

**INGENIX®**

# Coding Companion for Radiology

*A comprehensive illustrated guide to coding and reimbursement*

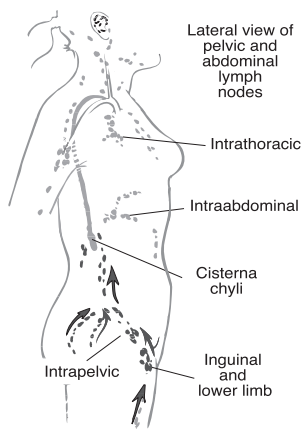
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# 75805-75807

**75805** Lymphangiography, pelvic/abdominal, unilateral, radiological supervision and interpretation

**75807** Lymphangiography, pelvic/abdominal, bilateral, radiological supervision and interpretation



A lymphangiography is performed on the pelvic or abdominal nodes. Report 75805 for one side only; report 75807 for both sides. Report for radiological supervision and interpretation

## Explanation

Vital blue dye is injected into the subcutaneous tissues for outlining of skin lymphatics. As soon as the lymphatic vessels are visualized by their blue color, the physician makes a small incision to gain access. The lymph vessel is cannulated with a needle and a fine catheter is attached. A small amount of dye is injected to ensure correct placement and the needle is advanced a few millimeters into the vessel. The needle and catheter are secured and dye is injected with a syringe. X-rays are made. Code 75805 reports the radiological supervision and interpretation for lymphangiography on one side only of the pelvic/abdominal region. Code 75807 reports the radiological supervision and interpretation for lymphangiography on both sides of the pelvic/abdominal region. Use a separately reportable code for the injection procedure.

## Coding Tips

Procedures 75805 and 75807 have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier. For a lymphatic injection procedure, see 38790. Contrast

media may be reported with A4641, Q9951, and Q9958–Q9967. Check with the specific payer to determine coverage.

## ICD-9-CM Procedural

- 87.08 Cervical lymphangiogram
- 88.04 Abdominal lymphangiogram

## Anesthesia

N/A

## ICD-9-CM Diagnostic

- 180.0 Malignant neoplasm of endocervix
- 180.1 Malignant neoplasm of exocervix
- 180.8 Malignant neoplasm of other specified sites of cervix
- 180.9 Malignant neoplasm of cervix uteri, unspecified site
- 186.0 Malignant neoplasm of undescended testis — (Use additional code to identify any functional activity)
- 186.9 Malignant neoplasm of other and unspecified testis — (Use additional code to identify any functional activity)
- 201.50 Hodgkin's disease, nodular sclerosis, unspecified site, extranodal and solid organ sites
- 201.60 Hodgkin's disease, mixed cellularity, unspecified site, extranodal and solid organ sites
- 201.70 Hodgkin's disease, lymphocytic depletion, unspecified site, extranodal and solid organ sites
- 785.6 Enlargement of lymph nodes

## Terms To Know

**catheter.** Flexible tube inserted into an area of the body for introducing or withdrawing fluid.

**contrast material.** Any internally administered substance that has a different opacity from soft tissue on radiography or computed tomograph; includes barium, used to opacify parts of the gastrointestinal tract; water-soluble iodinated compounds, used to opacify blood vessels or the genitourinary tract; may refer to air occurring naturally or introduced into the body; also, paramagnetic substances used in magnetic resonance imaging. Substances may also be documented as contrast agent or contrast medium.

**lymphatic system.** Lymph nodes, spleen, thymus gland, and bone marrow.

## supervision and interpretation.

Radiology services that usually contain an invasive component and are reported by the radiologist for supervision of the procedure and the personnel involved with performing the examination, reading the film, and preparing the written report.

## CCI Version 15.3

01916, 01924-01926, 36005, 76000-76001, 76350, 76942, 76998, 77002

Also not with 75805: 76810♦

Also not with 75807: 75805

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

## Medicare Edits

	Fac	Non-Fac	FUD	Assist
	RVU	RVU	FUD	Assist
<b>75805</b>	0.0	0.0	N/A	☒
<b>75807</b>	0.0	0.0	N/A	☒

**Medicare References:** 100-2,15,80; 100-4,3,10.4; 100-4,12,30; 100-4,13,10; 100-4,13,100

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## 10021-10022

**10021** Fine needle aspiration; without imaging guidance

**10022** with imaging guidance

### Explanation

Fine needle aspiration (FNA) is a percutaneous procedure that uses a fine gauge needle (22 or 25 gauge) and a syringe to sample fluid from a cyst or remove clusters of cells from a solid mass. First, the skin is cleansed. If a lump can be felt, the radiologist or surgeon guides a needle into the area by palpating the lump. If the lump is non-palpable, the FNA procedure is performed under image guidance using fluoroscopy, ultrasound, or computed tomography (CT), with the patient positioned according to the area of concern. In fluoroscopic guidance, intermittent fluoroscopy guides the advancement of the needle.

Ultrasonography-guided aspiration biopsy involves inserting an aspiration catheter needle device through the accessory channel port of the echoendoscope; the needle is placed into the area to be sampled under endoscopic ultrasonographic guidance. After the needle is placed into the region of the lesion, a vacuum is created and multiple in and out needle motions are performed. Several needle insertions are usually required to ensure that an adequate tissue sample is taken. CT image guidance allows computer-assisted targeting of the area to be sampled. At the completion of the procedure, the needle is withdrawn and a small bandage is placed over the area. Report 10021 if fine needle aspiration is performed without imaging guidance. Report 10022 if imaging guidance is used to assist in locating the lump.

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## 19030

**19030** Injection procedure only for mammary ductogram or galactogram

### Explanation

The physician performs an injection procedure for mammary ductogram or galactogram. A cannula or needle is inserted into the duct of the breast. Contrast media is introduced into the breast duct for the purpose of radiographic study. A dissecting microscope may be used to aid in placing the cannula. The needle or cannula is removed once the study has been completed.

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## 19102-19103

**19102** Biopsy of breast; percutaneous, needle core, using imaging guidance

**19103** percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance

### Explanation

The physician performs a breast biopsy with image guidance using a percutaneous needle core in 19102, and an automated vacuum assisted or rotating biopsy device, in 19103. In 19102, under

image guidance, the physician inserts a large gauge (e.g., 14 gauge), hollow core biopsy needle through the skin of the breast and into the suspicious breast tissue. The physician takes five or more cores of tissue to obtain a sufficient amount of tissue for diagnosis. In 19103, under image guidance, an automated vacuum assisted or rotating biopsy device is inserted through the skin into the suspicious breast tissue and a core of suspect tissue is removed for biopsy. The needle or automated vacuum assisted or rotating biopsy device is withdrawn. Pressure and bandages are applied to the puncture site.

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## 19290-19291

**19290** Preoperative placement of needle localization wire, breast;

**19291** each additional lesion (List separately in addition to code for primary procedure)

### Explanation

Placement of a needle localization wire into a breast lesion is performed to assist in operative identification of the suspect tissue. The physician punctures the skin overlying a breast mass and inserts a needle threaded with a guide wire. Using radiological guidance to facilitate placement, the physician inserts the wire into the mass. Sometimes dye is also injected into the suspect tissue. The wire will help identify a nonpalpable mass that is to be removed from the patient during a separate operative session. Report 19291 for each additional lesion localization wire placed.

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## 19295

**19295** Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)

### Explanation

The physician places a metallic clip prior to a breast biopsy or aspiration. Using image guidance, the physician places a metallic clip adjacent to a breast lesion to mark the site for a separately reportable breast biopsy or aspiration.

### Coding Tips

This code has been revised for 2010 in the official CPT description.

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## 19296-19297

**19296** Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy

**19297** concurrent with partial mastectomy (List separately in addition to code for primary procedure)

### Explanation

A remote afterloading balloon catheter for interstitial radiotherapy treatment is placed in the breast following partial mastectomy. Catheter placement is done at a later date, separate from the lumpectomy surgery in 19296, and concurrently with the lumpectomy in 19297. This is a single catheter with a balloon tip that holds the radioactive seed or treatment source, which is loaded and removed for each session. During the lumpectomy surgery, an uninflated balloon catheter is inserted into the recently created tumor cavity and positioned under imaging with a portion of the catheter remaining outside of the body. If a separate procedure is done after surgery, a small incision is first made and the uninflated balloon catheter is guided into position under imaging. After correct placement is determined, the balloon is inflated with saline to fit snugly into the lumpectomy cavity and the breast is bandaged. The catheter remains until radiotherapy treatment sessions are complete.

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## 19298

**19298** Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance

### Explanation

Using imaging guidance, at the time of a partial mastectomy, or subsequent to a partial mastectomy having been performed, remote afterloading catheters are placed into the breast for interstitial radiotherapy application. The lumpectomy site is identified. A template with pre-drilled holes that function as coordinates for catheter placement around the surgical area may be applied for imaging. Brachytherapy needles are first inserted into the chosen coordinates. The brachytherapy catheters are fed into position through the needles, which are then removed. A catheter button is positioned to hold each catheter in place and imaging confirms their position. These remain in place until the actual loading of the radioactive material for treatment. This code reports only the placement of the catheters.

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## 20220-20225

**20220** Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)

**20225** deep (eg, vertebral body, femur)

### Explanation

The physician usually performs a biopsy on bone to confirm a suspected growth, disease, or infection. The physician normally uses local anesthesia; however, general anesthesia may be used. The

# Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately \$29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

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## Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care

- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and