Hospital Outpatient Reimbursements for Pelvic/Abdominal CT
January 2012

IN BRIEF:

- Important 2012 reimbursement increase for pelvic/abdominal CT
- Modest 2012 reimbursement decrease for abdominal/pelvic CT angiography

Hospital outpatient imaging centers will see a favorable adjustment in 2012 Medicare payments for CTs performed simultaneously on the abdomen and pelvis. These increases, which range from 74 percent to 110 percent, took effect January 1, 2012, and vary by the type of study performed and the hospital's location.

Why the adjustments? In 2011, the American Medical Association (AMA) created three new CPT codes (74176, 74177, 74178) to capture instances when abdominal and pelvic CTs were performed at the same time, and Medicare assigned these new codes to existing Ambulatory Payment Classifications (APCs) with relatively low reimbursement rates. In 2012, Medicare reassigned the three new codes to two newly created composite APCs (0331, 0334) that have appropriately increased reimbursement rates.

The table below shows how Medicare changed the way that the three new CPT codes for abdominal/pelvic CTs were mapped to composite APCs in 2012, and the resulting percentage increase in reimbursements between the old and new APCs (74 percent – 115 percent). The actual reimbursement increases depend on where the hospital is located, and are available from GE Healthcare's reimbursement calculator here: *https://www.codemap.com/ge/index.cfm*

CPT[1] Code	2011		2012		Percent Change
	APC[2]	Facility Reimbursement	APC[3]	Facility Reimbursement	
74176 Computed tomography, abdomen and pelvis; without contrast material	0332	$194	0331	$406.60	110%
74177 Computed tomography, abdomen and pelvis; with contrast material	0283	$300	0334	$581.04	94%
74178 Computed tomography, abdomen and pelvis; without contrast in one or both body regions, followed by contrast material(s) and further sections in one or both body regions	0333	$334	0334	$581.04	74%

In a related change, Medicare also adjusted coding and reimbursement for CT angiography procedures performed simultaneously on the abdomen and pelvis in 2012. Procedure codes 74175 and 72191 were used to report these services in 2011, and were paid $626.81 under APC 8006. In 2012, the AMA created CPT code 74174 (Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including non-contrast images, if performed, and image post-processing) to report these services. Medicare mapped this new CPT code to composite APC 0334 that reimburses $581.04 in 2012. Consequently, reimbursements for CT angiography of the abdomen/pelvis adjusted downward by 7 percent.

CPT[1] Code	2011		2012		Percent Change
	APC[2]	Facility Reimbursement	APC[3]	Facility Reimbursement	
74175 Computed tomographic angiography, abdomen, with contrast material(s), including non-contrast images, if performed, and image post-processing	8006	$626.81			-7%
72191 Computed tomographic angiography, pelvis, with contrast material(s), including non-contrast images, if performed, and image post-processing	8006	$626.81			
74174 Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including non-contrast images, if performed, and image post-processing (In 2011 CPT 74145, 72191)			0334	$581.04	

The bottom line is that hospitals will see a favorable adjustment in Medicare payments for CTs performed simultaneously on the pelvis and abdomen, and a modest decrease in reimbursement for CT angiography of the abdomen/pelvis. The impact on Medicare revenues will depend on the volume of these services performed.

References

1. Current Procedural Terminology (CPT) is copyright 2011 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.

2. 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 the Federal Register, Vol. 75, No. 226, November 24, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

3. 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 the Federal Register, Vol. 76, No. 230, November 30, 2011. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

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