Coding and Billing Article

Article Type
LCD Companion Article

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

AMA CPT/ADA Copyright Statement

Article Effective Date

Article 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. Codes 75571 and 75573 are at this time deemed to be Experimental and Investigational (I&E) and therefore, not covered by Medicare.

Coding and Billing Guidelines

1. *As stated in the 2010 CPT, providers are instructed 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.

The American Medical Association (AMA) instructs physicians not to bill 75571 with 75572-75574.

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Revision History/Explanation/Number
*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 75571 and 75573. Under section entitled "Coding and Billing Guidelines" added sentence number four (one).