

GE Healthcare

Medicare Reimbursement for Diagnostic Computed Tomographic Angiography for Coronary Applications¹



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Coronary computed tomographic angiography (CCTA) involves the evaluation of the coronary arteries. CCTA is a technique for imaging vessels which includes reconstruction post-processing of angiographic images and interpretation.² This overview addresses coding, coverage, and payment for diagnostic CCTA when performed in the hospital outpatient department, physician office, and independent diagnostic testing facility (IDTF) settings.³ While this advisory 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.⁴ The CPT coding system was developed and is maintained by the American Medical Association (AMA) and the codes are updated annually.

The majority of CPT codes belong to CPT Category I. Designated with a five-digit code, these procedures/services satisfy prerequisites including:

- The procedure is performed in multiple locations by many practitioners.
- The clinical efficacy of the procedure/service is established and documented in published literature.
- The Food and Drug Administration (FDA) has cleared one or more products for specific use in the procedure/service.⁵

CPT Category III Codes

In order to track utilization of emerging technologies, such as cardiac CT and CCTA, separate CPT codes were developed by the AMA. Designated as CPT Category III, these codes have four digits followed by an alphabetic character. According to the AMA, **if a Category III code is available, this code must be reported instead of a Category I unlisted code or other Category I code.** Generally, a Category III code will be archived after five years if a Category I code is not assigned.

When reporting a service that is new and denoted using a CPT Category III code, payers may require a special report to accompany the medical claim in order to determine whether the service is medically appropriate for the patient. The following information should be included:⁶

Description of the nature, extent, and need for the procedure:

- Time, effort, and equipment needed to provide the procedure Other information may be required, including the following:
- Complexity of symptoms
- Final diagnosis
- Pertinent physical findings
- Diagnostic and therapeutic procedures
- Concurrent problems
- Follow-up care

For more information on Category III codes and their use, refer to the coding guidelines that accompany the relevant section of *CPT*® 2009. The guidelines also are posted on the AMA website at:

<http://www.ama-assn.org/ama/pub/category/3885.html#Introduction>.

Coding for CCTA Studies

On July 1, 2006, the AMA implemented eight new CPT Category III codes for the reporting of CCTA procedures.⁷ In 2008, the AMA revised the descriptions of the codes to clarify their original intent, “which was not to require noncontrast imaging but to include it when performed.”⁸ Table 1 lists the CCTA Category III codes and their full descriptions.

Table 1: 2009 Medicare Reimbursement for Cardiac Computed Tomography and Computed Tomographic

Angiography Procedures (Reflects National Rates, Unadjusted For Locality)

CPT Code/Application	Reimbursement Component	Hospital Outpatient Department ⁹	IDTF or Physician Office ^{10,11}
CPT 0146T - Contrast Cardiac CT/ CT Angiography Computed tomography, heart, with contrast material(s), including noncontrast images, if performed, cardiac gating and 3D image postprocessing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium	Technical	\$282.69	Carrier-Priced/CAP
	Professional	Carrier-Priced	Carrier-Priced
	Total	\$282.69 + Carrier-Priced	Carrier-Priced/CAP
CPT 0147T - Contrast Cardiac CT/ CT Angiography Computed tomography, heart, with contrast material(s), including noncontrast images, if performed, cardiac gating and 3D image postprocessing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium	Technical	\$282.69	Carrier-Priced/CAP
	Professional	Carrier-Priced	Carrier-Priced
	Total	\$282.69 + Carrier-Priced	Carrier-Priced/CAP
CPT 0148T - Contrast Cardiac CT/ CT Angiography Computed tomography, heart, with contrast material(s), including noncontrast images, if performed, cardiac gating and 3D image postprocessing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium	Technical	\$282.69	Carrier-Priced/CAP
	Professional	Carrier-Priced	Carrier-Priced
	Total	\$282.69 + Carrier-Priced	Carrier-Priced/CAP
CPT 0149T - Contrast Cardiac CT/ CT Angiography Computed tomography, heart, with contrast material(s), including noncontrast images, if performed, cardiac gating and 3D image postprocessing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium	Technical	\$282.69	Carrier-Priced/CAP
	Professional	Carrier-Priced	Carrier-Priced
	Total	\$282.69 + Carrier-Priced	Carrier-Priced/CAP

Technical - is the facility payment

**Professional - is the physician payment

The American College of Radiology (ACR) has issued guidance on the eight CPT Category III codes used to report cardiac CT and CCTA procedures.¹² According to the ACR, at any given patient encounter, only one of the primary codes (0146T-0149T) is used to describe the coronary CTA studies performed. The ACR gives guidance to the physician interpreting the study that states the physician interpreting the study is responsible for the “interpretation of all information on the axial source images of the pre-contrast, arterial phase sequence, and the venous phase sequence, as well as the 2D and 3D reformatted images resulting from the study, including cine review” as noted in the CPT code application.¹³

For additional information on CCTA, the ACR has dedicated a portion of their website to providing updates to this rapidly evolving area of imaging. The cardiac CT and CCTA web section of the ACR website is located at:

http://www.acr.org/Hidden/Economics/FeaturedCategories/Coding/ct_cta_resource.aspx

Per the ACR and AMA, the 2D and 3D rendering images resulting from the study are contemplated in the cardiac CT and CCTA codes; therefore, a separate 3D rendering code (ie, CPT codes 76376 or 76377) should not be reported with the cardiac CT and CCTA codes. Specifically, in CPT® 2009, immediately under the listings of the 3D rendering codes, the AMA provides a list of codes that should not be reported in conjunction with these codes and the cardiac CT and CCTA codes are included in this list.¹⁴

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).

Coverage

Third party coverage policies for diagnostic coronary CT angiography will vary by payer and by locality. Medicare’s National Coverage Determination (NCD) for computed tomography (CT) does not specifically address coverage of coronary CT angiography. The NCD states that CT scans may be covered as diagnostic services if reasonable and necessary, and if performed on an FDA-approved model of CT equipment. The local Medicare contractors have discretion to determine the specific circumstances under which a CT scan is covered. The NCD is described in the Internet Manual for Medicare National Coverage Determinations at:

http://cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf (scroll to Section 220.1).

Some local Medicare contractors have developed Local Coverage Determinations (LCDs) that address CCTA procedures. Importantly, these LCDs may restrict or deny coverage for such procedures. Coverage for coronary CT angiography may be restricted in terms of the type of provider, patient clinical indications, or frequency of procedures. Separate coverage determinations may be made for each procedure identified by the CPT III codes for CCTA. For example, a local Medicare contractor may cover CTA of coronary arteries, but limit coverage for the evaluation of coronary calcium. To confirm coverage, consult with your local Medicare contractor. A directory of local Medicare contractors can be accessed at:

http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf

To access the LCDs, refer to <http://www.cms.gov/mcd/search.asp> or the individual contractor’s website.

With respect to private payers, some may rely on Medicare reimbursement determinations, while others consider alternative information. Therefore, it is important to consult with individual private payers regarding coverage for these procedures as well.

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 referred to as the **global** or **total amount**.

Currently, Medicare reimburses diagnostic imaging procedures differently based on the site of care. In a **hospital outpatient department**, the technical component of a procedure is reimbursed under an Ambulatory Payment Classification (APC) under Medicare's hospital outpatient department prospective payment system (OPPS). For procedures performed in an **IDTF or physician office**, the technical component is reimbursed under the Medicare physician fee schedule. The professional component is reimbursed under the Medicare physician fee schedule, regardless of the setting.

Table 1 provides information concerning Medicare national payment amounts for CPT Category III codes for CCTA performed in hospital outpatient departments, IDTFs and physician's offices. Since national payment rates in the Medicare physician fee schedule are not assigned to CPT Category III codes, these codes are carrier-priced under certain circumstances, as listed in Table 1. Carrier-priced means the local Medicare contractors will establish, for their region, payment amounts for these services. For more information about reimbursement of CCTA procedures in your area, consult your local Medicare contractor.

¹ 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.

² 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.

³ 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.

⁴ CPT codes and descriptions only are copyright ©2008 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.

⁵ American Medical Association. CPT Process - How a Code Becomes a Code. <http://www.ama-assn.org/ama/pub/category/3882.html>

⁶ American Medical Association. CP[®] 2009 Professional Edition.

⁷ American College of Radiology, CPT Category III Code Update. Jul/ Aug 2006.

⁸ American Medical Association. CPT Changes 2008- An Insider's View.

⁹ 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 under the hospital outpatient prospective payment system, as published in Federal Register, Vol. 73, No. 223, November 18, 2008. The professional component is

generally paid based on the Medicare physician fee schedule, but for Category III CPT codes, local Medicare contractors determine the payment rate. 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.

¹⁰ Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are generally paid based on the Medicare physician fee schedule, but for Category III CPT codes, local Medicare contractors determine the payment rate. To confirm reimbursement rates for specific codes, please consult with your local Medicare contractor

¹¹ Per the Deficit Reduction Act of 2005, designated imaging services with a 2009 Medicare physician fee schedule technical payment (prior to geographic adjustment) that exceeds the comparable 2009 hospital outpatient prospective payment system (HOPPS) technical payment (prior to geographic adjustment), as published in Federal Register, Vol. 73, No. 224, November 19, 2008, will be capped at the 2009 HOPPS payment amount. For carrier-priced services subject to the DRA cap, the technical payment amount will be paid at the lower of the carrier-priced payment or the HOPPS payment rate. Accordingly, the global payment amount is the sum of the professional payment amount and the DRA capped technical payment amount.

¹² American College of Radiology. Update on Cardiac CT and Coronary CTA coding. Sep/Oct 2006.

¹³ American College of Radiology. Clinical Examples in Radiology, Vol. 2, Issue 1; Winter 2006.

¹⁴ American College of Radiology. Clinical Examples in Radiology. Winter 2006; Vol. 2, Issue.

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