Intraoperative Imaging Charge Capture

In recent years, hospital imaging departments have been prevented from reporting revenue for intraoperative imaging services on outpatient surgeries because many surgical CPT®s have been revised to include guidance and/or radiological supervision and interpretation. Since revenue is often used as a measure of productivity, the inability to separately report imaging interferes with the resource accounting and budgeting for the department's imaging services.

To account for resource consumption, the imaging department may choose one of three options:

1. Report a zero-dollar statistical charge code to track productivity; only the surgery department will report the revenue related to the case (OR time-based charge or hard-coded procedure charge); or

2. Transfer the labor expense of the radiology staff to the surgery department cost center for the time consumed in supporting OR/GI procedures; or

3. Create a time-based chargemaster procedure, such as "OR Imaging support", which applies a charge per 15 minutes of technician time. The time-based charge will generate revenue for the imaging department, but the added dollars should be applied to the same revenue code as the surgical procedure (usually 0360, 0361, or 0750). The radiology time-based charges can be combined with surgery time-based charges and reported together on one line of the claim with the HIM-assigned CPT®/HCPCS which represents both the surgical procedure and associated guidance.

The following example illustrates the third option. A CCI edit will prevent billing a guidance code with cholecystectomy HCPCS 47490 unless a modifier is appended to the guidance HCPCS:

PARA Data Editor - Demonstration Hospital [Sales] dbDemo Contact Support | Log Out

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx / Supplies | Filters | CDM | Calculator | Advisor | Admin | RAC | CAT | PARA

Report Selection | 2017 Hospital Based HCPCS/CPT® Codes Quarter: Q1 | CCI Edits OPPS (v23.0, Jan-Mar 2017) | 2017 CPT® Codes

CCI Edits OPPS (v23.0, Jan-Mar 2017)

Codes and/or Descriptions: **75989,76942,77002,77012,77021,47490**

Remove 'OK To Bill' Results | Export to PDF | Export to Excel | Copy to Clipboard

Column 1	Column 2	Edit Type	GB Modifier Indicator
75989 - RADIOLOGICAL GUIDANCE (IE, FLUOROSCOPY, ULTRASOUND, OR COMPUTED TOMOGRAPHY), FOR PERCUTANEOUS DRAINAGE (EG, ABSCESS, SPECIMEN COLLECTION), WITH PLACEMENT OF CATHETER, RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 2)	47490 - CHOLECYSTOSTOMY, PERCUTANEOUS, COMPLETE PROCEDURE, INCLUDING IMAGING GUIDANCE, CATHETER PLACEMENT, CHOLECYSTOGRAM WHEN PERFORMED, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 1)	Column 1/Column 2 Correct Coding	**1 - Code pair requires modifier to bill**
76942 - ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), IMAGING SUPERVISION AND INTERPRETATION (Column 2)	47490 - CHOLECYSTOSTOMY, PERCUTANEOUS, COMPLETE PROCEDURE, INCLUDING IMAGING GUIDANCE, CATHETER PLACEMENT, CHOLECYSTOGRAM WHEN PERFORMED, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 1)	Column 1/Column 2 Correct Coding	**1 - Code pair requires modifier to bill**
77002 - FLUOROSCOPIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) (Column 2)	47490 - CHOLECYSTOSTOMY, PERCUTANEOUS, COMPLETE PROCEDURE, INCLUDING IMAGING GUIDANCE, CATHETER PLACEMENT, CHOLECYSTOGRAM WHEN PERFORMED, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 1)	Column 1/Column 2 Correct Coding	**1 - Code pair requires modifier to bill**
77012 - COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 2)	47490 - CHOLECYSTOSTOMY, PERCUTANEOUS, COMPLETE PROCEDURE, INCLUDING IMAGING GUIDANCE, CATHETER PLACEMENT, CHOLECYSTOGRAM WHEN PERFORMED, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 1)	Column 1/Column 2 Correct Coding	**1 - Code pair requires modifier to bill**
77021 - MAGNETIC RESONANCE GUIDANCE FOR NEEDLE PLACEMENT (EG, FOR BIOPSY, NEEDLE ASPIRATION, INJECTION, OR PLACEMENT OF LOCALIZATION DEVICE) RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 2)	47490 - CHOLECYSTOSTOMY, PERCUTANEOUS, COMPLETE PROCEDURE, INCLUDING IMAGING GUIDANCE, CATHETER PLACEMENT, CHOLECYSTOGRAM WHEN PERFORMED, AND RADIOLOGICAL SUPERVISION AND INTERPRETATION (Column 1)	Column 1/Column 2 Correct Coding	**1 - Code pair requires modifier to bill**

Medicare's 2017 NCCI Edit manual explains that guidance should not be billed with the surgical procedure unless the guidance is for another procedure on the same date of service:

> CHAPTER VI - SURGERY: DIGESTIVE SYSTEM; CPT CODES 40000 - 49999
>
> 28. If the code descriptor for a HCPCS/CPT code, CPT Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a physician should not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code appropriate for that additional procedure may be reported separately with an NCCI-associated modifier if appropriate.

Instead of inappropriately charging an imaging procedure that will trigger a CCI edit, the radiology department could apply a charge per 15 minutes of technician time, which will roll up into the surgical procedure charge on the claim. Here's what the OR and radiology department charges could look like:

Department	Charge Code	Revenue Code	Description	HCPCS	Units	Unit Price	Charge
Surgery	3600123	0360	OR Level II - first 30 mins	(Assigned by HIM)	1	3,000.00	3,000.00
Surgery	3600124	0360	OR Level II - Ea Add'l 15 mins	(Assigned by HIM)	2	1,000.00	2,000.00
Radiology	3200125	0360	Rad Tech OR Support/15 min	(Assigned by HIM)	4	500.00	2,000.00
				Total Charge, Rev Code 0360:			**7,000.00**

The claim form rolls all revenue code 0360 lines into one line; HIM assigns the HCPCS according to the documentation of the surgical procedure:

Rev Code	Description	HCPCS	Units	DOS	Charge
0360	Operating Room	47490	1	2/14/2017	7,000.00

Note that the reporting option described above would suppress separate HCPCS for all imaging procedures, even when an imaging HCPCS may be permitted with certain surgical procedures. While the absence of a guidance code will not affect Medicare reimbursement under OPPS (for Acute or CAH hospitals), commercial and Medicaid reimbursement methodology should be evaluated to verify that payment will not be reduced due to the unreported guidance HCPCS.