



**INSIDE THIS ISSUE:**

*Extremity Venous Studies (Including Digits)* 1

*3D Rendering and Documentation* 1

## EXTREMITY VENOUS STUDIES (INCLUDING DIGITS)

In order to report complete studies, ACR has defined the requirement for coding ultrasound of the extremity veins.

ACR has defined CPT code 93970 to be used for bilateral venous duplex scanning. In the lower extremity this includes the common femoral, superficial femoral, proximal deep

femoral, greater saphenous and popliteal veins. Calf veins may also be evaluated. In the upper extremity the evaluation includes the subclavian, jugular, axillary, brachial, basilica and cephalic veins. Forearm veins may also be evaluated.

CPT code 93971 is defined as used for limited

bilateral or unilateral venous duplex evaluation, or follow-up studies that are otherwise not complete bilateral studies. Venous mapping of the extremities (other than for dialysis access planning) or ultrasound without Doppler evaluation is also included in this code. ♦

## 3D RENDERING AND DOCUMENTATION

CMS Medicare has determined MRCP is 74181-74183 and would not assume 3D was done if it isn't documented in the report and the order from the referring physician does not specifically state the request.

In response to the many questions posted on the RBMA web site regarding CT

vs. CTA coding, the following information will be published in an upcoming issue of the *AMA/ACR Clinical Examples in Radiology* and *ACR Radiology Coding Source*.

Prior to 2006, 2D reconstructions and 3D renderings were coded using the old 76375 reconstruction code. At that time, the ACR is-

sued advice that CTA required "angiographic reconstruction" imaging, and was comfortable with that being either 2D or 3D. With the deletion of code 76375 and the introduction of codes 76376 and 76377 in January 2006, and because of the advances in technology, the ACR raised the bar for CTA,

*(Continued on page 2)*



## 3D RENDERING AND DOCUMENTATION

*(Continued from page 1)*

and gradually redefined “angiographic reconstruction” as requiring 3D (which has since been defined in ACR publications).

The CPT codes for CTA procedures have always required angiographic reconstruction imaging. Since “angiographic reconstruction” has not been explicitly previously defined in CPT, the ACR has interpreted this to parallel CPT definitions of the independent reconstruction code. Previously, the now deleted CPT code 76375 could be used for 2D and/or 3D reconstruction imaging, and that was used as

the basis of the definition of angiographic reconstruction imaging. Since CPT codes 76376 and 76377 have been introduced, and have restricted the reporting of reconstruction imaging to 3D, such 3D imaging now serves as the basis of defining angiographic reconstruction imaging. Typically, for CTA, this includes maximum intensity pixel (MIP) reconstruction or shaded surface rendering imaging. Simple multi-planar reconstruction imaging is clearly 2D and bundled into the base procedure code, and no longer qualifies as angiographic reconstruction for CPT coding purposes.

It is the consensus of the Economics Committee on Coding & Nomenclature that it is necessary to have a permanent archive of 3D images acquired on a CTA study. The axial data set from which 3D images are created is insufficient for the reporting of a CTA study. When reformatted images are acquired and interpreted in addition to the CT axial images, the reformatted images are a part of the study and should be permanently archived. Just as it is required that a permanent hardcopy image be maintained for a plain film study, permanent CTA reformatted images should be permanently archived. ♦