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Technological advances drive new 3D CPT codes

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If your imaging practice frequently bills for 3D image reconstruction, you should be aware of recent changes in current procedural terminology (CPT) codes for advanced visualization techniques. The changes reflect the rapid pace at which 3D is being adopted for routine clinical use.

Prior to 2006, reimbursement for 2D and 3D image postprocessing and reconstruction was provided via CPT Code 76375. That code was declared obsolete on December 31, 2005, however, and permanently deleted from the American Medical Association Current Procedural Terminology (CPT) codes.

In its place, two new codes (CPT 76376 and CPT 76377) for 3D rendering procedures were activated on January 1; 2D reformatting has become part of the base procedure code for modalities and no longer has a separate reimbursement code.

These changes reflect the rapid and impressive advances in 2D and 3D reconstruction that have occurred over the past 10 years. With the adoption of multidetector spiral CT procedures, multiplanar 2D and 3D image postprocessing have proliferated.

Software improvements and increasing functionality have evolved as rapidly as market demand for volumetric imaging. What was previously a laborious process to create a 2D reformation may now be accomplished with simple computer commands.

Three-dimensional rendering software has not yet reached the automation level of 2D, however. The process to create an image by a technologist and/or radiologist often takes 20-45 minutes, and as much as an hour and a half for some complex cases.

Because volumetric imaging with reconstruction provides so much information beneficial to patient care, the use of 2D and 3D image postprocessing has increased dramatically. In the United States, claims submitted to Medicare alone for the now-expired CPT Code 76375 more than doubled between 2002 and 2004, climbing from approximately 300,000 claims in 2002 to more than 700,000 in 2004.

These statistics attracted the attention of the Centers for Medicare and Medicaid Services (CMS), which contacted the American College of Radiology (ACR) to request an explanation. CMS also studies technology trends, and pointed out that an increasingly large percentage of the code submissions were for work that had become automated.

"CMS intimated that multiplanar postprocessing requires little incremental work beyond that of the base scan," wrote ACR Economics Committee on Coding and Nomenclature chairman Dr. Richard Duszak, in an article published in the January 2006 issue of the *Journal of the American College of Radiology* ([JACR](#), January 2006, Vol. 3:1, pp. 67-68).

To avoid the possibility of universal non-payment for all multiplanar postprocessing and to permit appropriate valuation for dedicated 3D radiological services, the ACR initiated a review.

"It was obvious that ACR needed to modernize some previously established codes to reflect the rapid technological changes that have occurred," Duszak told *AuntMinnie.com*. "For now, we have defined two distinct 3D procedures reflecting different levels of difficulty and resource use. Our recommendations were accepted and approved by the American Medical Association."

The definitions for the new codes are:

76376:

*3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality -- **not requiring** image post-processing on an independent workstation*

76377:

*3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality -- **requiring** image post-processing on an independent workstation*

Specific utilization requirements and exceptions are explained in detail in the AMA's *Current Procedural Terminology 2006* publication.

The majority of 3D renderings are ordered by surgeons to facilitate surgical planning and provide additional information for a complex anatomic evaluation, with orders from orthopedic surgeons among the most common procedures. A 3D rendering of a complex acetabular fracture (a fracture in the cup of the hip) or a complex facial fracture better explains the location and nature of the fracture than an anatomic description of fragments and where they are displaced on a 2D, slice-by-slice perspective.

Another example is the rendering of congenital skull abnormalities, such as cranial synostosis, where the sutures of the skull of a newborn infant are abnormal and may close early, Duszak said. 3D rendering assists neurosurgeons in assessing the impact of early suture closure on the brain.

Duszak tells radiologists to exercise caution with regard to billing for any 3D procedure that hasn't been specifically ordered by the referring physician. He encourages radiologists to communicate directly with their medical colleagues to explain when 3D rendering may be beneficial if it has not been ordered, or if the radiologist believes that it can make a better interpretation.

"If a 3D procedure has not specifically been ordered, it may be interpreted by some payors as not medically necessary," Duszak said. "A radiology practice recently paid \$2.5 million to settle a U.S. Department of Justice suit related in part to allegations that the practice performed and billed for reformatting or rendering services when not medically necessary."

The ballpark Medicare global reimbursement rate is approximately \$124 for CPT Code 76376 and \$160 for CPT Code 76377 in the state of Pennsylvania.

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