Is your hospital adequately computing CTA costs and charges?

If CTA is to be reimbursed adequately, hospital and radiology administrators urgently need to check their claims (charges and cost calculations) for CTA relative to "CT without followed by with contrast" studies. Since CTA involves all the costs of CT studies plus the added costs of expensive image-processing workstations, added technologist time, and additional images from post-processing, etc., CTA costs and charges should always be higher than those for the analogous CT exams. Yet, analyses of the 2001 CMS claims data demonstrate that less than 50 percent of all hospitals actually charged more for CTA than for CT.

Background

Prior to 2001, CTA was billed as two distinct and separate procedures identified by two codes: a CT anatomy-specific scan code, plus a separate 3-D reconstruction code. In 2001 eight new CPT codes—based on body region scanned—were created for CT angiography (CTA). These new CTA codes were created so that all the work of CTA, including the CT images acquired and the additional cost of 3-D image post-processing of the vessels, would be appropriately reflected. The additional CTA costs related to the image post-processing are substantial and include technologist processing time for creating 3-D CTA images (average 53 minutes according to cost survey data); cost of 3-D imaging workstation ($80,000 to $200,000); additional films and supplies for the 3-D images (30-40 additional 3-D images per study); and hospital overhead costs.

Unfortunately for hospitals, the new CTA codes were grouped into the same ambulatory payment category (APC) as CT without followed by with contrast studies; there was no incremental reimbursement for the additional image post-processing that had previously been billed separately. Ideally CTA should have been recognized as a new technology until cost data could be collected to determine its APC relative weight. The Centers for Medicare and Medicaid Services (CMS) chose not to recognize it as a new technology.

In 2002, the ACR requested that CMS move CTA to a separate reimbursement category and reimburse it at a rate comparable to CT plus the 3-D code (76375). CMS agreed for 2003 to move CTA to a new APC category (CTA is now in APC 662, while CT without/with contrast remains in APC 333). Unfortunately, CMS also applied faulty 2001 claims data to set the reimbursement, and CTA (APC 662) is only paid $5 more than CT (APC 333) for 2003.

This faulty data resulted from confusing information and widespread misunderstanding among hospitals and radiology administrators about how to report costs and set charges for the new CTA codes. As stated above, if CTA is to be reimbursed adequately, hospital and radiology administrators must report their costs and charges for CTA relative to "CT without followed by with contrast" studies appropriately. CTA costs and charges should always be higher than those for the analogous CT exams.
Ultimately, patients benefit when hospitals report their costs and charges appropriately and are adequately reimbursed for CTA as a cost-effective and safer alternative to catheter angiography for many vascular imaging clinical applications. Even so, less than half of all hospitals that submitted claims for both CT and CTA in 2001 actually charged more for CTA. This proves that the majority of hospitals charged incorrectly in 2001 for CTA, which resulted in diminished CTA reimbursement rates in 2003. Hospitals that are charging less for CTA relative to CT are urged to submit their CTA claims so that CTA charges appropriately reflect additional costs involved in CTA post-processing relative to CT. If all hospitals correctly submit their CTA claims to appropriately reflect the higher costs and charges for CTA relative to CT, CTA reimbursements in the hospital outpatient setting will be computed appropriately by CMS from the 2003 claims data for determination of the 2005 payment rates.