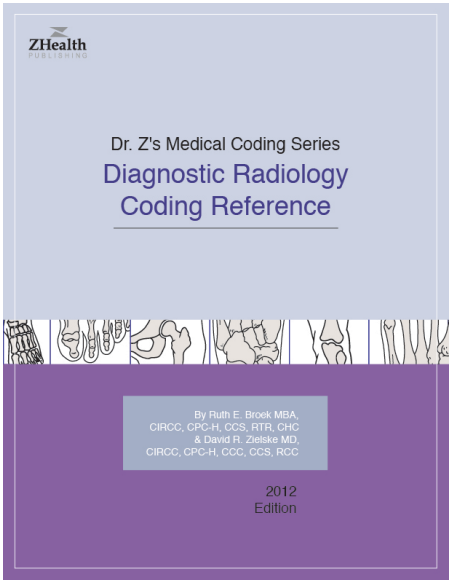
Dr Z's Medical Coding Series:
Diagnostic Radiology Coding Reference:
2012 Edition

2012 Book Errata



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

Page 8
MODIFIER 52 – REDUCED SERVICES *(2nd paragraph)*

The difference between hospital and physician use of modifier -52 is that hospitals have been instructed to use modifier -52 when procedures not requiring anesthesia are discontinued. It may not be used to report a discontinued procedure that utilizes anesthesia. Hospitals use modifiers -73 and -74 for these procedures. ~~Most diagnostic imaging procedures do not use anesthesia, so modifier -52 will not be used often by a hospital. Hospital do not use modifier -52 to indicate reduced services as physicians do. It is only utilized by hospitals to report aborted procedures not requiring anesthesia. All recommendations regarding the use of modifier -52 in this reference only apply to physician billing.~~ **Medicare has given mixed instructions on how modifier -52 should be used by a hospital. The most recent instruction is that it should also be utilized by the hospital to indicate reduced services.** Medicare discounts the fee schedule amount by 50% when modifier -52 is appended.

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CODING TABLE
The following should be added to the coding table in appropriate numeric order:

74174	**3.1**	**Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

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CODING INSTRUCTIONS

8. ~~Do not code follow-up mammography after biopsy for verification of clip placement. This is bundled unless the biopsy procedure was performed with ultrasound guidance, in which case you may code the follow-up mammogram.~~ **Follow-up mammography after biopsy for verification of clip placement may be reported separately, unless performed on the same equipment the biopsy was performed on.**

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CODING INSTRUCTIONS

3. ~~Do not code follow-up mammography after biopsy for verification of clip placement. This is bundled unless the biopsy procedure was performed with ultrasound guidance, in which case you may code the follow-up mammogram.~~ **Follow-up mammography after biopsy for verification of clip placement may be reported separately, unless performed on the same equipment the biopsy was performed on.**

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CODING INSTRUCTIONS

1. ~~Mammograms performed after mammographic or stereotactic needle/wire localization are not separately billable. Mammograms performed after ultrasound guided biopsy may be billed if medically necessary.~~ **Follow-up mammography after biopsy for verification of clip placement may be reported separately, unless performed on the same equipment the biopsy was performed on.**

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CODING INSTRUCTIONS

1. Do code MRI of the abdomen for MR cholangiopancreatography (MRCP) ~~if MRI of the abdomen is also performed,~~ plus 3-D reconstruction if performed~~, when billing Medicare. If only an MRCP is performed, report unlisted code 76498. Do not report both CT of the abdomen and the unlisted code together.~~ Use code S8037 for MRCP for non-Medicare payers that accept Temporary National HCPCS codes.

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CODING INSTRUCTIONS

11. Do code 78803, *Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); SPECT*, for parathyroid SPECT. ~~Do not bill separately for planar parathyroid imaging when SPECT is performed.~~ **If a complete planar imaging parathyroid scan and a parathyroid SPECT study are both performed, both may be reported separately.**

REFERENCES

The following reference should be added in appropriate alphabetic order:

Society of Nuclear Medicine, Coding Corner, October, 12, 2011

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