

New Reimbursement Codes

SCCT Coding Overview

This overview addresses coding, coverage, and payment for diagnostic cardiac computed tomography (CT) and computed tomographic angiography (CCTA) when performed in the hospital outpatient department, physician office and independent diagnostic testing facility (IDTF) settings.

While this advisory focuses on Medicare program policies, these policies also may be applicable to selected private payers throughout the country.

Coding

Currently the reimbursement system relies mostly on Current Procedural Terminology (CPT) codes to consistently identify diagnostic imaging procedures provided to Medicare patients. 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 that 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.
- The Food and Drug Administration (FDA) has cleared one or more products for specific use in the procedure/service.

Coding for Cardiac CT and CTA Studies

The American Medical Association (AMA) recently released the 2010 CPT codes that will take effect January 1, 2010. There are four new Category 1 codes to report cardiac computed tomography and cardiac computed tomography angiography (CCT/CCTA). Please note that only one code may be used per service. Table 1 lists the Cardiac CT and CCTA Category I codes and their full descriptions.

Table 1: 2009 CPT Code Descriptors for Cardiac Computed Tomography and Computed Tomographic Angiography Procedures

2010 CPT Code	Description	Comments
• 75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Potential Crosswalk -Replaces 0144T Do not bill with 75572-4.
• 75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3D image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Potential Crosswalk Replaces 0145T
• 75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of LV cardiac function, RV structure and function and evaluation of venous structures, if performed)	Potential Crosswalk Replaces 0150T
• 75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Potential Crosswalk Replaces 0146T-0149T



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The Role of Congress in Physician Payment

Congress created the payment systems (physician fee schedule and hospital outpatient prospective payment system) and the sustainable growth rate (SGR) formula that governs how physicians and other providers are paid. SGR is an expenditure target formula. Physician payments are cut if the growth in physician services exceeds expenditure targets.

As of the publication date of this toolkit, Congress passed and President Obama signed into law (December 21, 2009) a provision to delay the scheduled 21.2 percent Medicare physician payment cut until March 1, 2010. The cut was slated to take effect January 1, 2010, due to mandated adjustments in the conversion factor under the Sustainable Growth Rate (SGR) formula that governs physician payment.

This two-month delay allows Congress the opportunity to address physician payment reform early in the new year. Due to the number of changes pending, please refer to www.scct.org for up to date details on Medicare reimbursement.

How to Bill for Cardiac Computed Tomography Services

Cardiac computed tomography (CCT) and cardiac computed tomography angiography (CCTA) include interpretation of all information on the axial source images of the pre-contrast, arterial phase sequence, and venous phase sequence (if performed), and any quantitative assessment (if performed) as well as the 2D and 3D reformatted images resulting from the study.

Only one CPT code (75571-74) is used to describe the combination of cardiac CT and CCTA studies performed. The code 75571 is not to be reported in conjunction with any of the other heart CT codes, as it is the only code in which the sole purpose of the imaging is for quantitative evaluation of coronary calcium. Contrast if/when utilized is separately billable in the non-facility setting.

For additional information on cardiac CT and CCTA, the SCCT 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 SCCT website is located at: www.SCCT.org/payertoolkit.

Note - 2D and 3D rendering images resulting from the study are contemplated in the cardiac CT and CCTA services are included; therefore, a separate 3D rendering code (i.e. CPT codes 76376 or 76377) should not be reported with the cardiac CT and CCTA codes.

Coverage

Medicare covers certain services either nationally, under a national coverage determination (NCD) or locally, through the local coverage determination (LCD) process. Approximately 90 percent of the items and services covered by Medicare are covered under the LCD process.

Commercial payers have their own coverage processes and usually rely on technology evaluation committees to determine whether an item or service meets criteria for coverage.

Included in the SCCT Payer Toolkit is a copy of a Model Coverage Policy to be used by members when discussing coverage with payers. This document was revised in November 2009. Additional copies of the Model Coverage Policy and a listing of Medicare contacts and private payers is available on the SCCT website at www.scct.org/payertoolkit.



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Medicare Payment for Advanced Diagnostic Imaging Services

Through the Deficit Reduction Act (DRA) of 2005, signed into law February 8, 2006, Congress enacted numerous payment policy changes for advanced diagnostic imaging services, including CT, MR, PET and Nuclear Medicine. Please note – this only applies to Medicare billing.

The DRA caps the Technical Component (TC) payment for advanced diagnostic imaging services, at the lesser of the amount paid under the Medicare Physician Fee Schedule or the Hospital Outpatient Prospective Payment System rate. For cardiac computed tomography, this means that reimbursement is limited to that provided under the hospital outpatient prospective payment system.

It is important to understand that the four new Category I codes for CCT/CCTA, effective January 1, 2010, are an important step forward for the field. Category I codes are assigned to proven, established technology. However, despite the values assigned to the new codes by CMS in the 2010 Final Medicare Physician Fee Schedule (corrections pending), reimbursement for CCT/CCTA is lower because of the DRA cap.

It is imperative that the actual costs of performing CCT/CCTA are captured in the hospital charge masters. The challenge is to ensure that the charge master is updated and that all physicians understand the importance of coding appropriately for the services provided. Timely, accurate coding will assist in bringing the hospital charge masters up to date and therefore, result in a more appropriate payment for CCT/CCTA services.

We encourage you to contact the SCCT office at 800-876-4195 if you should have any questions or concerns.



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