There Should Be A CPT Code For That!

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—Mark Alson, MD, FACR, RCC

Not a month goes by without the ACR's economics staff being contacted about establishing new Current Procedural Terminology (CPT®) codes. Some requests are for new ways of doing something (such as ultra-low-dose lung CT or abbreviated breast MRI), while others are for screening codes (such as screening breast MRI or screening liver MRI). Some requests are for more specific forms of existing codes (prostate MRI rather than pelvic MRI), and some requests are for exams that may not currently have great options for coding (such as whole-body CT or MRI). Sometimes, codes are desired for unique clinical circumstances.

What most radiologists are unaware of is that everything we do in creating new codes has a risk/reward ratio. A decision to bring forth new codes must be carefully considered in terms of current coding and reimbursement. The purpose of this resource on CPT codes is to detail some of the many considerations that your ACR CPT and Relative Value Scale Update Committee (RUC) volunteers and staff undergo when contemplating new codes.

First, a short discussion of current CPT codes is in order, especially for those members who are new to this topic. Each CPT code descriptor (that you will find in the CPT book or online version) delineates the service that is performed. It is required that the service you are coding for matches the service described in CPT. That said, there are a few important points regarding coding.

For CT and radiographs, there is no definition of "dose." Folks often want codes for "low-dose" or "ultra-low-dose," but those are not defined, and it would then be necessary to define "high-dose" (and who would want to get a high-dose CT?). So, for example, whatever dose you use (it should be as low as possible, obviously) for a CT of the abdomen and pelvis without contrast, the procedure is coded as 74146. The only exception is CPT code 71271: Computed tomography, thorax, low-dose for lung cancer screening, without contrast material(s). This particular code had the term "low-dose" placed into the descriptor over our objections, to parallel the format of an existing temporary code (also known as G-code) that CMS insisted we follow — even though we argued that we always use the lowest dose possible.

Similarly, there are no separate MRI codes depending on how many sequences you perform. There are no separate codes to differentiate how many post-contrast sequences you perform (just a portal venous phase versus arterial, portal venous, and three sets of delayed sequences coded the same). Finally, there are no separate codes to capture how advanced your equipment is (0.3T versus 3T; 4-slice versus 246-slice CT; big-box US versus laptop US). Many of us, myself included, think there should be a quality differentiator and different codes that would recognize some of these differences, but as of now that is not possible — and trying to create those differentiating factors would require a complete revamp of existing CPT codes, with the associated risks outlined below.

So, what are the CPT rules that we play by? First, you can't "fragment" an existing CPT code without also updating the existing code. So, if a code already covers something we do and you want a new code, you will have to redefine the old code. If we wanted to create a new low-dose abdomen CT, we would have to define parameters of what constitutes low-dose and redefine the current codes as higher than that dose. Similarly, if we wanted a code for CT of just the thyroid or liver, we would have to differentiate those from CT neck or CT abdomen, which already include those body parts. If we wanted a new abbreviated MR code, we would first need to define specifically what "full" and "abbreviated" mean (and the literature would have to be consistent).

As you can see, this process is a little more complex that it might seem. Assuming we were able to define a new service as something different than what is covered by existing codes (and redefine the old codes) and we were successful in creating the new desired code(s), what's next? In the June issue of the Bulletin, we'll outline the subsequent steps in the lifecycle of a new code.

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Category I codes created through the Current Procedural Terminology (CPT®) process go to a committee called the Relative Value Scale Update Committee (RUC) that assigns relative value unit (RVU) values for physician work and practice expense. The work of the RUC is a zero-sum game, so for any new codes given value, other codes must go down proportionally. The RUC determines what is in the "family" of a new code being valued and requires revaluation of the codes in that family.

Unfortunately, "revaluation" usually means "lower valuation" in terms of decreased RVU values from what we previously had for these services. Consequently, when we make new codes, we try hard to consider the effect on other codes in what may be considered the same family. For example, if we created specific liver or breast elastography codes, then the abdominal US or breast US codes would have been revalued. Instead, we created

generic elastography codes that work with a large variety of existing US codes so as not to pose a valuation threat to specific existing codes.

Consequently, we must carefully consider any downstream effects and unintended consequences before we create any new code. We don't want to create codes where you get paid more for something you do 10% of the time but consequently get paid less for the things you do the other 90% of the time. We have to be very strategic. Sometimes, for example, we are forced to revalue existing codes because they have been identified by the RUC or CMS as "potentially misvalued" or "overvalued." In those circumstances, if we are forced to revalue existing codes, that is a good time to introduce changes. As an example, when we were forced to revalue breast MRI, we took the opportunity to divide existing codes into breast MR without contrast and breast MR with and without contrast. In this way, we were able to bundle breast computer-aided detection (CAD) into the later set. By purposefully doing this, we were able to capture increased value for the more complex services performed with and without contrast and capture CAD when performed.

So, what should folks do if they have questions about CPT codes? The answer is to ask the ACR. There may be a different coding mechanism to achieve the desired outcome. For example, let's look at abbreviated breast or liver MRI. Advocates want to improve access to screening with lower cost exams, and "full" exams can be quite costly — understanding that there is a huge variation in cost for these exams, depending on where they are performed (a topic for another day). In this particular example, a discussion of modifiers is helpful. Modifier –52 is a "reduced services" modifier. You can use it, at your discretion, whenever you feel that you did less than a full exam, and you have the ability to set a different price for that reduced services exam. There is a similar modifier –22 for increased professional services that you can use when you go above and beyond for that 27-sequence abdominal MRI but none of the payers or CMS pay for its use. If you have a shorter protocol, with fewer sequences than your standard protocol, you are not required in any way to use a –52 modifier since MRI codes do not specify how many sequences you must perform — but you have the "option" to use that modifier if you desire to charge less. This has been a source of confusion to members because they have gotten advice from the AMA and the ACR that the modifier is not necessary. That advice is correct. The modifier is not necessary but is an "option" to use if you desire to set a lower charge for an exam that is less than your standard.

In summary, there is a very coordinated interplay between your ACR CPT and RUC teams, and strategy always revolves around both patient care and reimbursement. We make new codes each year, but each code application is thought through as carefully as possible to ensure we are providing an accurate coding system while doing the right thing for our

members and to avoid unintended consequences. Your ACR CPT and RUC teams have dedicated physician volunteers and incredibly knowledgeable and dedicated staff — with decades of combined experience — who work tirelessly to ensure you can code and bill appropriately for what you do.

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