healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Non-Covered Computed Heart Tomography		
Policy Number:	PO-RE-139v1		
Effective Date:	01/01/2010	**Last Approval Date:**	6/16/2025

I. Policy Description

This reimbursement policy outlines Healthfirst's position on the non-coverage of Computed Tomography (CT) of the heart, specifically CPT code 75571, which pertains to computed tomography of the heart without contrast for quantitative coronary artery calcium scoring. In alignment with the Centers for Medicare & Medicaid Services (CMS) guidelines, Healthfirst will not reimburse for this service due to its classification as a non-covered benefit. This policy aims to ensure clarity and consistency in the reimbursement process related to this specific imaging procedure.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Essential Plan (EP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Medicare PPO
- Qualified Health Plan (QHP)

Policy Scope

This policy applies to:

- All Healthcare Providers billing for services rendered to Healthfirst members.
- Healthcare providers, including but not limited to hospitals, imaging centers, and independent practitioners who may seek reimbursement for CPT 75571.
- Situations where members may request or receive services related to quantitative coronary artery calcium scoring via non-contrast CT of the heart.

Healthfirst will not reimburse for services involving CPT code 75571, as it is classified as a non-covered benefit under current policy guidelines.

Providers are responsible for verifying coverage prior to rendering services. If a provider intends to bill for CPT 75571, they must reach out to Evicore for guidance on an alternative code or appropriate documentation.

Members should be informed beforehand that this service is non-covered to support informed healthcare decisions and avoid unexpected out-of-pocket expenses.

Adjudication and Appeal Process

1. Claims submitted with CPT code 75571 will be automatically denied or rejected due to non-coverage status.

2. Providers must ensure accurate coding to avoid processing delays or incorrect reimbursements.

3. Providers seeking reimbursement should contact Evicore to explore alternative codes or documentation that may be eligible for coverage under other policies or programs.

4. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

II. Applicable Codes

Code	Description	Comment
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

Article - Billing and Coding: Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) (A56737)
Ethics & Compliance | EviCore by Evernorth
Health First Code List

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for

the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.