Part B Insider (Multispecialty) Coding Alert

Correct Coding: Fluoroscopy Codes Come in for More Edits

Bill separately only if nonintegral

Your doctor may use fluoroscopic imaging for a number of surgical and diagnostic procedures, but now more than ever, he'll be unable to bill for it separately.

Version 9.3 of the National Correct Coding Initiative marks 76000 (Fluoroscopy [separate procedure], up to one hour physician time) and 76001 (Fluoroscopy, physician time more than one hour, assisting a nonradiologic physician) as components of a whole host of codes. The edits come on top of existing edits that bundled those codes with a number of others. For example, the NCCI has long bundled 76000 to vertebroplasty codes 22520-22521 as well as arthrodesis codes 22548-22558.

The new edits view 76000 and 76001 as components of dozens of codes, including pacemaker insertion (33200-33211, 33214-33220, 33224-33226, 33234-33235, 33243-33249), endoscopy (43260-43272), laparoscopy (47560-47570), right heart catheterization (93530-93556), intracardiac electrophysiological procedure/study (93615-93620) and many others.

Some of the edits merely serve to confirm existing CPT editorial panel guidelines, but others cite "standards of medical/surgical practice" instead. All of these new edits have a "1" next to them, meaning that you can override them with a modifier.

Some coding experts say it's proper to bill for a fluoroscopy separately from a surgical procedure if the fluoroscopy isn't integral to the procedure - for example, if a surgeon uses the fluoroscopy afterward to check the position of an implant screw or fixation, or to verify the absence of foreign bodies. n