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76376 & 76377 – Clearing Up the Confusion

If whether or not to bill for 2D or 3D reconstructions wasn't confusing enough, in 2006 the AMA deleted code 76375 and introduced two new codes to describe 3D rendering. The new codes are:

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

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

DELETED
76375 — Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality

The new codes were implemented due to the fact that with changes in technology code 76375 no longer adequately represented current methods of reformatting images. In addition, the new codes were implemented as a result of the over-utilization of code 76375. As of January 1, 2006 with the deletion of code 76375, reimbursement for 2D reconstructions will be considered bundled with the base procedure code.

Although CPT provides some instruction on how to use these codes through the parenthetical notes that follow them, providers are still left with questions regarding the proper use of these codes.

Method of Reformatting

When images are reformatted they may either be reformatted on the acquisition scanner with software or a separate independent workstation. The key to correct code selection is determining the method in which reformatted images are obtained. Typically the technologist performs reformatting work on the acquisition scanner and the physician performs reformatting on the independent work station or supervises a specially trained technologist reformatting images on the independent workstation.

It is important to note that many times the radiologist will dictate that coronal, sagittal, multiplanar or oblique reformats were constructed from axial images (2D). These reformatted images are not considered 3D rendering as described by the new codes. The new codes represent complex renderings including: shaded surface, volumetric rendering, quantitative analysis (segmental volumes and surgical planning) and maximum intensity projections (MIP).

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Physician Supervision

According CPT, codes 76376 and 76377 both require concurrent physician supervision of image post-processing 3D manipulation of volumetric data set and image rendering. This has raised the question "what constitutes concurrent physician supervision"? According to the AMA & ACR , concurrent supervision means active participation in and monitoring of the reconstruction process that includes:

- Design of the anatomic region that is to be constructed
- Determination of the tissue types and actual structures to be displayed
- Determination of the images or cine loops that are to be archived
- Monitoring and adjustment of 3D work product

The AMA/ACR definition of concurrent supervision is independent of the levels of supervision established by CMS. The following table shows the required levels of physician supervision for providers paid under the Medicare Physician Fee Schedule:

CPT Code	Professional (-26)	Technical (-TC)	Global
76376	09	01	09
76377	09	03	09

Key: 01=General Supervision 03=Personal Supervision 09=Concept does not apply

Levels of supervision are defined in *42 CFR 410.32*:

General supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Personal supervision means a physician must be in attendance in the room during the performance of the procedure.

Note: The supervision levels are not applicable to the hospital setting.

Codes 76376 and 76377 should be reported in addition in the base imaging procedure, however CPT specifically states that the 76376 and 76377 should not be reported in conjunction with the following codes: 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74175, 74185, 75635, 78814-78816, 0066T, 0067T. Furthermore, these

codes should not be reported in conjunction with nuclear medicine codes or the Category III cardiac CT and CTA codes. This clarification will be published in a future CPT Assistant article.

Documentation Required for Billing

The *ACR Practice Guideline for Communication: Diagnostic Radiology* states the radiology report should include "…a description of the studies and/or procedures performed…" If 3D images are produced, whether on the acquisition scanner or an independent workstation, the rendering and interpretation of the images should be clearly documented in the report.

As for whether or not a test order is required to code and bill for these procedures, a recent issue of the ACR Radiology Coding Source, provided clarification:

"In the past, the ACR maintained that an order for 2D and 3D reconstruction imaging was not necessary as this was covered under the Ordering of Diagnostic Tests rule test design exception. However, based on the exponential rise in the use of 76375 and in the number of practice investigations evolving out of over utilization (routine use), the ACR strongly encourages radiology practices to obtain an order from the referring physician in the non-hospital setting. In the hospital setting, radiologists may generate their own order, but they are strongly encouraged to justify medical necessity for the use of 3D rendering in a separate dictation.

The 3D rendering should be done at the request of or in consultation with the referring physician when there is medical necessity. Referring physicians should be educated as to the need for an order and when 3D rendering would be beneficial. 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. Those practices that routinely provide 3D rendering may prompt an investigation by the Office of the Inspector General."

Sources:
ACR Radiology Coding Source November/December 2005
ACR Radiology Coding Source September/October 2005
Source: Clinical Examples in Radiology, Volume 2, Issue 1: Winter 2006

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