Billing and Coding Guidelines

Title
Billing and Coding Guidelines for Computerized Tomography (CAT Scans) (RAD-033)

Effective Date
03/25/2009

Text
This article contains the coding guidelines and reasons for denial for computerized tomography. This article should be used in conjunction with LCD Computerized Tomography (RAD-033).

National Coverage
Title XVIII of the Social Security Act section 1862(a) (7). This section excludes routine physical examinations and services.

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.

42CFR410.32 Diagnostic tests may only be ordered by the treating physician (or other treating practitioners acting within the scope of their licenses and Medicare requirements) and diagnostic tests payable under the Physicians Fee Schedule must be furnished under the appropriate level of supervision by a physician.
Title XVIII of the Social Security Act section 1862(a) (1) (A). This section allows coverage and payment of those services that are considered medically reasonable and necessary.

CMS Pub.100-3, Ch.1, Part 4, §220.1

Coding Guidelines
1. List the appropriate CPT/ HCPCS code that most clearly describes the service(s) performed; include any necessary modifiers (e.g. 26, TC).
2. List the appropriate ICD-9 code that best supports the medical necessity for the CT scan. ICD-9 code(s) must be present on all Physicians' Service claims and must be codes to the highest degree of specificity and digit level specificity.
3. V67.00, V67.1, V67.2, and V71.1 are non-specific ICD-9 codes, which require an additional ICD-9-CM code to specify the disease entity treated**.**
   Example: When a metastasis of the primary neoplasm is suspected report V71.1 with a secondary neoplasm ICD-9 code (*140.0-209.79) or personal history of neoplasm ICD-9 code (V10.00-V10.91).
4. Consult the CCI for services that may be considered bundled into the CT scan.
5. When billing for screening tests, requested by the beneficiary for denial, report a screening ICD-9 code and modifier GY (items/services statutorily excluded or does not meet the definition of any Medicare benefit).
6. When billing services, requested by the beneficiary for denial, which do not meet the medical necessity criteria, report an ICD-9 code describing the beneficiary's condition and the GA modifier, if an ABN signed by the beneficiary is on file or the GZ modifier when there is no ABN on file.

Other Information
Mobile Equipment:

CT scans performed on mobile units are subject to the same Medicare coverage requirements applicable to scans performed on stationary units, as well as certain health and safety requirements recommended by PHS. As with scans performed on stationary units, the scans must be determined medically necessary for the individual patient. The scans must be performed on types of scanning equipment that have been approved for use as stationary units, and must be in compliance with applicable State laws and regulations for control of radiation.

a. *Hospital Setting*:
The hospital must assume responsibility for the quality of the scan furnished to inpatients and outpatients and must assure that a radiologist or other qualified physician is in charge of the procedure. The radiologist or other physician (i.e., one who is with the mobile unit) who is responsible for the procedure must be approved by the hospital for similar privileges.

b. *Ambulatory Setting:*
*If mobile scan services are furnished at an ambulatory health care facility other than a hospital-based facility, e.g., a freestanding physician-directed clinic, the diagnostic procedure must be performed by or under the direct personal supervision of a radiologist or other qualified physician.***)** *In addition, the facility must maintain a record of the attending physician's order for a scan performed on a mobile unit.*

c. *Billing for Mobile Scans:*
Hospitals, hospital-associated radiologists, ambulatory health care facilities, and physician owner/operators of mobile units may bill for mobile scans as they would for scans performed on stationary equipment.

d. *Claims Review:*
Evidence of compliance with applicable State laws and regulations for control of radiation may be requested from owners of mobile scan units upon receipt of the first claims. All mobile scan claims will be reviewed very carefully in accordance with instructions applicable to scans performed on fixed units, with particular emphasis on the medical necessity for scans performed in an ambulatory setting.

Reason for Denial

1. Services submitted without an ICD-9 code to support medical necessity would be denied as not medical necessity.
2. Services performed in other than approved settings will be denied as non-covered.
3. Services performed using other than FDA-approved equipment will be denied as non-covered.
4. Screening tests, in the absence of associated sign, symptoms, illness or injury will be denied as non-covered.
5. Physician's Service submitted without an ICD-9 code, or not coded to the greatest degree of specificity and digit level specificity will be denied as unprocessable.
6. EBCT procedures for measurement of coronary calcification or other screening applications will be denied as non-covered.

Non-covered ICD-9 Code(s)
V72.0-V83.89

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07/16/2012

Revision History Explanation
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.

10/01/2010, Reformatted (two).

10/01/2009, ICD-9 2010 update (two); 08/01/2009, Revised sentence number three under coding guidelines to include the ICD-9 range of 140.0-209.30. Effective 03/25/2009.

Last Reviewed On
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