Radiologic Associates of Fredericksburg

Diagnostic & Interventional Radiology Coding In-service 2025

Presented By: *Senior Director of Coding & Compliance*

MBMS
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AGENDA

- New Telemedicine Codes
- New MR Safety Service Codes
- 2025 Diagnostic & Interventional Radiology CPT Updates
- Pend Trends/ Documentation
- Policy Updates/ Looking Ahead..

New Telemedicine CPT Codes

- 17 New Telemedicine CPT codes created for reporting of telehealth services.
- Telehealth services were previously reported with standard outpatient E&M codes when audio/ video visits were performed during the pandemic, however since that time the CPT committee decided that dedicated telehealth codes would be beneficial to both providers and payors.
- An entirely new section was created in Evaluation & Management for these new Telemedicine service codes.
- New telemedicine CPT codes are broken down into subsections with 8 synchronous audio-video CPT codes and 8 audio-only CPT codes. Separate codes created for new vs established patients.
- Audio only CPT codes 99441- 99443 and the Medicare brief check in HCPCS code G2012 have all been deleted and are no longer active as of January 1, 2025.

New Telemedicine CPT Codes Continued..

Synchronous audio-video visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination

New Patient			Established Patient		
98000	Straightforward medical decision making	**15 minutes must be met or exceeded**	98004	Straightforward medical decision making	**10 minutes must be met or exceeded**
98001	Low medical decision making	**30 minutes must be met or exceeded**	98005	Low medical decision making	**20 minutes must be met or exceeded**
98002	Moderate medical decision making	**45 minutes must be met or exceeded**	98006	Moderate medical decision making	**30 minutes must be met or exceeded**
98003	High medical decision making	**60 minutes must be met or exceeded**	98007	High medical decision making	**40 minutes must be met or exceeded**

New Telemedicine CPT Codes Continued..

Synchronous audio only visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination AND more than 10 minutes of medical discussion

New Patient			Established Patient		
98008	Straightforward medical decision making	**15 minutes must be met or exceeded**	98012	Straightforward medical decision making	**10 minutes must be met or exceeded**
98009	Low medical decision making	**30 minutes must be met or exceeded**	98013	Low medical decision making	**20 minutes must be met or exceeded**
98010	Moderate medical decision making	**45 minutes must be met or exceeded**	98014	Moderate medical decision making	**30 minutes must be met or exceeded**
98011	High medical decision making	**60 minutes must be met or exceeded**	98015	High medical decision making	**40 minutes must be met or exceeded**

New MR Safety Service Codes

New MR Safety Service Codes

- New section added to the 2025 CPT code manual for Magnetic Resonance (MR) Safety Implant/ Foreign Body procedures
- 6 New CPT codes to report these services
- They describe the work involved to safely administer MR exams to patients with implants, foreign bodies or devices.

New Codes for

- Implant or Foreign Body Evaluation
- Implant Positioning or Immobilization
- Safety Consultation
- Electronics Preparation

New MR Safety Service Codes Continued..

3 CPT Codes for Pre-Planning- Done prior to MR Exam

- **76014- MR safety implant and/or foreign body assessment by trained clinical staff**, including identification and verification of implant components from appropriate sources (eg, surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; **initial 15 minutes**
- **76015- MR safety implant and/or foreign body assessment by trained clinical staff**, including identification and verification of implant components from appropriate sources (eg, surgical reports, imaging reports, medical device databases, device vendors, review of prior imaging), analyzing current MR conditional status of individual components and systems, and consulting published professional guidance with written report; **each additional 30 minutes (List separately in addition to code for primary procedure)**
- **76016- MR safety determination by a physician or other qualified health care professional** responsible for the safety of the MR procedure, including review of implant MR conditions for indicated MR examination, analysis of risk vs clinical benefit of performing MR examination, and determination of MR equipment, accessory equipment, and expertise required to perform examination, with written report **0.60 RVUs**

New MR Safety Service Codes Continued..

3 CPT Codes for Services provided on date of MR Exam

- **76017- MR safety medical physics examination customization, planning and performance monitoring by medical physicist or MR safety expert**, with review and analysis by physician or other qualified health care professional to prioritize and select views and imaging sequences, to tailor MR acquisition specific to restrictive requirements or artifacts associated with MR conditional implants or to mitigate risk of non-conditional implants or foreign bodies, with written report **0.76 RVUs**
- **76018- MR safety implant electronics preparation under supervision of physician or other qualified health care professional**, including MR-specific programming of pulse generator and/or transmitter to verify device integrity, protection of device internal circuitry from MR electromagnetic fields, and protection of patient from risks of unintended stimulation or heating while in the MR room, with written report **0.75 RVUs**
- **76019- MR safety implant positioning and/or immobilization under supervision of physician or other qualified health care professional**, including application of physical protections to secure implanted medical device from MR-induced translational or vibrational forces, magnetically induced functional changes, and/or prevention of radiofrequency burns from inadvertent tissue contact while in the MR room, with written report **0.60 RVUs**

2025 Diagnostic & Interventional Radiology CPT Updates

Diagnostic Radiology CPT Code Updates

Transcranial Doppler New CPT Codes

- **93896**- Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)
- **93897**- Emboli detection without intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)
- **93898**- Venous-arterial shunt detection with intravenous microbubble injection performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure)

  - *These CPT codes will be reported in addition to a complete transcranial doppler exam of intracranial arteries, which is CPT code 93886. They are not reported when only a limited transcranial doppler exam is performed.*
  - *CPT code 93893 description has been revised to describe venous- arterial shunt detection.*

New add-on Codes for

- Vasoreactivity study
- Emboli detection without intravenous microbubble injection
- Venous-arterial shunt detection with intravenous microbubble injection

Interventional Radiology CPT Code Updates

MRI- Monitored Transurethral Ultrasound Ablation (TULSA)

- **51721**- Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed *Insertion
- **55881**- Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation *Ablation
- **55882**-Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed *Insertion & Ablation

- Codes include guidance to access tissue, monitor procedure and place device
- Utilizes robotically driven directional thermal ultrasound and closed loop temperature feedback control software
- Delivers predictable physician-prescribed ablation of prostate tissue for treatment of prostate cancer

Interventional Radiology CPT Code Updates

Percutaneous Radiofrequency Ablation of Thyroid Nodule

- **60660**- Ablation of 1 or more thyroid nodule(s), one lobe or the isthmus, percutaneous, including imaging guidance, radiofrequency
- **60661**- Ablation of 1 or more thyroid nodule(s), additional lobe, percutaneous, including imaging guidance, radiofrequency (List separately in addition to code for primary procedure)

60660

- Ablation of one or more thyroid nodules in one lobe or the isthmus percutaneously
- Includes Imaging Guidance
- Includes radiofrequency administration

60661

- Add on code
- Ablation of one or more thyroid nodules in an additional lobe percutaneously
- Includes Imaging Guidance
- Includes radiofrequency administration

0673T- Reported for laser ablation of benign thyroid nodule(s)

Interventional Radiology CPT Code Updates

MRI- Guided high intensity- Focused Ultrasound

- **61715**- Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation of target, intracranial, including stereotactic navigation and frame placement, when performed

Previously reported with category 3 code 0398T

Interventional Radiology CPT Code Updates

New Fascial Plane Block CPT Codes

- **64466**- Thoracic fascial plane block, unilateral; by injection(s), including imaging guidance, when performed
- **64467**- Thoracic fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed
- **64468**- Thoracic fascial plane block, bilateral; by injection(s), including imaging guidance, when performed
- **64469**- Thoracic fascial plane block, bilateral; by continuous infusion(s), including imaging guidance, when performed
- **64473**- Lower extremity fascial plane block, unilateral; by injection(s), including imaging guidance, when performed
- **64474**- Lower extremity fascial plane block, unilateral; by continuous infusion(s), including imaging guidance, when performed

Interventional Radiology CPT Code Updates

New Fascial Plane Block CPT Codes for Thoracic & Extremity Fascial Plane Blocks

- **New codes 64466- 64469 Identify blocks of the thorax and designate:**
  - ✓ Where injections are performed (thoracic)
  - ✓ Laterality (unilateral vs bilateral)
  - ✓ How anesthetic is administered (Injection bs continuous infusion)

- **New codes 64473- 64474 Allow reporting for lower extremities and designate:**
  - ✓ Where injections are performed (lower extremity)
  - ✓ How anesthetic is administered (Injection bs continuous infusion)

Pend Trends/ Documentation

Radiology Pend Trends

3D Not Documented

- These pends are specific to CTA exams that are lacking the required documentation of 3D angiographic reconstructions being performed.
- Performance of 3D angiographic reconstructions are required for CTA exams, this does not have to be done by the radiologist and usually done by the tech.
- If 3D reconstructions are not documented, it can not be coded as a CTA exam and would have to be coded/ billed out as a normal CT exam per coding guidelines.
- If templates for CTA exams are used, they should be reviewed and updated to include this documentation.

Acceptable 3D Techniques/ Verbiage

- 3D reconstruction of images
- 3D Post-processing of Images.
- Maximum intensity pixel (MIP) reconstructions
- Volume-rendered images created
- Surface Shading images created

Not Acceptable Techniques/ Verbiage

- 2D post-processing of images / 2D reconstructions
- Multiplanar Reconstructions
- Coronal, sagittal and/or oblique reconstructions

Radiology Pend Trends Continued..

Header & Technique Mismatches

- Use of Contrast- The use of contrast documented in technique/ body of report differs from the order/ header. With, without or with & without
- Pelvic Ultrasounds- order/ header will state transabdominal or transvaginal and the technique will state opposite or have both documented as being performed.

Views Clarification

- The number of views in order/ header is different than that documented in technique.
- If the order/hears are correct, I would remind the providers to update the number of views taken in technique to match the order/header. As well as ensuring they are documenting just the views taken and not the total number of images

These two categories remain with high pend volumes from previous year. If the order/header is incorrect & your technique is accurate, adding a note or statement stating order is incorrect will reduce the number of pends you will receive.

Transabdominal & Transvaginal Pelvic Ultrasounds

- If both US exams are performed, you can report both cpt codes together.
- It is recommended that each service should have a separate report or separate paragraph within a single report, documenting all required elements as applicable.
- When both are performed together, the transvaginal ultrasound is considered to be a specialized and problem focused exam and should be performed only when medically necessary.
- The radiologist should document reason as to why transvaginal ultrasound had to be done. Example: Transvaginal US done to better visualize the uterus.

Importance of Proper Dictation

- Accurate and complete documentation of services, dictated by the radiologist, is critical to maximal reimbursement and compliance with CMS regulations.
- A radiology report is a legal documentation of what was done.
- The final radiology report must support the services billed.
- Every portion of a radiology procedure must be clearly documented.
- Coders can not assume services were performed if not documented.

Tips for accurate dictation of Exams

- Exam techniques should allow correct code assignment by including all necessary elements, such as the modality (such as MRI, ultrasound, CT, X-ray), anatomical site, views/ sequences, and whether contrast was used.
- Complete documentation should be provided to support a complete exam, including all elements.
- Documentation should precisely state the number of views, not the number of images taken.
- Proof read report to help eliminate contradictory and/or confusing statements for both referring physicians and coders.
- Identify and provide statement regarding any wrong information in order/ header.

Diagnosis Information in Radiology Reports

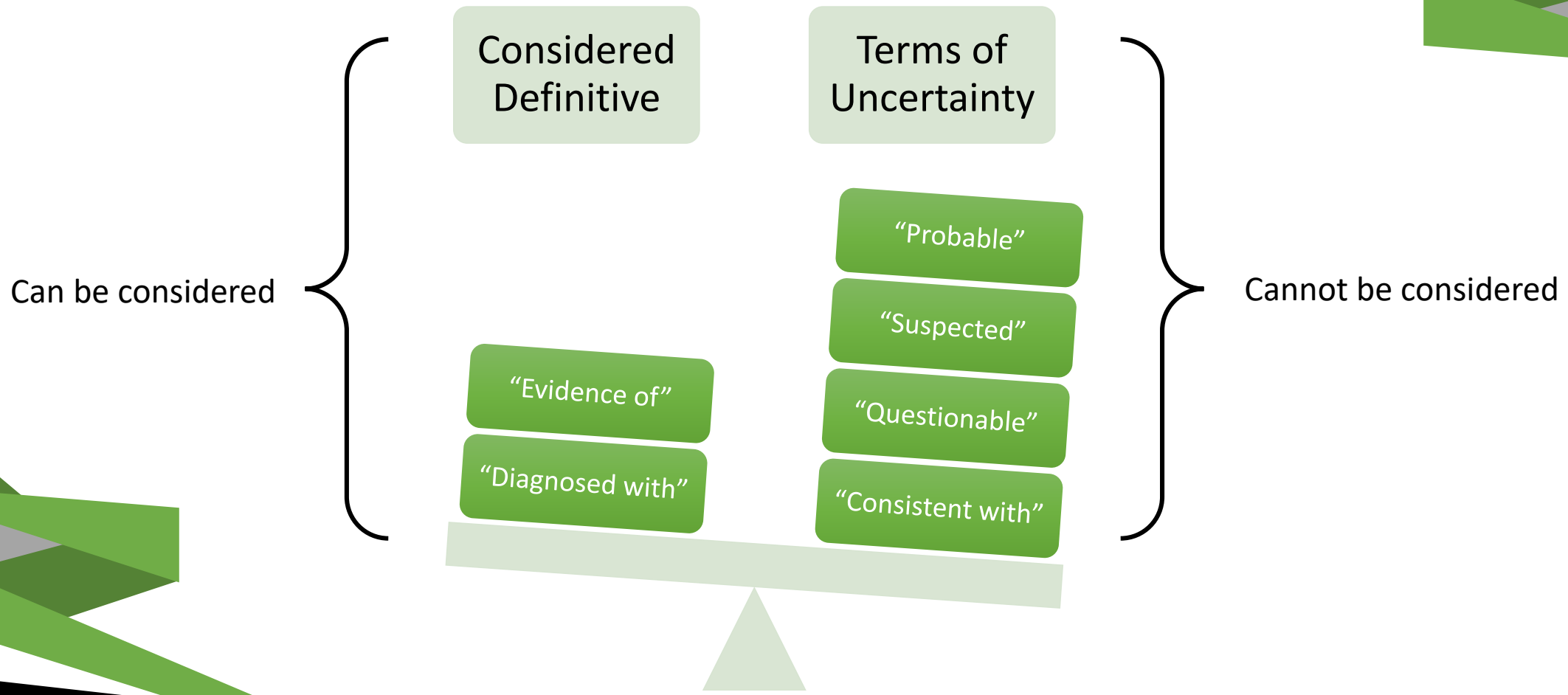
Patient Clinical History

- Signs/ Symptoms and/or reason for the radiology exam
- Chronic conditions and/or previously established diagnoses
- If a follow up exam, identify the conditions/ diagnosis being followed up on

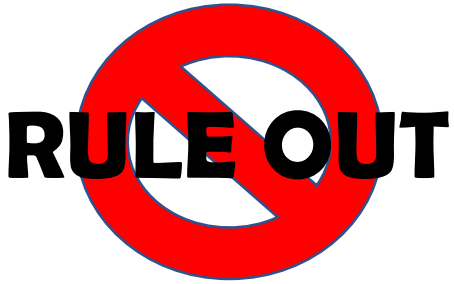
Impression/ Conclusion

- Should be listed in order of the severity as they relate to the reason for the exam
- Pertinent positive and negative findings
- Significant Incidental findings
- Diagnoses unrelated to the reason for th exam but may require further follow-up and/or treatment by the physician

Diagnosis Information in Radiology Reports



Diagnosis Information in Radiology Reports



- “Rule Out” indications provided can not be coded if exam does not find evidence of the condition.
- The coders would have nothing to use as diagnosis to submit on the claim, resulting in the charge being held for additional information to be found.
- The signs/ Symptoms that the patient is presenting with should be used in place of any “rule out” indications.

Policy Updates/ Looking Ahead..

Policy Updates/ Looking Ahead

- Insurance policies/ guidelines in regards to diagnosis coding is becoming very strict with what they will allow for payment.
- Major carriers such as Cigna & UHC, have come out with policies regarding all abdominal imaging and will no longer accept an unspecified diagnosis of Abdominal Pain, they now require a specific type of Abdominal pain in order to pay claims.
- It is expected that many other carriers that do not have set LCD policies will be adopting similar policies requiring specific diagnosis codes and denying any that are unspecified.
- Major carriers have also began releasing policies regarding laterality, requiring any claims billed have matching laterality details. It is important to make sure the diagnosis documented is specific to the side(s) of body being imaged.
- Expect more audits to be performed by insurances/ third parties, scrutinizing documentation and medical necessity of exams/ services.

Policy Updates/ Looking Ahead

Additional Interventional Radiology updates

- CPT code 75574 - Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)
  - ✓ Revised CPT code description to clarify that it can be reported for both arteries and veins for each additional vessel
- OIG will begin auditing Medicare payments for lower extremity peripheral vascular procedures in 2025.
  - ✓ Reviewing to determine compliance with CMS requirements and applicable treatment guidelines
  - ✓ Be sure that every part of procedure is documented and that any diagnostic angiograms being performed at the same time are medically necessary
  - ✓ Procedures improve blood flow for patients with PAD