2015 Radiology Coding Survival Guide
Chapter 12: Other Procedures (76000-76499)

You’ll find a variety of services listed in the “Other Procedures” section, but this is by no means a throwaway section for seldom-used codes. You’ll find fluoro codes and 3-D rendering codes, among others. But this section has a lot less codes than it used to. CPT® rearranged the “Radiology” chapter in 2007, moving several services (such as mammograms) from the “Other Procedures” section to other areas of the chapter.

Check for CCI Edits Before Charging Fluoro

To find a list of all the operating room procedures that are incidental with fluoroscopy codes 76000 and 76001, the best place to start is the list of Correct Coding Initiative (CCI) edits available online at www.cms.gov/NationalCorrectCodInitEd/. You’ll find both hospital and physician edits available for download.

You’ll find plenty of edits for 76000 (Fluoroscopy [separate procedure], up to 1 hour physician or other qualified healthcare professional time, other than 71023 or 71034 [e.g., cardiac fluoroscopy]) and 76001 (Fluoroscopy, physician or other qualified healthcare professional time more than 1 hour, assisting a non-radiologic physician or other qualified healthcare professional [e.g., nephrolithotomy, ERCP, bronchoscopy, transbronchial biopsy]).

Important: When CCI lists fluoro as a Column 2 code, you should not append a modifier to override the edit unless the fluoro is for a separate encounter or on a separate body part. If CPT® or CCI doesn’t define fluoro as part of a procedure, you can report fluoro for a physician who supervises and interprets the fluoroscopy during an operative procedure.

The physician must document fluoro use and what it revealed. Be sure to use modifier 26 (Professional component) for physician coding for hospital procedures.

Fluoro is inherent to all endoscopy codes, so you should not report it separately.

Time: CPT® defines 76000 and 76001 in terms of physician time. The physician does not have to personally operate the fluoro machine, but he is required to supervise the technologist who is operating it and must interpret the images. The op report again should indicate fluoro use and findings.

If the procedure has a specific imaging code, you should report the code most appropriate to the procedure performed, rather than fluoro.

**Example:** Report 75978 (Transluminal balloon angioplasty, venous [e.g., subclavian stenosis], radiological supervision and interpretation) for venous angioplasty imaging services.

Set Your Sights on Specimen Code

When a radiologist examines a tissue specimen removed during surgery, you should report 76098 (Radiological examination, surgical specimen) for the service.

**Note:** Code 76098 describes an examination of the removed specimen. You should not report the code for follow-up imaging performed on the patient herself.

**Remember:** When both the radiologist and pathologist report the specimen X-ray interpretation, the first claim in is typically the one that gets paid.

Payers May Label DMX ‘Experimental’

You should report 76120 (Cineradiography/videoangiography, except where specifically included) for digital motion X-ray (DMX), according to the AMA’s CPT® Assistant (April 2004). CPT® also includes an add-on code when the radiologist performs the service with another routine exam, +76125 (Cineradiography/videoangiography to complement routine examination [List separately in addition to code for primary procedure]).
Note: CPT® Assistant indicates 76120 is more appropriate than 76499 (Unlisted diagnostic radiographic procedure). But you may find payer policies matching digital motion X-ray to unlisted procedure codes. For example, Mountain State Blue Cross Blue Shield's "Radiographic Imaging Techniques" policy pairs videofluoroscopy/digital motion X-ray with 76496 (Unlisted fluoroscopic procedure [e.g., diagnostic, interventional]) and 76499 (Unlisted diagnostic radiographic procedure).

Reality: Payers, including Mountain State, may consider spinal digital motion X-ray experimental and won't cover it.

Don't Count on 76140 Pay

You may report 76140 (Consultation on X-ray examination made elsewhere, written report) when a patient brings the X-ray or another physician sends an imaging study to your physician for an opinion, and then your physician reviews the films/images and completes a formal report with an interpretation.

Caution: Don't report 76140 for reviewing old films at the time the radiologist interprets the patient's current films. Example: Interpretation of a mammogram should include comparison of the new exam to the patient's prior mammograms. Also, if you are coding for an E/M service, the review of the patient’s imaging studies is part of the medical decision making element of the E/M level.

Code 76140 should be reported per exam, not per film. Depending on payer policy, you may be able to report multiple units of 76140 if the consultation involves films from multiple exams (for example, CT of the thorax and CT of the abdomen).

Reality: Most payers (including Medicare) do not assign any RVUs to 76140, so don't be surprised if you are not reimbursed when reporting this code. In the past, some Medicare carriers have advised physicians to report the exam code (for example, 70450-26, Computed tomography, head or brain; without contrast material; Professional component) rather than 76140 when another physician asks for a written consultation on outside films. Be sure to verify with your carrier that this is an acceptable practice.

Ace 3-D Coding With 5 Can't-Miss Rules

Rule 1: Remember 1 Word Separates 76376 and 76377

CPT® 2006 added the following 3-D rendering codes:

- 76376 — 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation.
- 76377 — requiring image postprocessing on an independent workstation.

For 76376, which does not require an independent workstation, the physician discusses the need for 3-D imaging with the technologist and supervises the images' creation. For 76377, which does require an independent workstation, the physician supervises or creates the 3-D image and adjusts the projection for optimal anatomy and pathology visualization, according to the ACR 2006 Coding Update.

Documentation tip: The only way that you can tell which code to report is if the radiologist documents independent workstation use (or non-use).

Rule 2: Stop Trying to Report 2-D Reconstruction

CPT® added the 3-D rendering codes for complex renderings, including shaded surface rendering and maximum intensity projections (MIPs), fusion of images from other modalities, and quantitative analysis (segmental volumes and surgical planning), according to AMA’s CPT® Changes 2006: An Insider’s View.

Remember: You should not separately report 2-D reconstruction. This change occurred in 2006 when CPT® replaced 76375 (Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality) with 76376 and 76377.

So even if your radiologist documents constructing coronal, sagittal, multiplanar, or oblique reformats from axial images, remember that these are 2-D, and you should not report them separately.
Rule 3: Strive for Crystal-Clear Documentation

The January 2006 Journal of the American College of Radiology (JACR) advises that “when providing 3-D rendering services, particularly in the outpatient setting, a specific order is particularly helpful in defending a radiologist against allegations of ‘churning’ unnecessary services, as is explicit documentation in the report as to why such services were performed.”

Your local or regional carrier may have different rules, so check your payers' rules before coding.

Rule 4: Watch for Concurrent Supervision Signs

Another element required for 76376 and 76377 is concurrent physician supervision of image postprocessing, 3-D manipulation of volumetric data set, and image rendering.

According to the AMA and the ACR, concurrent supervision requires actively participating in and monitoring the reconstruction process, which includes the following:

- Designing the anatomic region to be constructed
- Determining tissue types and structures to display
- Determining images or cine loops to archive
- Monitoring and adjusting 3-D work product.

Watch out: The concurrent supervision definition is independent of CMS's established supervision levels.

Rule 5: Size up CCI's Impact on 3-D

You should check both CCI and CPT® before reporting the 3-D codes to ensure you comply with the existing edits for 76376 and 76377.

Watch out: You won't see cases requiring you to override the edits very often. Head to www.cms.gov/NationalCorrectCodInitEd/ to download the full list of edits, including the hundreds for 3-D rendering codes.

Don't miss: In addition to CCI, you can find many codes you can't report with the 3-D rendering codes in the CPT® manual. These codes include postprocessing, and the fee schedule factors 3-D rendering values into those codes.

Key Concepts:

Untangle Unlisted Procedure Code Coding

The "Other Procedures" section includes four unlisted procedure codes:

- **76496** — *Unlisted fluoroscopic procedure (e.g., diagnostic, interventional)*
- **76497** — *Unlisted computed tomography procedure (e.g., diagnostic, interventional)*
- **76498** — *Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)*
- **76499** — *Unlisted diagnostic radiographic procedure.*

The CPT® manual "Introduction" includes "Instructions for Use of CPT® Codebook." The first paragraph states, "Do not select a CPT® code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code."

- Published on 2015-01-01