

Billing and Coding Guidelines

Title

Billing and Coding Guidelines for RAD-034, Coronary Computed Tomography Angiography

Effective Date

08/16/2009

Text

The Benefit Improvement Protection Act (BIPA) §520 created Local Coverage Determinations (LCD) that consist of only reasonable and necessary information.

Computed Coronary Tomography Angiography (RAD-034) has been developed as a LCD, in compliance with the CMS regulations. Coding and other information has been placed in this article. This article should be used in conjunction with RAD-034.

CMS National Coverage/Citations

CMS Manual System, Pub 100-3, National Coverage Determination Manual, #9; Section 220.1. This section deals with diagnostic examination by CT scan.

CMS Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 13, Section 20. This section addresses payment conditions for radiology services.

CMS Manual System, Pub 100-9, Contractor Beneficiary and Provider #9; Communication Manual, Chapter 5, Section 20). This section addresses standards of medical/surgical practice and the correct coding initiative (CCI).

Reasons for Denial

1. Title XVIII of the Social Security Act, Section 1862 (a) (7)
This section excludes routine physical examinations.
2. 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.
3. 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.
4. *Quantitative calcium scoring (CPT code 0144T for dates of service prior to 01/01/2010, and CPT 75571 for dates of service on or after 01/01/2010 is a non-covered service and will be denied as not medically necessary. Calcium scoring reported in isolation is considered a screening service. When performed in association with CT angiography, there is neither separate nor additional included reimbursement for calcium scoring.

Coding and Billing Guidelines

1. As stated in the 2010 CPT, The American Medical Association (AMA) instructs physicians not to bill 75571 with 75572-75574.
2. ICD-9-CM code listings may cover a range and include truncated codes. It is the provider's responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM book appropriate to the year in which the service was performed.
3. It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.
4. Medicare will only pay one professional service for interpretation even if multiple interpretations are obtained by multiple specialties.

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07/01/2009

Revision History/Explanation/Number

*04/01/2012: Removed from Reasons for Denial, sentence four (4) restrictions of non-coverage for CPT code 75573. Clarified reason CPT code 75571 is non-covered. Minor formatting changes (three).

04/01/2011; Formatting changes only (two).

01/01/2010: Under section entitled "Reasons for Denial, "sentence number four, deleted codes 0144T, 10150T and 0151T per 2010 CPT Coding updates and replaced with new 2010 CPT codes. Under section entitled "C