Billing and Coding Guidelines

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Wisconsin Physicians Service Insurance Corporation

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Billing and Coding Guidelines for RAD-037; 3D Interpretation and Reporting of Imaging Studies.

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AMA CPT/ ADA CDT Copyright Statement

Article Text
This article contains the coding guidelines and reasons for denial for 3D imaging procedures. This article should be used in combination with LCD 3D Interpretation and Reporting of Imaging Studies (RAD-037).

Abstract
Multi-slice imaging and enhanced techniques allow for the generation of three- dimensional images. This technology may provide greater structural and volumetric assay of Central Nervous System (CNS), cardiac and peripheral vasculature, thoracic lesions, and many other applications. It is incumbent upon the requesting physician to maintain documentation supporting the medical necessity of the additional work involved in the rendering, interpretation and report of the three-dimensional (3D) images. It is incumbent upon the interpreting physician to adequately document that work and report the findings to the requesting physician for clinical use.

Coding Guidelines
1. List the appropriate ICD-9 code that most clearly describes the condition/diagnosis of the patient that is the reason for the 3-D imaging study.
2. ICD-9 codes must be present on all Physician Service claims and must be coded to the highest level of accuracy and digit level completeness.
3. CPT codes 76376 and 76377 must be performed in conjunction with the base imaging procedure. The base imaging procedure should be billed on the same claim as CPT code 76376 or 76377.

4. CPT codes 76376 and 76377 are allowed only when billed in conjunction with another computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality procedure code.
5. Do not report CPT 76376 or CPT 76377 in conjunction with any of the Nuclear Medicine Codes (78000-78999) or with the new Category III cardiac CT and CTA codes.
6. CPT 76376 and 76377 bundle into G0288 (Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery) and are not payable with G0288. G0288 only has a technical component with no professional component.
7. CPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This information does not take precedence over CCI edits. Please refer to CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare
8. Instructions on how to report primary and secondary ICD-9 codes;
    A. Medicare expects there will be a **primary** diagnosis code(s) that is representative of the patient's medical condition, which supports the need for the base imaging procedure.
    B. Coverage of the base imaging procedure may be determined by other LCDs.
    C. If the base imaging procedure is denied, the 3D rendering and interpretation will also be denied.
    D. Use the secondary diagnosis that most closely represents the body area that is to be 3D imaged

GY and GZ Modifiers
When billing for services, requested by the beneficiary for denial, that are statutorily excluded by Medicare (i.e. screening), report a screening ICD-9 code and the GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit)

When billing for services, requested by the beneficiary for denial, that would be considered **not** reasonable and necessary, report an ICD-9 code that best describes the patients condition and the GA modifier if an ABN signed by the beneficiary is on file or the GZ modifier (items or services expected to be denied as not reasonable) when there is no ABN for the service on file.

Reasons for Denial
1. Services that do not meet the medical necessity criteria will be denied as not medically necessary.
2. Services performed in other than approved setting will be denied as non-covered.
3. Services performed on other than FDA approved equipment will be denied as non-covered.
4. Services considered investigational, otherwise not covered or never medically necessary will be denied as non-covered.
5. Physicians' Services submitted without an ICD-9 code to support medical necessity or not coded to the greatest level of accuracy and digit completeness will be denied as unprocessable.
6. Lack of documentation supporting the medical necessity of the 3-D rendering or image post-processing.
7. Lack of documentation from the requesting physician authenticating the need for 3-D rendering of the obtained images.
8. The CPT/HCPS codes included in this policy will be subjected to procedure to diagnosis editing. If a covered secondary diagnosis is not included on the claim, the edit will automatically deny the claim.
9. Title XVIII of the Social Security Act, Section 1862 (a) (7)
   This section excludes routine physical examinations.
10. Title XVIII of the Social Security Act, Section 1862 (a) (1) (A)
    This section allows coverage and payment for only those services considered medically reasonable and necessary.

11. Title XVIII of the Social Security Act, Section 1833 (e)
This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.
12. *Title XVIII of the Social Security Act, Section 1861(s) (3) as implemented by 42 CFR §410.32.
This section requires that diagnostic tests must be ordered by the physician who is treating the beneficiary and uses the results in the management of the beneficiary's specific medical problem.

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06/01/2012 - This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.

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Notes
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