76942 would be reported twice.

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**Medicare NCCI Manual Chapter 9: Radiology Services**

- 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.

מזון **importance** of documentation as to whether it is compliant to separately bill the diagnostic ultrasound study!
...Based upon clinical literature and input from practicing physicians in several specialties, MAC J9 maintains that ultrasound guidance may not be reasonable and necessary and is not the established standard of care for all needle placement procedures.

Therefore, billing and coding the ultrasound guidance procedure code 76942 with an associated procedure must be clearly supported in the medical record as meeting the reasonable and necessary threshold for coverage for the given beneficiary or it should not be coded and submitted with the claim. ...

... It is not expected that a non-physician practitioner (NPP) would perform procedures utilizing 76942 as they are not qualified to “interpret” diagnostic ultrasounds.

Note that this code includes “imaging supervision and interpretation.” An interpretation of the ultrasound guidance must be documented in the patient’s medical record in order to separately bill this procedure code. ...
**Novitas JL Bulletin: Ultrasound Guidance for Knee Injections**

- Audits were performed by Novitas Solutions' Medical Review Department for procedure code 76942, …

- In reviewing the medical records provided to support these services, it was determined that providers were using ultrasound guidance for knee joint injections. The documentation **did not** provide any information which would support the medical necessity for using ultrasound guidance for knee injections.

- Medical necessity is defined as the need for an item(s) or service(s), to be reasonable and necessary for the diagnosis or treatment of disease, injury or defect. The need for the item or service **must** be clearly documented in the patient's medical record …

**Novitas JL Bulletin: Ultrasound Guidance for Knee Injections**

- The use of ultrasound guidance for knee joint injections may be considered medically reasonable and necessary by Novitas Solutions if the documentation supports one of the following:
  - The failure of the initial attempt at the knee joint injection where the provider is unable to aspirate any fluid.
  - The size of the patient's knee(s), due to morbid obesity or disease process, inhibits the provider's ability to inject the knee(s) without ultrasound guidance.
  - The provider is planning to drain a popliteal (Baker's) cyst.
Aetna Viscosupplementation Clinical Policy Bulletin 0179

- **Note:** Ultrasound guidance for viscosupplement injections is considered experimental and investigational because it has not been established that this approach will improve health outcomes.

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American Academy of Orthopedic Surgeons: AAOS Now 7/2013

**Q:** Can the ultrasound guidance CPR code – 76942 – be reported when the physician performs a major joint injection (CPT code 20610) using ultrasound guidance?

**A:** There is no AMA CPT coding restriction to reporting CPT code 76942 when ultrasound guidance is medically necessary to accurately place the needle for the injection. However, in most cases, imaging guidance to penetrate an easily palpable joint seems **neither reasonable nor necessary**
Fluoroscopy: Diagnostic Studies & Image Guidance

Diagnostic Study: Epidurography

72275 Epidurography, radiological supervision and interpretation

- Global RVU (2014): 3.30
  - Professional component (-26): 1.13
  - Technical component (-TC): 2.17

- Performed to assess the structure of the epidural space
- Not anatomically driven – allowable for any spinal region
- Medical necessity issues – injection of contrast does not equate to epidurography
Diagnostic Study: Epidurography

- CPT parenthetical notes
  - 72275 includes 77003
  - Use 72275 only when an epidurogram is performed, images documented and a formal radiologic report is issued
  - Do not report 72275 in conjunction with 22586, 0195T, 0196T, 0309T

- Medicare NCCI edits: 72275 is a column 2 component of epidural injection & infusion procedure codes
  - Modifier is allowed to bypass the edit
  - Documentation must support separate & distinct diagnostic study!

June 2012 CPT Assistant

- The codes for percutaneous lysis of adhesions (62263 and 62264) include the procedures defined by codes 72275 and 77003; therefore, codes 72275 and 77003 should not be used in conjunction with codes 62263 and 62264.
October 2009 CPT Assistant

**Q:** During various injections of therapeutic substances into the spine, contrast is often injected to ensure that the needle or catheter is in the epidural space. Is it appropriate to code 72275, Epidurography, radiologic supervision and interpretation, in addition to the appropriate injection code?

**A:** No. Code 72275 is only to be used when an epidurogram is performed, images documented, and a formal radiologic report issued. A statement indicating that contrast flows in the epidural space would only document contrast flows in the epidural space would only document localization and would not represent a diagnostic epidurogram...

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July 2008 CPT Assistant

- The **indications** for use of diagnostic epidurography is **limited**
  - To determine whether there are obstruction in the epidural space that would limit the spread of therapeutic substances that may be injected
  - Data obtained should **influence and improve** patient treatment options and contribute new information to that already obtained from other spinal imaging procedures commonly used, i.e. MRI and CT with myelography
  - **Should not** be used routinely for localization with the performance of most therapeutic spinal injections

- **Not indicated or appropriate** to use for needle localization in the majority of therapeutic epidural steroid injections or similar procedures in lieu of code 77003

- Hard Copy images in **multiple planes** documenting the flow of contrast **must** be obtained
Payer Coverage Limitations: CGS J15 L31845

- The CPT code 72275 (Epidurography, radiological supervision and interpretation) differs from CPT code 77003 in that it represents a formal recorded and reported contrast study that includes fluoroscopy.
- Epidurography should only be reported when it is reasonable and medically necessary to perform a diagnostic study.
- It may only be performed with a caudal or intrathecal approach and should not be billed for the usual work of fluoroscopy and dye injection that is integral to the epidural, paravertebral joint/nerve, or sacroiliac injection(s).

Payer Coverage Limitations: NGS JK L28529

- CPT code 72275 (Epidurography, radiological supervision and interpretation) represents a formal recorded and reported contrast study that includes fluoroscopy. Epidurography should only be reported when it is reasonable and medically necessary to perform a diagnostic study.
- It may only be performed with a caudal or intrathecal approach and should not be billed for the usual work of fluoroscopy and dye injection that is integral to the epidural, paravertebral joint/nerve, or sacroiliac injection(s).
CPT Radiologic Section Guidelines

- The codes designated as “separate procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

- However, when a procedure or service that is designated as a “separate procedure” is carried out independently or considered to be unrelated or distinct from other procedures / services provided at that time, it may be reported by itself, or in addition to the other procedures / services by appending modifier 59 to the specific “separate procedure” code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure.

- This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, separate injury, or area of injury in extensive injuries.

Fluoroscopy

76000 Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

- Global RVU (2014): 1.43
  - Professional component (-26): 1.19
  - Technical component (-TC): 0.24

- Reported when fluoroscopy is the only imaging performed and when there is no other fluoroscopy code that more accurately describes the imaging performed.

- Not used for billing for the fluoroscopy machine (C-arm)

- Medicare NCCI edits: 76000 is a column 2 component of 77002 and 77003
  - A modifier is allowed to bypass the bundling edits, however, the documentation must support the separate fluoroscopy
Fluoroscopy (76000) is considered to be an inclusive component of any other formal radiologic procedures and should not be reported separately. On the basis of payer requirements, modifier 59, Distinct Procedural Service, may be appended to code 76000 to indicate that a distinct or independent service was performed.

Code 76000 may be reported when fluoroscopy is the only imaging performed.

– For example, a patient presents to the radiology department with a prior joint x-ray series demonstrating a calcified body near the joint. The physician uses fluoroscopy with the joint flexed, extended, and rotated to determine whether the calcification is indeed loose within the joint. Because fluoroscopy is the only imaging procedure performed at that patient encounter, code 76000 is reported once (not for each joint position examined).

Another example is when there is no other fluoroscopy code that more accurately describes the imaging performed (ie, code 77001, 77002, or 77003).

– For example, a patient steps on a needle, and fluoroscopy (C-arm) is used to assist the physician to locate and remove this foreign body from the skin wound. In this instance, if C-arm fluoroscopic imaging is being provided without a diagnostic radiologic examination (ie, no hard copy record of the images is produced), then code 76000 should be used to identify the imaging procedure provided.

– Because code 76000 is designated as a separate procedure, modifier 59, Distinct Procedural Service, should be appended and reported in addition to the appropriate codes from the Integumentary System section.
Radiology Services – Fluoroscopic Guidance Section Guidelines

- **Do not** report guidance codes 77001, 77002, 77003 for services in which fluoroscopic guidance is included in the description.

Image Guidance: Fluoroscopy

- **77002** Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)
  - Global RVU (2014) 2.88
    - Professional component (-26) 0.79
    - Technical component (-TC) 2.09
  - Often used for **non-spinal** injections
    - Soft tissue & joint injections; Ex: knee, hip, shoulder
    - Nerve injections; Ex: somatic & sympathetic
  - June 2008 CPT Assistant: … Code 77002, … , is intended to be used to report fluoroscopic guidance during injection procedures when fluoroscopic guidance is required in the performance of needle placement in areas other than the spine, for pain management procedures.
Medicare NCCI Edits

- **77002** is a column 2 code (component) of the following column 1 (comprehensive) pain management procedure codes:
  - 64400
  - 64402
  - 64405
  - 64408
  - 64410
  - 64412
  - 64413
  - 64415
  - 64416
  - 64417
  - 64418
  - 64420
  - 64421
  - 64425
  - 64430
  - 64435
  - 64445
  - 64446
  - 64447
  - 64448
  - 64449
  - 64450
  - 64455
  - 64479
  - 64483
  - 64490
  - 64493
  - 64508
  - 64510
  - 64520
  - 64620
  - 64633
  - 64635

- NCCI bundling edits do carry a modifier indicator of “1” BUT the fluoroscopic guidance must be used with a separate and distinct procedure in order to bypass the edits!

Image Guidance: 77002 Fluoroscopy

- CPT Parenthetical notes:
  - See appropriate surgical code for procedure and anatomic location
  - **77002** is included in all arthrography radiological supervision and interpretation codes
  - Do not report **77002** in addition to 10030, 19081-19086, 19281-19288, 32554, 32555, 32556, 32557, 70332, 73040, 73085, 73115, 73525, 73580, 73615, 0232T
  - For injection(s) of platelet rich plasma, use **0232T**
  - **77002** is included in the organ/anatomic specific radiologic supervision and interpretation procedures 49440, 74320, 74355, 74445, 74470, 74475, 75809, 75810, 75885, 75887, 75980, 75989
June 2012 CPT Assistant

Q: How is a small injection of contrast into the hip under fluoroscopic guidance reported when performed to confirm needle tip placement prior to the injection of steroids or an anesthetic?

A: When a small amount of contrast is injected into the hip under fluoroscopic guidance to ensure proper needle location before administering an anesthetic or steroid injection, it is appropriate to submit code 77002, ..., to report the fluoroscopic imaging performed.

Fluoroscopic guidance is the radiologic technique by which the images are produced. As stated in the descriptor nomenclature, code 77002 is used to describe fluoroscopic guidance for all types of needle placement, such as for biopsy, aspiration, injection, or placement of a localization device.

The injection of a steroid or an anesthetic agent into the hip would also be reported using the joint injection code 20610, Arthrocentesis, aspiration and/or injection; major joint or bursa.

April 2012 CPT Assistant

- In the December 2011 issue of the CPT Assistant (page 8), instruction in the article stated that sciatic nerve injection code 64445, Injection, anesthetic agent; sciatic nerve, single, should not be used to report a piriformis muscle injection. However, from a CPT coding perspective, piriformis muscle injection(s) should be reported using CPT code 20552, Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s).

- For further clarification, should fluoroscopic guidance be performed, this is additionally reported using code 77002, Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device.
**Image Guidance: Fluoroscopy**

**77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid)**

- Global RVU (2014) 2.54
  - Professional component (-26) 0.86
  - Technical component (-TC) 1.68
- Used **only** for injections referenced in descriptor or specifically directed by CPT parenthetical notes
- January 2011 CPT Assistant: … code 77003 is reported in conjunction with codes 62267, 62270-62273, 62280-62282, and 62310-62319, when fluoroscopic guidance is necessary and performed with these injection, drainage or aspiration procedures.

**Medicare NCCI Edits**

- **77003** is a column 2 code (component) of the following column 1 (comprehensive) pain management procedure codes:
  - 0213T - 0219T
  - 0228T - 0231T
  - 22520 - 22521
  - 22523 - 22524
  - 22526 - 22527
  - 27096
  - 62263 - 62364
  - 62267, 62270-62273, 62280-62282, and 62310-62319
  - 62290 - 62291
  - 62350 - 62351
  - 62355
  - 64479 - 64484
  - 64490 - 64495
  - 64510
  - 64520
  - 64530
  - 64633 – 64636
  - 64680 - 64681

- NCCI bundling edits do carry a modifier indicator of “1” **BUT** the fluoroscopic guidance **must** be used with a separate and distinct procedure in order to bypass the edits!
Medicare NCCI Edits & 77003

- Left L4-L5 transforaminal epidural injection with fluoroscopic guidance
  - **Compliant coding:** 64483 – LT x 1
  - **NOT:** 64483 – LT x 1 and 77003 – 59 x 1
    - Incorrect use of modifier 59 to bypass NCCI bundling edits; fluoroscopic guidance was **not** used with a separate and distinct / different procedure
- Left L4-L5 transforaminal epidural injection with fluoroscopic guidance **AND** C7-T8 interlaminar epidural injection with fluoroscopic guidance
  - **Compliant coding:**
    - 64483 – LT x 1
    - 62310 x 1
    - 77003 – 59 x 1

Image Guidance: 77003 Fluoroscopy

- CPT Parenthetical notes
  - Injection of contrast during fluoroscopic guidance and localization [77003] is included in 22526, 22527, 27096, 62263, 62264, 62267, 62270-62282, 62310-62319
  - Fluoroscopic guidance for subarachnoid puncture for diagnostic radiographic myelography is included in the supervision and interpretation codes 72240-72270
  - **Do not** report 77003 in conjunction with 27096, 64479-64484, 64490-64495, 64633-64636
  - For percutaneous or endoscopic lysis of epidural adhesions, 62263, 62264 **include** fluoroscopic guidance and localizations
Image Guidance: 77003 Fluoroscopy

- Spine and Spinal Cord: Injection, Drainage, or Aspiration CPT Section Guidelines
  - **Injection of contrast** during fluoroscopic guidance and localization is an inclusive component in 62263, 62264, 66267, 62270-62273, 62280-62282, 62310-62319.

- Does **NOT** mean that fluoroscopic guidance is included, rather the injection of contrast is what is included

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Image Guidance: 77003 Fluoroscopy

- Spine and Spinal Cord: Injection, Drainage, or Aspiration CPT Section Guidelines
  - … Fluoroscopic guidance and localization is reported with **77003**, unless a formal contrast study (myelography, epidurography or arthrography) is performed, in which case the fluoroscopy is **included** in the supervision and interpretation codes.

  - Fluoroscopy (for localization) may be used in the placement of injections reported with **62310-62319**, but is not required. If used, fluoroscopy **should be reported with 77003**. For epidurography, use **72275**…
December 2010 CPT Assistant

Q: A physician uses fluoroscopic guidance while inserting a percutaneous epidural neurostimulator lead (code 63650). Is the fluoroscopic guidance separately reportable or is it considered inclusive of the percutaneous implantation?

A: Fluoroscopic guidance (codes 76000 and 77003) is considered inherent in the performance of the percutaneous implantation of the neurostimulator electrode array in the epidural space as represented by code 63650, Percutaneous implantation of neurostimulator electrode array, epidural. Therefore, it is not appropriate to additionally report the fluoroscopic guidance.

December 2008 CPT Assistant

Q: Is radiologic guidance (ie, fluoroscopy [codes 76000, 77002]) included in the percutaneous implantation of a peripheral nerve neurostimulator electrode (code 64555) or is any radiologic guidance used to place the neurostimulator components separately reportable?

A: Yes, the fluoroscopic guidance to place the peripheral neurostimulator electrode is considered an inclusive service of code 64555, Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve). Therefore, it would not be appropriate to additionally report fluoroscopic guidance.
November 2010 CPT Assistant

Q: Does the CPT codebook have a statement about permanent image acquisition?

A: No. The requirement of recording permanent images and the length of retention of these permanent images are dictated by state policies and regulations. Retention of permanent images, therefore, varies from state to state.

Q: Is a signed report required for guidance procedures?

A: From a CPT coding perspective, reporting a radiologic guidance procedure code, including codes 76000 and 77003, requires a separate distinctly identifiable report, or documentation within the report for the procedure where guidance was used, and should be signed by the interpreting physician, as indicated in the Radiology Guidelines.

November 2010 CPT Assistant

Q: If a signed report is required for guidance procedures, is the rule different for fluoroscopy?

A: No, all radiologic procedures require a written report signed by the interpreting physician.

Q: Is a hard copy of the produced images required to report a diagnostic radiologic examination?

A: Yes, but it is rare that a radiologist will perform fluoroscopic guidance for a procedure without producing and interpreting a permanent record of the image.

June 2008 & Sept 2002 CPT Assistant

- Code 77003 is intended to be reported per spinal region (eg, cervical, lumbar), and not per level
  - However, many payers will only reimburse 1 unit of service per session!
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.

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

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.
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 guidance (e.g., 76942, 76998) should not be reported separately.

Medicare Medically Unlikely Edits (MUE)

- Maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service
  - CMS does not publish entire list
- Based on anatomic considerations, code descriptions, CPT coding instructions, established CMS policies, nature of service/procedure, nature of equipment, and clinical judgment
- MUE for ultrasound and fluoroscopic image guidance
  - 76942: Maximum of 1 unit of service
  - 77002: Maximum of 1 unit of service
  - 77003: Maximum of 1 unit of service

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp
Payer Coverage Limitations: First Coast J9 L29307 Viscosupplementation

- “Imaging procedures performed routinely for the purpose of visualization of the knee to provide guidance for needle placement will **not** be covered.
- Fluoroscopy may be medically necessary and allowed if documentation supports that the presentation of the patient’s affected knee on the day of the procedure makes needle insertion problematic.
- **No** other imaging modality for the purpose of needle guidance and placement will be covered.”

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Payer Coverage Limitations: First Coast J9 L29307 Viscosupplementation

- It is not expected that routine imaging for the purpose of needle guidance would be required. Therefore, **routine use** of fluoroscopy **may result in a pre-payment medical review** of records.
- Documentation **should provide justification** when imaging is performed for the purpose of needle guidance.
- The use of hand held ultrasound devices are **not** separately reimbursed.
Medical Necessity Definition

- Varies by insurer and is typically addressed in each patient's insurance benefit plan

- Medical services and supplies which are medically necessary usually include only those which are…
  - Established as safe and effective
    - Not considered to be experimental or investigational
  - Consistent with the symptoms or diagnosis / treatment of the illness or injury
  - Justified as reasonable, necessary and/or appropriate based on evidence-based clinical standards of care
    - Including the duration and frequency of medical services / supplies

AMA: “Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations in a manner that is:

1) In accordance with generally accepted standards of medical practice;
2) Clinically appropriate in terms of type, frequency, extent, site and duration; and
3) Not primarily for the convenience of the patient, physician, or other health care provider.”

Medicare: By statute, may only pay for items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member", unless there is another statutory authorization for payment.
Compliant Reporting for Image Guidance

- Verify payer coverage policies & medical necessity
- Review and follow payer bundling edits
- Perform the diagnostic service & retain permanent image of guidance
- Documentation of image guidance, either with documentation for associated procedure or separate report
- Report correct CPT code when separately billable
- Report correct modifier if procedure performed in facility place of service

Marvel J Hammer
RN CPC CCS-P ACS-PM CPCO

MJH Consulting
www.marvelhammer.com
Denver, CO 80210
303-871-9484
marvelh@aol.com