CTA Now Requires 3D Postprocessing ... But That Hasn’t Always Been the Case

There has been a great deal of confusion regarding exactly what constitutes computed tomographic angiography (CTA) over the past several years. But the American College of Radiology (ACR) appears to be trying to clear the air.

In the May-June 2009 ACR Radiology Coding Source, the ACR stated that CTA required 3D angiographic rendering. The June 2009 CPT® Assistant reinforced this by stating that if a study involves only axial and two-dimensional postprocessing, you should report a normal CT scan rather than a CTA. “CT angiography (CTA) is a distinct type of CT service that includes three-dimensional (3D) angiographic postprocessing,” CPT® Assistant states.

But this has not always been the case, and that has generated the confusion.

Look Back

The March/April 2006 ACR Radiology Coding Source indicated that you could report a CTA code if only 2D reconstruction was performed. In fact, it went on to say, “CTA includes 2-D or 3-D reconstructions” [emphasis added].

Then, in the Fall 2008 Clinical Examples in Radiology, published jointly by the American Medical Association and ACR, CTA was said to “include” 3D angiographic postprocessing, but the article did not specifically state that CTA required 3D postprocessing.

Reporting CTA Today

The May-June 2009 Radiology Coding Source stated that the CTA CPT® codes have always required angiographic reconstruction, and that since the introduction of 76376 and 76377 in 2006, which restricted the reporting of angiographic reconstruction imaging to 3D, “such 3D imaging now serves as the basis for defining angiographic reconstruction imaging.”

“When CT scanning is performed using contrast enhanced dynamic-timed imaging and 2D reformatted axial images are obtained or multiplanar reconstructions (MPR) (e.g., coronal, sagittal, or even an off-axis view) are done, this should be reported with a standard CT with contrast code that identifies the anatomic area studied,” the recent Radiology Coding Source article indicates. “None of these 2D planar reconstructions qualify as ‘angiographic’ reconstruction.”

Radiology organizations also must keep a permanent archive of 3D images for any CTA study, the ACR pointed out in the article, adding that merely keeping the axial data set from which the 3D images were created was not sufficient. “When reformatted images are acquired and interpreted in addition to the CT axial images, the reformatted images are a part of the study and should be permanently archived.”

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Interventional Radiology Coding

Drainage vs. Aspiration: Recognize the Difference for Proper Code Assignment

CPT® differentiates between drainage and aspiration for coding purposes, but finding the fine line that separates the two procedures can be challenging.

Radiologists use drainage and aspiration procedures to treat various types of fluid collections, including abscesses, hematomas and cysts, among others. According to the American College of Radiology (ACR), here’s how to tell the difference:

• **Drainage** — the placement and maintenance of a catheter to provide complete or continuous drainage of the fluid collection that may be performed during a single session or as a staged procedure during multiple sessions.

• **Aspiration** — evacuation or diagnostic sampling of a fluid collection, using either a needle or catheter, during a single session with immediate removal of the catheter or needle after treatment.

**Don’t Forget Guidance**

When coding these two procedures, CPT® provides some specific codes based on anatomy. In addition, radiologists usually use imaging guidance to accomplish both drainage and aspiration, and you can report this guidance in addition to the drainage or aspiration code.

There is only one code for imaging guidance used during drainage, 75989. This code describes any and all guidance — whether fluoroscopy, ultrasound or CT — used to successfully place the drainage catheter, and you should not report 75989 with other imaging guidance codes for the same procedure, ACR says.

In contrast, CPT® offers multiple codes based on the modality for imaging guidance used for the aspiration:

• 76942 — ultrasound guidance for aspiration

• 77002 — fluoroscopic guidance for aspiration

• 77012 — CT guidance for aspiration

• 77021 — MRI guidance for aspiration

**Drainage Code Depends on Anatomy**

There are site-specific codes based on the anatomical areas where physicians most frequently perform drainage procedures. For example, for percutaneous drainage of a lung abscess or cyst, you should report 32201, whereas for percutaneous pelvic abscess drainage, you will use 58823. If there is no site-specific code available, you should report drainage with 20000 (Incision of soft tissue abscess (e.g., secondary to osteomyelitis); superficial), according to ACR.

All of the site-specific drainage codes have zero global days, so you can separately report follow-up care with the appropriate evaluation and management code(s). Code 20000, however, has 10 global days, so you cannot separately report follow-up care related to this type of drainage procedure during the 10 days immediately following the service’s performance.

Under the Hospital Outpatient Prospective Payment System, drainage is considered a “significant procedure” (status T) that is subject to multiple procedure payment reduction. Medicare does not pay hospitals separately for imaging guidance, but they should still report the guidance codes on their Medicare claims.

**Aspiration Codes Get Specific**

As with the drainage codes, reporting aspiration procedures depends on the anatomical site where the radiologist performs the service. For instance, for aspiration of a breast cyst, you should use 19000 for the first cyst and +19001 for each additional cyst. For a thyroid cyst aspiration, you should report 60001.

When CPT® does not provide a site-specific aspiration code, the ACR recommends submitting 10160 (Puncture aspiration of abscess, hematoma, bulla, or cyst). And, again, you should report imaging guidance used during aspiration based on the modality the radiologist employs for that procedure.

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Single-Session MRI/MRA of the Same Body Area Affects Your Reimbursement

Although Medicare and other payors allow you to code and bill for magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) performed on the same body area during the same session, assuming documentation supports both, you will find your payment doesn’t necessarily add up.

For example, an MRA of the head (70544-70546) is frequently performed with an MRI brain study (70551-70553). Both the MRI and the MRA should be coded if both are performed and documented.

Keep in mind, however, that Medicare and other payors may make multiple procedure payment reductions.

How It Works for Non-Hospital Settings

If you work for an imaging center, independent diagnostic testing facility (IDTF) or physician office, your Medicare technical component payments are subject to two different types of discounts. (Note: These discounts do not apply to your payment for the professional component.)

Effective Jan. 1, 2006, the Centers for Medicare and Medicaid Services (CMS) instituted a multiple procedure payment reduction policy for 11 “families” of exams. Each family includes exams performed with the same modality (for example, CT, MR, ultrasound) on contiguous body areas. When multiple exams from the same family are performed during the same session, the Medicare contractor will reimburse the highest-paying procedure at 100 percent and reduce payment for all other procedures in the same family by 25 percent. If you are billing services globally, only the technical component relative value units (RVUs) for the second exam will be reduced.

MRI and MRA of the head fall into one such family (Family 5). So if a patient undergoes a contrast MRA of the head (70545), and then has a contrast brain MRI (70552), the technical component of the MRI will be paid at 100 percent and the MRA’s technical component at 75 percent.

In addition, the payments for these exams are subject to a payment cap. Medicare limits payment for a technical component service in the non-hospital setting to no more than what Medicare would pay to a hospital for the same exam under the Outpatient Prospective Payment System (OPPS). The payment cap is applied before the multiple procedure (“family”) discount.

For example, if you are in Fort Lauderdale, the technical component payment for 70545 under the Physician Fee Schedule is $567, and the technical component payment for 70552 is $587, for a total of $1,154. But that’s not what you’ll receive from Medicare. The OPPS payment limit for 70545 is only $456, and the OPPS limit for 70552 is $460. So your actual payment can be no more than that amount. Then the multiple procedure discount is applied, and your payment for 70545 is reduced by 25 percent. After the OPPS cap and the multiple procedure discount are applied, your total payment is down to $802 ($342 for 70545 and $460 for 70552).

If the two exams are performed during separate sessions, the multiple procedure reduction does not apply, although the OPPS cap does. CMS defines a single session as “one encounter where a patient could receive one or more radiological services.” If two exams from the same family are performed during separate encounters on the same day, you should use modifier 59 (Distinct procedural service) to indicate the separate nature of the services. But CMS states, “Use of the modifier where not medically necessary in order to bypass the payment reduction constitutes fraud.” This is an unusually strong statement and indicates that CMS intends to take violations of this policy seriously.

OPPS Requires Composite APCs

If you work for a hospital that’s paid under OPPS, your Medicare payments are also subject to a discount. As of Jan. 1, 2009, CMS instituted several composite ambulatory payment classifications (APCs) for imaging services. These new APCs apply to multiple imaging procedures performed during a single session using the same imaging modality.

CMS defined three families of exams (ultrasound, CT and MR), and each family includes exams performed with the same modality, although not necessarily on contiguous (adja
cent) body areas. For the three families, the agency developed five “composite” APCs, and the two that affect MRIs and MRAs are 8007 (MRI and MRA without contrast) and 8008 (MRI and MRA with contrast).

The Medicare payment for these imaging studies will depend on the number and type of studies performed. If two or more studies are performed using the same technique (for example, without contrast), then the Medicare contractor will pay the reimbursement rate of the corresponding composite APC. For example, if the hospital bills for the technical component of a brain MRI without contrast (70551) and an MRA of the head without contrast (70544), one composite payment for APC 8007 ($711.05) will be made (assuming medical necessity requirements are met).

If two or more studies are performed using different techniques — one exam with contrast and one without — then Medicare will make one payment at the reimbursement rate for the corresponding “with contrast” composite APC. For instance, if the hospital bills for the technical component of a brain MRI without contrast (70551) and MRA of the head with contrast (70545), one composite payment at the APC 8008 rate ($990.32) will be made (again, assuming medical necessity requirements are met).
Advance beneficiary notices (ABNs) can prove particularly important to radiology practices and imaging facilities, which face specific challenges to ensure proper payment for the services they provide.

An ABN is a written notice to a Medicare beneficiary that the radiologist or facility must provide when they believe that Medicare will deny payment for a service because it is not medically necessary. The ABN gives the patient the opportunity to choose whether to receive the service. If the patient decides to receive the service after reviewing the ABN and Medicare does not pay, the patient is responsible for payment. On the other hand, if the health care provider does not give the patient an ABN if a service may not meet medical necessity requirements, the provider cannot bill the patient for any services that Medicare denies due to lack of medical necessity.

**Special Challenges in Radiology**

Radiology practices most often use ABNs in the following situations:

- A referring physician orders an exam that is not covered under a Medicare local coverage determination (LCD). Unless the exam reveals a covered condition, Medicare will deny this service as not medically necessary. For example, a physician orders an MRI of the brain because of a patient’s headache (784.0), which is not a covered diagnosis under the LCD. Unless the exam shows a covered condition that caused the patient’s headache, the exam will not be paid.
- An exam is subject to frequency limitations. For example, screening mammograms are covered on an annual basis for most women on Medicare. If the patient’s last screening mammogram was less than a year ago, Medicare will deny payment for the current mammogram.
- You may also issue ABNs for services that are excluded from Medicare coverage by law. These can include routine physical exams, most screening tests (other than covered tests such as screening mammograms) and cosmetic services, among others. Although providers are not required to issue an ABN for statutorily excluded services, the ABN can serve as a reminder to patients that Medicare will not pay for the service.

On the other hand, you should not issue an ABN if you do not have a specific reason to believe that Medicare will deny the service. Issuing “blanket” ABNs to all Medicare patients is not permitted, but you can give ABNs to all patients who receive services with frequency limitations because there is no way to be certain when the patient had the last such exam.

In addition, providers must present the ABN before performing the service in question. The patient must have sufficient time to consider the options before making a decision whether to proceed. This means you cannot wait until the patient is prepped and about to undergo the service before presenting them with the ABN.

**Know the Patient’s Options**

Once you have presented the patient with an ABN, he has three options regarding how to proceed:

- **Option 1:** The patient wishes to receive the service and have it submitted to Medicare. The provider may collect payment at the time of service, but if Medicare decides to pay, the provider must refund the patient’s payment.
- **Option 2:** The patient wants to receive the service but does not want it to be submitted to Medicare. The provider does not have to submit a claim if the patient selects this option.
- **Option 3:** The patient chooses not to undergo the service.

These are the only three options available to the patient. The patient cannot choose to go through with the procedure and not pay for it.

Let’s look at some examples of common ABN situations:

**Example 1:** The patient has an order for a CT of the abdomen and pelvis. The clinical indications listed by the referring physician are covered for the abdomen but not the pelvis. You should ask the patient to sign an ABN for the pelvis but not for the abdomen because there is no reason to believe the abdomen CT will be denied as not medically necessary. If the patient selects Option 1, you should append modifier GA (Waiver of liability on file) to the pelvis CT code to show that the patient agreed to pay for the exam if it is denied as not medically necessary.

**Example 2:** The referring physician orders an MRA for a non-covered indication, but the facility staff does not realize this until after the exam has been completed. At this point, you can no longer ask the patient to sign an ABN. The facility and radiologist should submit the claim to Medicare with modifier GZ (Item or service expected to be denied as not reasonable and necessary), which tells Medicare that the provider expects the service to be denied but did not obtain an ABN.

**Example 3:** The patient refers himself for a vascular screening exam that includes ultrasound of the legs and the abdominal aorta. A physician did not order the exam. Medicare will not cover this service, and normally you should not submit a claim for it. If the patient asks you to bill it to Medicare so he can get a denial for a secondary payor, however, ask the patient to document this request by selecting Option 1. When you submit the claim to Medicare, be sure to use modifier GY (Item or service statutorily excluded and does not meet the definition of any Medicare benefit), which indicates that the item is not a Medicare benefit, and assign an ICD-9-CM diagnosis code for screening (for example, V81.2, Special screening for other and unspecified cardiovascular conditions).

For more information about ABNs, you can visit the CMS Web site at www.cms.gov/bni.