Codify
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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 74176-74178: Compare 2011 Coding to How You Tackled These Notes in 2010

Test yourself to be sure you've mastered this year's coding changes.

Codes for abdominal and pelvic CTs are among those most frequently reported to Medicare by radiologists. In 2011, the addition of several codes means you have to choose among a mix of old and new options to report these services.

Follow along with this sample case study, choosing the codes you would report for 2011 and seeing if they line up with the analysis below.

Read the Report and Choose Your Codes

Header: Abdominal and pelvic CT with enhance, CT reformation body

Dictated report: CT of abdomen and pelvis

Indication: 26-year-old female with abdominal pain, rule out acute appendicitis

Technique: Contiguous axial images were obtained from the lung bases through the pubic symphysis following the uneventful administration of oral and intravenous contrast, 150 cc Isovue-300 at 3 cc/sec. FOV=32 cm.

Findings: Lung windows demonstrate subpleural opacity in the right lower lobe, likely representing atelectasis. No parenchymal nodule or mass within the visualized lung bases. No pleural or pericardial effusion.

The liver, gallbladder, adrenal glands, spleen, pancreas, and kidneys are normal. The bladder is adequately distended without evidence for bladder wall thickening. Both ovaries are visualized, contain normal-appearing follicles. There is also a 2.1- x 1.4-cm physiologic cyst within the right ovary.

The appendix is distended, contains a few 3- to 4-mm appendicoliths, demonstrates abnormal bowel wall enhancement, and is associated with moderate adjacent periappendiceal fat stranding. The remaining bowel is normal. No periappendiceal fluid collection or abscess.

Impression: Acute appendicitis.

Narrow Code Choices Based on Anatomic Area

In our sample report, the radiologist notes the state of the abdominal structures (liver, gallbladder, pancreas, intestines) and the pelvic structures (bladder, ovaries).

Old way: Before 2011, this information would lead you to narrow your CPT® choices to 74150-74170 (Computed tomography, abdomen ...) and 72192-72194 (Computed tomography, pelvis ...).

New way: Your options change with the addition of2011codes that represent both abdominal and pelvic CTs in a single code:

- 74176, Computed tomography, abdomen and pelvis; without contrast material
- 74177, Computed tomography, abdomen and pelvis; with contrast material(s)
- 74178, Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions.

CPT® 2011 keeps 74150-74170 (abdomen only) and 72192-72194 (pelvis only), but because the sample case represents an abdominal and pelvic CT in the same session, you will be choosing from new codes 74176- 74178, assuming this case has a 2011 date of service.

Dig Into the Meaning of 'With Contrast'

To select the proper code, you'll need to determine whether the provider performed the studies with contrast, without contrast, or without contrast followed by with contrast.

Rule: The CPT® manual states that only contrast agents supplied intravascularly, intrathecally, or intra-articularly qualify as contrast for "with contrast" studies. CPT® does not consider oral and rectal contrast studies to be "with contrast" studies.

For the sample report, the statement that slices were obtained after the administration of oral and IV contrast implies that both the oral and IV contrast were given before any imaging was done. "In that case, the documentation supports 'with' contrast instead of 'without and with,'" says radiology coding consultant **Cheryl A. Schad, BA Ed, CPC, ACS-RA, PCS,** President/CEO of Schad Medical Management in Mullica Hill, N.J.

To report a code for studies without contrast followed by with contrast, the sample report would have needed "to clearly state that slices were taken without contrast (or with the oral contrast only) prior to IV contrast administration," Schad explains.

Old way: Before 2011, you would have used the following codes for these with contrast exams, Schad says:

- 74160, Computed tomography, abdomen; with contrast material(s)
- 72193, Computed tomography, pelvis; with contrast material(s).

New way: For 2011 dates of service, you should report "with contrast" code 74177 for our sample case, says Schad.

Remember to append modifier 26 (Professional component) if you're reporting only the physician's services and not the technical component.

Round Out Your Claim With HCPCS and ICD-9

Your HCPCS and ICD-9 coding for this case will look the same as it has for the past several years.

HCPCS: This real-life exam was performed in the hospital setting, so the hospital reported the contrast code. But in cases where a CT is performed at your own facility and your practice pays for the contrast material, you should report the appropriate HCPCS code. Example: Claim the Isovue-300 with the proper code for your payer, such as Q9967 (Low osmolar contrast material, 300-399 mg/mliodine concentration, per ml). The patient received 150 cc of contrast, so report 150 units (1 cc = 1 ml).

ICD-9: The sample CT was ordered to "rule out" appendicitis. Per ICD-9 official guidelines, you should never code a diagnosis that has not been confirmed and is documented only as a "rule out" diagnosis. But in the sample case, the impression confirms acute appendicitis, so you may report that diagnosis. There is no mention of peritonitis, so you should assign 540.9 (Acute appendicitis without mention of peritonitis).

Size Up Secondary Diagnoses

When reports include findings that are incidental (not causing the problem that needs medical attention), guidelines don't require you to code them, but you're allowed to report them as secondary diagnoses. In our sample report, that means you technically couldadd a diagnosis for the ovarian cyst (620.2, Other and unspecified ovarian cyst).

You shouldn't report atelectasis (518.0, Pulmonary collapse), however, because the radiologist records this as "likely" atelectasis, which isn't a definitive diagnosis.

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