GE Healthcare

REIMBURSEMENT INFORMATION FOR DIGITAL X-RAY TOMOSYNTHESIS (DXT) WHEN PERFORMED IN CONJUNCTION WITH X-RAY EXAMINATIONS[i]

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This overview addresses coding, coverage, and payment for digital x-ray tomosynthesis when it is performed in conjunction with an x-ray examination, specifically of the chest. DXT can be performed with the Discovery XR656 Digital Radiographic System. 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.

2013 Reimbursement Rates

Currently, there is no code that accurately describes digital x-ray tomosynthesis (DXT) performed in conjunction with an x-ray examination. Therefore, the unlisted code 76499 Unlisted diagnostic x-ray procedure could be used to describe DXT. In addition, the appropriate CPT code for the base procedure with which DXT is used would be coded as well. It would not be appropriate to report a three-dimensional reconstruction code in conjunction with the DXT service as 2D reconstruction is performed.

The following are CPT codes that may apply depending on where on the body the DXT was performed. Also included are the 2013 national average Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates for the CPT codes. **Payment will vary in geographic locality.**

2013 Medicare Reimbursement for Procedures Related to DXT and Other X-Ray Services

CPT[ii]/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Payment[iii]	APC	Hospital Outpatient Payment[iv]	Ambulatory Surgery Center[v]
CPT 76499 Unlisted diagnostic x-ray procedure	Professional (-26)*	Carrier Priced	260	$45.95	$25.78
	Technical (-TC)**	Carrier Priced			
	Global	Carrier Priced			
CPT 71010 Radiologic examination, chest; single view, frontal	Professional (-26)	$8.85	260	$45.95	$10.75
	Technical (-TC)	$14.97			
	Global	$23.82			
CPT 71015 Radiologic examination, chest; stereo, frontal	Professional (-26)	$10.21	260	$45.95	$15.50
	Technical (-TC)	$21.09			
	Global	$31.30			
CPT 71020 Radiologic examination, chest, 2 views, frontal and lateral	Professional (-26)	$10.55	260	$45.95	$14.75
	Technical (-TC)	$20.41			
	Global	$30.96			

CPT[ii]/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Payment[iii]	APC	Hospital Outpatient Payment[iv]	Ambulatory Surgery Center[v]
CPT 71021 Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure	Professional (-26)	$13.27	260	$45.95	$18.25
	Technical (-TC)	$25.18			
	Global	$38.45			
CPT 71022 Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections	Professional (-26)	$15.31	260	$45.95	$24.75
	Technical (-TC)	$33.68			
	Global	$48.99			
CPT 71030 Radiologic examination, chest, complete, minimum of 4 views	Professional (-26)	$14.63	261	$70.84	$23.75
	Technical (-TC)	$32.32			
	Global	$46.95			

* 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 charge.

Coverage Policies

Use of DXT services may be a covered benefit if such usage meets all requirements established by that particular payer. It is advisable that you check with your local Medicare Contractor for specific coverage requirement. Also, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record.

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-9-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-9-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-9-CM Procedure Coding

ICD-9-CM procedure codes are used to report procedures performed in a hospital inpatient setting. The following are the ICD-9-CM procedure codes that are typically used to report chest x-ray services:

87.44 Routine chest x-ray, so described
87.49 Other chest x-ray

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[i] Information presented in this document is current as of June 1, 2013. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

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[iii] 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 the Federal Register (Vol. 77, No. 222/ November 16, 2012) and subsequent updates based upon legislation enacted by CMS. These changes are effective for services provided from 1/1/13 through 12/31/13. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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..

[iv] 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. The payment amounts indicated are based upon data elements published in the Federal Register Vol 77, No. 221 published on November 15, 2012. These changes are effective for services provided from 1/1/13 through 12/31/13. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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.

[v] 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 77, No. 221 published on November 15, 2012. These changes are effective for services provided from 1/1/13 through 12/31/13. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA.

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Data subject to change.

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