LCD - 3D Interpretation and Reporting of Imaging Studies (L33256)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
First Coast Service Options, Inc.	A and B MAC	09101 - MAC A	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09102 - MAC B	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09201 - MAC A	J - N	Puerto Rico Virgin Islands
First Coast Service Options, Inc.	A and B MAC	09202 - MAC B	J - N	Puerto Rico
First Coast Service Options, Inc.	A and B MAC	09302 - MAC B	J - N	Virgin Islands

LCD Information

Document Information

LCD ID
L33256

LCD Title
3D Interpretation and Reporting of Imaging Studies

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

Original Effective Date
For services performed on or after 10/01/2015

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N/A

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N/A

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CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for 3D Interpretation and Reporting of Imaging Studies. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for 3D Interpretation and Reporting of Imaging Studies and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site.

Internet Only Manual (IOM) Citations:

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*,
  - Chapter 15, Sections 80, 80.6 – 80.6.4
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*,
  - Chapter 3, Section 3.2.3 Requesting Additional Documentation During Prepayment and Postpayment Review
  - Chapter 13, Section 13.5.4 Reasonable and Necessary Provision in an LCD

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

Federal Register References:

- 42 CFR §410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.
- 42 CFR §482.26 - Condition of participation: Radiologic services.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

History/Background and/or General Information

The technological approach of multi-slice imaging along with the enhanced imaging techniques has allowed for the generation of three-dimensional (3D) images known as 3D reconstruction or 3D rendering. Three-dimensional imaging has been applied to ultrasound, echocardiography, computed tomography (CT), magnetic resonance imaging

(MRI), and other tomographic modalities. Applications of this technology include, for example, coronary artery imaging, visualization of central nervous system vasculature, and enhanced imaging of the thorax which includes, for example, aortic aneurysms, embolic disease, and inflammatory and neoplastic lesions.

Covered Indications

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.

As with any diagnostic testing, the procedure should be furnished in accordance with accepted standards of medical practice based on the patient's diagnosis, signs, and symptoms. This additional procedure applied to a base procedure must meet but not exceed the patient's medical need.

Three dimensional rendering codes should be reserved for situations where the additional image is necessary for a complete depiction of an abnormality from the 2D study or for surgical planning.

For non-hospital based outpatient services, it is expected that the ordering/referring physician/non-physician practitioner generate a written order/referral indicating the medical necessity for the additional 3D imaging. In addition, it is expected that the interpreting physician maintain a copy of the test results and interpretation along with a copy of the ordering/referring physician/non-physician practitioner's order for the study. The interpreting physician's report should address the medical necessity identified by the ordering/referring physician/non-physician practitioner. In the event it is deemed by the interpreting physician that a 3D interpretation is urgently needed and the ordering/referring physician/non-physician practitioner is not immediately available, the interpreting physician must document the following on the radiology report: the time of the study; specific medical need for the study; and a legible summary of the findings that were urgently transmitted to the ordering/referring physician/non-physician practitioner whose name is on the order for the study.

For hospital based services (inpatient/outpatient), it is expected that there should be an order for the 3D image. In the absence of the order for the 3D image, if the hospital's interpreting physician deems that the 3D interpretation is needed, he or she should clearly state in the interpretation the medical necessity for this separate service, in addition to the base procedure.

Limitations

3D rendering with interpretation and reporting requiring and not requiring image post processing will not be considered medically reasonable and necessary if equivalent information obtained from the test has already been provided by another procedure (ultrasound, MRI, angiography, etc.) or if it could be provided by a standard CT scan (two-dimensional) without reconstruction.

3D rendering with interpretation and reporting during a radiation oncology episode of care is included in 3D simulation when applicable or IMRT plan when applicable and, therefore, should not be billed.

Three-dimensional imaging will not be covered when performed based on internal protocols of the testing facility; a referral for one 3D imaging is not a blanket referral for all studies. In most cases, it is expected that the provider treating the patient specifically orders the procedure in writing and that the order should be on record for each 3D imaging performed.

For guidance regarding ordering tests, provider qualifications and supervision of diagnostic testing, please refer to 42 CFR §410.32 - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

For guidelines regarding conditions of participation, please refer to 42 CFR §482.26 - Condition of participation: Radiologic services.

As published in the CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.4, an item or service may be covered by a contractor LCD if it is reasonable and necessary under the Social Security Act Section 1862 (a)(1)(A). Contractors shall determine and describe the circumstances under which the item or service is considered reasonable and necessary.

Summary of Evidence

N/A

Analysis of Evidence (Rationale for Determination)

N/A

General Information

Associated Information

Documentation Requirements

Please refer to the Local Coverage Article: Billing and Coding: 3D Interpretation and Reporting of Imaging Studies (A56920) for documentation requirements that apply to the reasonable and necessary provisions outlined in this LCD.

Utilization Guidelines

Please refer to the Local Coverage Article: Billing and Coding: 3D Interpretation and Reporting of Imaging Studies (A56920) for utilization guidelines that apply to the reasonable and necessary provisions outlined in this LCD.

Sources of Information

First Coast Service Options, Inc. reference LCD number(s) – L32312

Other Contractors' Policies

Palmetto GBA, L28229 3D Interpretation and Reporting of Imaging Studies

Trailblazer, L26740 3D Interpretation and Reporting of Imaging Studies

Wisconsin Physicians Services Insurance Corporation, L30729 3D Interpretation and Reporting of Imaging Studies

Bibliography

American College of Radiology (ACR). ACR Radiology Coding Source™ November-December 2005 Q and A. ACR Website. Accessed 2011.

American College of Radiology. 2006 CPT® Code Update. 2006.

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
01/08/2019	R7	12/06/2019: The content in the LCD was revised to be consistent with the new format supported by CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 13, Section 13.5.1.	• Other
01/08/2019	R6	Revision Number: 4 Publication: August 2019 Connection LCR A/B2019-049 Explanation of Revision: Based on change request (CR) 10901, the local coverage determination (LCD) for 3D interpretation and reporting of imaging studies, if performed was revised to remove all billing and coding information as well as all language not related to reasonable and necessary provisions ("Bill Type Codes", "Revenue Codes", "CPT/HCPCS Codes", "ICD-10 Codes that Support Medical Necessity', "Documentation Requirements" and "Utilization Guidelines" sections of the LCD) and place them into a newly created billing and coding article. Also, during the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. In addition, the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) language has been removed from the "Limitations" section of the LCD and instead, the IOM citation related to this language is referenced. The effective date of this revision is for claims processed on or after January 8, 2019, for dates of service on or after October 3, 2018. 01/08/2019: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD.	• Other (Revisions based on CR 10901)
10/01/2018	R5	Revision Number: 3	• Revisions Due To

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASONS FOR CHANGE
		Publication: September 2018 Connection LCR A/B2018-074 Explanation of Revision: Based on CR 10847 (Annual 2019 ICD-10-CM Update), the LCD was revised to delete ICD-10-CM diagnosis code R93.8 and replace it with ICD-10-CM diagnosis code R93.89. The effective date of this revision is based on date of service. 10/01/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.	ICD-10-CM Code Changes
10/01/2016	R4	Revision Number: 2 Publication: October 2016 Connection LCR A/B2016-097 Explanation of Revision: Based on CR 9677 (Annual 2017 ICD-10-CM Update), the LCD was revised to delete ICD-10-CM diagnosis code R93.4 and add ICD-10-CM diagnosis codes R93.41, R93.421, R93.422, and R93.49. The effective date of this revision is based on date of service.	• Revisions Due To ICD-10-CM Code Changes
10/01/2016	R3	Revision Number: 2 Publication: October 2016 Connection LCR A/B2016-097 Explanation of Revision: Based on CR 9677 (Annual 2017 ICD-10-CM Update), the LCD was revised to delete ICD-10-CM diagnosis code R93.4 and add ICD-10-CM diagnosis codes R93.41, R93.421, R93.422, and R93.49. The effective date of this revision is based on date of service.	• Revisions Due To ICD-10-CM Code Changes
10/01/2015	R2	10/28/2015-Added ICD-10 code; R93.8 - Abnormal findings on diagnostic imaging of other specified body structures	• Other (Added ICD-10 code; R93.8)
10/01/2015	R1	The language and/or ICD-10-CM diagnoses were updated to be consistent with the current ICD-9-CM LCD’s language and coding.	• Provider Education/Guidance • Public Education/Guidance

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Articles

A56919 - (MCD Archive Site)

A56920 - Billing and Coding: 3D Interpretation and Reporting of Imaging Studies

Related National Coverage Documents

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
12/06/2019	01/08/2019 - N/A	Currently in Effect (This Version)
08/16/2019	01/08/2019 - N/A	Superseded
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.		

Keywords

N/A