

# Medicare Reimbursement For 3D Rendering<sup>1</sup>

This advisory discusses Medicare coding, coverage and payment for three-dimensional (3D) rendering procedures performed in the hospital inpatient, hospital outpatient department, independent diagnostic testing facility (IDTF) and physician office settings.<sup>2,3</sup> While it focuses on Medicare program policies, these policies also may be applicable to selected private payers throughout the country.

## Coding

Medicare's reimbursement system relies mostly on Current Procedural Terminology (CPT) codes to consistently identify diagnostic imaging procedures provided to Medicare patients.<sup>4</sup> The CPT coding system was developed and is maintained by the American Medical Association (AMA) and the codes are updated annually.

For many procedures, the review of images in alternative display formats is contemplated in the definition of the CPT code for the imaging procedure being performed, regardless of the imaging modality. However, for selected imaging procedures, the CPT coding system provides for separate coding for image reformatting when such reformatting entails complex 3D rendering of the original image.

The AMA indicates the CPT codes listed in Table 1 should be reported when 3D rendering is performed. These codes are to be reported in conjunction with the code(s) for the base imaging procedure(s).<sup>5</sup>

Codes for 3D rendering services differentiate between those studies in which reformatting is performed on the acquisition scanner (CPT 76376) and those performed on an independent workstation (CPT 76377).<sup>6</sup> The American College of Radiology (ACR) and the AMA have provided documentation to clarify the codes, as follows: *Both of the 3D codes require concurrent physician supervision of image post-processing, 3D manipulation of volumetric data set and image rendering.*<sup>7</sup> *For the 3D reconstructions not requiring image post-processing on an independent workstation, the physician will discuss with the technologist the need for 3D imaging and supervise the technologist in creating 3D images. For studies performed on an independent workstation, the physician will supervise and/or create the 3D reconstructions and adjust the projection to optimize visualization of anatomy or pathology.*<sup>8</sup> *The 3D rendering codes are intended to address complex renderings such as shaded surface rendering, volumetric rendering, maximum intensity projections (MIPs), fusion of images from other modalities, and quantitative analysis (segmental volumes and surgical planning).*<sup>9</sup>



According to the ACR, it is not appropriate to report the 3D rendering codes with certain selected procedures since these procedures already contemplate the review of images in alternative display formats. Specifically, in *CPT® 2009*, immediately under the listing of the 3D rendering codes descriptions, the AMA provides a list of codes that should not be reported in conjunction with these 3D rendering codes (see Table 1). In addition, effective with the introduction of the 3D rendering codes, **all 2D reconstructions (reformatting) will be considered part of the base procedure code and should not be reported separately.**<sup>10</sup>

The ACR also indicates the 3D codes should not be used when 3D is not medically necessary. When providing 3D rendering services, particularly in the outpatient setting, a specific order is especially helpful to justify medical necessity. In addition, the ACR states the reformatting study should be documented in a separate report or in a separate section of the radiologist's report.<sup>11</sup>

When submitting claims to Medicare, procedural CPT codes are reported with diagnosis codes describing the patient's documented medical conditions. These diagnoses are reported using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

## Reimbursement

Medicare reimbursement for diagnostic imaging procedures is comprised of a **professional component**, the amount paid for the physician's interpretation and report, and a **technical component**, the amount paid for all other services (including staffing and equipment costs). When combined and paid to the same individual or entity, this amount is often referred to as the **total** or **global reimbursement**.

Currently, Medicare reimburses 3D rendering differently based on the site of care. In a **hospital inpatient** site of care, the technical (facility) component is subsumed within the payment to the hospital that is determined based on the Diagnosis Related Group (DRG) to which the patient is assigned. In a **hospital outpatient department**, the technical component payment is packaged into the technical payment for the primary procedure which is reimbursed under an Ambulatory Payment Classification (APC) under Medicare's hospital outpatient prospective payment system (HOPPS). The technical component of 3D rendering performed in an **IDTF or physician office** is reimbursed under the Medicare physician fee schedule. The professional component is reimbursed under the Medicare physician fee schedule regardless of the setting.

Refer to Table 1 for a summary of Medicare national payment amounts for 3D rendering when it is performed in the hospital inpatient, hospital outpatient department, IDTF and physician office settings.

**Table 1: 2009 Medicare Reimbursements for 3D Rendering Procedures**  
 (Reflects National Rates, Unadjusted for Locality)

CPT/HCPCS Code	Medicare Reimbursement Component	Hospital Inpatient Department <sup>12</sup>	Hospital Outpatient Department <sup>13</sup>	IDTF or Physician Office <sup>14,15</sup>
<b>CPT 76376</b> 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation [Use 76376 in conjunction with code(s) for base imaging procedure(s)] [Do not report 76376 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75635, 75557-75564, 76377, 78000-78999, 0066T, 0067T, 0144T0151T, 0159T]	Technical	Included in MS-DRG	Packaged in APC	\$69.25
	Professional	\$10.82	\$10.82	\$10.82
	Total	MS-DRG + \$10.82	APC + \$10.82	\$80.07
<b>CPT 76377</b> 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation [Use 76376 in conjunction with code(s) for base imaging procedure(s)] [Do not report 76377 in conjunction with 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75635, 75557-75564, 76377, 78000-78999, 0066T, 0067T, 0144T0151T, 0159T]	Technical	Included in MS-DRG	Packaged in APC	\$72.13
	Professional	\$41.84	\$41.84	\$41.84
	Total	MS-DRG + \$41.84	APC + \$41.84	\$113.97

\* Technical is the facility payment

\*\*Professional is the physician payment

## Coverage

Currently, Medicare does not have a national coverage policy that addresses the application of image reformatting procedures in general.<sup>16</sup> Coverage of these procedures is at the discretion of local Medicare contractors who process claims on behalf of the Medicare program. To the extent image reformatting is part of a base imaging procedure; providers should ascertain coverage for the imaging procedure itself, in addition to coverage for reformatting.

To confirm coverage, consult with your local Medicare contractor. If you are unfamiliar with your local Medicare contractor, a local Medicare contractor directory can be found at: [http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02\\_ICdirectory.pdf](http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf). With respect to private payers, some may rely on Medicare reimbursement policies, while others consider alternative information. Therefore, it is important to consult with individual private payers regarding coverage for this procedure as well.

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<sup>1</sup> Information presented in this document is current as of January 1, 2009. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

<sup>2</sup> The Food and Drug Administration (FDA) approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this customer advisory. Some payers may in some instances treat a procedure which is not specifically covered by the equipment's FDA-approved labeling as a non-covered service.

<sup>3</sup> The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

<sup>4</sup> CPT codes and descriptions only are copyright © 2007 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

<sup>5</sup> CPT Changes 2006 - An Insider's View.

<sup>6</sup> CPT Changes 2006- An Insider's View and American College of Radiology, 2006 CPT® Code Update, Sept/Oct 2005.

<sup>7</sup> Ibid.

<sup>8</sup> American College of Radiology, 2006 CPT® Code Update. Sept/Oct 2005.

<sup>9</sup> CPT Changes 2006- An Insider's View.

<sup>10</sup> American Medical Association and American College of Radiology. Clinical Examples in Radiology. Winter 2006; Vol. 2, Issue 1.

<sup>11</sup> Duszak, R. The New Reconstruction Codes: 3-D is Better Than No D. JACR. January 2006; Vol. 3(1).

<sup>12</sup> Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is paid pursuant to the hospital inpatient prospective payment system. The professional component for diagnostic imaging procedures performed in the hospital inpatient setting is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 73, No. 224, November 19, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

<sup>13</sup> Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification (APC) under the hospital outpatient prospective payment system, as published in Federal Register, Vol. 73, No. 223, November 18, 2008. The professional component is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 73, No. 224, November 19, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

<sup>14</sup> Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 73, No. 223, November 18, 2008. The total reimbursement amount for the IDTF and physician office settings reflects the DRA cap adjustment when applicable. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

<sup>15</sup> Per the Deficit Reduction Act (DRA) of 2005, designated imaging services with a 2008 Medicare physician fee schedule technical payment (prior to geographic adjustment) that exceeds the comparable 2008 hospital outpatient prospective payment system (HOPPS) technical payment (prior to geographic adjustment), as published in Federal Register, Vol. 73, No. 223, November 18, 2008, will be capped at the 2009 HOPPS payment amount.

<sup>16</sup> Medicare's national coverage policy for CT addresses reformatted imaging as follows: "In usual computerized tomography (CT) scanning procedures, a series of transverse or axial images are reproduced. These transverse images are routinely translated into coronal and/or sagittal views. Multiplanar diagnostic imaging (MPDI) is a process which further translates the data produced by CT scanning by providing reconstructed oblique images which can contribute to diagnostic information. MPDI, also known as planar image reconstruction or reformatted imaging, is covered under Medicare when provided as a service to an entity performing a covered CT scan."  
[http://www.cms.hhs.gov/manuals/downloads/ncd103c1\\_Part4.pdf](http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf) (Scroll to section 220.1)

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