GE Healthcare

Reimbursement Information for Diagnostic Ultrasound Procedures[1] Completed with the Vscan* Pocket-sized Ultrasound Device in Intensive Care Unit (ICU) and Critical Care Unit (CCU) Settings

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This overview addresses coding, coverage, and payment for diagnostic ultrasound procedures performed with a Vscan pocket-sized ultrasound visualization tool used in the Intensive Care Unit and Critical Care Unit settings.[2] Vscan ultrasound is a small, battery-powered device that fits in a physician's pocket and is intended for use in performing focused, non-invasive diagnostic ultrasound imaging, to assist physicians with real-time, point-of-care visual information at the bedside. While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

Billing Criteria

The use of a Vscan pocket-sized ultrasound device may be billable in certain circumstances. Any use has minimum criteria (see Billing Requirements below) that have to be met before it can be billed separately from an initial evaluation ultrasound exam.

Extension of Physical Exam

When using the Vscan pocket-sized ultrasound device as an extension of the **patient's physical examination**, it would not be appropriate to bill separately for these ultrasound exams. Rather, these ultrasound exams would be included as an extension of an Evaluation and Management (E/M) examination. Refer to your coding manual to select appropriate CPT codes that address E/M examinations.

Diagnostic Use

When the Vscan pocket-sized ultrasound device is being utilized for a documented **appropriate medical necessity**, is being performed by appropriately qualified providers, and meets all Medicare requirements including documentation and storage of images, it may be possible for it to be billed and considered for coverage and payment by a payer.[3]

Billing Requirements

According to many of the local Medicare contractors, billing for a limited diagnostic ultrasound procedure requires that the following minimum requirements be met:

1. It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
2. It should be done for the same purpose as a reasonable physician would order a standard ultrasound.
3. It must be billed using the CPT code that accurately describes the service performed.
4. The technical quality of the exam must be in keeping with the accepted national standards and not require a follow-up ultrasound to confirm the results.
5. The study must be performed and interpreted by qualified individuals.
6. The medical necessity, images, findings, interpretation and report must be documented in the medical record.[4]

Payers or their local branches and the local Medicare contractors may have distinct requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer and/or Medicare contractor.

Qualifications of Personnel

- The American Medical Association (AMA) policy states*:

H-230.960 Privileging for Ultrasound Imaging

1. AMA affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians;
2. AMA policy on ultrasound acknowledges that broad and diverse use and application of ultrasound imaging technologies exist in medical practice;
3. AMA policy on ultrasound imaging affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staffs and should be specifically delineated on the Department's Delineation of Privileges form; and
4. AMA policy on ultrasound imaging states that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty. (Res. 802, I-99; Reaffirmed: Sub. Res. 108, A-00)

- The American College of Chest Physicians (ACCP) has written a consensus statement for critical care ultrasonography. This statement addresses the elements of ultrasonography that are required to achieve competence in general critical care ultrasonography[5]. The complete publication can be found at http://chestjournal.chestpubs.org/content/135/4/1050.full.pdf+html.
- The American Institute of Ultrasound in Medicine (AIUM) also has published their practice guidelines and training requirements for physicians as well as practices on their website. This information can be accessed at www.aium.org/publications/viewStatement.aspx?id=26.
- *Payers or their local branches and the local Medicare contractors may have distinct requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer.*

** (page 354) http://www.ama-assn.org/resources/doc/medical-schools/sms-a12-agenda-book.pdf*

Current Procedural Terminology (CPT) Coding, Definitions and Medicare Payment Rates

2013 Reimbursement Rates

If the ultrasound procedure performed with a Vscan pocket-sized ultrasound device does not meet all of the aforementioned requirements, it would not be considered to be separately reportable. It would be considered part of the physical exam.

The following are diagnostic ultrasound CPT codes that may apply depending on where on the body the ultrasound was performed. Also included are the 2013 national average Medicare Physician Fee Schedule (MPFS) payment rates for the CPT codes. **Payment will vary in geographic locality.**

2013 Medicare professional component (-26) reimbursement for procedures related to ultrasound procedures performed in the hospital ICU and CCU settings.

CPT[6] Code	Reimbursement Component	Medicare Physician Fee Schedule Amount[7]
CPT 76604 Ultrasound, chest (includes mediastinum), real-time with image documentation	Professional (-26)*	$ 26.54
CPT 76705 Ultrasound, abdominal, real-time with image documentation; limited (eg, single organ, quadrant, follow-up)	Professional (-26)	$ 28.24
CPT 76775 Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real-time with image documentation; limited	Professional (-26)	$ 27.90
CPT 76815 Ultrasound, pregnant uterus, real-time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	Professional (-26)	$ 30.96
CPT 76857 Ultrasound, pelvic (nonobstetric), real-time with image documentation; limited or follow-up (eg, for follicles)	Professional (-26)	$ 18.71
CPT 93304 Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	Professional (-26)	$ 36.06
CPT 93308 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study**	Professional (-26)	$ 24.84

* *Professional (-26) - The professional component is the interpretation of the results of the test. When the professional component is reported separately the service may be identified by adding modifier 26.*

** *CPT code 93308 refers to the use of echocardiographic imaging (2D only or 2D with M mode recording) when a study is performed to evaluate one specific problem or region of the heart.*[8]

Payment for the Ultrasound Services Technical Component Performed in the Hospital Inpatient ICU or CCU

Charges for the ultrasound services occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services (-26) regardless. Note: Medicare reimburses for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary.

Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of ultrasound for diagnostic ultrasound procedures.

26-Professional Component
A physician who performs the interpretation of an ultrasound exam in the hospital outpatient setting may submit a charge for the professional component of the ultrasound service using a modifier (-26) appended to the ultrasound code.

52-Reduced Services
This modifier would be used in certain circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion.

76*-Repeat Procedure by Same Physician
This modifier is defined as a repeat procedure by the physician on the same date of service or patient session. The CPT defines "same physician" as not only the physician doing the procedure but also as a physician of the same specialty working for the same medical group/employer.

77*-Repeat Procedure by Another Physician
This modifier is defined as a repeat procedure by another physician on the same date of service or patient session. "Another physician" refers to a physician in a different specialty or one who works for a different group/employer. Medical necessity for repeating the procedure must be documented in the medical record in addition to the use of the modifier.

**Should NOT be used for "confirmation" exams. Could be used for monitoring patient conditions over time in ICU/CCU settings.*

Hospital Inpatient- ICD-9-CM Procedure Coding

ICD-9-CM procedure codes are used to report procedures performed in a hospital inpatient setting. The following are ICD-9-CM procedure codes that are typically used to report diagnostic ultrasound performed in the hospital ICU and CCU settings:

88.72 Diagnostic ultrasound of heart
88.73 Diagnostic ultrasound of other sites of thorax
88.74 Diagnostic ultrasound of digestive system
88.75 Diagnostic ultrasound of urinary system
88.76 Diagnostic ultrasound of abdomen and retroperitoneum
88.77 Diagnostic ultrasound of peripheral vascular system
88.79 Other diagnostic ultrasound
88.90 Diagnostic imaging, not elsewhere classified

ICD-9-CM Diagnosis Coding

It is the physician's responsibility to select the codes that appropriately represent the service performed, and to report the ICD-9-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the ultrasound.

Revenue Code

Revenue codes are used for facility billing of ultrasound services in the ICU and CCU settings. The revenue code that applies is 402 – Other imaging services, ultrasound.

Medicare Multiple Imaging Payment Rules for Hospital Outpatient Facilities

The Centers for Medicare & Medicaid Services (CMS) have established five imaging composite Ambulatory Payment Classification (APC) groups, (APCs 8004, 8005, 8006, 8007, and 8008) that are based on the families of codes used for the multiple imaging procedure payment reduction policy under the Medicare Physician Fee Schedule (MPFS). Medicare provides a single APC composite payment when two or more imaging procedures using the same imaging modality are provided in a single session. The following chart lists the ultrasound family of services, which are paid under Medicare's Ultrasound Composite APC 8004.

Ultrasound Family (APC 8004) Code Description

76604	Ultrasound exam, chest
76700	Ultrasound exam, abdominal, complete
76705	Ultrasound exam, abdominal, limited
76770	Ultrasound exam, abdominal back wall, complete
76775	Ultrasound exam, abdominal back wall, limited
76776	Ultrasound exam, kidney transplant w/Doppler
76831	Ultrasound exam, uterus
76856	Ultrasound exam, pelvic, complete
76857	Ultrasound exam, pelvic, limited
76870*	Ultrasound exam, scrotum

A single payment would be made if one or more imaging services that are categorized within the ultrasound family chart listed above and performed on the same date of service. The 2012 national average Medicare hospital outpatient payment rate for the Ultrasound Composite (APC 8004) is $196.61.

Limited vs. Complete Ultrasound

Complete and limited ultrasound studies are defined in the ultrasound introductory section notes of the CPT 2013 code book. According to CPT, the report should contain a description of all elements or the reason that an element could not be visualized. As stated in the guidelines, If less than the required elements for a 'complete' exam are reported (eg, limited number of organs or limited portion of region evaluated), the limited code for that anatomic region should be used once per patient exam session.[9]

Documentation Requirements

Ultrasound performed using a pocket-sized ultrasound device, hand-held ultrasound, a compact portable or a console ultrasound system may be reported using the same CPT codes **as long as** the studies performed meet the requirements addressed above as well as all the following requirements:

- Medical necessity as determined by the payer
- Completeness
- Documented in the patient's medical record

A separate **written** record of the ultrasound procedure(s) should be maintained in the patient record.[10] This should include a description of the structures or organs examined, the findings, and reason for the ultrasound procedure(s). Images are to be labeled with patient identification, facility identification, examination date, the anatomical site imaged, transducer orientation and the initials of the operator. The use of ultrasound without a thorough evaluation of organ(s) or anatomical region, image documentation, and final written report is not separately reportable.

In order to be separately reportable, diagnostic ultrasound procedures require the **production** and **retention** of **image** documentation. It is recommended that permanent ultrasound images, either electronic or hardcopy, from all ultrasound services be retained in the patient record or other appropriate archive.

** Not indicated use for Vscan device*

Other Considerations

The American Society of Echocardiography (ASE) published a position statement (J Am Soc Echocardiog 2002; 15: 369-73) about hand carried ultrasound in April 2002. This position establishes that "The safety and effectiveness of a diagnostic study should be judged on the medical indications of the study, the qualifications and experience of the providers of service, the quality and completeness of the diagnostic information obtained, and the adherence to published and widely accepted professional standards and processes developed, and not based on the size or cost of the instrumentation used to perform the study."[11]

Coverage

Use of diagnostic ultrasound services may be a covered benefit if such usage meets all requirements established by that particular payer. It is advisable that you check with your local Medicare Contractor for specific coverage requirement. Also, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record.

Coverage by private payers varies by payer and by plan with respect to which medical specialties may perform ultrasound services. Some payers will reimburse ultrasound procedures to all specialties while other plans will limit ultrasound procedures to specific types of medical specialties. In addition, there are plans that require providers to submit applications requesting these services be added to the list of services performed in their practice. It is important that you contact the payer prior to submitting claims to determine their requirements.

Disclaimer

1 Information presented in this document is current as of January 1, 2013. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

2 The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

3 Local Coverage Article for HAND-CARRIED ULTRASOUND Examinations (A11626) http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=11626&ver=3&ContrId=47&ContrVer=1&CntrctrSelected=47*1&DocID=A11626&SearchType=Advanced&bc=IAAAAAgAAAAA&

4 Ibid.

5 American College of Chest Physicians. www.chestjournal.org.

6 CPT copyright 2012 American Medical Association. All rights reserved.

7 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in the Federal Register Vol. 77, No. 222 / November 16, 2012 and subsequent updates based on legislation enacted by CMS. These changes are effective for services provided from 1/1/13 through 12/31/13. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

8 American College of Cardiology Foundation. Cardiovascular Coding 2009: Practical Reporting of Cardiovascular Services and Procedures; Pg 3.17. CPT Copyright 2008 American Medical Association. All rights reserved.

9 2013 CPT Professional Edition, copyright 2012 American Medical Association.

10 Certain Medicare carriers require that the physician who performs and/or interprets some types of ultrasound examinations to prove that they have undergone training through recent residency training or post-graduate CME and experience. For further details, contact your Medicare contractor.

11 American Society of Echocardiography Report on Hand Carried Ultrasound (HCU) April 2002 (J Am Soc Echocardiog 2002; 15:369-73).

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GE Healthcare
9900 Innovation Drive
Wauwatosa, WI 53226
U.S.A.

www.gehealthcare.com

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