REIMBURSEMENT INFORMATION FOR LUNG CANCER SCREENING WITH LOW-DOSE COMPUTED TOMOGRAPHY (LDCT)¹

February, 2017

gehealthcare.com/Reimbursement
This overview addresses coding, coverage, and payment for Lung Cancer Screening with Low-Dose Computed Tomography when performed in the hospital outpatient, inpatient department, as well as the physician's office. While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

The following table provides 2017 national average Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates. Actual CMS payments are adjusted to reflect the variation in practice costs from area to area using for each locality a geographic practice cost index.

### 2017 National Average MPFS and APC Reimbursement for Lung Cancer Screening with LDCT

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Medicare Freestanding Facility/Physician Office</th>
<th>Hospital Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reimbursement Component</td>
<td>Medicare Physician Fee Schedule Payment</td>
</tr>
<tr>
<td>G0297*</td>
<td>Low Dose CT scan (LDCT) for lung cancer screening</td>
<td>Professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
</tr>
<tr>
<td>71250</td>
<td>Computed tomography, thorax; without contrast material</td>
<td>Professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
</tr>
<tr>
<td>76497***</td>
<td>Unlisted computed tomography procedure (eg, diagnostic, interventional)</td>
<td>Professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
</tr>
<tr>
<td>S8032</td>
<td>Low-dose computed tomography for lung cancer screening</td>
<td>The S codes are used by the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) S Codes are not paid under Medicare Physician Fee Schedule</td>
</tr>
<tr>
<td>G0296</td>
<td>Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT)****</td>
<td>Professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Technical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Global</td>
</tr>
</tbody>
</table>

* Professional (-26) – The professional component encompasses physician work interpreting a diagnostic test or performing a procedure, and includes indirect practice and malpractice expenses related to the work. When the professional component is reported separately the service may be identified by adding modifier 26.

** Technical (-TC) – The technical component encompasses all non-physician work, and includes administrative, personnel, capital costs, and related malpractice expenses. This is identified by adding modifier “TC” to the procedure code identified for the technical component charge.

*** The unlisted CPT code 76497 may be recommended for use by non-Medicare payers. Please check with your payer for coding requirements.

**** Service is for eligibility determination and shared decision-making (CMS patients only).

## Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of pain management procedures. This is not an all-inclusive list of applicable modifiers. Refer to your current CPT and/or HCPCS manual for a complete list of modifiers and instructions for specific CPT codes.

- **-26 Professional Component**
  Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. The professional component is the interpretation of the results of the test. When the professional component is reported separately the service may be identified by adding modifier 26.

- **-TC Technical Component**
  Under certain circumstances, a charge may be made for the technical component alone and is identified by adding modifier ‘TC’ to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians. However, portable X-ray suppliers only bill for technical component and should utilize modifier TC.
ICD-10 Coding

ICD-10-CM and ICD-10-PCS codes were effective October 1, 2015. As with the ICD-9-CM diagnosis coding, it is the physician’s responsibility to select and report the appropriate diagnosis codes that pertain to the patient’s symptoms or conditions that reflect the reason for doing the Lung Cancer screening with LDCT. Regarding ICD-10-PCS coding, it is recommended to check with the individual payers to obtain their specific coding requirements. The following codes may be appropriate to reflect the Lung Screening with Low Dose CT:

<table>
<thead>
<tr>
<th>ICD-10-PCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BB242ZZ</td>
<td>Computerized Tomography (CT Scan) of Bilateral Lungs</td>
</tr>
<tr>
<td>Z12.2</td>
<td>Encounter for screening for malignant neoplasm of respiratory organs</td>
</tr>
<tr>
<td>Z72.0</td>
<td>Tobacco use</td>
</tr>
<tr>
<td>Z87.891</td>
<td>Personal history of nicotine dependence</td>
</tr>
</tbody>
</table>

Documentation Requirements

As with all medical procedures performed, Medicare requires documentation to support that the procedure(s) performed are medically necessary. The following requirements should be met in order to be considered for coverage and reimbursement by Medicare:

- Medical necessity as determined by the payer
- Completeness
- Documented in the patient’s medical record

Coverage

The Centers for Medicare & Medicaid Services (CMS) issued a final National Coverage Determination (NCD), effective February 5, 2015, that provides for Medicare coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT). The CMS has determined that the evidence is sufficient to add a lung cancer with Low Dose Computed Tomography (LDCT), as an additional preventive service benefit under the Medicare program only if all of the following criteria are met:

- They are age 55 – 77, and are either current smokers or have quit smoking within the last 15 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- They have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years);
- Current smoker or one who has quit smoking within the last 15 years; and
- They receive a written order from a physician or qualified non-physician practitioner that meets certain requirements. Medicare coverage includes a visit for counseling and shared decision-making on the benefits and risks of lung cancer.

Medicare coverage includes a visit for counseling and shared decision-making on the benefits and risks of lung cancer screening. The CMS NCD provides patient radiation exposure criteria that are consistent with the U.S. Preventive Services Task Force analysis of lung cancer screening benefits and potential harms. These low-dose criteria can generally be achieved with modern helical CT scanners. Before performing lung cancer screening examinations, providers are advised to confirm with their payer network (CMS and commercial) what scanner requirements must be achieved in order to receive routine payment for the examinations.

Several GE systems are cleared by FDA for low-dose lung cancer screening. These GE systems are capable of meeting the relevant imaging facility requirements and only those units are within scope of this Reimbursement Advisory, namely:

- **16-Slice Systems**
  - LightSpeed™ 16
  - BrightSpeed™ Elite
  - LightSpeed Pro16
  - Optima™ CT540

- **Wide-Bore Systems**
  - LightSpeed RT16
  - LightSpeed Xtra
  - Discovery™ CT590 RT
  - Optima CT580
  - Optima CT580 W
  - Optima CT 580 RT

- **Revolution™**
  - Revolution CT

- **PET/CT Systems**
  - Discovery PET/CT 610
  - Discovery PET/CT 710
  - Discovery IQ

- **VCT/Optima CT 660 Systems**
  - LightSpeed VCT
  - LightSpeed VCT XT
  - LightSpeed VCT XTe
  - LightSpeedPro32
  - LightSpeed VCT Select
  - Optima CT 660
  - Revolution EVO

- **HD Systems**
  - Discovery CT 750 HD with or without VEO™
  - Revolution Discovery CT
  - Revolution GSI
  - Revolution HD

- **SPECT/CT Systems**
  - Discovery CT670 (16-Slice)
  - Discovery CT670 Pro

Eligible radiology imaging facilities furnishing lung cancer screening with LDCT are required to submit data to a CMS-approved registry for each lung cancer LDCT screening performed. Below is the list of CMS-approved lung cancer screening registries:

- American College of Radiology (ACR) Lung Cancer Screening Registry (LCSR)
  - Email: nrdr@acr.org
  - Phone: 1-800-227-5463, extension 3535

For additional information regarding the ACR Lung Cancer Screening Registry, please go to: [http://www.acr.org/Quality-Safety/National-Radiology-Data-Registry/Lung-Cancer-Screening-Registry](http://www.acr.org/Quality-Safety/National-Radiology-Data-Registry/Lung-Cancer-Screening-Registry)

Medicare carriers may issue Local Coverage Decisions (LCDs) addressing the requirements that must be met for services to be covered. It is strongly recommended that physicians review these LCDs or contact their local payers to inquire about these requirements. Medicare LCDs may be found at this link: [http://www.cms.gov/medicare-coverage-database/](http://www.cms.gov/medicare-coverage-database/)

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 Lung Cancer Screening with LDCT as well.
Disclaimer

THE INFORMATION PROVIDED WITH THIS NOTICE IS GENERAL REIMBURSEMENT INFORMATION ONLY; IT IS NOT LEGAL ADVICE, NOR ADVICE ABOUT HOW TO CODE, COMPLETE OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. IT IS ALWAYS THE PROVIDER’S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES, MODIFIERS AND BILLS FOR THE SERVICES THAT WERE RENDERED. THIS INFORMATION IS PROVIDED AS OF FEBRUARY 2017 AND ALL CODING AND REIMBURSEMENT INFORMATION IS SUBJECT TO CHANGE WITHOUT NOTICE. PAYERS OR THEIR LOCAL BRANCHES MAY HAVE DISTINCT CODING AND REIMBURSEMENT REQUIREMENTS AND POLICIES. BEFORE FILING ANY CLAIMS, PROVIDERS SHOULD VERIFY CURRENT REQUIREMENTS AND POLICIES WITH THE LOCAL PAYER.

THIRD PARTY REIMBURSEMENT AMOUNTS AND COVERAGE POLICIES FOR SPECIFIC PROCEDURES WILL VARY INCLUDING BY PAYER, TIME PERIOD AND LOCALITY, AS WELL AS BY TYPE OF PROVIDER ENTITY. THIS DOCUMENT IS NOT INTENDED TO INTERFERE WITH A HEALTH CARE PROFESSIONAL’S INDEPENDENT CLINICAL DECISION-MAKING. OTHER IMPORTANT CONSIDERATIONS SHOULD BE TAKEN INTO ACCOUNT WHEN MAKING DECISIONS, INCLUDING CLINICAL VALUE. THE HEALTH CARE PROVIDER HAS THE RESPONSIBILITY, WHEN BILLING TO GOVERNMENT AND OTHER PAYERS INCLUDING PATIENTS, TO SUBMIT CLAIMS OR INVOICES FOR PAYMENT ONLY FOR PROCEDURES WHICH ARE APPROPRIATE AND MEDICALLY NECESSARY. YOU SHOULD CONSULT WITH YOUR REIMBURSEMENT MANAGER OR HEALTHCARE CONSULTANT, AS WELL AS EXPERIENCED LEGAL COUNSEL.

1. Information presented in this document is current as of February, 2017. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

2. Current Procedural Terminology (CPT) is copyright 2016 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

3. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The MPFS payment is based on relative value units published in Federal Register/ Vol. 81, No. 220/Tuesday, November 15, 2016 as well as subsequent updates and legislation. Amounts do not necessarily reflect any subsequent changes in payment since publication. The fee schedule amounts indicated are effective for services provided from 1/1/17 through 12/31/17. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

4. 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 under the hospital outpatient prospective payment system, as published in Federal Register/ Vol. 80, No. 219/ Monday, November 14, 2016. These changes are effective for services provided from 1/1/17 through 12/31/17. The professional component is generally paid based on the Medicare physician fee schedule. Amounts do not necessarily reflect any subsequent changes in payment since publication. Consult your local Medicare Contractor to confirm reimbursement rates for specific codes.

5. HCPCS code G0297 to be billed no more than once per annum for CMS patients. At least 11 months must elapse from the date of last screening. Before the first LDCT screening the CMS patient must receive a lung cancer screening counseling and shared decision meeting visit reported by G0296 (Counseling visit to discuss need for lung cancer screening (LDCT) using Low Dose CT scan).