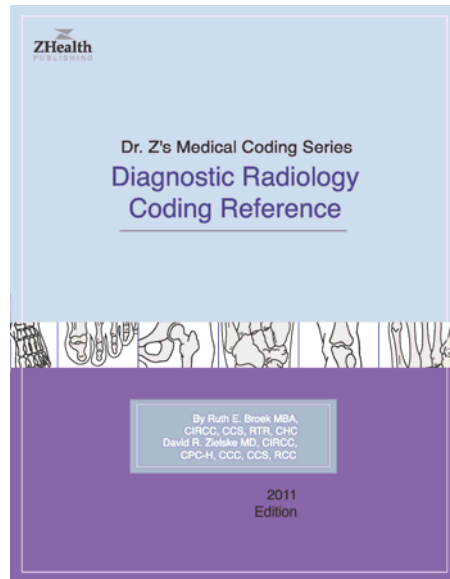


**Dr Z's Medical Coding Series:
Diagnostic Radiology Coding Reference: 2011 Edition**

2011 Book Errata



Text to be deleted has been crossed out and new text noted in blue font.

Page 69

CODING INSTRUCTIONS

7. Do code finger imaging once per hand, **not** per finger imaged. **However per CMS,** fingers modifiers, F1-F9 and FA, do apply to code 73140 ~~are not required when billing to finger x-rays since all fingers imaged on one hand are included in code 73140.~~

Page 72

CODING INSTRUCTIONS

9. Do code toe imaging once per foot, **not** per toe imaged. **However per CMS,** toe modifiers, T1-T9 and TA, do apply to code 73660 ~~are not required when billing toe x-rays since all toes imaged on one foot are included in code 73660.~~

Page 96

CODING INSTRUCTIONS

1 Fluoroscopy (76000) has been designated as a “separate procedure” and is inherent in many other procedures, such as radiological supervision and interpretation procedures, implantation of neurostimulators, lithotripsy, bronchoscopy, etc. **A CPT code with the “separate procedure” designation may be reported with another procedure if it is performed during a separate patient encounter or at the same patient encounter in**

6/1/2011

1

an anatomically unrelated area. Fluoroscopy may not be reported in addition to images of the same area unless performed during a separate encounter.

2. Fluoroscopy greater than 1 hour (76001) is an NCCI edit with most surgical procedures. Caution should be used when billing fluoroscopy in the operating room, as it is usually ~~may be~~ bundled. **Code 76001 is reported by a radiologist when performing fluoroscopy in assistance of another physician, such as during an ERCP if it is the only service the radiologist is performing. If the physician interprets ERCP films, a code describing the radiological supervision and interpretation (RS&I) of the ERCP is reported and code 76001 is not reported, as fluoroscopy is included in all RS&I procedures.**

Pages 96 - 97

CODING INSTRUCTIONS

3. For physician billing, if the radiologist is **not** in the operating room during a procedure that uses fluoroscopy, the radiologist cannot bill fluoroscopy, as it requires direct supervision. The code describing the anatomy evaluated should be submitted **for physician billing** if the radiologist is required to produce a formal report of the images recorded. **The hospital should not report the images archived using the c-arm as a procedure. These are part of the fluoroscopic exam for hospital billing.**

Page 202

CODING INSTRUCTIONS

4. When duplex Doppler (codes 93975 and 93976) is **medically indicated and** performed of abdominal, pelvic, scrotal contents, and/or retroperitoneal organs in addition to abdominal and retroperitoneal ultrasound, append modifier -59 to code 76700, 76705, 76770, or 76775. **This should be a rare occurrence.**

5. When duplex Doppler (codes 93978 and 93979) is **medically indicated and** performed of the aorta, inferior vena cava, iliac vasculature, or bypass grafts in addition to retroperitoneal ultrasound, append modifier -59 to code 76770 or 76775. **This should be a rare occurrence.**

7. Do code transvaginal ultrasound separately with transabdominal pelvic ultrasound when both are performed in the same setting. The reason for performing both should be documented. **In addition, there should be separate orders from the treating physician for the two procedures.**

Page 212 - 213

5. Use CPT code 76942, *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*, when billing for ultrasonic guidance for cyst aspiration or ultrasonic guidance for needle biopsy of the extremity. **Do not** use CPT procedure codes ~~76880~~ **76881 or 76882** to report guidance procedures.

Page 250

CODING INSTRUCTIONS

5. **Do not** report code **93990** ~~93970~~ (duplex scan of hemodialysis access) with code 93970 or 93971, as they are considered mutually exclusive under NCCI edits and only code 93990 will be paid.

Page 252

CODING INSTRUCTIONS

3. **Do not** report code **93990** ~~93970~~ (duplex scan of hemodialysis access) with code 93970 or 93971, as they are considered mutually exclusive under NCCI edits and only code 93990 will be paid.
