

ACR Offers Recommendation for Valuation of New S-Code for Lung Cancer Screening

A new “S” code for low-dose CT (LDCT) for lung cancer screening (S8032 Low-dose computed tomography for lung cancer screening) was included in the quarterly update of Healthcare Common Procedure Coding System (HCPCS) codes released by the Centers for Medicare and Medicaid Services (CMS) in early July. The codes in this update will be effective Oct. 1, 2014.

Private insurers use “S” codes to report drugs, services and supplies when no national codes are available. The codes are useful for claims processing and implementing private sector policies and programs. The codes are also used by the Medicaid program, but they are not payable by either Medicaid or Medicare.

As “S” codes are not valued by CMS, private payers are responsible for assigning values to the codes and often look to specialty societies for assistance in valuation. The ACR Economics Commission and Commission on Body Imaging developed recommendations for the valuation of LDCT for lung cancer screening.

The ACR holds that the value of CPT® code 71250 (Computed tomography, thorax; without contrast material) should serve as the reimbursement floor for LDCT with additional RVUs assigned for the numerous value added activities required of an effective lung cancer screening program. 71250 (Non-contrast CT of the thorax) was reviewed by the American Medical Association Relative Value Scale Update Committee (RUC) in October of 2009. The RUC validated the existing physician work value of 1.16 forwarding this recommendation to CMS for inclusion in the 2011 Medicare Physician Fee Schedule. CMS, through flawed methodology, reduced the value to 1.02.

To pay less for the screening code than a non-contrast chest CT implies that LDCT is somehow less physician work. In actuality, the work of LDCT for screening is greater because the radiologist must also perform added steps, such as following up on positive screens, ensuring that appropriate followup has occurred and determining the outcome of that additional follow-up. It has been asserted that the LDCT images show less detail (i.e. soft tissues) equating to less work when in fact images of lesser detail entail more work for the radiologist to make diagnoses.

In addition to establishing baseline reimbursement that is at least equivalent to a CT thorax scan without contrast, payers should increase the payment amount to reimburse providers’ achievement in obtaining ACR Lung Cancer Screening Center designation and participation in the ACR Dose Index Registry® and future registries. There is a precedent for such increased payment in mammography, as the screening codes have a higher value based on the Mammography Quality Standards Act (MQSA) requirements and the quality control work involved.

Failure to pay for LDCT at an adequate rate will limit patient access to this potentially life-saving service. We are willing and able to work with members and payers to ensure proper reimbursement and patient access to care. Please contact Katie Keysor at kkeysor@acr.org if you have any questions.