American College of Radiology

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Re: Blue Cross Blue Sheild of North Carolina Reimbursement Policy Update: 3D Radiology Services – Bundling Guidelines https://www.bluecrossnc.com/providers/provider-news/2024/3d-radiology-services-bundling-guidelines

Dear Dr. Sotunde,

The American College of Radiology (ACR), a professional medical specialty society representing over 41,000 physicians practicing diagnostic radiology, interventional radiology, radiation oncology, and nuclear medicine as well as medical physicists, is writing to express our concern with the Blue Cross Blue Shield policy that considers 3D rendering of imaging services (e.g., 76376 and 76377) "integral to the primary service" not separately reimbursable.

The ACR respectfully opposes this policy update for the following reasons:

- 3D renderings using DICOM data are not automatically or routinely done as part of standard imaging interpretation and consume additional resources beyond what is accounted for in the primary imaging CPT code. As stated in the American Medical Association (AMA) CPT Assistant, June 2009: "The 3D rendering should be done at the request of or in consultation with the referring physician when there is medical necessity… The 3D codes should be reserved for situations where additional imaging is necessary for surgical planning or for complete depiction of an abnormality from the two-dimensional study."
- The creation of 3D renderings involves dedicated work by trained personnel, specialized software, and requires concurrent physician input. 3D rendering post-processing provides additional diagnostic information that can clarify anatomical relationships, assist in surgical planning, and enhance visualization in complex cases. These codes describe complex reformatting that is beyond and in addition to the more common types of reformatted images, like sagittal and coronal reconstructions.
- Code 76377 requires personal supervision (indicator "3"), meaning a physician must be in attendance in the room during the performance of the procedure. This requirement applies even when the base imaging study, such as a non-contrast CT or MRI, does not typically necessitate the radiologist's physical presence. https://www.cms.gov/medicare/physician-fee-schedule/search?Y=0&T=4&HT=0&CT=3&H1=76377&M=5
- The manipulation, review, analysis, and reporting of 3D renderings involves significant additional physician work beyond base imaging codes. This often includes image segmentation, adjustment of the projection and shading of the 3D renderings to optimize

visualization of anatomy or pathology, comparison to the base 2D images and to all pertinent available prior studies, and discussion of surgical implications with referring physicians.

- The existence of these specific CPT codes (i.e., 76376 and 76377) indicates that the AMA CPT Editorial Panel recognizes 3D rendering as a distinct service. These codes have their own definitions and documentation requirements, further distinguishing them from routine image interpretation. According to the CPT code book, the following codes should not be reported in conjunction with 76376 and 76377:
    - (Do not report 76376 in conjunction with 31627, 34839, 70496, 70498, 70544, 70545, 70546, 70547, 70548, 70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261, 74262, 74263, 75557, 75559, 75561, 75563, 75565, 75571, 75572, 75573, 75574, 75635, 76377, 77046, 77047, 77048, 77049, 77061, 77062, 77063, 78012- 78999, 93319, 93355, 0523T, 0559T, 0560T, 0561T, 0562T, 0623T, 0624T, 0625T, 0626T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0710T, 0711T, 0712T, 0713T, 0876T)
    - (Do not report 76377 in conjunction with 34839, 70496, 70498, 70544, 70545, 70546, 70547, 70548, 70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261, 74262, 74263, 75557, 75559, 75561, 75563, 75565, 75571, 75572, 75573, 75574, 75635, 76376, 77046, 77047, 77048, 77049, 77061, 77062, 77063, 78012-78999, 93319, 93355, 0523T, 0559T, 0560T, 0561T, 0562T, 0623T, 0624T, 0625T, 0626T, 0633T, 0634T, 0635T, 0636T, 0637T, 0638T, 0710T, 0711T, 0712T, 0713T, 0876T)
- CPT codes 76376 and 76377 are not valued in all primary services and should be separately reimbursable, when appropriate.
- 3D renderings may be performed concurrently with the base-imaging study or subsequently on a different date, based on clinical circumstances. As stated in the AMA CPT Assistant, Oct 2019: "Codes 76376 and 76377 are appropriate for reporting 3D rendering services provided on a date separate from the base-imaging services."
- CMS and many commercial payers recognize situations where advanced post-processing justifies additional payment, especially when it is properly ordered, documented, and separately reported. Their medical policies and Local Coverage Determinations (LCDs) clearly outline the criteria for reimbursing 3D rendering separately.
    - **Novitas Solutions** "Medicare expects that no more than 20 percent of the total CT and Magnetic Resonance (MR) imaging of any practice be submitted with 3D rendering or interpretation, with or without image post-processing. However, for cancer evaluation applications, such as staging/monitoring for pulmonary metastases, this threshold may be often exceeded. Therefore, if data suggests providers are billing at higher rates for other indications for 3D rendering, then Medical Review may do pre- or post-pay reviews to validate the use and medical necessity of the test."
    - **First Coast Service Options, Inc. "**The provider is responsible for ensuring the medical necessity of procedures and maintaining the medical record, which must be made available upon request. Three-dimensional imaging is medically reasonable and necessary only if the outcome will potentially impact the diagnosis

> or clinical course of the patient. Providers are encouraged to obtain additional information from referring providers and/or patients or medical records to determine the medical necessity of studies performed. Referring physicians are required to provide appropriate diagnostic information to the performing provider."

In conclusion, we respectfully disagree with Blue Cross Blue Shield of North Carolina's assertion that CPT codes 76376 and 76377 are integral to the primary imaging service and, therefore, not eligible for separate reimbursement. These codes represent distinct services that provide added clinical value, require additional time as well as dedicated resources and specialized expertise, are not inherently performed with every imaging study, and, as in the case for code 76377, require personal supervision by the radiologist during the performance of the procedure. The use of these codes is driven by medical necessity and is only applied when warranted by the clinical scenario, which underscores their separability. The existence of specific CPT codes for 3D rendering further affirms their status as standalone procedures. Moreover, reimbursement for these services is consistent with CMS policy and many commercial payer precedents. For these reasons, the ACR affirms that when 3D post-processing is appropriately performed, ordered, and documented, it should be separately reimbursed.

If you have any questions or wish to schedule a meeting to discuss this issue further, please contact Katie Keysor, Senior Director, Economic Policy at kkeysor@acr.org.

Sincerely,

Rich Heller, MD

Richard E. Heller III, MD, MBA, FACR
Chair, ACR Payer Relations Committee