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Coding Superheroes with X-Ray Vision

2020 Radiology and Imaging CPT® Changes

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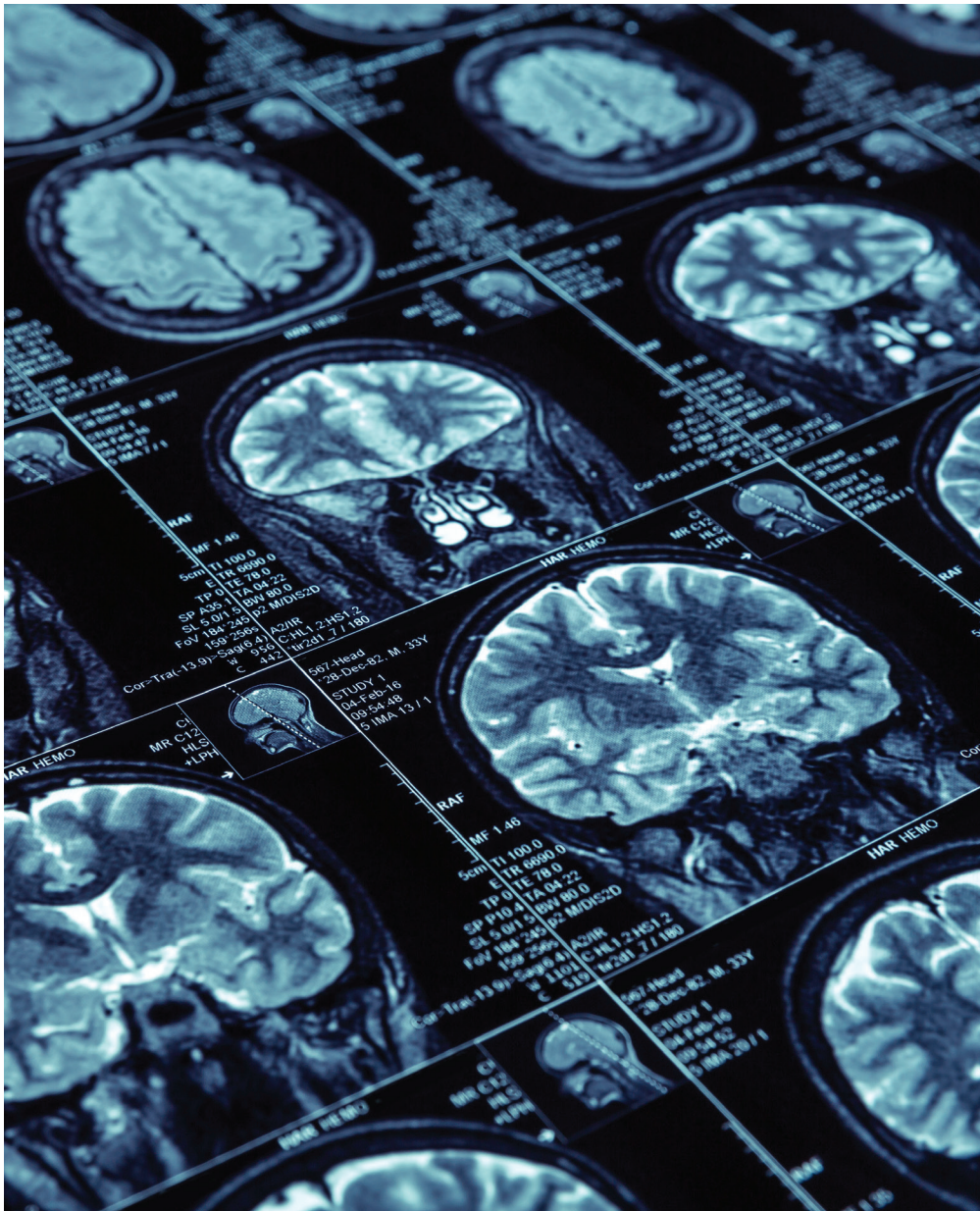
There has been a recent upsurge in questions related to CPT® codes that include various types of imaging guidance.

When is imaging separately reported, and how? The RVU for some codes include the provider's use of imaging to accurately visualize the specimen or problem the code is meant to address. The most notable changes for 2020 regarding radiology can be found in the Gastrointestinal and Nuclear Medicine sections of the CPT® codebook. Anatomic region is highlighted, and codes are revised to offer greater consistency. We will discuss these changes as well as some helpful reminders throughout this article.



When imaging guidance is involved, coders may have difficulty selecting the correct procedure code due to these common factors:

- **Inadequate or unclear documentation by the provider regarding the type of imaging used**
- **Misunderstanding of the extent of an imaging code's description**
- **Body region being studied within a specific imaging code set**
- **Outdated understanding of NCCI edits and/or lack of current educational materials that specify coding updates**

As coding professionals, it is our responsibility to keep abreast with changes in our field and advance our education to include the most up-to-date information available to us. When we encounter portions of a provider's documentation that may be unclear, or as cutting-edge medicine continues to outstrip black-and-white coding definitions, we are obligated to ask questions that will clarify our understanding of what was performed — so we can select the CPT® that best represents the full body of work for our patient. Reimbursement is under constant scrutiny, and bulletproof coding can go a long way toward enhancing your practice's bottom line. Variances in RVUs for procedures incorrectly billed add up over time, and the difference between profit and loss often comes down to coder knowledge.

For example, let's go back in time to the Fine Needle Aspiration Biopsy (FNA) code changes that 2019 brought us. Services were previously reported either as **without imaging guidance** (10021), or **with imaging guidance** (10022). The CPT® Assistant of April 2019, Volume 39, Issue 4 tells us that, "code 10022 was reported with imaging guidance more than 75% of the time; therefore, imaging guidance should be bundled into the service". That being said, one code was revised, 5 "first lesion" codes, and 3 "additional lesion" codes were added in order to differentiate between the type of imaging used for FNA. The difference in total RVUs between imaging modalities is pronounced.

Code	Description	Total Non-Facility RVUs	Total Facility RVUs
10021	FNA, without imaging; 1st lesion	2.80	1.60
10005	FNA; ultrasound guidance; 1st lesion	3.67	2.07
10007	FNA; fluoroscopic guidance; 1st lesion	8.43	2.69
10009	FNA; CT guidance; 1st lesion	13.32	3.28
10011	FNA; MR guidance; 1st lesion	0.00	0.00

What is the moral of the story?

If your provider is still using outdated language like, "**FNA performed with imaging guidance**" in documentation, we'll have to ask what type of imaging was used. A difference of nearly 10 RVUs (on the non-facility side) between our lowest and our highest valued code that contains imaging in its description cannot be ignored. Details like this can easily become the target of an audit if an in-doubt coder should bypass the step of clarifying. On the other side, picking the lowest-valued code because it seems "safest" could be result in a serious disservice to your practice's revenue.

Let's dive into the revisions to GI imaging. As a coder, I get excited when I see red circles, blue triangles, and green text in my new CPT® code book. I'll even spend several evenings of my leisure time poring over the pages, highlighting what's been added, what's been changed, and what's been taken away. Starting with CPT® 74210, which has been expanded to include the fact scout radiographs and delayed images are being performed, as well as the type of contrast being used- Barium. The previous code description did not include the addition of the optional images (usually standard procedure when contrast is utilized), nor did it specify exactly what type of contrast was being used. While not new information, it's important to note that this code is specific to the pharynx and cervical portion of the esophagus. As you move through the code set, and the human anatomy it corresponds to, you'll see this pattern repeat, with both the optional images and the type of contrast used now specified as part of the code description. CPT® has also given us new code 74221, which specifies the use of double-contrast modality for the esophagus, as well as small intestine follow-through, coded with the add-on 74248.

Also important to note is the advice regarding which codes may be billed together. Take the code pair 74220 and 74240. These codes may never be billed together, according to National Correct Coding Initiative (NCCI) edits. The work associated with 74240 includes the entire esophagus, not just the portion 74220 describes (the cervical esophagus). Make the most accurate code selection by paying attention to both the anatomy described and the modality used to perform the study. When in doubt as to whether two codes may be billed together, utilize available resources to confirm whether the services are significant and separate enough to warrant the use of modifier 59, or if the work described in documentation may be reported with one all-encompassing CPT® code.

Additions are also noted to the nuclear medicine section. The greatest concentration of new codes may be found in relation to Positron Emission Technology (PET scans). CPT® codes 78429-78434 specify whether metabolic evaluation studies, to include ventricular wall motion and or ejection fraction measurements, were performed. Additionally, these codes specify whether another type of imaging modality, CT, was performed at the same time. Be careful when noting whether these metabolic studies were performed versus perfusion studies, as this will influence code selection.

Scan documentation of these studies to identify if single or multiple studies were performed, and whether stress (exercise or pharmacologic) studies were administered in addition to studies at rest. "And/or" is especially prevalent in this section; read the code description thoroughly and be on the lookout to make sure your code selection is accurate and covers all imaging modalities used. Knowing the equipment used is key, as PET can be performed on a dedicated machine using only PET imaging, OR it may be performed using a combination PET/CT camera. These types of studies will include reviewing anatomy in the field of view by examining the CT transmission images.

SPECT imaging also has revisions to code descriptions, as well as 4 new codes. The description revisions allow for greater definition of the extent of the examination as it relates to body areas. The new codes 78830-78835 describe imaging for localization of tumor, inflammatory processes, or distribution of radiopharmaceutical using SPECT imaging. These codes also include concurrent CT transmission in two cases. Again, reading imaging reports carefully to determine which region of the body is being addressed, as well as being aware of the type of technology used to perform the study will be crucial in correct code selection.

In summary, pay close attention to the coding advice at the beginning of each section. Thoroughly explore the changes made to the code set that year, especially if it has a significant impact on the specialty you code for. Utilize any trusted specialty resources that offer verified information that corresponds with both NCCI edits and CPT® guidelines. This will power up your coding vision and help you successfully implement new guidelines.

Sources:

CPT® 2020, Professional edition, Copyright AMA
CPT® Assistant of April 2019, Volume 39, Issue 4
NCCI Policy Manual for Medicare Services- Effective January 1, 2020
Medicare Physician Fee schedule, Copyright CMS 2018, 2019, and 2020

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Elizabeth has worked in medical billing, coding, and auditing for 15 years. Originally, Elizabeth started with reviewing insurance claims to determine what, if any, errors existed on the claims being filed. From there, Elizabeth began working with a group of 22 hospitalists and 8 intensivists billing, coding, and submitting claims for inpatient and critical care services, which saw a rise in accuracy and revenue received over the 2 ½ years Elizabeth was involved with the department. Elizabeth is now with the AAPC Audit Services family, working as an auditor and client advisor, assisting organizations with audits and education.

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