ERRATA for
Diagnostic Radiology Coding Reference
2014 Edition

Text deletions are ~~crossed out~~. New text is **blue and bolded**. Ordered by appearance in text.

Page 102, Coding Instructions

13. There is no code at this time for a breast tomosynthesis study. Tomosynthesis combines the data from several low-dose 2D breast images to create a single 3D composite image of the breast. There are conflicting recommendations on how to report tomosynthesis. ~~BCBS of North Carolina recommends an unlisted code be reported in addition to the mammography codes (77055-77057 or G0202-G0206), while Novitas Solutions, Inc. recommends using codes G0202-G0206 for tomosynthesis. The American College of Radiology recommends unlisted code 76499. When it is performed using the Holographic C-view for reconstruction, code 76499 is reported for the tomosynthesis, code G0202 is reported for the reconstruction of the 2D tomosynthesis data~~. **The ACR recommends unlisted code 76499 be reported; however, CMS has told the ACR that tomosynthesis is included in codes G0202-G0206 and an unlisted code may not be billed to Medicare for this procedure. The ACR recommends reporting tomosynthesis separately with code 76499 to non-Medicare payers.**

Pages 107-108, Coding Instructions

1. The new CPT codes in 2014 bundle the breast biopsy, imaging guidance, localization device placement, and imaging of the biopsy specimen, when performed. The mammogram to verify the clip placement is also bundled **when mammographic or stereotactic imaging guidance is used for the biopsy**.

4. Needle biopsies are coded per lesion. **The "first lesion" codes (19081, 19083, 19085) are unilateral. If lesions are biopsied in both breasts, use the initial lesion code with modifier -50 (bilateral) appended. Code each additional lesion biopsied separately (do not append modifier -50 to the "each additional lesion" code).** Do not code based on the number of cores obtained or passes with the needle. The codes are differentiated between first lesion **in each breast** and each additional lesion.

5. Use codes 19081 and 19082 for stereotactic-guided breast needle biopsy. Report code 19081 for the initial lesion biopsied, **appending modifier -50 if lesions in both breasts are biopsied,** and report code 19082 for any additional lesions biopsied when utilizing the same guidance.

6. Use codes 19083 and 19084 for ultrasound-guided breast needle biopsy. Report code 19083 for the initial lesion biopsied, **appending modifier -50 if lesions in both breasts are biopsied,** and report code 19084 for any additional lesions biopsied when utilizing the same guidance.

7. Use codes 19085 and 19086 for MR-guided breast needle biopsy. Report code 19085 for the initial lesion biopsied, **appending modifier -50 if lesions in both breasts are biopsied,** and report code 19086 for any additional lesions biopsied when utilizing the same guidance.

10. ~~Report each first lesion code only one time per session; it is not per breast. Lesions in the other breast are additional lesions when performed with the same type of imaging guidance.~~ **The "first lesion" codes are unilateral. Append modifier -50 when lesions in both breasts are biopsied with the same type of imaging guidance. Do not append modifier -50 to the each additional lesion codes.**

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8. Code only one initial placement of a localization device **per breast** with the "first lesion" code **(append modifier -50 if localization is performed in both breasts with the same imaging guidance). Use** ~~using~~ the "each additional lesion" code for each separate and distinct lesion localized in the same setting using the same type of imaging guidance. If ~~a second~~ **an additional** lesion is localized with a different type of imaging guidance, report ~~a second~~ **the** "initial" placement of a localization device **with that imaging guidance modality** ~~code as appropriate~~.

Page 133, Coding Instructions

6. Do code non-contrast CT imaging of the head (**code** 70450) in addition to code 0042T **when performed in the same session.** ~~Codes~~ **The codes for "with contrast" and "with and without contrast" CT imaging of the head (**70460 and 70470**)** are NCCI edits with code 0042T, so only report the non-contrast CT **when CT imaging of the head and a perfusion study are performed together. If CT imaging of the head with contrast is performed in a separate session, append modifier -59 to code 70460 or 70470 to indicate it was performed as a distinct procedure**. ~~Report the CT scan in addition to the perfusion analysis; it is not included.~~

Page 159, Codes

The following should be added to the bottom of the code table:

Cerebral perfusion analysis using computed tomography with contrast administration, including post-processing of parametric maps with determination of cerebral blood flow, cerebral blood volume, and mean transit time	**0042T**	**N/A**	**0.00**

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3. **Do code CTA of the head (70496) in addition to code 0042T. The CTA is not included in the perfusion analysis and is usually performed following the perfusion study.**

Page 159, References

CPT Changes: An Insider's View 2001, **2003,** 2008

Page 261, Coding Instructions

5. Venous duplex requires the use of spectral Doppler. If not performed or documented, do not report code 93970 or 93971. Report code ~~76880~~ **76881** or 76882.