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MANAGEMENT SERVICES NETWORK



MSN UPDATE

July 6, 2009

To: MSN Clients and Friends,

You may have seen recent discussion regarding CTA documentation requirements on the RBMA forum. We wanted to wait to communicate with you until the *ACR Coding Source* came out for better clarification. The Q&A portion of this publication is shown below with key points in “red”. If 3D Reconstructions are not performed and documented, the procedure should be coded as a CT not CTA. When performed, permanent 3D images should be documented also. Many practices do not perform 3D reconstructions for procedures such as CT-Chest for PE. In this case you would bill these as CT, not CTA.

We hope that you find this information helpful.

Q&A

Q: A Q&A in *Clinical Examples in Radiology* (Fall 2008, p. 11) states that 3D rendering must be performed in order to assign a CTA code. However, prior guidance from the ACR (e.g., July 2001 ACR Bulletin) has indicated that either 2D or 3D rendering is acceptable. The CPT code description specifies “images post processing,” but it is not clear if this is referring to 2D or 3D. Please clarify if 2D rendering is still acceptable for CTA. If not, why has this changed?

Two dimensional (2D) postprocessing does not constitute a computed tomographic angiography (CTA) study. When CT scanning is performed using contrast enhanced dynamic-timed imaging and 2D reformatted axial images are obtained or multiplanar reconstructions (MPR) (e.g., coronal, sagittal, or even an off-axis view) are done, this should be reported with a standard CT with contrast code that identifies the anatomic area studied. None of these 2D planar reconstructions qualify as “angiographic” reconstruction.

As noted in the Fall 2008 issue of *Clinical Examples in Radiology*, Computed Tomography Angiography is a distinct type of service that includes postprocessing for angiographic reconstructions. **In order to report “angiographic reconstructions” the physician needs to use different techniques which can all broadly be classified as 3D techniques. These include maximum intensity pixel (MIP) reconstruction, volume-rendered images, or other 3D techniques. If a referring physician orders a CT study for a vascular indication and the radiologist feels a CTA study is clinically indicated, appropriate documentation of the medical necessity for the CTA is strongly recommended.**

Some historical background may help to understand why different information was provided by ACR in 2001. When 2D reformatting and 3D rendering were reported using code 76375 (*Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality*) the ACR and AMA issued advice that CTA required "angiographic reconstruction" imaging.

The deletion of code 76375 and the introduction of 76376 (*3D 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*) and 76377 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality; requiring image post-processing on an independent workstation*), **raised the bar for CTA studies, and "angiographic reconstruction" was gradually redefined as requiring 3D rendering.**

With the evolution of scanner capabilities to produce 2D reformatting virtually in real time, it was felt that the 2D reformats should be included in the base procedure code and not separately reported. On the other hand, complex 3D image rendering often requires extensive independent workstation processing by a supervising physician and specially trained technologist.

The CPT codes for CTA have always required angiographic reconstruction. However, "angiographic reconstruction" has not been explicitly defined in CPT. The ACR has interpreted this to parallel CPT definitions of the independent reconstruction code. Previously, the now deleted CPT code 76375 could be used for 2D and/or 3D reconstruction imaging, and that was used as the basis of the definition of angiographic reconstruction imaging. Since CPT codes 76376 and 76377 have been introduced, and have restricted the reporting of reconstruction imaging to 3D, such 3D imaging now serves as the basis of defining angiographic reconstruction imaging.

Q: Is it necessary to have a permanent archive of 3D images acquired on a CTA study?

Yes, the ACR believes that it is necessary to have a permanent archive of 3D images acquired on a CTA study. The axial data set from which 3D images are created is insufficient for the reporting of a CTA study. When reformatted images are acquired and interpreted in addition to the CT axial images, the reformatted images are a part of the study and should be permanently archived. Just as it is required that a permanent hardcopy image be maintained for a plain film study, permanent CTA reformatted images should be permanently archived.

Questions and Comments? **Contact MSN:**

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