Nuclear Medicine Coding 101
June 16, 2008
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Presented by:
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ASNC
Bracco Diagnostics
IBA Molecular
Molecular Insight
Triad Isotopes

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Coding 101 - The Basics

**Coding**
- CPT, HCPCS II, ICD-9, Rev code

**Coverage**
- ICD, LCD, NCD

**Payment**
- RBRVS, CF, HOPPS

Reimbursement
Coding Basic Steps

procedure

supply

diagnosis

ICD-9

Why

HCPCS

What

Hospital Revenue Code

Where

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# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>HOPPS</td>
<td>Hospital Outpatient Prospective Payment System</td>
</tr>
<tr>
<td>APC</td>
<td>Ambulatory Payment Classification</td>
</tr>
<tr>
<td>NUBC</td>
<td>National Uniform Billing Committee</td>
</tr>
<tr>
<td>AHA</td>
<td>American Hospital Association</td>
</tr>
<tr>
<td>RBRVS</td>
<td>Resource Based Relative Value Scale</td>
</tr>
<tr>
<td>PFS</td>
<td>Physician Fee Schedule</td>
</tr>
<tr>
<td>ICD-9</td>
<td>International Classification of Diseases 9th Revision Clinical Modification</td>
</tr>
<tr>
<td>NCHS</td>
<td>National Center for Health Statistics</td>
</tr>
<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
</tr>
</tbody>
</table>
Healthcare Common Procedure Coding System (HCPCS) Level I

Five Digit Numerical System
Developed and maintained by the American Medical Association (AMA) to describe medical procedures

Nuclear Medicine Section
78xxx series Diagnostic & 79xxx series Therapeutic

Organized by 9 Identified Systems primarily Organ Based
78300-78399 Musculoskeletal System
78400-78499 Cardiovascular
78X99 Unlisted procedure
New procedure numbers added to the CPT codebook are identified throughout the text with the symbol (red circle) placed before the code number.

In instances where a code revision has resulted in a substantially altered procedure descriptor, the symbol (blue triangle) is placed before the code number.

The symbols (Green) are used to indicate new and revised text other than the procedure descriptors.

The add-on code concept (black plus sign) in CPT 2008 applies only to add-on procedures or services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure "➕"
References to AMA Resources
CPT Changes, CPT Assistant & Clinical Examples in Radiology

The symbol (green circle arrow) refers to the CPT Assistant monthly newsletter and CPT Changes: An Insider's View, an annual book with all of the coding changes for the current year.

The symbol (red circle arrow) refers to the quarterly newsletter Clinical Examples in Radiology.
The CPT code set has been developed as stand-alone descriptions of medical procedures. However, some of the procedures in the CPT codebook are not printed in their entirety but refer back to a common portion of the procedure listed in a preceding entry. This is evident when an entry is followed by one or more indentations. This is done in an effort to conserve space.

- **CPT 78015** Thyroid CA metastases imaging limited area (e.g., neck and chest only)
- **CPT 78016** with additional studies (e.g., urine recovery)
- **CPT 78018** whole body
- + **CPT 78020** Thyroid CA mets uptake (List separately in addition to primary procedure)
  (Use 78020 in conjunction with 78018 only)
Add-ons are never reported alone; they must be reported with one of the primary codes listed in their CPT entry.

The service described in the add-on must be performed in the same session as the primary procedure and billed on the same claim.

Never use the 51 modifier on add-ons;
- Medicare won't take a 'multiple procedure' reduction off the fee because the cut is built into the add-on code.

Remember that all add-ons follow these rules, and they are marked with a plus sign in the CPT book.
Nuclear Medicine Add-On Codes

- **78020 Thyroid carcinoma metastases uptake** (List separately in addition to code for primary procedure 78018)
- **78478** Myocardial perfusion study with **wall motion**, qualitative or quantitative study (List separately in addition to code for primary procedure 78460, 78461, 78464, 78465)
- **78480** Myocardial perfusion study with **ejection fraction** (List separately in addition to code for primary procedure 78460, 78461, 78464, 78465)
- **78496** Cardiac blood pool imaging, gated equilibrium, single study, at rest, **with right ventricular ejection fraction** by first pass technique (List separately in addition to code for primary procedure 78472)
- **78730** Urinary bladder residual study (List separately in addition to code for primary procedure 78740)
Nomenclature

terminology: a system of words used to name things in a particular discipline

The selection of a word or phrase in CPT is carefully considered by the CPT Editorial Panel:

For example: *when or if performed*, means that the wording preceding this phrase is part of the procedure, however, if *not performed* would NOT preclude you from selecting that CPT code. If there is NO mention, the procedure must be performed to select that particular CPT code.
<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78460</td>
<td>Myocardial perfusion imaging; (planar) single study, at rest or stress (exercise and/or pharmacologic), with or without quantification</td>
</tr>
<tr>
<td>78461</td>
<td>Myocardial perfusion imaging; multiple studies, (planar) at rest and/or stress (exercise and/or pharmacologic), and redistribution and/or rest injection, with or without quantification</td>
</tr>
<tr>
<td>78464</td>
<td>Myocardial perfusion imaging; tomographic (SPECT), single study (including attenuation correction when performed), at rest or stress (exercise and/or pharmacologic), with or without quantification</td>
</tr>
<tr>
<td>78465</td>
<td>Myocardial perfusion imaging; tomographic (SPECT), multiple studies (including attenuation correction when performed), at rest and/or stress (exercise and/or pharmacologic) and redistribution and/or rest injection, with or without quantification</td>
</tr>
</tbody>
</table>
Nuclear Medicine has Unlisted CPT codes in each section 78X99.

CPT states, “Select the name of the procedure of service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code.”
Requests to Update the CPT Nomenclature

The effectiveness of the CPT nomenclature depends on constant updating to reflect changes in medical practice. This can only be accomplished through the interest and timely suggestions of practicing physicians, medical specialty societies, state medical associations, and other organizations and agencies. Accordingly, the AMA welcomes correspondence, inquiries, and suggestions concerning old and new procedures, as well as other matters such as codes and indices.

To submit a suggestion to add, delete, or revise procedures contained in the CPT codebook, please contact:
CPT Editorial Research & Development
American Medical Association
515 North State Street
Chicago, Illinois 60610

Coding change request forms are available at the AMA’s CPT Web site: www.ama-assn.org/ama/pub/category/3866.html.

All proposed changes of the CPT codebook will be considered by the CPT Editorial Panel with consultation of appropriate medical specialty societies.
# Myocardial Perfusion Imaging

**CPT 78460-78465**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78460</td>
<td>Myocardial Perfusion Planar - Single study</td>
</tr>
<tr>
<td>78461</td>
<td>Myocardial Perfusion Planar – Multiple studies</td>
</tr>
<tr>
<td>78464</td>
<td>Myocardial Perfusion SPECT – Single study</td>
</tr>
<tr>
<td>78465</td>
<td>Myocardial Perfusion SPECT – Multiple studies</td>
</tr>
</tbody>
</table>

### Key Word(s)

<table>
<thead>
<tr>
<th>Key Word(s)</th>
<th><strong>Important</strong> for Code Choice</th>
<th><strong>NOT</strong> part for Code Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planar vs SPECT</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Single Study vs Multiple Study</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Protocols; Rest/Stress, Stress/Rest, Dual Isotope, prone, Redistribution--- Multiple Day’s (general rule 7-10 days)</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

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**Question:**
Can we charge separately a single gated SPECT stress and later the next day, if needed, charge a single study SPECT resting procedure?

**Simple Answer: NO**

**Rational**

We call your attention to the words "Multiple Studies" and "Single Study". There is no distinction regarding performing MPI using a one or two day protocol.

When performing a stress study only (or resting only), then it would be appropriate to code and bill CPT® 78464 once.
Multiple Studies Cardiac Imaging
Two or More Studies are performed
(one single CPT Code)

- Stress Study
- Rest Study
- Redistribution Study

Often requires two doses (scout or QC dose is not coded separately)
No difference in coding for
Single day protocol versus Two day protocols

Note: Prone Imaging is not considered a separate study. Prone imaging can be obtained as part of any one of the three studies mentioned above.
Limited is one area

Multiple can be two or more Areas Imaged or Two or More DAYS – Be Careful

Whole body is head to toe (almost) for bone scan imaging and in CPT; for PET (CPT 78812) is the base of skull to mid thigh, for thyroid cancer head to below pelvis
Procedures performed over multiple days are typical in nuclear medicine and should NOT be coded for each individual day, read the code descriptions carefully.

SPOT or Delayed (on same or next day) imaging are part of the CPT procedure codes, additional coding is not appropriate.
## Bone Imaging

**CPT 78300-78320**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78300</td>
<td>Bone Imaging – Limited Area</td>
</tr>
<tr>
<td>78305</td>
<td>Bone Imaging – Multiple Area</td>
</tr>
<tr>
<td>78306</td>
<td>Bone Imaging – Whole Body</td>
</tr>
<tr>
<td>78315</td>
<td>Bone Imaging – Three Phase</td>
</tr>
<tr>
<td>78320</td>
<td>Bone Imaging – Tomographic SPECT</td>
</tr>
</tbody>
</table>

### Key Word(s)

<table>
<thead>
<tr>
<th>Planar vs SPECT vs Three Phase</th>
<th>Important for Code Choice</th>
<th>NOT part for Code Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Body vs Limited vs Multiple</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

**Protocols:** Spot Planar views are included in all types of Bone Imagine--- SPECT and Whole Body is acceptable code pair together

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Acceptable code pairs are Whole body and SPECT for Bones or Tumor codes

Not acceptable pairs are multiple spot (ie limited planar) and SPECT or with Whole body – Considered Unbundling

Spot or Delay Imaging is part of the base code for nuclear medicine and is not coded separately

Triple Phase (flow, BP, Delay) and other codes (ie SPECT) modifiers may work for rare situations but sites should choose to bill only one, the triple phase, or SPECT.
Multiple Studies Other
Two or More Studies are performed
(one single CPT Code)

- Lung Ventilation
- Lung Perfusion
- Kidney with Drug
- Kidney without Drug

Requires two doses
No difference in coding for
Single day protocol versus Two day protocols

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### Correct Coding Initiatives (CCI)

<table>
<thead>
<tr>
<th>Mutually Exclusive Codes</th>
<th>Comprehensive and Component Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes that would not or could not be done at same session</td>
<td>Combinations bundled into single code</td>
</tr>
</tbody>
</table>

**Example:**

<table>
<thead>
<tr>
<th>CPT 78465 &amp; 78473</th>
<th>MPI</th>
<th>GBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT 78464 &amp; 78465</td>
<td>sgl</td>
<td>multi</td>
</tr>
</tbody>
</table>

**Column 1/Column 2 Modifiers (0) and (1)**

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In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs.

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.
Medically Unlikely Edits (MUE)

Appeals process will not be allowed or required, providers should resubmit corrected claims.

Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

The first set implemented on January 1, 2007 established anatomical considerations addressing approximately 2,800 codes.
Specific guidelines are presented at the beginning of each of the sections. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section.
**Question:**
Is the stress test included as part of the nuclear cardiology MPI CPT code(s)?

**Simple Answer:** NO

**Rational**  
**Cardiovascular System (78414-78499)**

Myocardial perfusion and cardiac blood pool imaging studies may be performed at rest and/or during stress. When performed during exercise and/or pharmacologic stress, the appropriate stress testing code from the 93015 93016 93017 -93018 series **should be reported in addition to code(s)** 78460 78461 78464 -78465, 78472, 78473, 78478, 78480, 78481, 78483, 78491, and 78492.
# Stress Test Codes

CPT 93015-93018

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>93015 †</td>
<td>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; <strong>with physician supervision, with interpretation and report</strong></td>
</tr>
<tr>
<td>93016 †</td>
<td>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; <strong>physician supervision only, without</strong> interpretation and report</td>
</tr>
<tr>
<td>93017 †</td>
<td>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; <strong>tracing only, without interpretation and report</strong></td>
</tr>
<tr>
<td>93018 †</td>
<td>Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; <strong>interpretation and report only</strong></td>
</tr>
</tbody>
</table>

† Not subject to TC or 26 modifier

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Nuclear Medicine Introduction:
“The services listed do not include the radiopharmaceutical or drug. Diagnostic and therapeutic radiopharmaceuticals and drugs supplied by the physician should be reported separately using the appropriate supply code(s), in addition to the procedure code.”

Providers use HCPCS LEVEL II supply codes for drugs & radiopharmaceuticals with nuclear medicine procedures
Radiopharmaceutical Coding

- Every NM Procedure needs at least one
- Are billed separately from the Procedure
- Are coded using HCPCS LEVEL II codes
Single Alpha Four Digit Numerical Coding System
Developed and maintained by the Centers for Medicare and Medicaid Services (CMS) to describe medical Drugs, Radiopharmaceuticals, Contrast Agents, Supplies and Procedures
Radiopharmaceutical (RP) HCPCS Level II Description Format

<table>
<thead>
<tr>
<th>Element</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>All RPs are AXXXX Codes</td>
<td>RP and/or radioelement with or without compound and with form if necessary i.e capsule(s)/solution/aerosol</td>
<td>Diagnostic or Therapeutic</td>
<td>Billing unit, per study dose, per treatment dose, per millicurie (mCi), per microcurie (uCi)</td>
<td>If description, per study dose an “up to” amount is listed for most RPs</td>
</tr>
<tr>
<td>Example: A9503</td>
<td>Technetium Tc-99m medronate</td>
<td>diagnostic (dx)</td>
<td>per study dose</td>
<td>up to 30 millicuries</td>
</tr>
</tbody>
</table>
# Myocardial Perfusion Imaging (MPI) Radiopharmaceuticals

<table>
<thead>
<tr>
<th>HCPCS Level II</th>
<th>Trade Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9500</td>
<td>Cardiolite®</td>
<td>Technetium Tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries</td>
</tr>
<tr>
<td>A9502</td>
<td>Myoview®</td>
<td>Technetium Tc-99m tetrofosmin, diagnostic, per study dose, up to 40 millicuries</td>
</tr>
<tr>
<td>A9505</td>
<td>Generic</td>
<td>Thallium TI-201 thallous chloride, diagnostic, per millicurie</td>
</tr>
</tbody>
</table>

Caution w/ units, thallium round up to highest full mCi administered. Single study one (1) per study dose, multiple studies two (2) doses of Tc labeled or PET MPI Agents.
# Pharmacological Stress Agents

<table>
<thead>
<tr>
<th>HCPCS Level II</th>
<th>Description</th>
</tr>
</thead>
</table>
| J0152          | Inj, Adenosine per 30 mg  
(do not use J0150 adenosine per 6 mg for ED use)  
(90 mg vial and 60 mg vial) |
| J1245          | Inj, Dipyridamole per 10 mg |
| J1250          | Inj, Dobutamine HCL/250 mg |
| J3490 C9399    | Unclassified drugs  
(eg regadenoson trade name Lexiscan)  
(use one unit, in box 19 drug details) C9399 is used by Hospitals only |
| JW             | Drug amount discarded/not administered to any patient |

NDC for Lexiscan is 0469-6501-89
### Other Drugs

<table>
<thead>
<tr>
<th>HCPCS Level II</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0280</td>
<td>Inj, Aminophyllin up to 250 mg</td>
</tr>
<tr>
<td>J0460</td>
<td>Inj, Atropine sulfate, up to 0.3 mc</td>
</tr>
<tr>
<td>J1160</td>
<td>Inj, Digoxin, up to 0.5 mg</td>
</tr>
<tr>
<td>J1265</td>
<td>Inj, dopamine HCL, 40 mg</td>
</tr>
<tr>
<td>J1800</td>
<td>Inj, Propranolol HCL, up to 1 mg</td>
</tr>
</tbody>
</table>

Document waste, round up.
Drugs Used in Nuclear Medicine Procedures are Coded Separately, if administered

With or without Pharmacological Intervention

- **Stress Agents for Cardiac Stress Tests**
  - Adenosine, Dipyridamole, Dobutamine

- **Hepatobiliary Imaging**
  - Morphine, Kinevac, CCK, Sincalide

- **Kidney or Brain Imaging**
  - Ace Inhibitors, Digoxin, Lanoxin, Diamox
## Medicare Non-Covered PET Procedures

<table>
<thead>
<tr>
<th>HCPCS Level II</th>
<th>Description</th>
</tr>
</thead>
</table>
| G0219          | PET imaging whole body; *melanoma for non-covered indications*  
*Initial staging regional lymph nodes* |
| G0235          | PET imaging, any site, *not otherwise specified* |
| G0252          | PET imaging, full and partial-ring PET scanners only, for *initial diagnosis of breast cancer* and/or *surgical planning for breast cancer* (e.g. initial staging of axillary lymph nodes) |

For PET codes that do not currently correspond to any Medicare covered conditions, providers may choose to obtain a signed ABN from the patient.
Modifiers –
Two Digit Letter or Number

A modifier provides the means to report or indicate that a service or procedure that has been performed has been *altered by some specific circumstance but not changed in its definition or code*. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities.

Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure had both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure was increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.
## CPT Modifiers

<table>
<thead>
<tr>
<th>COMMON</th>
<th>OTHERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 26 Professional</td>
<td>• - 51 Multiple procedures</td>
</tr>
<tr>
<td>• TC Technical</td>
<td>• - 59 Separate procedure</td>
</tr>
<tr>
<td>• <strong>JW Discarded Drugs</strong></td>
<td>• - <strong>22 Increased service</strong></td>
</tr>
<tr>
<td>(See CR 5520 Transmittal 1248 Implemented July 2, 2007)</td>
<td>• - <strong>52 Reduced service</strong></td>
</tr>
<tr>
<td></td>
<td>• - <strong>77 Repeat Procedure by another physician</strong></td>
</tr>
</tbody>
</table>
Modifier 59

Use when PET or PET/CT and Diagnostic CT are both performed on same patient, same day (SDOS)

Per CPT Append

Modifier 59 to the CT codes
Patient does not show up for scheduled procedure and you are left with cost of radiopharmaceutical

- Medicare states that if services are not rendered then you cannot bill. It is the facility choice to decide to bill patient directly, similar to the dentist.

- CMS Instructions for Charges for Missed Appointments
  - Tab 8 See Transmittal 1279 CR5613

Patient shows up, has radiopharmaceutical and for some reason does not return; or patient gets ill, or claustrophobic, etc

- Bill for procedure with Modifier 52 (reduced service) or Modifier 53 (discontinued service).
- In some locations payer systems can not accommodate modifier 52 and payer may instruct you to code for radiopharmaceutical plus appropriate administration code.
What about using injection and other administration codes?

- Resources INCLUDED in most NM procedures
- Exceptions: CSF, sentinel node (lymphoscintigraphy w/o scintigraphy) peritoneal shunts, intra-arterial therapy
# Hospital Revenue Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0254</td>
<td>Drugs Incident to Other Diagnostic Tests</td>
</tr>
<tr>
<td>0255</td>
<td>Drugs Incident to Radiology</td>
</tr>
<tr>
<td>0340</td>
<td>Nuclear Medicine - General</td>
</tr>
<tr>
<td>0341</td>
<td>Nuclear Medicine - Diagnostic procedure</td>
</tr>
<tr>
<td>0342</td>
<td>Nuclear Medicine - Therapeutic procedure</td>
</tr>
<tr>
<td>343</td>
<td>Nuclear Medicine - Diagnostic RadioPharm Established Oct 1, 2004</td>
</tr>
<tr>
<td>344</td>
<td>Nuclear Medicine - Therapeutic RadioPharm Established Oct 1, 2004</td>
</tr>
<tr>
<td>0349</td>
<td>Nuclear Medicine - Other</td>
</tr>
<tr>
<td>0350</td>
<td>CT Scan - General</td>
</tr>
<tr>
<td>0352</td>
<td>CT Body Scan</td>
</tr>
<tr>
<td>0404</td>
<td>Other Imaging Services - (PET)</td>
</tr>
<tr>
<td>0480</td>
<td>General Cardiology</td>
</tr>
<tr>
<td>0482</td>
<td>Stress Test</td>
</tr>
<tr>
<td>0636</td>
<td>Drugs requiring detailed coding</td>
</tr>
</tbody>
</table>

Charges for drugs and biologicals *(with the exception of radiopharmaceuticals, which are reported under Revenue Codes 0343 and 0344)* requiring specific identification as required by the payer.

*Intermediary Manual, Part 3, Claims Processing, Transmittal 1875 Feb 7, 2003*

Note: Choice of specific revenue code is up to the hospital. For revenue codes, coding to the highest level of specificity is NOT required.
### AHA – Hospital Revenue Codes

**034X  Nuclear Medicine**

Charges for procedures, tests and RPs provided by a department handling radioactive materials as required for diagnosis and treatment.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0341</td>
<td>Diagnostic Procedures</td>
</tr>
<tr>
<td>0342</td>
<td>Therapeutic Procedures</td>
</tr>
<tr>
<td>0343</td>
<td>Diagnostic Radiopharmaceuticals</td>
</tr>
<tr>
<td>0344</td>
<td>Therapeutic Radiopharmaceuticals</td>
</tr>
</tbody>
</table>

**0636  Drugs requiring detailed coding**

Charges for drugs and biologicals (other than RPs) requiring specific identification as required by the payer.

Note: Choice of specific revenue code is up to the hospital. For revenue codes, coding to the highest level of specificity is NOT required.
Universal diagnosis codes used by all medical specialties used to describe current problem as well as past history

Organized by disease state

Used by gov’t to track trends
• **REASON** for the procedure

• Code to highest level of **SPECIFICITY** and degree of certainty

• **MATCH** ICD-9 code to each CPT code
• How Patient Presented
• Related to Definitive Diagnosis
• Signs or Symptoms may be used

New Guidelines Effective October 1, 2007
# Authoritative Documents & Implementation Dates

<table>
<thead>
<tr>
<th>Publication: Codes &amp; Systems</th>
<th>Who Owns?</th>
<th>Where Can I Find?</th>
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| **CPT Category I Codes**     | AMA      | Published Books/CDs for purchase through the AMA and other publishers | Annually  
**Available** October/November  
Effective **January 1st** |
| **CPT Category III Codes**   | AMA      | Published Books/CDs for purchase through the AMA and other publishers & on AMA web site for July 1st implementation | Twice Yearly  
**Available** with above annual printed CPT book, electronic version on AMA web site release January 1st for July 1st implementation  
Effective **January 1st and July 1st** |
| **HCPCS Level II Codes**     | CMS      | Public information available on the CMS web site  
Additionally, published Books/CDs for purchase through AMA and other publishers annually. | Annually (with exceptions below)  
**Available** October/November  
Effective **January 1st**  
C, Q and G codes may change quarterly |
| **ICD-9 CM Codes & Coding Clinic ICD-9-CM** | DHHS/NCHS, CMS & AHA | Public information available on the CMS & CDC web site  
Additionally, published Books/CDs for purchase through AMA and other publishers annually. | Twice Yearly  
**Available** (1) to (2) months prior to effective date  
Effective **April 1st & October 1st**  
April 1st new with MMA 2003 |
| **Revenue Codes (Hospital)** | NUBC AHA | [www.nubc.org/become.html](http://www.nubc.org/become.html) | Annual printed version with online subscription quarterly |
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