

Medicare Reimbursement for Diagnostic Breast Magnetic Resonance Imaging¹

This advisory discusses Medicare coding, coverage and payment for diagnostic applications of breast magnetic resonance imaging (MRI)² when performed in the hospital inpatient, hospital outpatient, independent diagnostic testing facility and physician office settings.³ While it focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

Coding

Medicare's reimbursement system relies mostly on Current Procedural Terminology (CPT) codes to consistently identify diagnostic imaging procedures provided to Medicare patients.⁴ The CPT coding system was developed and is maintained by the American Medical Association (AMA) and the codes are updated annually.

In addition to the use of CPT codes, Medicare utilizes Healthcare Common Procedure Coding System (HCPCS) level II (national) codes to report the use of diagnostic breast MRI. The agency developed the alphanumeric HCPCS level II coding system to describe and identify many supplies and services (i.e., technical component of breast MRI) that are not included in the CPT coding system. Table 1 lists the CPT codes and HCPCS Level II codes for diagnostic breast MRI services.

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Diagnostic Breast MRI CAD Coding

Effective July 1, 2006, the AMA designated a CPT Category III add-on code to report computer-aided detection (CAD) when performed with diagnostic breast MRI. Category III codes were developed by the AMA to track utilization of emerging technologies. These codes have four digits followed by an alphabetic character. According to the AMA, **if a Category III code is available and appropriate, this code must be reported instead of a Category I unlisted code or other Category I code. Generally, a Category III code will be archived after five years if a Category I code is not assigned.**



When reporting a service that is new and denoted using a CPT Category III code, payers may require a special report to accompany the medical claim in order to determine whether the service is medically appropriate for the patient. The following is information that should be included:⁵

- Description of the nature, extent and need for the procedure
- Time, effort and equipment needed to provide the procedure

Other information may be required, including the following:

- Complexity of symptoms
- Final diagnosis
- Pertinent physical findings
- Diagnostic and therapeutic procedures
- Concurrent problems
- Follow-up care

Listed on Table 1 is the Category III add-on code for CAD, CPT code 0159T, computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis when performed with diagnostic breast MRI. This code is to be reported in conjunction with the code for the base imaging procedure (i.e., 77058 or 77059).⁶ Per the American Medical Association and the American College of Radiology (ACR), this code “should be used to describe any type of CAD” when performed in conjunction with MRI of the breast.⁷ The ACR indicates 3D rendering is an inherent and intrinsic part of the CAD software; therefore, a separate 3D rendering code (i.e., CPT codes 76376 or 76377) should not be reported with this specific CAD add-on code.⁸

For more information on Category III codes and their use, refer to the coding guidelines that accompany the relevant section of CPT® 2008. The guidelines are also posted on the AMA website at <http://www.ama-assn.org/ama/pub/category/3885.html#Introduction>.

When submitting claims to Medicare, procedural CPT codes are reported with diagnosis codes describing the patient’s documented medical conditions. These diagnoses are reported using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

The preceding coding guidance has been provided by authoritative sources; however, individual circumstances can be an important factor in appropriate coding for imaging procedures. It is the provider’s responsibility to consult with an authoritative coding resource to determine and submit appropriate codes. The existence of a code does not necessarily mean the procedure is covered and payable.

Reimbursement

Medicare reimbursement for diagnostic imaging procedures is comprised of a **professional component**, the amount paid for the physician’s interpretation and report, and a **technical component**, the amount paid for all other services (including staffing and equipment costs). When combined and paid to the same individual or entity, this amount is often referred to as the **total** or **global reimbursement**.

Currently, Medicare reimburses diagnostic imaging procedures based on the site of care. The technical component of a procedure performed in an **IDTF** or in a **physician’s office** is reimbursed under the Medicare physician fee schedule. In a **hospital outpatient department**, the technical component of a procedure is reimbursed under an Ambulatory Payment Classification (APC) under Medicare’s hospital outpatient prospective payment system (HOPPS). It is important to note that, in the hospital outpatient site of care, MRI CAD procedures are not reimbursed separately, but rather are “packaged” or included in the APC payment to the hospital. In a **hospital inpatient** site of care, the technical (facility) payment is subsumed within the payment to the hospital that is determined based on a Diagnosis Related Group (DRG) to which the patient is assigned. The professional component is reimbursed under the Medicare physician fee schedule, regardless of setting.

Table 1 provides information concerning Medicare national average payment rates for diagnostic Breast MRI for relevant sites of service. Please note that, as Table 1 indicates, the technical component of MR breast imaging procedures is coded and reimbursed on the basis of HCPCS codes, rather than CPT codes, when provided in the hospital outpatient department setting. This is because Medicare’s HOPPS reimburses hospitals for MR breast procedures at varying amounts, depending on the use of contrast. Existing CPT codes for MR breast procedures do not specifically distinguish MR procedures that use contrast from those that do not.

| CPT/HCPCS Code | Reimbursement Component | Hospital Inpatient Departments ⁹ | Hospital Outpatient Department ¹⁰ | IDTF and Physician Office ^{11, 12} |
|---|-------------------------|---|--|---|
| CPT 77058 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral | Technical | Included in DRG | Not Applicable | \$525.24 |
| | Professional | \$78.46 | \$78.46 | \$78.46 |
| | Total | DRG + \$78.46 | Not Applicable | \$603.70 |
| CPT C8903 Magnetic resonance imaging with contrast, breast; unilateral | Technical | Not Applicable | \$397.13 | Not Applicable |
| | Professional | Not Applicable | Not Applicable | Not Applicable |
| | Total | Not Applicable | \$397.13 | Not Applicable |
| CPT C8904 Magnetic resonance imaging without contrast, breast; unilateral | Technical | Not Applicable | \$343.52 | Not Applicable |
| | Professional | Not Applicable | Not Applicable | Not Applicable |
| | Total | Not Applicable | \$343.52 | Not Applicable |
| CPT C8905 Magnetic resonance imaging without contrast followed by with contrast; breast; unilateral | Technical | Not Applicable | \$525.24 | Not Applicable |
| | Professional | Not Applicable | Not Applicable | Not Applicable |
| | Total | Not Applicable | \$525.24 | Not Applicable |
| CPT 77059 Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral | Technical | Including in DRG | Not Applicable | \$525.24 |
| | Professional | \$78.46 | \$78.46 | \$78.46 |
| | Total | DRG + \$78.46 | Not Applicable | \$603.70 |
| CPT C8906 Magnetic resonance imaging with contrast, breast; bilateral | Technical | Not Applicable | \$397.13 | Not Applicable |
| | Professional | Not Applicable | Not Applicable | Not Applicable |
| | Total | Not Applicable | \$397.13 | Not Applicable |
| CPT C8907 Magnetic resonance imaging without contrast, breast; bilateral | Technical | Not Applicable | \$343.52 | Not Applicable |
| | Professional | Not Applicable | Not Applicable | Not Applicable |
| | Total | Not Applicable | \$343.52 | Not Applicable |
| CPT C8908 Magnetic resonance imaging without contrast followed by with contrast, breast; bilateral | Technical | Not Applicable | \$525.24 | Not Applicable |
| | Professional | Not Applicable | Not Applicable | Not Applicable |
| | Total | Not Applicable | \$525.24 | Not Applicable |
| CPT 0159T Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/ characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure) (Use 0159T in conjunction with 77058, 77059) (Do not report 0159T in conjunction with 76376, 76377) | Technical | Including in DRG | Packaged in APC | Carrier Priced |
| | Professional | Carrier Priced | Carrier Priced | Carrier Priced |
| | Total | Included in DRG + Carrier Priced | APC + Carrier Priced | Carrier Priced |

Table 1: 2008 Medicare Payments for Diagnostic Breast MRI. (Reflects National Average Rates, Unadjusted for Locality)

HCPCS codes provide such a distinction and, as a result, are used to report the technical component of MR breast procedures provided in this setting. In addition, national payment rates in the Medicare physician fee schedule are not assigned to CPT Category III codes, these codes are carrier-priced under certain circumstances, as listed in this table. Carrier-priced means the local Medicare contractors will establish, for their region, payment amounts for these services. To obtain more information about local Medicare reimbursement rates go to the GE Magnetic Resonance Medicare Reimbursement Calculator at <http://www.gehealthcare.com/usen/community/reimbursement/>. To confirm reimbursement rates, consult your local Medicare contractor.

Coverage

Medicare's national coverage policy, *Magnetic Resonance Imaging (MRI)*, states that MRI scans may be covered as diagnostic services if reasonable and necessary, and if performed on an FDA-approved model of MRI equipment. Local Medicare contractors have discretion to determine the circumstances under which a diagnostic breast MRI scan is covered. The national coverage policy is contained in the Internet Manual for Medicare National Coverage Determinations at <http://www.cms.hhs.gov/manuals/downloads/clm104c13.pdf> (scroll to section 40).

Some local Medicare contractors have developed Local Coverage Determinations (LCDs) that address diagnostic breast MRI procedures. Coverage may be restricted in terms of the type of provider, patient clinical indications or frequency of procedures. To confirm coverage, consult with your local Medicare contractor. A directory of local Medicare contractors can be accessed at http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf. To access the LCDs, refer to <http://www.cms.gov/mcd/search.asp> or the individual contractor's website.

With respect to private payers, some may rely on Medicare reimbursement policies, while others consider alternative information. Therefore, it is important to consult with individual private payers regarding coverage for these procedures as well.

MR Accreditation

Select payers may require certain imaging providers to be accredited in order to receive reimbursement for MR imaging. The major accrediting agencies for diagnostic imaging include the American College of Radiology (ACR), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC/Accreditation Association) and the Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories (ICAMRL).¹³ Accreditation by these agencies is a rigorous process which generally includes a comprehensive application or self-assessment and a thorough review by the accrediting body. Accreditation standards vary greatly by reviewing agency; however, they all seek to verify applicants meet specific standards of care and performance, including those related to diagnostic imaging, protocols and equipment. Payers may specify which of these accreditation organizations should be used to secure MR imaging accreditation. To obtain more information about specific accreditation standards for each agency, visit their websites at: www.acr.org, www.jointcommission.com, www.aaahc.org and www.intersocietal.org.

In addition, private payers may have additional accreditation standards that must be met. Therefore, it is important to consult with individual private payers to determine the specific accreditation requirements for MR imaging.

¹ Information presented in this document is current as of January 15, 2008. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

² The Food and Drug Administration (FDA) approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this customer advisory. Some payers may in some instances treat a procedure which is not specifically covered by the equipment's FDA-approved labeling as a non-covered service.

³ The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients in those states. In addition, licensure, certificate of need, and other restrictions may be applicable.

⁴ CPT codes and descriptions only are copyright © 2007 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

⁵ American Medical Association. CPT® 2008 Professional Edition.

⁶ CPT Changes 2007- An Insider's View.

⁷ American College of Radiology and American Medical Association. Clinical Examples in Radiology, Vol. 3, Iss. 2; Spring 2007. and CPT Assistant. July 2007, vol. 17, Issue 7.

⁸ American College of Radiology- Coding Q & A, Jan/Feb 2006.

⁹ Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The professional component for imaging procedures in the hospital inpatient setting is paid under the Medicare physician fee schedule (MPFS); however, for Category III CPT codes, local Medicare contractors determine the payment rate. The MPFS payment is based on relative value units published in Federal Register, Vol. 72, No. 227, November 27, 2007 with revisions published in Federal Register, Vol. 73, No. 10, January 15, 2008 and an update to the conversion factor of 0.5%. Per the Medicare, Medicaid and SCHIP Extension Act of 2007, these 2008 professional payment amounts are applicable through June 30, 2008. The technical component is paid pursuant to the hospital inpatient prospective payment system. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, please consult with your local Medicare contractor.

¹⁰ Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification unless the procedure is packaged under another procedure or not reimbursed using a CPT code under the hospital outpatient prospective payment system, as published in Federal Register, Vol. 72, No. 227, November 27, 2007. The professional component is paid under the Medicare physician fee schedule; however, for Category III CPT codes, local Medicare contractors determine the payment rate. The MPFS payment is based on relative value units published in Federal Register, Vol. 72, No. 227, November 27, 2007 with revisions published in Federal Register, Vol. 73, No. 10, January 15, 2008 and an update to the conversion factor of 0.5%. Per the Medicare, Medicaid and SCHIP Extension Act of 2007, these 2008 professional payment amounts are applicable through June 30, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, please consult with your local Medicare contractor.

¹¹ Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. Both the technical and professional components are paid under the Medicare physician fee schedule; however, for Category III CPT codes, local Medicare contractors determine the payment rate. The MPFS payment is based on relative value units published in Federal Register, Vol. 72, No. 227, November 27, 2007 with revisions published in Federal Register, Vol. 73, No. 10, January 15, 2008. Per the Medicare, Medicaid and SCHIP Extension Act of 2007, these 2008 technical and professional payment amounts are applicable through June 30, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, please consult with your local Medicare contractor.

¹² Per the Deficit Reduction Act (DRA) of 2005, designated imaging services with a 2008 Medicare physician fee schedule technical payment (prior to geographic adjustment) that exceeds the comparable 2008 hospital outpatient prospective payment system (HOPPS) technical payment (prior to geographic adjustment), as published in Federal Register, Vol. 72, No. 227, November 27, 2007, will be capped at the 2008 HOPPS payment amount.

¹³ GE Beyond. Examining Accreditation Trends in the Imaging Environment, April 2007.

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