# Part B Insider (Multispecialty) Coding Alert

## PART B CODING COACH: Perfect Your Radiology Coding Skills By Using 5 CCI Lessons

Wonder if there's a method to the 76001 madness? Here's where you can look for answers.

The silver lining of 18,000 recently added Correct Coding Initiative (CCI) edits is that analyzing them can help you master radiology coding essentials -- including follow-up CTs, fluoro, and more.

Apply these five lessons to keep your claims looking their best.

Remember: The latest round of edits, version 15.3, went into effect Oct. 1. You can download the updates at the beginning of each quarter from the CMS Web site (www.cms.hhs.gov/NationalCorrectCodInitEd/), suggests **Alice E. Wonderchek, CMBS, CPC,** billing and coding specialist with Franklin & Seidelmann Subspecialty Radiology in Beachwood, Ohio. You can download the CCI manual here, as well.

1. Proceed With Caution When Coding 76380

Randomly choose a code for computed tomography (CT) or computed tomography angiography (CTA), and odds are that CCI 15.3 bundles 76380 (Computed tomography, limited or localized follow-up study) into it.

Example: The radiologist performs calcium scoring and a follow- up CT. You should report only 0144T (Computed tomography, heart, without contrast material, including image postprocessing and quantitative evaluation of coronary calcium). You should not add 76380 for this claim, according to the new edits.

These additions join edits in place since 1997, bundling 76380 into 71260 (Computed tomography, thorax; with contrast material[s]) and 74150-74170 (Computed tomography, abdomen ...). These edits have a modifier indicator of "1," which means you may override them with a modifier when appropriate.

You may not use 76380 often, but CPT Assistant (July 2007) states that for a limited CT, 76380 is an alternative to using a procedure-specific CT code with modifier 52 (Reduced services) appended, says **Stacie L. Buck, RHIA, CCS-P, RCC, CIC,** president and senior consultant of RadRx in Stuart, Fla.

Example: ACR's July/August 2006 Radiology Coding Source demonstrates a potential use of 76380, depending on payer preference, Buck says. In the example, the patient's condition warrants an abdominal CT as well as a limited pelvic CT. You should choose the appropriate abdominal CT code (74150-74170, Computed tomography, abdomen ...) and then report the limited pelvic CT based on the payer'spreference. Two possibilities include (1) 76380 or (2) a pelvic CT code (72192-72194, Computed tomography, pelvis...) with modifier 52 appended.

2. Keep 76001 for Fluoro-Assist

CCI 15.3 continues the trend of adding bulky lists of fluoro edits to the file. This round the focus is on 76001 (Fluoroscopy, physician time more than 1 hour, assisting a nonradiologic physician [e.g., nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy).

The logic: This code refers to "assisting a nonradiologic physician" -- meaning you report this code when the radiologist provides the fluoro but doesn't perform the procedure. So it makes sense that you wouldn't have the procedure codes and the bundled fluoro (76001) on the same claim.

And remember that the edits don't apply when your radiologist reports 76001 and another physician reports the

procedure for the same patient: "the National Correct Coding Initiative Policy Manual for Medicare Services and NCCI edits have been developed for application to Medicare services billed by a single provider for a single patient on the same date of service," according to the CCI manual's introduction.

3. Sedation Codes Are Nothing to Snooze At

The fluoro edits are lengthy, but they're nothing compared to the moderate sedation additions. Roughly 80 percent of the new bundles relate to moderate sedation codes 99148-99150 (Moderate sedation services [other than those services described by codes 00100-01999],provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports ...), states the Sept. 11 "NCCI 15.3 Update"

by **Frank Cohen, MPA,** senior analyst with MIT Solutions Inc. in Clearwater, Fla. These edits carry a modifier indicator of "0," which means you can't override the edit with a modifier.

Example: CCI edits bundle 99148-99150 into renal procedure codes 50390-50398. But don't start counting the dollars you'll be losing. As the descriptors indicate, the codes describe sedation by a second physician -- not by the physician performing the diagnostic or therapeutic service. So the edits shouldn't change how you code your claims for procedures.

You'll also see some bundles for +99145 (Moderate sedation services ... provided by the same physician ... each additional 15 minutes intra-service time). For example, CCI bundles +99145 into 36561 (Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older). But your CPT manual or software should alert you that CPT considers moderate sedation already included in this service, meaning you shouldn't be reporting +99145 with 36561 anyway.

4. Always Expect Anesthesia Bundles

If your interventional radiology practice includes pain management  procedures, don't miss CCI's bundling of numerous anesthetic injection codes (623xx and 64xxx) into G0260 (Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography).

CCI already bundles these sorts of codes into similar sacroiliac (SI) code 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid).

Basic idea: "Medicare Anesthesia Rules prevent separate payment for anesthesia services by the same physician performing a surgical or medical procedure," states the CCI manual, Chapter 1, Section C.2.

The edits are Medicare's way of preventing physicians who perform surgical procedures (such as SI joint injection) from reporting any form of anesthesia, including nerve blocks, explains **Marvel Hammer, RN, CPC,CCS-P, ACSPM, CHCO,** of MJH Consulting in Denver. Check the modifier indicator to see if you can override the edit when the physician performs the nerve block as a separate and distinct procedure rather than as anesthetic or an analgesic block for the SI injection, she advises.

5. Heed CPT Instructions on Proper S&I Code

Sometimes CCI offers a little nudge to be sure you follow directions, as you can see by new edits for "extremity" code 36005 (Injection procedure for extremity venography [including introduction of needle or intracatheter]) and "caval" codes 75825-75827 (Venography, caval ...).

CPT's directions with 36005 instruct that "extremity" codes 75820-75822 (Venography, extremity...) are the proper codes for extremity venography supervision and interpretation (S&I).

The new edits address an ongoing problem, as the CCI manual, Chapter 9, Section H.19, reveals the following: "CPT code 36005 ... 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."