The head and neck diagnostic imaging section of CPT® includes codes specific to various modalities — such as radiography, computed tomography (CT), and magnetic resonance (MR), as well as codes that specify "supervision and interpretation." (See Section I, "Radiology Guidelines" for the definition of "supervision and interpretation.") This section also includes CT angiography codes. In this chapter of the Survival Guide, you'll find answers to many of the questions radiology coders face when coding head and neck diagnostic imaging.

Keep Radiograph Coding on Track with Vocabulary Tips

You need to know several terms to apply the radiography codes correctly. Here's a rundown of some of the terms you'll see in codes 70010-70390.

**Myelography**: Myelography is a radiographic study showing contrast material's passage in the subarachnoid space (around the spinal cord) and nerve roots using fluoroscopy. Example: For the radiological supervision and interpretation of posterior fossa myelography, you should report code 70010 (Myelography, posterior fossa, radiological supervision and interpretation).

**Cisternography**: If documentation shows radiography of the brain's basal cistern after subarachnoid injection of contrast, check out 70015 (Cisternography, positive contrast, radiological supervision and interpretation).

**Dacryocystography**: When the study visualizes the lacrimal sacs and associated structures with contrast, look for dacryocystography code 70170 (Dacryocystography, nasolacrimal duct, radiological supervision and interpretation).

**Cephalography**: Code 70350 (Cephalogram, orthodontic) describes a diagnostic study of the patient's skull, jaw, and teeth — sometimes called as a cephalometric radiograph — to help in planning correction. The patient may have the test repeated over time to show change.

**Orthopantography**: An X-ray film that shows all of the patient's teeth, jaw bones, and nearby structures on a single film is an orthopantogram (70355, Orthopantogram [eg, panoramic x-ray]). (See "Master Radiography Coding with 4 Head and Neck FAQs" in this section for more on this code.)

**Laryngography**: Choose 70373 (Laryngography, contrast, radiological supervision and interpretation) for reporting a radiographic contrast study of the larynx (also called the voice box).

**Sialography**: A sialogram (70390, Sialography, radiological supervision and interpretation) involves an X-ray study of the salivary ducts and the related glandular structures.
Key Concepts:

Master Radiography Coding With 4 Head and Neck FAQs

Submitting clean claims requires more than simply matching modality and anatomy to code descriptors. Modifiers, fee schedule indicators, and more all come into play. Read through these head and neck examples to learn some crucial coding essentials that you can apply to the claims you see every day.

1: Match Modifiers to Pre- and Post-Op Imaging

**Question:** Documentation shows one set of X-rays when the patient presents with a suspected mandible fracture and another set of X-rays taken to check for alignment after a surgeon performs closed reduction. How should you code this?

**Answer:** For diagnosing mandibular fractures, most oral and maxillofacial surgeons will use an orthopantogram (70355, Orthopantogram [eg, panoramic x-ray]). If the surgeon requests this form of imaging for both diagnosis and post-reduction, you would append modifier 76 (Repeat procedure or service by same physician or other qualified health care professional) to the second orthopantogram code.

But if he uses different types of preoperative and postoperative imaging, you can't consider the second X-ray a repeat procedure.

2: Understand Bilateral Indicator ‘3’ for Mastoids

**Question:** How should you report a bilateral 70120 service?

**Answer:** Before you report bilateral services, be sure you understand whether your payer considers the code 70120 (Radiologic examination, mastoids; less than 3 views per side), to be unilateral or bilateral.

**What to do:** If you check the "Bilat Surg" column in Medicare's Physician Fee Schedule, you'll see a "3" for 70120. According to the fee schedule, that means "bilateral payment adjustment does not apply," and you should charge both sides separately at their normal fee. Most services with a "3" are radiology procedures.

**Resource:** You can search the fee schedule online at [www.cms.gov/pfslookup/](http://www.cms.gov/pfslookup/) or download the files at [www.cms.gov/PhysicianFeeSched/](http://www.cms.gov/PhysicianFeeSched/). Note that this fee schedule is specific to Medicare, but many private payers adopt Medicare rules.

To report the procedure bilaterally, check for your payer's preference. You may need to report the code twice and append modifier 50 (Bilateral procedure) to the second code. Or the payer may have a different preference, such as reporting the procedure as a single line item with 50 appended.

**Bonus tip:** Likely ICD-9 codes for 70120 include the following:

- 383.x — Mastoiditis and related conditions
- 386.x — Vertiginous syndromes and other disorders of vestibular system
- 784.2 — Swelling, mass, or lump in head and neck.

3: Meet Medical Necessity for 70140-70150

**Question:** You perform a three-view X-ray of the facial bones for a patient who suffered facial injuries in a car accident. Does this usually meet the requirements for medical necessity?

**Answer:** You should check with your payer to be positive, but X-rays to assess injuries to the facial bones typically do qualify for reimbursement.

You should report the diagnosis with the ICD-9 code supported by your documentation alone. You may also need to report an E code to explain the external cause of the injury, such as E813.0 (Motor vehicle collision with other vehicle, injuring driver of motor vehicle other than motorcycle).
CPT® considers three views of the facial bones to be a "complete" exam. Because the example states documentation of three views, you should report 70150 (Radiologic examination, facial bones; complete, minimum of 3 views). If your documentation reveals fewer than three views, you should report 70140 (... less than 3 views).

4: Use 70210 Example to Grasp TC/26 Concept

**Question:** An otolaryngologist orders X-rays for two sinus views. How should the radiologist report the services?

**Answer:** You should report 70210 (Radiologic examination, sinuses, paranasal, less than 3 views). If your office completes both the professional (modifier 26, Professional component) and the technical component (modifier TC, Technical component), you should not append 26 or TC.

Using the global X-ray code (70210 without TC or 26) tells the insurer that the office owns the X-ray equipment and the supplies, and the physician interprets the film and writes a report of his findings.

If a facility performs the X-ray, the hospital bills for the technical side, and you should not bill the global X-ray code or the technical component. So the radiologist would report 70210-26.

**Potential problem:** Some ordering physicians want to personally review the films and charge for interpreting the X-ray. If a radiologist performs that portion, the ordering physician should not bill for it also.

**CCI Spells Out 70120, 70130 Bundle Rationale**

Correct Coding Initiative (CCI) edits spell out which codes Medicare and other payers who adopt these edits bundle together, meaning that if CCI bundles code B into code A, you should report and expect payment for only code A.

CCI links a "standard policy statement" to each code pair, and the CCI Coding Policy Manual, Chapter 1 (available at [www.cms.hhs.gov/NationalCorrectCodInitEd/](http://www.cms.hhs.gov/NationalCorrectCodInitEd/)), explains the meaning of these standards.

**For example:** You will see the "HCPCS/CPT® Procedure Code Definition" policy statement when one code is part of another based on the descriptor language.

In many cases, that's because an indented code includes all of the services described by the main entry preceding a semicolon.

CCI offers this example:

- 70120 — Radiologic examination, mastoids; less than 3 views per side
- 70130 — ... complete, minimum of 3 views per side.

For a complete radiologic exam of the mastoids, you should report 70130. You don't need to report 70120 in addition to 70130 if you imaged only one side because the descriptor for 70130 (at least three views per side) includes the services described by 70120 (less than three views per side).

**ICD-9:** The following diagnosis codes may support medical necessity for sinus views. Check with your payers for their lists of appropriate and payable ICD-9 codes. But choose your ICD-9 code based on the documentation — don't choose a code just to get paid:

- 461.x — Acute sinusitis
- 473.x — Chronic sinusitis
- 784.0 — Headache (includes facial pain and Pain in head NOS)

**Special Feature:**

**Tackle TMJ Coding Regardless of Modality**

**X-rays:** Codes 70328 (Radiologic examination, temporomandibular joint, open and closed mouth; unilateral) and 70330 (... bilateral), both describe X-rays of the temporomandibular joint (TMJ).

If the documentation indicates a TMJ X-ray in two projections of one side, one film with the mouth open and one with the
mouth closed, you should report 70328 (... unilateral). The bilateral code 70330 should be reported only when the documentation shows the TMJ exam on both sides.

**MRI**: Having separate codes for unilateral and bilateral TMJ X-rays distinguishes these services from 70336 (Magnetic resonance [e.g., proton] imaging, temporomandibular joint[s]). The term “joint[s]” in the MRI descriptor indicates that you should use this code either for unilateral or bilateral services.

**Arthrography**: Arthrography (70332, Temporomandibular joint arthrography, radiological supervision and interpretation) is a radiographic contrast joint study. The provider injects contrast into the joint, and then takes X-rays in multiple projections. The contrast allows the radiologist to see more details than a conventional X-ray.

**Tip**: You may report the contrast injection separately with 21116 (*Injection procedure for temporomandibular joint arthrography*).

You should report 70332 and 21116 twice (each with modifier RT and LT) if the radiologist performs the procedure on both the right and left sides.

**CT**: Choosing which code to assign for CT views of TM (temporomandibular) joints can be confusing. Although both 70486 (Computed tomography, maxillofacial area; without contrast material) and 70450 (Computed tomography, head or brain; without contrast material) describe CTs performed on areas of the head, TMJs are a part of the maxillofacial area and so experts consider 70486 as a more appropriate code for reporting CT views of TM joints. Protocols for 70450 generally do not provide adequate evaluation of the TM joints.

If the evaluation includes contrast, you should assign 70487 (Computed tomography, maxillofacial area; with contrast material[s]). In addition, if the study was done without contrast followed by contrast, you should report 70488 (... without contrast material, followed by contrast material[s] and further sections).

**ICD-9**: A physician may order TMJ services for diagnoses, including the following:

- TMJ pain (524.62, *Arthralgia of temporomandibular joint*)
- TMJ -pain-dysfunction syndrome (524.60, *Temporomandibular joint disorders, unspecified*)
- TMJ disc disease (524.63, *Articular disc disorder [reducing or non-reducing]*)
- Abnormal sounds, such as clicking noises when opening and closing the jaw (524.64, *Temporomandibular joint sounds on opening and/or closing the jaw*).

**Set Speech and Swallowing Study Claims on the Path to Success**

If you code speech and swallowing studies, be sure you know these radiology codes:

- 70370 — *Radiologic examination; pharynx or larynx, including fluoroscopy and/or magnification technique*
- 70371 — *Complex dynamic pharyngeal and speech evaluation by cine or video recording*
- 74230 — *Swallowing function, with cineradiography/videoradiography*.

**70370**: You may rarely, if ever, use 70370. It describes a radiologic exam using fluoroscopy and/or magnification techniques, but does not include the dynamic elements of the speech evaluation code in which the movements of the mouth and tongue are required.

**70371**: Code 70371 describes a radiologic study using cineradiography or video recording for pharyngeal and speech evaluation. Typically, a speech pathologist is present, and the patient repeats sounds to allow for evaluation of the mouth and tongue during speech. Fluoroscopy is used to record how the tongue, palate, and other soft tissues in the mouth function. As the words and sounds are repeated, the speech pathologist and radiologist are able to see where problems may lie.

**74230**: The swallowing function exam described by 74230 is used to evaluate the oropharynx, hypopharynx, and upper esophagus. You should report 74230 to represent the radiologic supervision and interpretation for a speech language pathologist's performance of the service that 92611 (Motion fluoroscopic evaluation of swallowing function by cine or video recording) describes. You may see this study referred to as videofluoroscopic swallow study (VFSS).
The procedure includes cineradiography or videoradiography use. Imaging exams included in this procedure include an AP (anteroposterior) film of the barium-distended esophagus from the neck to the diaphragm and right anterior oblique projection to include the neck and thorax. The exam may also include a left anterior oblique projection.

Patients who require these tests have often had a stroke and are experiencing dysphagia (438.82, Dysphagia due to cerebrovascular disease). Other diagnosis codes that may justify this procedure include 150.0-150.9 (Malignant neoplasm of esophagus...), 235.6 (Neoplasm of uncertain behavior of larynx), 787.2x (dysphagia...), and 507.0 (Pneumonitis due to inhalation of food or vomitus). Medicare carriers' policies vary, however, so always confirm your payers' guidelines before you perform swallowing studies.

**Smart move:** Because of the potential for confusion between 74230 (for swallowing disorders) and 70371 (speech evaluation), the radiologist’s dictation is vital. You need to know exactly what the radiologist studied and recorded to be able to assign the appropriate code.

If you interchange the two codes, you could put your practice at risk. Because payers reimburse you more for 70371, insurers are on the lookout for practices that "upcode" their procedures from 74230.

If the radiologist’s documentation is too vague to determine whether she performed a pharyngeal evaluation or a swallowing study, you should always double check with her. Avoid the temptation to select the correct CPT® code based on the diagnoses listed in the report. Some conditions, such as 784.5x (Other speech disturbance...), are specific to pharyngeal/speech evaluations. But as other diagnoses overlap between both procedures, this won't help you select the appropriate code. Stroke (434.91) and throat cancer (149.0), for example, are payable diagnoses for both procedures.

**Chew on These 70480 Edits**

For a temporal bone CT performed with a head CT, take care how you code.

You would typically report a temporal bone CT using either 70480 *(Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material), 70481 (... with contrast material)*, or 70482 *(... without contrast material, followed by contrast material[s] and further sections)*.

**Take the Pressure Out of 'CT Sinus' Coding**

When you're coding sinus CTs, look to maxillofacial area codes 70486-70488 *(Computed tomography, maxillofacial area ...)*. Get a little extra insight into coding these services with these two from-the-trenches scenarios.

**Scenario 1:** A patient undergoes a CT without contrast, and the radiologist focuses his report on the sinuses. You believe the correct code is 70486 *(... without contrast material)*. Should you append modifier 52 *(Reduced services)* because the radiologist doesn't describe the full area in detail?

**Solution:** No need for 52 here. According to the American College of Radiology (ACR), you don't have to code CTs by the slice. Code 70486 should be appropriate on its own.

**Scenario 2:** Which CPT® code(s) should you report for the following? Your freestanding imaging center performs a sinus CT without contrast. The images and data scans are taken to get computerized data, so a surgeon can use the information to build a 3-D image with the Insta Trak for guidance during surgery.

The radiologist dictates his scan findings and labels them as "CT sinuses w/3-D." You have permanent files of the images and can print hard-copy images from the data at any time.

**Solution:** You should report the sinus CT with 70486.

But fight the urge to report 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)* or 76377 *(... requiring image postprocessing on an independent workstation)*.

The AMA's CPT® Changes 2006: An Insider's View explains that the 3-D codes describe 3-D rendering with interpretation. CPT® 76376 and 76377 codes descriptor clearly states "require concurrent supervision of image postprocessing 3-D manipulation of volumetric data set and image rendering."
You may use the 3-D rendering codes with 70486, but only when your service meets those requirements, and in the above scenario description, the radiologist neither supervises the creation of 3-D images nor interprets them.

For more on proper use of 76376 and 76377 see "Ace 3-D Coding with 5 Can't-Miss Rules" in Chapter 12, "Other Procedures (76000-76499)."

Case Study:

Knock Out Neck CT Questions with This How-To Guide

Start by analyzing the report (in the gray box below) from an imaging center, and decide which CPT®, ICD-9, and HCPCS codes you would report on the center's global service claim.

Size Up Your CPT® Solution

For this exam, you should report 70491 (Computed tomography, soft tissue neck; with contrast material[s]).

You can't automatically depend on the "Neck CT with contrast" header to choose your code, but the report describes neck anatomy and intravenous contrast, confirming that the neck CT with contrast code is correct.

Beware: The report says that "sagittal and coronal computer reconstruction images were also obtained." You should not report 76376-76377 (3D rendering with interpretation and reporting of computed tomography ...) because converting an axial scan into the coronal or sagittal plane is 2-D reformatting. CPT® guidelines specify that you may not report 2-D formatting separately.

Exam: CT neck with contrast

Indication: Left vocal cord paralysis

Technique: Axial CT cuts were obtained from the top of the orbits down to the thoracic inlet using 100 cc of Isovue 300. 1.3-mm axial CT cuts were also obtained through the larynx. Sagittal and coronal computer reconstruction images were also obtained.

Indications for use of non-ionic contrast: None reported

Findings: No mass lesion within the posterior nasopharynx or oropharynx. There are multifocal punctuate calcifications in the right palatine tonsil. The submandibular and parotid glands are unremarkable. There are subcentimeter anterior cervical and left submandibular lymph nodes. There are subcentimeter left internal jugular lymph nodes. The left pyriform sinus is slightly larger than the right, and there is dilatation of the left laryngeal ventricle. There is probably atrophy of the left true vocal cord best seen on the 1.3-mm thick images. The left arytenoid cartilage has a more medial position than the right. The thyroid glands are unremarkable. The visualized upper mediastinum is unremarkable.

Impression:

1. Left vocal cord paralysis
2. No cervical mass or adenopathy

Follow These ICD-9 Accuracy Tips

You'll have to overcome a few obstacles to choose the most accurate diagnosis code for this service, which includes the finding of "left vocal cord paralysis."

ICD-9 limits your vocal cord paralysis choices to 478.3x (Paralysis of vocal cords or larynx...).

Problem: The radiologist documented that the vocal cord paralysis was left side only, but to choose the most specific code, you also need to know whether the paralysis is partial or complete.

Solution: If you can't get a confirmed diagnosis from the ordering physician, you should report the unspecified code: 478.30 (Unspecified paralysis of vocal cords).

Don't Miss These Contrast Unit Tips
To achieve the "with contrast" portion of this exam, the provider administered 100 cc of Isovue 300 (non-ionic contrast) intravenously. If you bear the drug's cost, then you should report the contrast with Q9967 (Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml).

The descriptor says to report the code "per ml," so you should report 100 units for the 100 cc administered. Why: One milliliter (ml) equals one cubic centimeter (cc).

**Remember:** CPT® defines "with contrast" for imaging as contrast administered intravascularly, intra-arterially, or intrathecally. If the patient received only oral or rectal contrast, you would not choose a "with contrast" imaging code option.

**Note:** The report says, "Indications for use of non-ionic contrast: None reported." But this missing information isn't an issue. The restrictive criteria for LOCM (low osmolar contrast material) went away a few years ago.

**Special Feature:**

**Keep Sight of Anatomic Site to Select CTA Code**

As with computed tomography (CT) scan codes, CPT® breaks the CT angiography (CTA) codes down according to anatomic site.

If your documentation is unclear regarding the specific site (for instance, abdomen versus pelvis), always ask the physician to select the most accurate CPT® code rather than just choosing one that you believe to be "close."

**Good news:** CTA codes got a 2008 facelift aimed at bolstering your right to report CTAs without modifier 52 (Reduced services).

**The lowdown:** The phrase "without contrast material(s), followed by contrast material(s) and further sections" in pre-2008 CTA codes led many auditors to claim that if the physician didn't perform imaging without contrast, coders had to append modifier 52 to the CTA code.

But the codes' original intent was to include non-contrast imaging when performed — not to require it.

The revision clarifies that you can report these CTA codes even without documentation of non-contrast imaging. This coding concept applies to multiple CTA codes, such as the following:

- 70496 — Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 70498 — Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 71275 — Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 72191 — Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 73706 — Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 74175 — Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing
- 75635 — Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing.

**Catch These Head and Neck MRI Coding Opportunities**

CPT®’s organization of radiology codes by anatomic regions is handily self-explanatory — until you come across imaging of an area that codes don't name explicitly or have two studies of the same area. Use this FAQ to keep your head and neck MRI coding on track.
1: Look to 70540-70543 for Brachial Plexus MRI

**Question:** What code should you report if you perform a brachial plexus MRI to the thyroid gland level to diagnose head and neck cancers?

**Answer:** You should choose the appropriate code from 70540-70543 (Magnetic resonance [e.g., proton] imaging, orbit, face and/or neck ...), according to the February 2001 ACR Bulletin.

The American College of Radiology (ACR) maintains that you should use 70540-70543 for orbit, face, and neck MRIs, but also “for reporting an MRI of the brachial plexus, when the study is performed to the level of the thyroid gland for diagnosing head and neck cancers.”

**Remember:** Medical specialty societies offer a wealth of invaluable technical knowledge, but don't forget their coding opinions are nonbinding. If CMS or the AMA offers guidelines, those trump nonbinding opinions may become the standards an insurance audit holds providers to.

Is 70540-70543 for Face Alone OK?

**Tip:** In 2007, CPT® changed the descriptors for 70540-70543 from "and" to "and/or."

**Reason:** The "and" inaccurately suggested that you had to image all of the sites — face, head, and neck — to report one of the codes, according to the AMA's CPT® Changes 2007. The "and/or" clarifies that you also may use the codes if the patient has imaging performed on just the face, just the orbits, or just the neck.

2: Count Brain and IAC MRIs as 1, Usually

**Question:** What is the appropriate way to bill MRI of the brain and IACs? If two studies are performed, is it appropriate to bill MRI of the brain two times?

**Answer:** You may report two brain MRIs (70551-70553, Magnetic resonance [e.g., proton] imaging, brain [including brain stem] ...) only if the physician performs and documents separate and distinct exams for the brain and IACs (internal auditory canals) with separate and distinct indications for each.

**Watch for:** You should not consider a few additional sequences of the IACs to be a separate exam. And even if you meet the separate-and-distinct requirements, your payer is unlikely to cover the second service. Some payers may suggest appending modifier 22 (Increased procedural services) if you take extra images — just remember that the extra work required and the extra scrutiny modifier 22 brings, may not be worth the trouble.

**Careful:** Some practices document the IAC scan separately and use orbit, face, and neck MRI codes 70540, 70542, and 70543 for the IAC. But you shouldn't use these codes for this service unless your payer instructs you in writing to do so.

**Reason:** Brain MRI codes 70551-70553 are appropriate for IACs because the inner ear and eighth nerve are part of the brain stem, according to the AMA 2003 coding symposium.

**Bonus tip:** The AMA cited the same reasoning for instructing you to report 70551-70553 (Magnetic resonance [eg, proton] imaging, brain [including brain stem]...) for pituitary studies.

3: Dig Into Codes for DTI

**Question:** Does CPT® offer codes other than 70551-70553 (Magnetic resonance [e.g., proton] imaging, brain [including brain stem] ...) for diffusion tensor imaging?

**Answer:** No. You should stick to 70551-70553 for diffusion tensor imaging (DTI), which evaluates the direction and amount of water diffusion within the body. The same holds true for two other special brain MRI techniques:

- **Diffusion weighted imaging (DWI),** which evaluates water diffusion within the body
- **Perfusion imaging,** including perfusion weighted imaging, which evaluates microscopic blood flow levels.

**Head Off MRA Blunders With This 70544-70546 Guide**
Medicare supplies you with a national coverage determination (NCD) for magnetic resonance angiography (MRA), but that doesn't mean coding these services is cut-and-dried. Make sure you're making the grade with this in-depth look at head MRA coding.

Don't Fall Prey to the 'With Contrast' Trap

CPT® lists the following head MRA codes:

- 70544 — Magnetic resonance angiography, head; without contrast material(s)
- 70545 — ... with contrast material(s)
- 70546 — ... without contrast material(s), followed by contrast material(s) and further sequences.

**Key:** Do not report 70544 with 70545 for head MRA without contrast followed by head MRA with contrast. Report only 70546 (*Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences*) for these services.

Be sure you use the latest contrast supply codes when your facility bears the cost of the contrast. For example, HCPCS 2008 deleted Q9952 (Injection, gadolinium-based magnetic resonance contrast agent, per ml) and created a new gadolinium code, A9579 (Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified [NOS], per ml), in the "Administrative, Miscellaneous and Investigational" section.

**Remember:** CPT® guidelines state that "with contrast" in a code descriptor means "contrast material administered intravascularly, intra-articularly, or intrathecally." You should not consider a study to be "with contrast" if the patient only receives oral and/or rectal contrast.

In other words, don't think that just because you report contrast code Q9954 (Oral magnetic resonance contrast agent, per 100 ml) you should report "with contrast" MRA code 70545. You can't count oral contrast as "with contrast," according to CPT®.

**Tip:** If HCPCS doesn't have a code for the contrast used, you should report A4641 (*Radiopharmaceutical, diagnostic, not otherwise classified*).

Check Out What the MRA NCD Reveals

The MRA NCD describes covered conditions but does not list covered ICD-9 codes. The NCD states:

All of the following criteria must apply in order for Medicare to provide coverage for MRA of the head and neck:

- MRA is used to evaluate the carotid arteries, the circle of Willis, the anterior, middle or posterior cerebral arteries, the vertebral or basilar arteries or the venous sinuses;
- MRA is performed on patients with conditions of the head and neck for which surgery is anticipated and may be found to be appropriate based on the MRA. These conditions include, but are not limited to, tumor, aneurysms, vascular malformations, vascular occlusion, or thrombosis. Within this broad category of disorders, medical necessity is the underlying determinant of the need for an MRA in specific diseases. The medical records should clearly justify and demonstrate the existence of medical necessity; and
- MRA and contrast angiography (CA) are not expected to be performed on the same patient for diagnostic purposes prior to the application of anticipated therapy. Only one of these tests will be covered routinely unless the physician can demonstrate the medical need to perform both tests.

**Crucial:** Diagnosis codes that payers cover for MRA may differ, but you should never choose a diagnosis code based on coverage. Stick to coding the diagnosis your physician's documentation supports.

**Check it out:** You can find the MRA NCD by searching the Medicare NCD database available at [www.cms.gov/mcd/search.asp](http://www.cms.gov/mcd/search.asp).

Payers may consider head MRA services (70544-70546) medically necessary for the following:

- Vascular dementia (290.40)
- Hemiplegia (342.90)
- Migraine (346.90)
- Trigeminal nerve disorders (350.9)
- Occlusion and stenosis
- Visual disturbances (368.9)
- Paralytic strabismus (378.50)
- Cerebral thrombosis or embolism (434.0x/434.1x)
- Fracture
- Subdural or extradural hemorrhage following injury (852.2x/852.4x)
- Arterial or venous injury (904.9)

Example: The physician documents a head MRA without/with contrast for a patient diagnosed with cerebral thrombosis, so you report 70546 and a code from the 434.0x range (Cerebral thrombosis ...).

Should You Switch Codes for Vein MRA?

When the radiologist interprets magnetic resonance venography of the brain, you should use the same codes you would use for magnetic resonance imaging of the brain arteries: 70544-70546.

Helpful: "Angiography" refers to imaging of the blood vessels. The term is not specific to only arteries or only veins. An "arteriogram" is artery imaging, and a "venogram" is vein imaging.

You'll find a general consensus that if the radiologist performs MRA of the veins and arteries at the same session, you should report only one brain MRA.

Key Concepts:

Use This MRI Example to Remember Order Rules

Here's What the 70554 and 70555 fMRI Rules Mean for You

CPT® guidelines lay down the law that you can't report 70555 "unless 96020 is performed." This section explains how you should apply this rule and when you're most likely to need these codes for your radiology claims.

The service: Functional magnetic resonance imaging (fMRI) measures the tiny metabolic changes that take place in an active part of the brain.

The codes: For fMRI, you need to know the following codes:

- 70554 — Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration
- 70555 — ... requiring physician or psychologist administration of entire neurofunctional testing
- 96020 — Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report.

See if 1 Claim Must Show 70555/96020

CPT® designed 70555 and 96020 to be used together but not necessarily on the same claim form. Code 96020 is the testing code, and 70555 is the actual imaging code. One physician could do one procedure, and another physician could do the other.

For example: Neurosurgeons and neurologists use functional brain mapping as a noninvasive way to help predict the potential for neurological problems that tumor growths, surgical interventions, or other factors might cause. Conducting the test helps the physician and patient make informed decisions concerning surgery or other appropriate treatments.

If a neurosurgeon performs the testing, but you're coding for the radiologist who performed the MRI, then you should report 70555 and the neurosurgeon should report 96020.
**Note:** You won't find technical component payment for 70555 or 96020 on the Medicare physician fee schedule. Providers rarely — if ever — perform these services in an office.

Physicians who perform the test in the office setting rather than a facility must negotiate with the carrier for reimbursement.

**Key Phrases Explain the 70554/96020 Ban**

Sometimes a technologist or physicist — instead of a physician or psychologist — performs the MRI and the testing. In that case, 70554 is appropriate. You should not report 70554 with 96020.

**Here’s why:** The codes conflict because of physician involvement. Code 70554’s descriptor states, "not requiring physician or psychologist administration," while 96020 states, "with test administered entirely by a physician or psychologist."

Also, the 70554 and 96020 services overlap. Both the testing methodology and the imaging are encompassed in 70554.

**Match fMRI With Proper Diagnosis**

Some payers are creating policies that explain when they find fMRI medically necessary.

For example, payers may look for the following conditions:

1. The fMRI is part of a preoperative evaluation for a planned craniotomy.
2. The fMRI is required to localize areas of the brain such as those responsible for speech, language, motor function, and senses, which a proposed surgery might put at risk.

**ICD-9:** Diagnoses you might see associated with functional brain mapping include the following:

- Arteriovenous malformations, 747.x (*Other congenital anomalies of circulatory system*)
- Epilepsy, 345.x (*Epilepsy and recurrent seizures*)
- Traumatic brain injury, 854.xx (*Intracranial injury of other and unspecified nature*)
- Parkinson’s disease, 332.x (*Parkinson's disease*)
- Schizophrenia, 295.xx (*Schizophrenic disorders*)
- Huntington's disease, 333.4 (*Huntington's chorea*)

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