CT Colonography RAD-035: Billing and Coding Guidelines

Original Effective Date
11/15/09

Revision Effective Date
01/01/2010

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Article Text
This article contains the coding guidelines and reasons for denial of CT Colonography services. This article should be utilized in combination with the CT Colonography LCD.

Coverage Topic
Diagnostic Tests and X-rays

Coding Information
1. To bill the professional component only for the diagnostic CT colonography report 74261 or 74262 on a single claim line with a 26 modifier in the first modifier position (74261-26).
2. To bill the technical component only for the diagnostic CT colonography report 74261 or 74262 on a single claim line with a TC modifier in the first modifier position (74261TC).
3. To bill the professional and technical components for the diagnostic CT colonography, in the office setting (POS 11), report 74261 or 74262 on a single claim with no modifiers.
4. It is incorrect coding to report procedure code 74261 or 74262 when performing a screening procedure. Screening procedures should be reported using procedure code 74263, and will be denied as non-covered
5. It is incorrect coding to report a diagnostic CT colonography as, or in conjunction with, CT of pelvis/abdomen (72192-72194, 74150-74170) and CT 3-D reconstruction (76376, 76377).
6. List the appropriate ICD-9 code that best supports the medical necessity for the procedure. The primary diagnosis should be placed in the first position in item 21 of the CMS 1500 claim form or equivalent field for electronic submission, secondary diagnosis codes should be placed in the subsequent positions. ICD-9 codes must be present on all Physicians' Service claims and must be codes to the highest degree of specificity and digit level completeness.
7. The name and UPIN of the ordering/referring physician or non-physician practitioner (acting within the scope of their licensing and Medicare requirements) are required in item 17 and 17a of the CMS-1500 claim form, or electronic equivalent field.
8. When billing for services, requested by the beneficiary for denial, that are statutorily excluded by Medicare (i.e. screening CT colonography - 74263), report a screening ICD-9 code (V76.51) and the GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit).
9. 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 (waiver of liability on file) 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.

Denial Summary
The following situations will result in the denial of initially billed CT Colonography (Virtual Colonoscopy) services or in some cases as a result of a post-payment review.

1. Title XVIII of the Social Security Act, Section 1862 (a)(7). This section excludes routine physical examinations and services.
    a. Screening CT colonography (74263) will be denied as non-covered.

2. Title XVIII of the Social Security Act section 1862(a)(1)(A). This section excludes coverage and payment for items and services that are not considered reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body member.
    a. Services submitted without an ICD-9 code to support medical necessity will be denied as not medically necessary.

    b. Diagnostic CT colonography performed in the absence of signs or symptoms of disease, regardless of family history or other risk factors for the development of colonic disease, will be denied as not medically necessary.

    c. CT of pelvis/abdomen (72192-72194, 74150-74170) and CT 3-D reconstruction (76376, 76377) will be denied as not medically necessary if billed with CT colonography.

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.

    a. Physicians' Services submitted without an ICD-9 code or not codes to the highest level of specificity will be denied as unprocessable.

Notes
An asterisk (*) indicates a revision to that section of the article.

Publication Date
10/01/09

Revision Date/Number/Explanation
01/01/10- Added 74261-74263, deleted codes 0066T, 0067T