KOSMOS

KOSMOS Reimbursement Guide

OVERVIEW

Coding

Ultrasound services may be performed by a variety of ultrasound systems described from handheld, pocket-sized, point of care, all describe portable; to cart based systems. All studies are reported using the same ultrasound codes so long as all applicable requirements for that code are met. For example, all ultrasound examinations must meet the requirements of medical necessity set forth by payer, must meet the requirements of completeness for the code that is chosen and must be documented in the patient's record, regardless of the type of ultrasound equipment that is used.

It is the provider's responsibility to select the codes that accurately describe the service performed and the corresponding diagnosis codes reflecting the reason for the study.

These guides provide coverage and payment information for diagnostic ultrasound and related guided procedures. This information was obtained from third–party sources and is subject to change without notice, as Medicare and other payers may change their reimbursement policies at any time. It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for service rendered and to ensure any services provided to patients and submitted for reimbursement are medically necessary. EchoNous makes no guarantees concerning reimbursement or coverage. If you have any questions related to how to bill for these services appropriately, please contact your own reimbursement staff or patient's insurers.

How Claims are Reported and Paid

Imaging procedures may be performed in hospital inpatient and outpatient departments, physician offices, or imaging centers, which are classified by Medicare as independent diagnostic testing (IDTFs). In order for ultrasound procedures to be paid by a payer, two sets of codes are used: procedure codes, CPT and diagnosis codes, ICD-10-CM. Procedure codes describe to the health plan what study was done. ICD-10-CM diagnosis codes describe why it was done, this establishes the medical necessity of the imaging. In addition, the study must meet any plan and/or payer coverage criteria as set forth in policy.

National Correct Coding Initiative

As of January 2017, evaluation of an anatomic region and guidance for a needle placement procedure in that anatomic region by the same radiologic modality at the same or different patient encounter(s) on the same date of service are not separately reportable. For example, a physician should not report a diagnostic ultrasound CPT code and CPT code 76942 (ultrasonic guidance for needle placement…) when performed in the same anatomic region on the same date of service. Physicians should not avoid these edits by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service. In addition, per NCCI, " the unit of service for these guidance codes is the patient encounter, not the number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations."[1] Providers should review the complete NCCI sourced below should any other coding edits apply.

1 National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) Effective January 1, 2017, page IX-1
National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) Effective January 1, 2017, page IX-22

Billing Components for Ultrasound

Procedures are reported using Current Procedural Terminology (CPT) codes or Common Procedural Coding Systems (HCPS) codes. Payments are assigned to procedure codes. Payments for ultrasound procedures performed in non-hospital setting are composed of a professional component and a technical component. The professional component represents physician work only and the technical component represents facility overhead, including equipment costs, and staff time. When the physician component is reported separately, the service is identified by adding modifier (see Use of Modifier section) to the procedure code. In the case of procedures performed in a hospital, the physician only bills for the professional component, and the hospital bills for the facility overhead, equipment and staff time as a facility services.

Limited verses Complete Codes

For those anatomic regions that have "complete" and "limited" ultrasound codes, note the elements that comprise a complete exam. The report should contain a description of these elements. 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 once per patient exam session.

Diagnosis Codes

ICD-10-CM diagnosis codes are reported to describe the findings of the study, based on patient's signs, symptoms, or condition. In cases when a procedure is provided for screening asymptomatic patients, specific ICD-10-CM codes are reported, and coverage is generally denied. (Note, however, that AAA screening is among the preventative services that Medicare and private payers are required to cover, under specified circumstances).

Use of Modifiers

In the office setting a physician who owns the equipment and performs the service him or herself or through an employed or contracted sonographer, may generally bill the global fee, which is represented by the CPT[2] code without any modifiers.

If the site of serve is the hospital or Ambulatory Surgical Center (ASC), the -26 modifier, indicating the professional service only was provided, must be added by the physician to the CPT code for the ultrasound service. Payers will not reimburse physicians for the technical component in the hospital or ASC setting.

Documentation Requirements

Ultrasound procedures performed using a handheld or portable device or traditional ultrasound system may be reported using the same CPT code as long as all applicable requirements are met. All ultrasound studies must meet the requirements of:

- Medical necessity as determined by the payer
- Completeness and accuracy for the code selected
- Documented in the patient record (images can be stored on a digital medium or as printed images). The written report for all ultrasound studies should be maintained in the patient record. The written report for US guidance studies may be filed as a separate item in the patient record. These guidance procedures also require permanent recording of the site to be localized as well as a documented description of the localization process, within the report, or separately, of the procedure where guidance is utilized.

The CPT includes very specific requirements for reporting and documenting both diagnostic ultrasound examinations and ultrasound guidance procedures. Providers are cautioned to review these requirements prior to billing for procedures performed by an ultrasound system.

 CPT 2020 Professional Edition, American Medical Association, Page 495

Certification Requirements to Perform POCUS Exams

Generally there is no certification for physicians to perform POCUS. Physicians working in hospitals must get hospital credentialed to make decisions from their ultrasound scans. At that point they can also issue appropriately coded bills. Thus, a licensure is enough if one has reached competency and that is determined by the physician's specialty. Certain services such as echocardiography may have requirements. Consult your local Medicare Administrative Contractor (MAC) for any existing Local Coverage Determinations (LCD). Other non-Medicare payers may have similar policy by plan.

In addition practitioners that are eligible for a National Provider Number (NPI) and/or individually contracted with payers, such as PA, ARNP, CRNA, when working within their scope of practice and appropriate supervision, may bill for ultrasound.

Reimbursement for Non-radiologists Providing Ultrasound Services

Private insurance payment policies vary by payer and plan. Some payers may require specific credentials and/or restrict the imaging procedures covered to specific specialties. Contact your private payer's requirements, request they add ultrasound to your list of services.

Some Medicare contractors require any physician who bills for certain ultrasound examinations to meet certain training and qualification requirements. Check the Local Coverage Determinations issued by your Medicare Administrative Contractor (MAC) to determine whether they impose any qualifications requirements for the examinations that are performed or contact your Medicare Part B Contractor to confirm their requirements.

The following list provides some guidance on what to ask of non-Medicare payers:

- What do I need to do to have ultrasound added to my practices contract or list of services?
- Are there any specific training requirements that I must meet or credentials that I must obtain in order to be privileged to perform ultrasound in my office?
- Do I need to send a letter or can I submit the request verbally?
- Is there an application that must be completed?
- If there is a privileging program, how long will it take after submission of the application before we are accepted?
- What is the fee schedule associated with these codes?
- Are there any bundling edits in place covering any of the services I am considering performing? (Be prepared to provide the codes for any non-ultrasound services you will be performing in conjunction with the ultrasound services.)
- Are there any preauthorization requirements for specific studies?

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