CHCPP NEWS
COMMISSION ON
HEALTH CARE POLICY AND PRACTICE

Common Nuclear Medicine Coding Questions

The Commissions Coding and Reimbursement Committee, chaired by Kenneth McKusick, MD, is accepting SNM members questions on coding and reimbursement that pertain to nuclear medicine. All questions must be put in writing and submitted to Wendy Smith at SNM headquarters via fax (703-708-9015), mail or e-mail (wsmith@snm.org). The questions are circulated to Committee members and recommendations are usually available within 10 business days. Several of the most frequently asked coding questions are presented below.

ENDOCRINE

Q: Does 78007 (thyroid imaging, with uptake, multiple determinations) include 78001 (thyroid uptake, multiple determinations) and 78010 (thyroid imaging only)?

A: Yes, separating the two codes would be considered unbundling. The terminology of 78007 specifically states that is a procedure that entails multiple determinations of both uptake and imaging. 78007 does not differ from 78001 + 78010, except for total relative value units.

BONE

Q: Is the SPECT code an additional code/charge for bone scans, brain scans, tumor or abscess scans?

A: If a whole-body study is done (e.g., 78802) and reported, then a SPECT 78803 can be done on the same day. Billing is for the SPECT and the whole-body studies, for which the party will be paid 100% for the SPECT and 50% for the whole-body study. This applies to bone, abscess and tumor studies as well.

In addition, the SPECT study can be done on any area. There is no convenient way to code and bill for doing SPECT on several different areas, although we think that the -59 modifier, Distinct Procedural Service, should apply.

Q: My local Medicare carrier is denying coverage for CPT codes 76070 (computerized tomography, bone density study) and 76075 (dual-energy x-ray absorptiometry (DEXA) bone density study). How do I code for these procedures?

A: Bone densitometry studies should be coded in 1997 with the use of HCPCS codes (G codes) not CPT codes. G codes are used for Medicare and Medicaid billing purposes. The HCPCS code for peripheral bone densitometry is G0062 and central bone densitometry is G0063. DEXA is to be coded as G0063. This coding change went into effect on January 1, 1997 for Medicare patients. It has been reported that in many regions bone density studies are only reimbursed based on medical necessity. Always check with your local carrier medical director as policies may vary by region.

CARDIOVASCULAR

Q: For myocardial perfusion SPECT studies, can I use both 78478 (myocardial perfusion study with wall motion, qualitative or quantitative study) and 78480 (myocardial perfusion study with ejection fraction) in addition to primary 78465 (myocardial perfusion imaging; tomographic (SPECT), multiple studies, at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification), or can only one be used?

A: Yes, both the CPT codes 78478 and 78480 are "add-on" codes and may be used in conjunction with 78465, when performed. There is a general consensus that these codes should be used only if a ^{99m}Tc-labeled myocardial perfusion agent is being used for the study. The report for the study should clearly state that the two additional procedures were done, describe the findings and comment on the "impression" about the significance of the observations.

BRAIN

Q: How is brain death being coded if there is no separate code for it. Is it a cerebral perfusion study? What is the CPT code under which it is billed?

A: The correct code could be either 78601 (brain imaging, limited procedure, with vascular flow) or 78606 (brain imaging, complete study, with vascular flow). If a SPECT study is performed then use 78607 (brain imaging, complete study, tomographic).

RENAL

Q: What is the appropriate way to code for captopril renography studies when two separate renogram sets are actually obtained, one before and one after the administration of captopril?

A: Currently, there is no convenient way to code for these procedures. However, CPT 1998 will include several codes that are specifically designed for single and multiple renal studies with and without pharmaceutical intervention. Until that time, when performing only one renal study with captopril, we suggest using 78707 (kidney imaging, with vascular flow and function study) with the modifier -22. When performing renal studies with and without captopril on the same day, we suggest 78707-22 for the captopril study and 78707 with the new modifier -59 (distinct procedural service—different patient encounter or session) for the study without captopril.

Q: If a baseline renal study is done on Day 1 and given 78707 (kidney imaging, with vascular flow and function study) followed by an intervention study on second day given 78726 (kidney function study including pharmacologic intervention), why should the pre- and post-renal studies done on the same day be given CPT code 78726?

A: If renal studies are done on separate days, use 78707 both times. Codes 78725/78726 do not reflect the procedure by definition.

DRUGS AND RADIOPHARMACEUTICALS

Q: Are there any approved CPT codes for radiopharmaceuticals? Is pre-approval for reimbursement required?

A: The Health Care Financing Administration (HCFA) pays the reasonable costs for radiopharmaceuticals. There are no CPT codes for radiopharmaceuticals,

although some carriers (not HCFA) will recognize 78990 (provision of diagnostic radiopharmaceutical) and 79900 (provision of therapeutic radiopharmaceuticals). There are HCPCS level II codes (A and J codes) for some radiopharmaceuticals.

To our knowledge there is no preapproval for reimbursement for any radiopharmaceutical. However, you should contact your main insurance providers for clarification. In some instances preapproval may be necessary for therapeutic uses.

Q: How do you code for adenosine and/or dobutamine which are used to stress the heart during myocardial perfusion studies?

A: HCPCS level II codes are: J0150 for injection of adenosine, 6 mg and J1250 for injection of dobutamine hydrochloride, per 250 mg.

OTHER CODING QUESTIONS

Q: When performing tumor imaging with SPECT using sestamibi on any area such as the breast, could CPT code 78803 [radiopharmaceutical localization of tumor, tomographic (SPECT)] be used?

A: Code 78803 is correct.

Q: If a SPECT study is started and a planar study is also performed because of patient movement, do you bill for two CPT codes or just one?

A: You should code for the procedure that was completed and which you honestly can say was used for interpretation. To do otherwise may be considered fraud. The -53 modifier for discontinued procedure may also be applicable.

Q: Injection of gallium is typically 8-10 mCi. Patients typically have infection or tumor. The clinical standard is to inject and wait three days to take the nuclear medicine images. A certain percentage of these patients films cannot be completely interpreted because of GI activity preventing a clear interpretation. The patient is then brought back on Day 4 and/or Day 5 and additional radiology reports are generated. SPECT imaging may also be used. How can we best code for this activity? Can we bill the same gallium CPT code for reports generated on Days 4 or 5 because it required more time for physicians to interpret the additional images taken, or is it considered additional studies for which the physician reached the same outcome?

A: You should not charge again for each report generated from the same study. Occasionally delayed and/or additional images may require the patient to return more than the usual number of times to the facility. This could be compensated using the -22 modifier because additional work was performed. This is a gray area and billing of the procedure in this matter should be discussed with your local Medicare carrier.

The opinions referenced are those of members of the SNM Coding and Reimbursement Committee based on their coding experience and they are provided, without charge, as a service to the profession. They are based on the commonly used codes in nuclear medicine, which are not all inclusive. Always check with your local insurance carriers as policies vary by region. The final decision for coding of any procedure must be made by the physician considering regulations of insurance carriers and any local, state or federal laws that apply to the physician's practice. The SNM and its representatives disclaim any liability for claims arising from use of these opinions. Additional coding questions will be published in a future month of *Newsline*.

—Wendy J.M. Smith, MPH, is the associate director of health care policy

Coding for Right Ventricular Function

In response to numerous questions on coding for right ventricular ejection fraction by first-pass in combination with gated blood studies, the Coding and Reimbursement Committee has developed the following policy statement:

There currently is no separate CPT code for measurement of right ventricular function by the first-pass technique in combination with a gated cardiac function study. Relative value units for cardiac blood-pool imaging, first-pass (78481), and for cardiac blood-pool imaging, gated equilibrium (78472), are based on assessment of both left and right heart function. It is generally agreed that quantitative measurement of right ventricular function is more accurately measured using the first-pass technique, and that left ventricular function is assessed better using the gated equilibrium method.

Gated equilibrium cardiac blood-pool imaging can be done following a first-pass cardiac blood-pool study. There are clinical situations, such as pulmonary disease or right-sided heart failure in cardiomyopathy, in which an accurate quantitative measurement of global right ventricular function (ejection fraction) is requested in addition to measurement of global left ventricular function and overall assessment of regional wall function (movement). These requests are best fulfilled by performing both a first-pass right ventricular cardiac blood pool study followed by a gated equilibrium cardiac blood pool study.

The SNM Coding and Reimbursement Committee believes that the most appropriate way to code for these procedures when requested, is the following: 78472, 78481 with a -59 (-GB) modifier. The -59 modifier seems more appropriate than -51, multiple procedures, since the two cardiac CPT codes both pertain to the same organ system and have been specifically included in the correct coding initiative.

The New -59 Modifier

The -59 modifier, distinct procedural service, indicates a procedure or service that was distinct or separate from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site, separate lesion or separate injury. The secondary additional procedure, or lesser procedure, may be identified by adding modifier -59.

Indications for the need for doing both a right ventricular first pass and an equilibrium gated cardiac blood pool study should be reflected in the ICD-9 codes and/or the clinical background on the completed consultative report.