CHAPTER IX
RADIOLOGY SERVICES
CPT CODES 70000 - 79999
FOR
MEDICARE NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL

CMS issues the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

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Table of Contents

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A. Introduction

The principles of correct coding discussed in Chapter I apply to the Current Procedural Terminology (CPT) codes in the range 70000-79999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians shall report the Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code shall be reported only if all services described by the code are performed. A physician shall not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services performed. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician shall not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

B. Evaluation & Management (E&M) Services

This section summarizes some of the Medicare Global Surgery Rules for reporting Evaluation & Management (E&M) services in the global period.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Medicare Administrative Contractor (MAC). All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are applied to same day services by the same provider/supplier to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 days under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M service is performed on the same date of service as a major surgical procedure to decide whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical

procedure are included in the global payment for the procedure and are not separately reportable. The NCCI program does not contain edits based on this rule because MACs have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider/supplier is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. The NCCI program contains many, but not all, possible edits based on these principles.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed, unless related to a complication of surgery, may be reported separately on the same day as a surgical procedure with modifier 24 (Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period).

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work shall not be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician shall not report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and post-operative work of the procedure on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as a "XXX" procedure may be appropriate in some instances.

When physician interaction with a patient is necessary to accomplish a radiographic procedure, typically occurring in invasive or interventional radiology, the interaction generally involves limited pertinent historical inquiry about reasons for the examination, the presence of allergies, acquisition of informed consent, discussion of follow-up, and the review of the medical record. In this setting, a separate E&M service is not reported. As a rule, if the medical decision making based on the information from the patient is limited to whether the procedure should be

performed, whether comorbidity may impact the procedure, or involves discussion and education with the patient, an E&M code is not reported separately. If a significant, separately identifiable service is rendered, involving taking a history, performing an exam, and making medical decisions distinct from the procedure, the appropriate E&M service may be reported.

In radiation oncology, E&M CPT codes are separately reportable for an initial visit at which time a decision is made whether to proceed with the treatment.

C. Non-interventional Diagnostic Imaging

Non-invasive/interventional diagnostic imaging includes (but is not limited to) standard radiographs, single or multiple views, contrast studies, computed/computerized tomography, and magnetic resonance imaging. The *CPT Professional* codebook allows for various combinations of codes to address the number and type of radiographic views. For a given radiographic series, the procedure code that most accurately describes what was performed shall be reported. Because the number of views necessary to obtain medically useful information may vary, a complete review of CPT coding options for a given radiographic session is important to assure accurate coding with the most comprehensive code describing the services performed rather than billing multiple codes to describe the service.

1. If imaging studies (e.g., radiographs, computerized tomography, magnetic resonance imaging) are repeated during the course of a radiological encounter due to substandard quality or need for additional views, only one unit of service for the appropriate code may be reported. If the radiologist elects to obtain additional views after reviewing initial films in order to render an interpretation, the Medicare policy on the ordering of diagnostic tests must be followed. The CPT code describing the total service shall be reported, even if the patient was released from the radiology suite and had to return for additional services. The CPT descriptors for many of these services refer to a "minimum" number of views. If more than the minimum number specified is necessary and no other more specific CPT code is available, only that service shall be reported. However, if additional films are necessary due to a change in the patient's condition, separate reporting may be appropriate.

2. CPT code descriptors that specify a minimum number of views include additional views if there is no more comprehensive code specifically including the additional views. For example, if 3 views of the shoulder are obtained, CPT code 73030 (Radiologic examination, shoulder; complete, minimum of 2 views) with 1 unit of service shall be reported rather than CPT code 73020 (Radiologic examination, shoulder; 1 view) plus CPT code 73030.

3. When a comparative imaging study is performed to assess potential complications or completeness of a procedure (e.g., post-reduction, post-intubation, post-catheter placement, etc.), the professional component of the CPT code for the post-procedure imaging study is not separately payable and shall not be reported. The technical component of the CPT code for the post-procedure imaging study may be reported.

4. Some studies may be performed without contrast, with contrast, or with and without contrast. There are separate codes to describe all of these combinations of contrast use. When studies require contrast, the number of radiographs obtained varies between patients**.** All radiographs necessary to complete a study are included in the CPT code description.

5. 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 shall not be reported separately.

6. Preliminary radiographs before contrast administration or delayed imaging radiographs are not separately reportable.

7. *CPT Professional* codebook instructions state that in the presence of a clinical history suggesting urinary tract pathology complete ultrasound evaluation of the kidneys and urinary bladder constitutes a complete retroperitoneal ultrasound study (CPT code 76770). A limited retroperitoneal ultrasound (CPT code 76775) plus limited pelvic ultrasound (CPT code 76857) shall not be reported in lieu of the complete retroperitoneal ultrasound (CPT code 76770).

8. CPT code 76380 (Computed tomography, limited or localized follow-up study) shall not be reported with other computed tomography (CT), computed tomography angiography (CTA), or computed tomography guidance codes for the same patient encounter.

9. When a central venous catheter is inserted, a chest radiologic examination is usually performed to confirm the position of the catheter and absence of pneumothorax. Similarly, when an emergency endotracheal intubation procedure (CPT code 31500), chest tube insertion procedure (e.g., CPT codes 32550, 32551, 32554, 32555), or insertion of a central flow directed catheter procedure (e.g., Swan-Ganz) (CPT code 93503) is performed, a chest radiologic examination is usually performed to confirm the location and proper positioning of the tube or catheter. The chest radiologic examination is integral to the procedures, and the chest radiologic examination (e.g., CPT codes 71045, 71046) shall not be reported separately.

10. CPT code 77075 (Radiologic examination, osseous survey; complete (axial and appendicular skeleton)) includes radiologic examination of all bones. CPT codes for radiologic examination of other bones shall not be reported in addition to CPT code 77075. However, if a separate and distinct radiologic examination with additional films of a specific area of the skeleton is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with an NCCI PTP-associated modifier.

11. CPT code 77073 (Bone length studies...) includes radiologic examination of the lower extremities. CPT codes for radiologic examination of lower extremity structures shall not be reported in addition to CPT code 77073 for examination of the radiologic films for the

bone length studies. However, if a separate and distinct radiologic examination with additional films of a specific area of a lower extremity is performed to evaluate a different problem, the appropriate CPT code for the additional radiologic examination may be reported with a NCCI PTP-associated modifier.

12. CPT code 75635 describes computed tomographic angiography of the abdominal aorta and bilateral iliofemoral lower extremity runoff. This code includes the services described by CPT codes 73706 (Computed tomographic angiography, lower extremity...image postprocessing) and 74175 (Computed tomographic angiography, abdomen...image postprocessing). CPT codes 73706 and 74175 shall not be reported with CPT code 75635 for the same patient encounter. CPT code 73706 plus CPT code 74175 shall not be reported in lieu of CPT code 75635.

13. Ultrasound examination of a transplanted kidney and retroperitoneal structures at the same patient encounter may be reported with CPT code 76770 (Ultrasound, retroperitoneal...; complete). It shall not be reported with CPT code 76776 (Ultrasound, transplanted kidney...) plus CPT code 76775 (Ultrasound, retroperitoneal...; limited).

14. Computed tomography (CT) of the spine with intrathecal contrast shall not be reported with myelography (e.g., CPT codes 72240-72270) unless both studies are medically reasonable and necessary. Radiography after injection of intrathecal contrast to perform a CT of the spine in order to confirm the location of the contrast is not separately reportable as myelography.

15. CPT code 77063 is an Add-on Code (AOC) describing screening digital tomosynthesis for mammography. This procedure requires performance of a screening mammography producing direct digital images. Beginning calendar year 2018, CPT code 77063 may be reported with CPT code 77067.

16. Screening and diagnostic mammography are normally not performed on the same date of service. However, when the 2 procedures are performed on the same date of service, Medicare requires that the diagnostic mammography HCPCS/CPT code be reported with modifier GG (Performance and Payment of a Screening and Diagnostic Mammogram on the Same Patient, Same Day) and the screening mammography HCPCS/CPT code be reported with modifier 59 or XU.

17. CPT codes 72081-72084 describe radiologic examination of the entire spine, the codes differing based on the number of views. The other codes in the CPT code range 72020-72120 describe radiologic examination of specific regions of the spine differing based on the region of the spine and the number of views. If a physician performs a procedure described by CPT codes 72081-72084 and at the same patient encounter performs a procedure described by one or more other codes in the CPT code range 72020-72120, the physician shall sum the total number of views and report the appropriate code in the CPT code range 72081-72084. The physician shall not report a code from the CPT code range 72081-72084 plus another code in the CPT code range 72020-72120 for services performed at the same patient encounter.

18. Since the foot includes the toes and calcaneous bone, CPT code 73630 (Radiologic examination, foot; complete, minimum of 3 views) includes radiologic examination of the toes and calcaneous. A physician shall not report CPT code 73650 (Radiologic examination; calcaneus, minimum of 2 views) or 73660 (Radiologic examination; toe(s), minimum of 2 views) with CPT code 73630 for the same foot on the same date of service.

D. Interventional/Invasive Diagnostic Imaging

1. If a radiologic procedure requires that contrast be administered orally (e.g., upper GI series) or rectally (e.g., barium enema), the administration is integral to the radiologic procedure, and the administration service is not separately reportable. If a radiologic procedure requires that contrast material be administered parenterally (e.g., IVP, CT, MRI), the vascular access (e.g., CPT codes 36000, 36406, 36410) and contrast administration (e.g., CPT codes 96360-96379) are integral to the procedure and are not separately reportable.

2. Many services using contrast are composed of a procedural component (CPT codes outside the 70000 section) and a radiologic supervision and interpretation component (CPT codes in the 70000 section). If a single physician performs both components of the service, the physician may report both codes. However, if different physicians perform the different components, each physician reports the CPT code corresponding to that component.

3. Many interventional procedures require contrast injections for localization and/or guidance. Unless there are CPT instructions directing the physician to report specific CPT codes for the localization or guidance, the localization or guidance is integral to the interventional procedure and is not separately reportable.

4. Diagnostic angiography (arteriogram/venogram) performed on the same date of service by the same provider/supplier as a percutaneous intravascular interventional procedure should be reported with modifier 59 or XU. If a diagnostic angiogram (fluoroscopic or computed tomographic) was performed before the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the second angiogram with modifier 59 or XU. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier 52 in addition to modifier 59 or XU to the angiogram CPT code. If the prior diagnostic angiogram (fluoroscopic or computed tomographic) was complete, the provider/supplier shall not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.

5. The individual CPT codes in the 70000 section identify which injection or administration code, if any, is appropriate for a given procedure. In the absence of a parenthetical CPT note, the injection or administration service is integral to the procedure and is not

separately reportable. If an intravenous line is inserted (e.g., CPT code 36000) for access for the procedure or administration of contrast, it is integral to the procedure and is not separately reportable. CPT code 36005 describes the injection procedure for contrast venography of an extremity and includes the introduction of a needle or an intracatheter (e.g., CPT code 36000). CPT code 36005 shall not be reported for injections for arteriography or venography of sites other than an extremity.

6. For lymphangiography procedures, injection of dye into subcutaneous tissue is integral to the procedure. CPT code 96372 (Therapeutic, prophylactic, or diagnostic injection...; subcutaneous or intramuscular) shall not be reported separately for this injection of dye.

7. When urologic radiologic procedures require insertion of a urethral catheter (e.g., CPT code 51701-51703), this insertion is integral to the procedure and is not separately reportable.

8. Fluoroscopy reported as CPT code 76000 is integral to many procedures including, but not limited, to most spinal, endoscopic, and injection procedures and shall not be reported separately. For some of these procedures, there are separate fluoroscopic guidance codes which may be reported separately.

9. Computed tomography (CT) and computed tomographic angiography (CTA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is used to generate images for separate CT and CTA reports, only one procedure, either the CT or CTA, for the anatomic region may be reported. Both a CT and CTA may be reported for the same anatomic region if they are performed at separate patient encounters or if 2 separate and distinct technical studies, 1 for the CT and 1 for the CTA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

   Similarly, magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is used to generate images for separate MRI and MRA reports, only one procedure, either the MRI or MRA, for the anatomic region may be reported. Both an MRI and MRA may be reported for the same anatomic region if they are performed at separate patient encounters or if 2 separate and distinct technical studies, 1 for the MRI and 1 for the MRA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

10. Computed tomography of the heart (CPT codes 75571-75573) and computed tomographic angiography of the heart (CPT code 75574) include electrocardiographic monitoring if performed. CPT codes 93000-93010 (Electrocardiogram...) and 93040-93042 (Rhythm ECG...) shall not be reported separately with CPT codes 75571-75574 for the ECG monitoring integral to these procedures.

11. If a breast biopsy, needle localization wire, metallic localization clip, or other breast procedure is performed with mammographic guidance (e.g., 19281, 19282), the

provider/supplier shall not separately report a post procedure mammography code (e.g., 77065-77067) for the same patient encounter. The radiologic guidance codes include all imaging by the defined modality required to perform the procedure.

12. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an AOC for reporting the same procedure at each additional level without specification of the spinal region for the AOC. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a provider/supplier shall report only one primary code within the family of codes for one level and shall report additional contiguous levels using the AOC(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed at multiple vertebral levels that are not contiguous and in different regions of the spine, the provider/supplier may report one primary code for each non-contiguous region.

    For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment. CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an AOC describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code, the one for the first procedure, may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4, the provider/supplier may report CPT codes 22532 and 22533.

    CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the provider/supplier may report only one primary procedure code and the AOC for each additional level(s) whether the additional level(s) are contiguous or not.

13. Reserved for future use.

14. Diagnostic studies of the cervicocerebral arteries (CPT codes 36221-36227) include angiography of the thoracic aortic arch. Providers/suppliers shall not separately report CPT codes 75600 or 75605 (Thoracic aortography) for this examination unless it is medically reasonable and necessary to additionally examine the descending thoracic aorta. A provider/supplier shall not report CPT codes 75600 or 75605 for the examination of the descending thoracic aorta with the runoff of the dye used to examine the thoracic aortic arch included in the diagnostic studies of the cervicocerebral arteries. Additionally, if an unexpected abnormality of the descending thoracic aorta is identified while examining the dye runoff in the descending aorta, CPT codes 75600 or 75605 shall not be reported separately.

15. Three-dimensional (3D) rendering of an imaging modality (e.g., CPT codes 76376, 76377) shall not be reported for mapping the sites of multiple biopsies or other needle placements under radiologic guidance. For example, a provider performing multiple prostate biopsies under ultrasound guidance (e.g., CPT code 76942) shall not report CPT codes 76376 or 76377 for developing a map of the locations of the biopsies.

E. Nuclear Medicine

The general policies described above apply to nuclear medicine as well as standard diagnostic imaging.

1. The injection of a radiopharmaceutical is an integral component of a nuclear medicine procedure. CPT codes for vascular access (e.g., CPT code 36000) and injection of the radiopharmaceutical (e.g., CPT codes 96360-96379) are not separately reportable.

2. Single photon emission computed tomography (SPECT) studies represent an enhanced methodology over standard planar nuclear imaging. Several nuclear medicine CPT codes describe combinations of planar, single photon emission computed tomography (SPECT), flow imaging, or SPECT with CT imaging for evaluation of a specific anatomic area. Unless specified by a single code that combines 2 or more imaging modalities, no additional information is procured by obtaining both planar and SPECT studies for a limited anatomic area.

3. Myocardial perfusion imaging (CPT codes 78451-78454) is not reportable with cardiac blood pool imaging by gated equilibrium (CPT codes 78472-78473) because the 2 types of tests use different radiopharmaceuticals.

4. CPT codes 76376 and 76377 (3D rendering) are not separately reportable for nuclear medicine procedures (CPT codes 78012-78999). However, CPT code 76376 or 76377 may be separately reported with modifier 59 or XS on the same date of service as a nuclear medicine procedure if the 3D rendering procedure is performed in association with a third procedure (other than nuclear medicine) for which 3D rendering is appropriately reported.

5. CPT codes 78451-78452 (Myocardial perfusion imaging... additional quantification...) include calculation of the heart-lung ratio if obtained. CPT code 78580 (Pulmonary perfusion imaging, particulate) shall not be reported for calculation of the heart-lung ratio during the processing of a SPECT myocardial perfusion procedure.

6. Subsection deleted, January 1, 2024.

7. Positron emission tomography (PET) procedures include a finger stick blood glucose level. CPT codes 82948 (Glucose; blood, reagent strip) or 82962 (Glucose, blood by glucose monitoring device(s)...home use) shall not be reported separately for the measurement of the finger stick blood glucose included in a PET procedure.

8. HCPCS code A9512 (Technetium Tc-99m pertechnetate, diagnostic, per millicurie) describes a radiopharmaceutical used for nuclear medicine studies. Technetium Tc-99m pertechnetate is also a component of other Technetium Tc-99m radiopharmaceuticals with separate AXXXX codes. Code A9512 shall not be reported with other AXXXX radiopharmaceuticals containing Technetium Tc-99m for a single nuclear medicine study. However, if 2 separate nuclear medicine studies are performed on the same date of service, 1 with the radiopharmaceutical described by HCPCS code A9512 and 1 with another AXXXX radiopharmaceutical labeled with Technetium Tc-99m, both codes may be reported using an NCCI PTP-associated modifier. HCPCS codes A9500, A9540, and A9541 describe radiopharmaceuticals labeled with Technetium Tc-99m that may be used for separate nuclear medicine studies on the same date of service as a nuclear medicine study using the radiopharmaceutical described by HCPCS code A9512.

9. Generally, diagnostic nuclear medicine procedures are performed on different dates of service than therapeutic nuclear medicine procedures. However, if a diagnostic nuclear medicine procedure is performed on an organ and the decision to proceed with a therapeutic nuclear medicine procedure on the same organ on the same date of service is based on results of the diagnostic nuclear medicine procedure, both procedures may be reported on the same date of service using an NCCI PTP-associated modifier. A provider/supplier shall not report a radiopharmaceutical therapy administration code for the radionuclide administration that is integral to diagnostic nuclear imaging procedures.

10. A 3 phase bone and/or joint imaging study (CPT code 78315) includes initial vascular flow imaging. CPT code 78445 (Non-cardiac vascular flow imaging (ie, angiography, venography)) shall not be reported separately for the vascular flow imaging integral to CPT code 78315.

11. Non-cardiac vascular flow imaging, when performed, is integral to a nuclear medicine procedure. CPT code 78445 (Non-cardiac vascular flow imaging (ie, angiography, venography)) shall not be reported with any other nuclear medicine procedure code.

12. Supervision and handling of radionuclides is integral to nuclear medicine procedures (e.g., CPT codes 78012-79999). Providers/suppliers shall not separately report CPT code 77790 (Supervision, handling, loading of radiation source) for this service.

13. The NCCI program contains PTP edits that bundle some radiopharmaceutical codes into nuclear medicine procedure codes. In some situations where a patient has 2 nuclear medicine procedures performed on the same date of service, the radiopharmaceutical used for 1 nuclear medicine procedure may be incompatible with the second nuclear medicine procedure. In this circumstance, it may be appropriate to report the radiopharmaceutical with modifiers 59 or XE or XS.

14. Tumor imaging by positron emission tomography (PET) may be reported with CPT codes 78811-78816. If a concurrent computed tomography (CT) scan is performed for attenuation correction and anatomical localization, CPT codes 78814-78816 shall be

reported rather than CPT codes 78811-78813. A CT scan for localization shall not be reported separately with CPT codes 78811-78816.

A medically reasonable and necessary diagnostic CT scan may be separately reportable with an NCCI PTP-associated modifier. If the data set for the diagnostic CT is obtained concurrently on the same PET/CT integrated system where the CT portion of the study is co-registered with the PET images for the purpose of attenuation correction and anatomic localization, the diagnostic CT CPT code may be reported with PET CPT codes 78811-78813 using an NCCI PTP-associated modifier. Under these circumstances, the diagnostic CT CPT code shall not be reported with PET/CT CPT codes 78814-78816. However, if a data set for the PET/CT for attenuation correction and anatomic localization and a separate data set for the diagnostic CT are obtained separately, the diagnostic CT CPT code may be reported with CPT codes 78811-78816 using an NCCI PTP-associated modifier.

F. Radiation Oncology

1. Except for an initial visit E&M service at which the decision to perform radiation therapy is made, E&M services are not separately reportable with radiation oncology services with the following exceptions as noted below. The initial E&M visit for radiation oncology services may be reported with office/outpatient E&M CPT codes 99202-99215, initial hospital care E&M CPT codes 99221-99223, subsequent hospital care E&M CPT codes 99231-99233, or observation/inpatient hospital care with same day admission and discharge E&M CPT codes 99234-99236.

   E&M services in addition to an initial visit E&M service may be reported with CPT codes 77770-77772 (Remote afterloading high dose rate radionuclide brachytherapy...) E&M services reported with these brachytherapy codes must be significant, separate, and distinct from radiation treatment management services.

   E&M services (i.e., 99211-99213) may be reported with CPT code 77401 (Radiation treatment delivery, superficial and/or ortho voltage, per day) with modifier 25 for the purpose of reporting physician services for certain aspects of radiation therapy planning. Modifier 59 is not appropriate to use with weekly radiation therapy management codes (77427) or with evaluation and management services codes (99202 - 99499).

2. Continuing medical physics consultation (CPT code 77336) is reported “per week of therapy.” It may be reported after every 5 radiation treatments. (It may also be reported if the total number of radiation treatments in a course of radiation therapy is less than 5.) Since radiation planning procedures (CPT codes 77261-77334) are generally performed before radiation treatment commences, the NCCI program contains edits preventing payment of CPT code 77336 with CPT codes 77261-77295, 77301-77318, and 77332-77334. Because radiation planning procedures may occasionally be repeated during a course of radiation treatment, the edits allow modifiers 59 or XE, XP, XS, XU to be appended to CPT code 77336 when the radiation planning procedure and continuing medical physics consultation are reported on the same date of service.

3. The *Internet-Only Manual* (IOM), *Medicare Claims Processing Manual* (MCPM), Publication 100-04, Chapter 13, Section 70.2 (Services Bundled Into Treatment Management Codes) defines services that may not be reported separately with radiation oncology procedures. Based on these requirements, the NCCI program contains edits bundling certain CPT codes into all radiation therapy services.

4. Brachytherapy (CPT codes 77750-77790) includes radiation treatment management (CPT codes 77427 and 77431) and continuing medical physics consultation (CPT code 77336). CPT codes 77427, 77431, and 77336 should not in general be reported separately with brachytherapy services. However, if a patient receives external beam radiation treatment and brachytherapy treatment during the same time period, radiation treatment management and continuing medical physics consultation may be reported for the external beam radiation treatments. Additionally, if a patient has multi-step brachytherapy, it may be appropriate to separately report continuing medical physics consultation with the brachytherapy.

5. Reserved for future use.

6. The procedure described by CPT code 77778 (Interstitial radiation source application, complex...when performed) requires that a radiation source be applied interstitially. Reporting a CPT code requires that all essential components of the procedure are performed. These codes shall not be reported by a radiation oncologist for intraoperative work with another physician who surgically places catheters interstitially unless the radiation oncologist also applies the radiation source at the same patient encounter. The intraoperative work of the radiation oncologist may be reportable with a non-brachytherapy code. If the radiation source application occurs postoperatively in a different room, the radiation oncologist may report CPT codes 77770-77772 (Remote afterloading high dose rate radionuclide brachytherapy...) for the radiation source application.

7. Stereotactic radiosurgery (SRS) treatment delivery (CPT codes 77371-77373) includes stereotactic guidance for placement of the radiation therapy fields for treatment delivery. CPT code 77014 (Computed tomography guidance for placement of radiation therapy fields) and HCPCS code G6001 (Ultrasonic guidance for placement of radiation therapy fields) should not be reported additionally for guidance for placement of the radiation therapy field for SRS treatment delivery.

8. Since HCPCS code G6017 (Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy...of treatment) includes localization of the radiation field, it should not be reported with other HCPCS/CPT codes describing localization of the radiation field such as HCPCS/CPT codes G6001 (Ultrasonic guidance for placement of radiation therapy fields), 77014 (Computed tomography guidance for placement of radiation therapy fields), or G6002 (Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy).

9. Since CPT code 77387 (Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed) includes localization of the radiation field, it should not be reported with other HCPCS/CPT codes describing localization of the radiation field such as HCPCS/CPT codes G6001 (Ultrasonic guidance for placement of radiation therapy fields) or 77014 (Computed tomography guidance for placement of radiation therapy fields).

10. Partial breast high dose rate brachytherapy may be performed 2 times a day. The first therapeutic radiology simulation for the course of therapy may be complex and reported as CPT code 77290. However, subsequent simulations during the course of therapy shall be reported as CPT code 77280.

11. Intensity modulated treatment (IMRT) delivery (e.g., CPT codes G6015,77385, 77386) is not normally reported with treatment device design and construction CPT codes 77332-77334. The latter codes are generally reported for treatment device(s) design and construction for external beam radiation therapy. IMRT planning (CPT code 77301) includes many treatment device(s) required for IMRT. Multi-leaf collimator (MLC) device(s) (CPT code 77338) may be reported separately once per IMRT plan. However, patients receiving IMRT occasionally require an additional treatment device at a later date due to decreased tumor volume or patient weight. This device may be reported with CPT codes 77332-77334.

12. CPT code 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan) shall not be reported with CPT code 77385 (Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple) if the IMRT is compensator based. However, if the IMRT is not compensator based, CPT code 77338 may be reported separately.

13. Calculations described by CPT code 77300, if performed, are integral to some clinical brachytherapy procedures (e.g., CPT codes 77767-77772, 77778). CPT code 77300 shall not be reported with these clinical brachytherapy procedure codes.

14. IMRT plan (CPT code 77301) includes therapeutic radiology simulation-aided field settings. Simulation-aided field settings for IMRT shall not be reported separately using CPT codes 77280-77290. Although NCCI PTP edits based on this principle exist in the NCCI program for procedures performed on the same date of service, these edits shall not be circumvented by performing the 2 procedures described by a code pair edit on different dates of service.

15. CPT codes 77280-77290 (Simulation-aided field settings) shall not be reported for verification of the treatment field during a course IMRT treatment.

G. Medically Unlikely Edits (MUEs)

1. Medically Unlikely Edits (MUEs) are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim using modifiers to bypass MUEs. The MUE values are set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service (UOS) incorrectly. The provider/supplier may consider contacting their national healthcare organization or the national medical or surgical society whose members commonly perform the procedure to clarify the correct reporting of UOS.

3. 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.

4. The MUE values for J0153 injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds) and J1245 (Injection, dipyridamole, per 10 mg) were set for single pharmacologic stress tests. For the unusual patient who requires 2 different types of pharmacologic stress tests (e.g., myocardial perfusion and echocardiography) on the same date of service, the amount of drug used for each stress test should be reported on separate lines of a claim with modifier 59 or XU appended to the code on 1 of the claim lines.

5. The code descriptor for CPT code 77417 states “Therapeutic radiology port image(s).” The MUE value for this code is “1” since it includes all port films.

6. A single unit of service for an isodose plan (CPT codes 77316-77318) includes dose calculations at multiple points. For example, calculations for the craniocaudal position and mediolateral position are included in the same unit of service.

H. General Policy Statements

1. The MUE values and NCCI PTP edits are based on services provided by the same provider/supplier to the same beneficiary on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

2. In this manual, many policies are described using the term “physician.” Unless indicated differently the use of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules, CMS IOM, Publication 100-04 MCPM, Chapter 12 (Physician/Nonphysician Practitioners), Section 50 (Payment for Anesthesiology Services), and Global Surgery Rules, CMS IOM,

Publication 100-04 MCPM, Chapter 12 (Physician/Nonphysician Practitioners), Section 40 (Surgeons and Global Surgery) do not apply to hospitals.

3. Providers/suppliers reporting services under Medicare's hospital Outpatient Prospective Payment System (OPPS) shall report all services in accordance with appropriate Medicare IOM instructions.

4. In 2010, the *CPT Professional* codebook modified the numbering of codes so that the sequence of codes as they appear in the *CPT Professional* codebook does not necessarily correspond to a sequential numbering of codes. In the *Medicare NCCI Policy Manual*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Professional* codebook.

5. With few exceptions, the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures using adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances, wound closure using tissue adhesive may be reported separately. If a practitioner uses a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (Wound closure utilizing tissue adhesive(s) only). If a practitioner uses tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under the OPPS, HCPCS code G0168 is not recognized and paid. Facilities may report wound closure using sutures, staples, or tissue adhesives, singly or in combination with each other, with the appropriate CPT code in the "Repair (Closure)" section of the *CPT Professional* codebook.

6. Any abdominal radiology procedure that has a radiological supervision and interpretation code (e.g., CPT code 75625 for abdominal aortogram) includes abdominal x-rays (e.g., CPT codes 74018-74022) as part of the total service.

7. Reserved for future use.

8. Evaluation of an anatomic region and guidance for a needle placement procedure by the same radiologic modality on the same date of service may be reported separately if the 2 procedures are performed in different anatomic regions. For example, a provider/supplier may report a diagnostic ultrasound CPT code and CPT code 76942 (Ultrasonic guidance for needle placement...and interpretation) when performed in different anatomic regions on the same date of service. Providers/suppliers shall not avoid edits based on this principle by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

9. Reserved for future use.

10. CPT code 77790 (Supervision, handling, loading of radiation source) is not separately reportable with any of the brachytherapy codes (e.g., CPT codes 77770-77772, 77778) since these procedures include the supervision, handling, and loading of the radioelement.

11. Bone studies such as CPT codes 77072-77076 require a series of radiographs. Separate reporting of a bone study and individual radiographs obtained in the course of the bone study is inappropriate.

12. Radiological supervision and interpretation codes include all radiological services necessary to complete the service. CPT codes for fluoroscopy/fluoroscopic guidance (e.g., 76000, 77002, 77003) or ultrasound/ultrasound guidance (e.g., 76942, 76998) shall not be reported separately.

    Radiological guidance procedures include all radiological services necessary to complete the procedure. CPT codes for fluoroscopy (e.g., 76000) shall not be reported separately with a fluoroscopic guidance procedure. CPT codes for ultrasound (e.g., 76998) shall not be reported separately with an ultrasound guidance procedure. A limited or localized follow-up computed tomography study (CPT code 76380) shall not be reported separately with a computed tomography guidance procedure.

13. Abdominal ultrasound examinations (CPT codes 76700-76775) and abdominal duplex examinations (CPT codes 93975, 93976) are generally performed for different clinical scenarios, although there are some instances where both types of procedures are medically reasonable and necessary. In the latter case, the abdominal ultrasound procedure CPT code should be reported with an NCCI PTP-associated modifier.

14. Tumor imaging by positron emission tomography (PET) may be reported with CPT codes 78811-78816. If a concurrent computed tomography (CT) scan is performed for attenuation correction and anatomical localization, CPT codes 78814-78816 shall be reported rather than CPT codes 78811-78813. A CT scan for localization shall not be reported separately with CPT codes 78811-78816.

    A medically reasonable and necessary diagnostic CT scan may be separately reportable with an NCCI PTP-associated modifier. If the data set for the diagnostic CT is obtained concurrently on the same PET/CT integrated system where the CT portion of the study is co-registered with the PET images for the purpose of attenuation correction and anatomic localization, the diagnostic CT CPT code may be reported with PET CPT codes 78811-78813 using an NCCI PTP-associated modifier. Under these circumstances, the diagnostic CT CPT code shall not be reported with PET/CT CPT codes 78814-78816. However, if a data set for the PET/CT for attenuation correction and anatomic localization and a separate data set for the diagnostic CT are obtained on separate pieces of equipment, the diagnostic CT CPT code may be reported with CPT codes 78811-78816 using an NCCI PTP-associated modifier.

15. Axial bone density studies may be reported with CPT codes 77078 or 77080. Peripheral site bone density studies may be reported with CPT codes 77081, 76977, or G0130.

Although it may be medically reasonable and necessary to perform an axial and a peripheral bone density study on the same date of service, NCCI PTP edits prevent the reporting of more than one axial bone density study or more than one peripheral site bone density study on the same date of service.

16. When existing vascular access lines or selectively placed catheters are used to procure arterial or venous samples, reporting sample collection separately is inappropriate. CPT codes 36500 (Venous catheterization for selective organ blood sampling) or 75893 (Venous sampling through catheter with or without angiography...and interpretation) may be reported for venous blood sampling through a catheter placed for the sole purpose of venous blood sampling with or without venography. CPT code 75893 includes concomitant venography. If a catheter is placed for a purpose other than venous blood sampling with or without venography (CPT code 75893), it is a misuse of CPT codes 36500 or 75893 to report them in addition to CPT codes for the other venous procedure(s). CPT codes 36500 or 75893 shall not be reported for blood sampling during an arterial procedure.

17. CPT codes 70540-70543 are used to report magnetic resonance imaging of the orbit, face, and/or neck. Only 1 code may be reported for an imaging session regardless of whether 1, 2, or 3 areas are evaluated in the imaging session.

18. An MRI study of the brain (CPT codes 70551-70553) and MRI study of the orbit (CPT codes 70540-70543) are separately reportable only if they are both medically reasonable and necessary and are performed as distinct studies. An MRI of the orbit is not separately reportable with an MRI of the brain if an incidental abnormality of the orbit is identified during an MRI of the brain since only one MRI study is performed.

19. If the code descriptor of a HCPCS/CPT code includes the phrase “separate procedure,” the procedure is subject to NCCI PTP edits based on this designation. The Centers for Medicare & Medicaid Services (CMS) does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

20. CPT code 36005 (Injection procedure for extremity venography (including introduction of needle or intracatheter)) shall not be used to report venous catheterization unless it is used for an injection procedure for extremity venography.

21. Most NCCI PTP edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI PTP-associated modifiers (Correct Coding Modifier Indicator (CCMI) of “1”) because the 2 codes of the code pair edit may be reported if the 2 procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI PTP-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI PTP edit indicates that the 2 codes generally should not be reported together unless

the 2 corresponding procedures are performed at 2 separate patient encounters or 2 separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI PTP-associated modifiers should generally not be used.

22. Providers/suppliers shall not report radiologic supervision and interpretation codes, radiologic guidance codes, or other radiology codes where the radiologic procedure is integral to another procedure being performed at the same patient encounter. Procedure-to-procedure edits that bundle these radiologic codes into the relevant procedure codes have CCMI of "1" allowing use of NCCI PTP-associated modifiers to bypass them. An NCCI PTP-associated modifier may be used to bypass such an edit if and only if the radiologic procedure is unrelated to the procedure to which it is integral. For example, fluoroscopy is integral to a cardiac catheterization procedure and shall not be reported separately with a cardiac catheterization. However, if on the same date of service, the physician performs another procedure in addition to the cardiac catheterization, the additional procedure requires fluoroscopy, and fluoroscopy is not integral to the additional procedure, the fluoroscopy procedure may be reported separately with an NCCI PTP-associated modifier.

23. CPT code 36591 describes "collection of blood specimen from a completely implantable venous access device." CPT code 36592 describes "collection of blood specimen using an established central or peripheral catheter, venous not otherwise specified." These codes shall not be reported with any service other than a laboratory service. However, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

24. CPT code 96523 describes "irrigation of implanted venous access…" This code may be reported only if no other service is reported for the patient encounter.