

Medicare Reimbursement for Functional Magnetic Resonance Imaging for Pre-operative Neurosurgical Planning¹

This advisory addresses coding, coverage and payment for functional magnetic resonance imaging (fMRI)² for pre-operative neurosurgical planning when performed in the hospital inpatient, hospital outpatient, and independent diagnostic testing facility (IDTF) settings.³ While it focuses on Medicare program policies, these policies may also 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 AMA and American Academy of Neurology announced that effective January 1, 2007, the codes listed in Table 1 should be reported when fMRI is performed for pre-operative neurosurgical planning.⁵

Pre-operative neurofunctional planning during MR imaging may require interaction with a physician or psychologist or may be performed by a technologist or physicist. When neurofunctional testing is performed by an individual other than a physician or psychologist, CPT code 70554 should be reported.⁶

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When the fMRI procedure requires interaction with a physician or psychologist, the procedure is not limited to physicians of a particular specialty (i.e., neurologists, neurosurgeons, neuropsychologists) but instead may be performed by any qualified provider.⁷ Per the AMA, CPT codes 70555 and 96020 are used in conjunction to report pre-operative neurofunctional MRI testing administered entirely by a physician or psychologist, as indicated in Table 1. CPT code 70555 is used to report the fMRI while CPT code 96020 is used to report the testing component by the physician or psychologist. The physician or psychologist is responsible for *“selection and administration of testing of language, memory, cognition, movement, sensation, and other neurological functions when conducted with functional neuroimaging, monitoring of performance of this testing, and determination of validity of neurofunctional testing relative to separately interpreted functional magnetic resonance images”*.⁸

Per the AMA, the testing component of functional brain mapping described in CPT code 96020 encompasses the psychological, neuropsychological and neurobehavioral testing methodologies (CPT codes 96101-96103 and 96116-96120); therefore, CPT code 96020 should not be reported in conjunction with these other codes as indicated in Table 1. Additionally, the AMA states that evaluation and management services codes should not be reported on the same day as 96020.⁹

According to the American College of Radiology (ACR), reporting a traditional diagnostic brain MRI study on the same day as an fMRI study would be unusual. If a diagnostic brain MRI study is performed on the same day as an fMRI study, a separate order would be necessary and modifier-59 should be used to designate a separate and distinct service was performed in addition to the fMRI study.¹⁰

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 diagnostic imaging procedures differently based on the site of care. In a **hospital inpatient** site of care, 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. In a **hospital outpatient department**, the technical component of a procedure is reimbursed under an Ambulatory Payment Classification (APC) under Medicare’s hospital outpatient prospective payment system (HOPPS). In some cases, a procedure is not reimbursed separately, but rather is “packaged” or included in the APC payment to the hospital. The technical component of a procedure performed in an **IDTF** is reimbursed under the Medicare physician fee schedule (MPFS). 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 fMRI for preoperative neurosurgical planning performed in the hospital inpatient, hospital outpatient department, IDTF and ASC setting. The MPFS technical component payment rates for CPT codes 70555 and 96020 are “carrier-priced.” Carrier-priced means the local Medicare contractors will establish, for their region, payment amounts for these services. For more information about reimbursement of fMRI procedures in your area, consult your local Medicare contractor.

CPT /HCPCS Code	Reimbursement Component	Hospital Inpatient Departments ¹¹	Hospital Outpatient Department ^{12,13}	IDTF or Physician Office ^{14,15}
CPT 70554 Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration [Do not report 70554 in conjunction with 96020] [Do not report 70554, 70555 in conjunction with 70551-70553 unless a separate diagnostic MRI is performed]	Technical*	Included in MS-DRG	\$348.06	\$510.70
	Professional**	\$108.50	\$108.50	\$108.50
	Global	MS-DRG + \$108.50	\$456.56	\$619.26
CPT 70555 Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing [Do not report 70555 unless 96020 is performed] [Do not report 70554, 70555 in conjunction with 70551-70553 unless a separate diagnostic MRI is performed]	Technical	Included in MS-DRG	\$348.06	Carrier-Priced
	Professional	\$130.92	\$130.92	\$130.92
	Total	MS-DRG + \$130.92	\$478.98	Carrier-Priced + \$130.92
CPT 96020 Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or psychologist, with review of test results and report [For functional magnetic resonance imaging (fMRI), brain, use 70555] [Do not report 96020 in conjunction with 70554] [Do not report 96020 in conjunction with 96101-96103, 96116-96120] [Evaluation and Management services codes should not be reported on the same day as 96020]	Technical	Included in MS-DRG	Packaged in APC	Carrier-Priced
	Professional	\$177.81	\$177.81	\$177.81
	Total	MS-DRG + \$177.81	APC + \$177.81	Carrier-Priced + \$177.81

Table 1: 2009 Medicare Reimbursement for Functional Magnetic Resonance Imaging with CPT Codes (Reflects National Rates, Unadjusted for Locality)

* Technical- is the facility payment

**Professional- is the physician payment

MR Accreditation

Select payers may require certain imaging providers to be accredited in order to receive reimbursement for MR imaging. The major accrediting agencies for diagnostic imaging include the American College of Radiology (ACR), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Accreditation Association for Ambulatory Health Care (AAHC/Accreditation Association), and the Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories (ICAMRL). Accreditation by these agencies is a rigorous process which generally includes a comprehensive application or self-assessment and a thorough review by the accrediting body. Accreditation standards vary greatly by reviewing agency; however, they all seek to verify applicants meet specific standards of care and performance, including those related to diagnostic imaging, protocols, and equipment. Payers may specify which of these accreditation organizations should be used to secure MR imaging accreditation. To obtain more information about specific accreditation standards for each agency, visit their websites at: www.acr.org, www.jointcommission.com, www.aaahc.org and www.intersocietal.org.

In addition, private payers may have additional accreditation standards that must be met. Therefore, it is important to consult with individual private payers to determine the specific accreditation requirements for MR imaging.

Coverage

Medicare's National Coverage Determination (NCD), *Magnetic Resonance Imaging (MRI)*, does not specifically address coverage of MRI for pre-operative neurofunctional planning. The NCD states that MRI scans may be covered as diagnostic services if reasonable and necessary, and performed on an FDA-approved model of MRI equipment. The NCD is described in the Internet-Only Manual (IOM) for Medicare National Coverage Determinations at http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf (scroll to section 220.2).

According to the NCD, local Medicare contractors have discretion to determine the circumstances under which fMRI is covered. Some local Medicare contractors have developed Local Coverage Determinations (LCDs) that address fMRI. Importantly, these LCDs may provide for, restrict or deny coverage for this procedure based on a variety of factors such as the provider type or patient clinical indications. Providers are encouraged to consult their local Medicare contractors for specific information on coverage of fMRI. A directory of local Medicare payers 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 policies while others consider alternative information. Therefore, it is important to consult with individual private payers regarding coverage for fMRI as well.

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 CPT Changes 2007 – An Insider's View.

⁶ A CPT Assistant, February 2007, Volume 17, Issue 2.

⁷ Ibid.

⁸ CPT Changes 2007 – An Insider's View and ACR Radiology Coding Source™, September–October 2006.

⁹ CPT Changes 2007 – An Insider's View.

¹⁰ ACR Radiology Coding Source™, September–October 2006 and Journal of American College of Radiology, January 2007.

¹¹ 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.

¹² Third party reimbursement amounts and coverage policies for specific procedures 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.

¹³ The Centers for Medicare & Medicaid Services (CMS) has established five imaging composite APCs (APCs 8004, 8005, 8006, 8007, and 8008) based on the families of codes used for the multiple imaging procedure payment reduction policy under the Medicare Physician Fee Schedule (MPFS). The composite APCs provide a single APC payment when two or more imaging procedures using the same imaging modality were provided in a single session.

The single payment will cover those imaging services that qualify for composite APC payment, as well as the packaged services furnished on the same date of service. If a with and without are reported together, they are paid at the higher with contrast payment category. If they are reported alone on a claim, they are paid separately as a stand alone study. The new imaging composite APCs include:

- Ultrasound (APC 8004)
- Computed tomography (CT) and computed tomographic angiography (CTA) without contrast (APC 8005)
- CT and CTA with contrast (APC 8006)
- Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) without contrast (APC 8007), and
- MRI and MRA with contrast (APC 8008)

The composite APCs will be marked with the conditional packaging indicator of "Q". However CMS has expanded the definitions of "Q" at levels of "Q1", "Q2", and "Q3". The new status indicators are defined as: "Q1" is assigned to all "STVX-packaged codes;" status indicator "Q2" is assigned to all "Tpackaged codes;" and status indicator "Q3" is assigned to all codes that are paid through a composite APC based on composite-specific criteria or separately through single code APCs when the criteria are not met.

Note: a hospital performs a procedure without contrast during the same session as at least one other procedure with contrast using the same imaging modality, payment is made for the "with contrast" composite APC.

¹⁴ 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 under the Medicare physician fee schedule (MPFS); however, the technical component payment rate for CPT codes 70555 and 96020 are determined by local Medicare contractors. 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.

¹⁵ Per the Deficit Reduction Act (DRA) 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. Accordingly, the global payment amount is the sum of the professional payment amount and the DRA capped technical payment amount.

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