



SPOCUS

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SPOCUS REIMBURSEMENT STATEMENT

Disclaimer: This statement is intended to serve as a guiding reference for clinicians seeking information on CUS billing. It may not be consistent with the most current/published guidelines and may not accurately reflect local billing procedures or current CMS guidelines. Clinicians are encouraged to verify national level billing guidelines and local billing practices.

Clinical ultrasound is widely considered to be separate from and complementary to the physical examination and adds anatomic, functional, and physiologic information to the care of the acutely-ill patient.¹ The use of clinical ultrasound is sufficiently developed that it can be considered essential to good patient care in diagnosing, monitoring and treating a wide variety of conditions, and when employed as such should be billed as a separate billable procedure.²

Although billing for diagnostic and procedural ultrasound is rather straightforward, SPOCUS frequently encounters questions regarding advanced practice provider (APP) billing. Diagnostic and procedural ultrasound performed by PA/NPs should be coded and reimbursed in the same manner as any other procedure which is performed in the course of the patient's care, using Current Procedure Terminology (CPT) codes. The CPT code and the modifier that most accurately describes the ultrasound exam/procedure performed should be included in the documentation. It is essential to verify each payer's specific payment and coverage policy through the payer or the local CMS representative.

Nearly all payers, including Medicare and Medicaid, cover medical and surgical services provided by APPs, in accordance with state law. The services are submitted/billed under the name of the APP or under the name of the physician depending on payer policy. It is essential to verify each payer's specific payment and coverage policy for APPs.

Medicare pays the PA's employer for medical and surgical services provided by PAs in all settings at 85 percent of the physician fee schedule. These settings include hospitals (inpatient, outpatient, operating room and emergency departments), nursing facilities, offices, clinics, the patient's home and for first assisting at surgery. In certain circumstances, evaluation and management services provided by PAs may be billed under the physician's name and provider number by meeting Medicare's "incident to" or shared visit billing guidelines. Medicare authorizes PAs to personally provide all diagnostic services and requires that those services be billed under the PA.

Commercial insurers do not necessarily follow Medicare policies regarding reimbursement amounts and coverage rules, but are similar to Medicare in that services are billed either under the PA's name or the collaborating physician's name. Always obtain local payer requirements to ensure proper billing.

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Generally, APPs are covered when performing diagnostic ultrasound or using ultrasound guidance during the performance of a procedure, as authorized by state law. Depending on the particular imaging requirement, the location of the service and other factors, there may be a distinction between the technical component (TC) and professional component (PC) of ultrasound utilization. When appropriate, APPs may report a global service (PC and TC combined) or either the PC or TC, based on the service(s) delivered.

APPs, like physicians, must meet applicable payer guidelines for medical necessity, coverage policy and documentation requirements to obtain reimbursement for their services. In addition, PAs and physicians use the same International Classification of Diseases or ICD codes and Current Procedure Terminology or CPT codes and modifiers to report and describe the services they render.

SPOCUS supports The American College of Emergency Medicine's policy, on certification by external entities and believe that an external certification process would impede the use of this critical clinical skill and adversely affect patient care. Further, **any external certification process should not be utilized as a requirement for hospital privileges or credentialing, nor for reimbursement by accountable care organizations (ACOs), managed care organizations (MCOs), the Centers for Medicare and Medicaid Services (CMS) or other third-party payers.**³

Current Procedural Terminology (CPT) codes are a uniform coding system that facilitates the reporting of procedures. The CPT coding system has descriptive terms that help with identifying the codes for the reporting of medical, surgical, and diagnostic services. This system provides a communication tool for medical care and utilization review as well as a claim-processing tool utilized by both governmental and private payers.

CPT codes describe procedures that have been performed. CPT codes are the same for every provider, regardless of specialty, clinical field or practice setting.²

Complete versus Limited Ultrasound Exams: Within the CPT codes for ultrasound procedures, there is often a distinction between complete and limited studies. Ultrasound examinations are considered to be "complete" studies unless specified as "limited" studies in their code definitions. A complete study, as defined by the CPT, is one in which an attempt is made to visualize and diagnostically evaluate all of the major structures within the anatomic description.

If less than the required elements for a "complete" exam are reported (e.g. limited number of organs or limited portion of region evaluated), the "limited" code for that anatomic region should be used. If a limited examination is performed and a clinical finding is encountered which necessitates a complete exam then the complete study may be performed and billed.

If there was a limited exam performed and billed, and another service or provider still has a clinical question that was not addressed by the limited study, then a complete exam may be ordered and billed. However, Medicare and other insurance companies will typically only pay for the exam which answered the clinical question.

When there is a choice to code for a limited or for a complete study, ultrasound used in a "focused," way most often will be appropriately coded as a limited study, as its mission was to answer a

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specific clinical question in a particular region or area of the body. Some situations may require several limited studies which may be billed and coded individually.

For example, a young male with signs of shock after a motor vehicle accident may need a FAST exam performed. However, there is no CPT code for a FAST examination. A FAST examination will be coded by the anatomic location where the exam was performed. The question becomes, "Is my patient in shock because of free fluid, pericardial effusion or a pneumothorax?". This investigation requires three distinct codes. 1.) cardiac 93308, 2) abdomen 76705, and 3) chest 76604.2⁸

Diagnostic Ultrasound versus Ultrasound Guidance Procedures: A second CPT code distinction is made between diagnostic ultrasound procedures and ultrasound guidance procedures. Diagnostic ultrasound procedures investigate a source of disease or exclude pathology by answering a narrow clinical question, such as "does my patient have gallstones?" or "does my patient have free fluid?" Conversely, ultrasound guidance procedures are used to guide an invasive procedure, for example needle placement.

Per the National Correct Coding Initiative, there may be situations where the diagnostic ultrasound and procedural ultrasound codes can be reported for the same patient on the same date. "Ultrasound guidance and diagnostic ultrasound (echography) procedures may be reported separately only if each service is distinct and separate. If a diagnostic ultrasound study identifies a previously unknown abnormality that requires a therapeutic procedure with ultrasound guidance at the same patient encounter; both the diagnostic ultrasound and ultrasound guidance procedure codes may be reported separately. However; a previously unknown abnormality identified during ultrasound guidance for a procedure should not be reported separately as a diagnostic ultrasound procedure." 5

An example is an ultrasound to image a soft tissue infection to differentiate cellulitis from abscess. If the initial ultrasound diagnosed a previously unknown abscess, a separate procedural ultrasound used as guidance to drain the soft tissue infection and identify nearby sensitive anatomy.

Modifiers: Modifiers are additional numbers added to the CPT code which help further describe the procedure being performed without changing the definition of the code. More than one modifier can be used per CPT code. The modifier essentially "splits the bill" and adds information so the payor can better understand the events and circumstances of the visit.

Professional Component -26: This modifier is reported by the provider for interpreting the examination and preparing a separate complete written report.

Reduced Services -52: Under certain circumstances a service is partially reduced or eliminated at the providers discretion. The usual CPT code is used with the added -52 modifier indicating that the typical procedure was not performed as described, but rather at some reduced level of service.

Distinct Procedural Service -59: This modifier is used to report procedures that are distinct but have the same CPT code. For example, if a patient had multiple foreign bodies in both the right upper and lower extremities, the 76881 complete or 76882 limited as appropriate code for ultrasound extremity, nonvascular, real time with image documentation, would be used twice, with a -59 modifier.

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Repeat Procedure by Same Provider -76: This modifier defines a repeat procedure by the “same physician or provider” on the same date of service or patient session. Providers in the same specialty, same group and during the same encounter are viewed from a billing perspective as the “same physician”. Payment is based on the group’s Medicare provider number, not the unique physician identifier number. For example, if a patient requires repeated FAST exams a repeat examination may be warranted. Since the CPT defines the “same physician” as the same physician or a physician of the same specialty working for the same medical group/employer, a second provider in your group, or working for the same employer, who repeats and codes a second thoracoabdominal trauma examination during the evaluation should have a -76 modifier.

The professional component (PC) represents the supervision and interpretation of a procedure provided by the physician or other healthcare professional. It is identified by appending modifier 26 to the procedure code. The technical component (TC) represents the cost of the equipment, supplies and personnel to perform the procedure. It is identified by appending modifier TC to the procedure code. A global service includes both professional and technical components. The global service is identified by reporting the eligible code without modifier 26 or TC.

CMS and private insurers make a distinction between services provided at a private office and those provided at the hospital. The same patient visiting the emergency room with the same ultrasound should receive the code 76705-26, as the hospital will then bill for the facility fees.

Hospital based providers contemplating ownership of ultrasound equipment who are planning on billing globally (both the Professional Component and the TC) should consider the legal implications. Some references have opined, “Purchasing an ultrasound machine is not considered a Stark II violation, as the Centers for Medicare and Medicaid Services has ruled that diagnostic health services personally performed or provided by the referring physician are not official referrals.”⁷ Others sources disagree and suggest seeking competent legal counsel before entering into such an arrangement.²

Selecting the correct CPT code: Under the Medicare program, the physician should select the diagnosis or ICD-11 code based upon the test results, with two exceptions. If the test does not yield a diagnosis or was normal, the physician should use the pre-service signs, symptoms and conditions that prompted the study. If the test is a screening examination ordered in the absence of any signs or symptoms of illness or injury, the physician should select “screening” as the primary reason for the service and record the test results, if any, as additional diagnoses⁸

Documentation Requirements

Medical necessity: Ultrasounds must have documented medical necessity or study indications, and meet the requirements of completeness for the specific Current Procedural Terminology (CPT) code that is billed. This may at first appear to be simplistic but it is an important premise to understand. Each component of a FAST exam cannot be properly coded unless there is a medical indication for the exam, such as documented chest pain, bruising, hypotension, dyspnea, or similar complaint to substantiate medical necessity.

Written Interpretation: Ultrasound documentation reflects the nature of the exam. As the clinical ultrasound exam is immediately interpreted, the findings should be immediately communicated

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to other providers and consultants by a separate written report and interpretation maintained in the patient's medical record.

The report should include:

- Date and time of examination
- Name and hospital identification number of the patient
- Patient age, date of birth, and sex
- Name of the person who performed and/or interpreted the study, clinical findings
- Indication for the study, the scope (complete vs limited), and if this is a repeat study by the same provider, repeat by a different provider, or reduced level of service
- Impression (including when a study is nondiagnostic) and differential diagnosis, as well as the need for follow on exams and incidental findings.
- Mode of archiving the data (where can the images be found to be viewed) ³
- Expediency in placing these handwritten, transcribed, templated, or computerized reports into the medical record facilitates communication between the healthcare team and insures proper patient management as well as being is vital to peer review and quality analysis.

In the case of ultrasound guidance studies, the written report may be filed as a separate item in the patient's record or it may be included within the report of the procedure for which the guidance is utilized.

Image Capture: All diagnostic ultrasound examinations, including those when ultrasound is used to guide a procedure, should have the orienting anatomy labeled and must have permanently recorded images maintained in the patient record. The stored images do not need to be submitted with the claim, however documentation of the study must be available to the insurer upon request. Images can be stored as printed images, or digital images. Timely documentation and image capture and recording will also facilitate peer review and quality analysis.

The CPT does not require a certain number of images, but does require that the images captured reflect the reported finding(s).⁶ Medicare payer policy regarding image retention requirements vary significantly by regional carrier. Some carriers have no published policies; others require only that the study indication or the physician report appear in the medical record. Some carriers require that images be available for review upon request.

Current practice suggests capturing one image in each orthogonal plane of each relevant structure and/or in the case of echocardiograph, one image of each of the classic windows and levels. If there is any doubt consult relevant local payers' policies, with which participating providers are obligated to comply.²

Furthermore, when performing procedures that require needle placement, it is not necessary to capture an image of the needle in the relevant anatomy, as this distraction may pose a risk to the patient at a critical point in the procedure. It is sufficient to capture an image of the relevant point of interest. However, the procedure note should reflect the needle was guided and visualized under ultrasound.

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Conclusion

Clinicians, to include APPs, performing clinical ultrasound should code and bill for ultrasound exams as they would for any other billable procedure performed during the patient's encounter. This document is intended to provide general information and knowledge of the billing process which will ensure the financial well-being of all clinicians employing clinical ultrasound. This document is not intended to be a comprehensive or definitive reference. Individual questions should be referred to the payor or to the local CMS representative.

REFERENCES

1. Geria RN, Raio CC, Tayal V. Point-of-care ultrasound: not a stethoscope-a separate clinical entity. *J Ultrasound Med* 2015;34:172-3.
2. "ACEP Coding and Reimbursement Document 2009." Emergency Ultrasound Section, American College of Emergency Physicians. Resnick, Hoffenberg, Tayal, Dickman
3. Emergency Ultrasound Certification by External Entities. American College of Emergency Physicians, Clinical Practice and Management Policy Statement. Accessed Aug 31, 2016.
<https://www.acep.org/Clinical---Practice-Management/Emergency-Ultrasound-Certification-by-External-Entities/>
4. National Correct Coding Initiative. Radiology Section, IX-21, revised 1/1/2016.
<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>
5. ACR PRACTICE PARAMETER FOR COMMUNICATION OF DIAGNOSTIC IMAGING FINDINGS. American College of Radiology.
http://www.acr.org/~media/ACR/Documents/PGTS/guidelines/Comm_Diag_Imaging.pdf
6. "ACEP Clinical and Practice Management Questions." American College of Emergency Physicians. McKenzie C. <https://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues/-Reimbursement/Ultrasound-FAQs/>
7. Ness, E. How to Set Up an Ultrasound Presence in Your ED. ACEP Clinical Practice and Management, American College of Emergency Physicians. <https://www.acep.org/clinical---practice-management/focus-on--how-to-set-up-an-ultrasound-presence-in-your-ed/> . Accessed Aug. 31st, 2016
8. "ICD-10-CM Official Guidelines for Coding and Reporting FY 2016."
http://www.cdc.gov/nchs/data/icd/10cmguidelines_2016_Final.pdf