

REIMBURSEMENT INFORMATION FOR DIGITAL X-RAY TOMOSYNTHESIS (DTS) WHEN UTILIZED FOR THORACIC, ORTHOPEDIC, or UROLOGY X-RAY EXAMINATIONS¹

August, 2019

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This overview addresses coding, coverage, and payment for digital x-ray tomosynthesis (DTS) for chest and musculoskeletal (Orthopedic) and urology examinations. DTS can be performed with the Definium 8000, Discovery XR650, Discovery XR656, and Discovery XR656 Plus digital radiographic systems. While this advisory focuses on Medicare program policies, the information may also be applicable to selected private payers throughout the country. For appropriate code selection, contact your local payer prior to claims submittal.

2019 Reimbursement Rates

CPT code 76100 is defined as Radiologic examination, single plane body section (eg, tomography), other than with urography. While it is ultimately the physician's discretion as to what codes to report based on services rendered, it may be appropriate to report this code when performing digital x-ray tomosynthesis for thoracic and musculoskeletal examinations. Specifically, the American College of Radiology (ACR) has indicated that CPT 76100 may be reported for chest and musculoskeletal (e.g., upper extremity, lower extremity, or spine) tomosynthesis studies.² ACR has also indicated that digital tomosynthesis may be utilized when performing intravenous urography examinations where CPT 74400 is reported.³

As with any medical services performed, it is recommended to check with your individual payer for coding and coverage requirements as they may vary by payer. It would not be appropriate to report a three-dimensional reconstruction code in conjunction with the DTS service as 2D reconstruction is performed.

The following table includes the 2019 national average Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates. Payment will vary in geographic locality.

2019 Medicare Reimbursement for Procedures Related to DTS X-Ray Services

| CPT ⁴ Code / Description | Physician Office | | Facility | | |
|---|-------------------------|---|------------------|---|---|
| | Reimbursement Component | Medicare Physician Payment ⁵ | APC ⁶ | Medicare Hospital Outpatient Payment ⁶ | Medicare Ambulatory Surgery Center ⁷ |
| 76100 Radiologic examination, single plane body section (eg, tomography), other than with urography | Professional (-26)* | \$32.07 | 5522 | \$112.51 | Bundled service when performed in an ASC - no separate payment. |
| | Technical (-TC)** | \$64.15 | | | |
| | Global | \$96.22 | | | |
| 74400 Urography (pyelography), intravenous, with or without KUB, with or without tomography | Professional (-26) | \$25.23 | 5571 | \$201.74 | Bundled service when performed in an ASC - no separate payment. |
| | Technical (-TC) | \$95.86 | | | |
| | Global | \$121.09 | | | |
| 76499 Unlisted diagnostic radiographic procedure | Professional (-26) | Carrier Priced | 5521 | \$62.30 | Bundled service when performed in an ASC - no separate payment. |
| | Technical (-TC) | Carrier Priced | | | |
| | Global | Carrier Priced | | | |

* Professional (-26) - 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"

** Technical (-TC) - The technical component is the equipment and technician performing the test. This is identified by adding modifier "TC" to the procedure code identified for the technical component change.

Some payers may recommend the unlisted CPT code 76499 to report this service. As stated above, it is always recommended to check with your individual payer for coding requirements.

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 DTS coverage.

Coverage Policies

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: <https://www.cms.gov/medicare-coverage-database/>

Payment

For payment, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record. Consult payers for specific documentation requirements.

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 x-ray services.

26 - Professional Component

A physician who performs the interpretation of an x-ray exam in the hospital outpatient setting may submit a charge for the professional component of the x-ray service using a modifier (-26) appended to the x-ray code.

TC - Technical Component

This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

52 - Reduced Services

This modifier would be used in certain circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion.

76 - Repeat Procedure by Same Physician

This modifier is defined as a repeat procedure by the physician on the same date of service or patient session. The CPT defines "same physician" as not only the physician doing the procedure but also as a physician of the same specialty working for the same medical group/ employer.

77 - Repeat Procedure by Another Physician

This modifier is defined as a repeat procedure by another physician on the same date of service or patient session. "Another physician" refers to a physician in a different specialty or one who works for a different group/employer. Medical necessity for repeating the procedure must be documented in the medical record in addition to the use of the modifier .

ICD-10-CM Diagnosis Coding

It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-10-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the x-ray service.

Hospital Inpatient – ICD-10-PCS Procedure Coding

ICD-10-PCS procedure codes are used to report procedures performed in a hospital inpatient setting. The following are the ICD-10-PCS procedure codes that are typically used to report chest x-ray and musculoskeletal services:

BW00ZZZ Plain Radiography of Abdomen
BW01ZZZ Plain Radiography of Abdomen and Pelvis
BW03ZZZ Plain Radiography of Chest
BW0BZZZ Plain Radiography of All Long Bones
BW0CZZZ Plain Radiography of Lower Extremity
BW0JZZZ Plain Radiography of Upper Extremity
BW0KZZZ Plain Radiography of Whole Body
BW0LZZZ Plain Radiography of Whole Skeleton

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- 1 Information presented in this document is current as of January 1, 2019. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.
- 2 ACR Radiology Coding Source™ Nov Dec 2016, Q&A, www.acr.org/Advocacy/Economics-Health-Policy/Billing-coding/Coding-Source-List/2016/November-December-2016/QA Click here to access ARC Website
- 3 ACR Radiology Coding Source™ May June 2017, Q&A, www.acr.org/Advocacy/Economics-Health-Policy/Billing-Coding/Coding-Source-List/2017/May-June-2017/QA Click here to access ARC Website
- 4 Current Procedural Terminology (CPT) is copyright 2018 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.
- 5 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 83, No. 226 November 23, 2018. 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.
- 6 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 Medicare Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in the Federal Register, Vol. 83, No. 226, November 21, 2018. 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.
- 7 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. If the procedure is not listed on the ASC covered procedure listing, no technical or professional payment is listed. The technical payment is a payment amount assigned to an APC based payment rate under the ambulatory surgical center prospective payment system as published in Federal Register, Vol. 83, No. 226, November 21, 2018. 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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