

GE Healthcare

Reimbursement Information for Diagnostic Computer Tomographic Colonography¹

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Computed tomographic colonography (CTC) provides an evaluation of the colon to detect polyps, masses, cancers and other lesions.²

This overview addresses coding, coverage and payment for diagnostic CTC when performed in the inpatient hospital setting, hospital outpatient department and independent diagnostic testing facility (IDTF).³ While it focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

Current Procedural Terminology (CPT)⁴ Coding, Definitions and Medicare Payment Rates

The following provides 2010 national Medicare Physician Fee Schedule (MPFS) and facility payment rates, for example, CPT codes that may be used. **Payment will vary by geographic region.**

2010 Medicare reimbursement for procedures related to CT Colonography. (Reflects national rates, unadjusted for locality.)

CPTCode ⁵	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Payment ⁶	APC	Hospital Outpatient Payment ⁷
CPT 74261 Computed tomographic colonography (CTC), diagnostic, including image postprocessing; without contrast material (Do not report 74261, 74262 in conjunction with 72192-72194, 74150-74170, 74263, 76376, 76377)	Professional*	\$ 110.78	0332	\$ 195.07
	Technical ^{8**}	\$ 195.22 (DRA-CAP)		
	Global	\$ 306.00		
CPT 74262 Computed tomographic colonography (CTC), diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed (Do not report 74261, 74262 in conjunction with 72192-72194, 74150-74170, 74263, 76376, 76377)	Professional	\$ 121.61	0283	\$ 297.03
	Technical	\$ 296.98 (DRA-CAP)		
	Global	\$ 418.58		
CPT 74263 Computed tomographic colonography (CTC), screening, including image postprocessing*** (Do not report 74263 in conjunction with 72192-72194, 74150-74170, 74261, 74262, 76376, 76377)	Professional	\$ 115.83	N/A	N/A
	Technical	\$ 589.98		
	Global	\$ 705.81		

*Professional – is the physician payment.

**Technical – is the facility payment.

***Screening tests are not paid by Medicare.

Coding

Medicare's reimbursement system relies mostly on Current Procedural Terminology (CPT) codes to consistently identify diagnostic imaging procedures provided to Medicare patients.⁹ 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 which include:

- The procedure is performed in multiple locations by many practitioners
- The clinical efficacy of the procedure/service is established and documented in published literature and
- The Food and Drug Administration (FDA) has cleared one or more products for specific use in the procedure/service⁸

Coding for CTC Studies

The AMA announced that effective January 1, 2010 CPT category III code 0067T, *Computed tomographic colonography (CTC) (ie, virtual colonoscopy); diagnostic*, has been deleted and is being replaced with two CPT Category I codes. Codes 74261 or 74262 should be used when CTC is performed for the diagnostic evaluation of the colon to detect colonic polyps and colon cancer.¹⁰

Immediately under the listing of these codes in CPT® 2010, the AMA has provided an instruction that CPT codes for CT of the abdomen or pelvis (i.e., 72192-72194, 74150-74170) should not be reported in conjunction with CPT 74261, 74262 or 74263.¹¹

In addition, per the American College of Radiology (ACR) and the AMA, the diagnostic CTC code contemplates 3D reconstruction of the colon including the endoluminal fly-through and the 360° dissection view;¹¹ therefore, a separate 3D rendering code (i.e., CPT codes 76376 or 76377) should not be reported with the diagnostic CTC code.¹² Specifically, in CPT 2010, 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 74261 and 74262 are included in this list.

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).

Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of CT colonography.

26-Professional Component

A physician who performs the interpretation of a computed tomographic colonography exam in the hospital outpatient setting may submit a charge for the professional component of the computed tomographic colonography service using a modifier (-26) appended to the appropriate CPT code.

TC-Technical Component

This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service.

ICD-9-CM Diagnosis Coding

It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-9-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the CT colonography.

Payment Methodologies for Ultrasound Services

Medicare reimburses for diagnostic imaging services when the services are within the scope of the provider's license and are deemed medically necessary. The following describes the various payment methods by site of service. The professional component of these services would be paid under the Medicare physician fee schedule no matter which setting it is performed in.

Site of Service

Hospital Outpatient Setting

The technical component of a procedure is reimbursed under an Ambulatory Payment Classification (APC) under Medicare's hospital outpatient prospective payment system (HOPPS).

Hospital Inpatient Setting

The technical (facility) payment is subsumed within the payment to the hospital that is determined based on the Medicare Severity Diagnosis Related Group (MS-DRG) to which the patient is assigned.

Coverage

Medicare's National Coverage Determination (NCD) for computed tomography (CT) does not specifically address coverage of diagnostic CT colonography (CTC). 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 national coverage determination is described in the Internet Manual for Medicare National Coverage Determinations at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf (scroll to Section 220.1).

According to the NCD, local Medicare contractors have discretion to determine the specific circumstances under which a CT scan is covered. Some local Medicare contractors have developed Local Coverage Determinations (LCDs) that address diagnostic CTC procedures. Importantly, these LCDs may provide for, restrict or deny coverage for this procedure based on a variety of factors such as the provider type, patient clinical indications or frequency of procedures. You will need to confirm coverage for diagnostic CTC by consulting your local Medicare contractors for specific information on coverage. A directory of local Medicare contractors is available at http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf. To access specific LCDs, refer to <http://www.cms.hhs.gov/mcd/search.asp> or the individual contractor's website.

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 CTC as well.

For definition of Medicare terms and acronyms, refer to the following websites: <http://www.cms.hhs.gov/apps/acronyms/> and <http://www.cms.hhs.gov/apps/glossary/>.

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- 1 Information presented in this document is current as of January 1, 2010. 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 Current Procedural Terminology © 2009 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
- 5 American Medical Association. CPT 2010 Professional Edition.
- 6 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. 74, No. 226, November 25, 2009 and the Federal Register, Vol. 74, No. 236, December 10, 2009, and updated as per Transmittal R1887CP, dated January 6, 2010. 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.
- 7 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. 74, No. 223, November 20, 2009. The professional component is generally paid under the Medicare physician fee schedule. 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.
- 8 For 2010, Medicare will continue the 25% multiple procedure payment reduction to the technical component of specific procedures performed in IDTF and physician offices that are listed in one of eleven (11) families of codes. The reduction applies to CT colonography when it is performed as a second or subsequent procedure during one imaging session involving a single family of codes (not across multiple families). The multiple procedure discount will be applied prior to determining the HOPPS capped technical component amount. See the 2010 physician fee schedule final rule, Federal Register, Vol. 74, No. 226, November 25, 2009.
- 9 CPT codes and descriptions only are copyright © 2009 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.
- 10 CPT Assistant, March 2005, Volume 15, Issue 3.
- 11 American Medical Association. CPT 2010 Professional Edition.
- 12 ACR Radiology Coding Source™. March/April 2004; Vol. 2(2) and the CPT Changes 2005 – An Insider's View.

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