Policy Title	CT Cerebral Perfusion Studies Reimbursement Policy
Policy Department	Payment Strategy Operations
Effective Date	1/1/2022
Revision Date(s)	3/1/2022
Next Review Date	

Disclaimer:

Clover Health applies The Center for Medicare and Medicaid Services (CMS) criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

Computed Tomography (CT) Cerebral Perfusion Studies are required to be billed with certain conditions in order to be considered covered by CMS. This policy reviews the Clover Health requirements in order for a claim to be paid.

Definitions:

- **National Coverage Policy**
  - A policy established by The Center for Medicare and Medicaid Services (CMS) that describes the requirements for a specific item or service to be considered medically necessary and payable
- **Healthcare Common procedure Coding System (HCPCS)**
  - A uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures
- **International Classification of Diseases, Tenth Revision (ICD-10)**
  - A coding system designed to communicate the diagnosis (coding and reporting) code billed.

Policy:

Clover Health has aligned with CMS policy on the billing requirements for Cerebral Perfusion Analysis using Computed Tomography (HCPCS code 0042T). There are specific diagnosis codes that must be present on the claim form and supported in the medical record in order for this service to be considered for payment by Clover Health. In addition to the diagnosis code requirement, the claim will only be paid if the claim is billed appropriately.

Those diagnosis codes are included below. If a claim is billed with 0042T and does not include one of the CMS covered diagnosis codes, that claim line will be denied. The diagnosis code billed must best describe the member's condition for which the service was performed.

Claim Codes (if applicable)	• **HCPCS**
	  ○ **0042T -** CEREBRAL PERFUSION ANALYSIS USING COMPUTED TOMOGRAPHY WITH CONTRAST ADMINISTRATION, INCLUDING POST-PROCESSING OF PARAMETRIC MAPS WITH DETERMINATION OF CEREBRAL BLOOD FLOW, CEREBRAL BLOOD VOLUME, AND MEAN TRANSIT TIME
	• **ICD-10**
	  ○ **I63.031 -** Cerebral infarction due to thrombosis of right carotid artery
	  ○ **I63.032 -** Cerebral infarction due to thrombosis of left carotid artery
	  ○ **I63.131 -** Cerebral infarction due to embolism of right carotid artery
	  ○ **I63.132 -** Cerebral infarction due to embolism of left carotid artery
	  ○ **I63.311 -** Cerebral infarction due to thrombosis of right middle cerebral artery
	  ○ **I63.312 -** Cerebral infarction due to thrombosis of left middle cerebral artery
	  ○ **I63.411 -** Cerebral infarction due to embolism of right middle cerebral artery
	  ○ **I63.412 -** Cerebral infarction due to embolism of left middle cerebral artery

References
CMS Article A58152 - Billing and Coding: Computed Tomography Cerebral Perfusion Analysis (CTP)
ICD-10-CM Official Guidelines for Coding and Reporting