

System Wide Clinical Ultrasound Program Development

Section 4: Revenue Management (CUS Coding, Billing, and Reimbursement)

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Introduction

The purpose of this section is to explain and summarize the terminology and processes associated with CUS coding, billing, and reimbursement when performed in a hospital-wide setting. Because this includes both the inpatient and outpatient environment, an exhaustive discussion of these complexities exceed the limits of this section, and the intent is to provide a basic introduction to the topic. Additionally, because reimbursement varies by location and payer, the information provided should be applied with understanding of provider region, setting, and payer mix. Because Emergency Medicine has played a significant role in the development and practice of CUS, this section relies heavily on guidelines developed by the American College of Emergency Physicians (ACEP) Emergency Ultrasound (EUS) section,¹ with appropriate modifications for the inpatient setting. For a more in-depth discussion of ED CUS billing, coding and reimbursement, please see information contained in the ACEP EUS Reimbursement section which includes the 2009 ACEP EUS Coding and Reimbursement Document, the 2015 ACEP EUS Coding and Reimbursement Update, and the Top 10 EM Ultrasound Reimbursement FAQs.² Finally, the reader is advised to seek out any specialty-specific billing and reimbursement resources which may be relevant to that particular specialty, eg, the American College of Chest Physicians 2016 edition of Coding for Chest Medicine: A Coding and Billing Update, which contains intensivists-specific information regarding POCUS.³ The System CUS director should be a liaison and resource to assist departments attempting to establish CUS billing and work closely with the health system revenue management department.

CUS Coding basics

Current Procedural Terminology (CPT) codes describing CUS services are known as global codes, broken down into physician services (performance and interpretation, known as the professional component) and hospital-based services (equipment, maintenance, supplies, etc., known as the technical component). As with all CPT codes, CUS codes are consistent across provider and specialty. Modifiers are used to delineate the two components, and billing procedures will differ depending on the physician's relationship to his or her facility. An office-based physician who owns the equipment would submit and bill with an unmodified global code, whereas a hospital-based physician would submit and bill for the professional component only, allowing the hospital to bill for the technical (facility) fee. In the Inpatient Prospective Payment System (IPPS), patients/cases are categorized into a

Medicare Severity-Diagnosis Related Group (MS-DRG), which generates a set payment based on the average cost to treat a similar patient. Accordingly, services (including CUS exams performed in the ED, on the hospital floor and in the ICU) may be bundled into the DRG reimbursement for that hospital stay. As always, private payer policies may differ and should be verified as needed.

Most CUS studies are coded as “limited” studies, in comparison to their “complete” counterparts which are classified by distinct CPT codes in most cases. These studies are limited in that they are meant to answer specific focused, often binary “yes/no” questions such as the presence or absence of a pericardial effusion or tamponade, rather than the many diagnostic descriptors obtained during a complete echocardiogram. A common question arises regarding the billable nature of a CUS study when a “complete” study is also performed in another department, most commonly radiology or cardiology. Both studies may be billed, but *only* if the limited study generated diagnostic uncertainty or the need for the complete study, which should be documented in the medical record. If the limited study does not meet these criteria, the complete study is billed and the limited study is typically denied. Additionally, the timing of bill submission may also affect which study is denied. The CUS director is advised to clarify billing practices with service line leaders of traditional imaging specialties such as Radiology and Cardiology to ensure transparency and avoid confusion.

Coding Decodified, in the ED and Beyond

CPT codes describe services performed; this includes both cognitive processes (often called Evaluation and Management (E&M) codes) and procedures, including CUS. CPT codes may contain additions, or “modifiers” that provide additional information not contained in the code alone. ED-performed CUS uses the -26 to describe the physician-performed aspect of the study and -TC modifiers for the hospital-based services, respectively (this includes the cost of equipment, supplies, etc.). International Classification of Diseases, 10th Edition (ICD-10) codes assign diagnosis and procedure codes to a visit and clinicians should be aware of the relationship between ICD-10 and CPT coding. Specifically, diagnosis codes may be used by payers to determine medical necessity of procedures performed, and procedures performed may increase the complexity of the diagnostic E&M code. Thus, it is helpful to understand the ICD-10 codes which most commonly support certain CPT codes, and demonstrate consistency in documentation.

Additionally, some CPT modifiers may trigger automatic denial of payment on first pass edits. Examples include -52 (Reduced Services), -59 (Distinct Procedural Service), -76 (Repeat Procedure by Same Physician), and -77 (Repeat Procedure by Another Physician). Careful documentation of medical necessity can help mitigate payment denial (eg, change in hemodynamic status prompting a repeat exam). Finally, diagnosis-specific Local

Coverage Determinations (LCDs) will reflect the likelihood of reimbursement within one's specialty/region.⁴ Note that not all CPT codes have an associated LCD.

Image documentation and Reporting

In all clinical settings, POCUS studies should include documentation of the person performing the study, scope of study (the -52 "limited" modifier, if relevant), medical necessity, a description of relevant anatomy, interpretation of findings, and a signature.⁵ In cases where the -26 modifier is used to report the limited ultrasound, with the intention of billing only for the professional component of the exam, CPT guidelines do not require retention of an image. However, in cases where the global CPT code is used (which includes the technical component and thus, the facility fee), it is a CPT requirement that all diagnostic and procedural POCUS images are archived. Although there is no specific method of archival mandated, it should be noted that the inclusion of the electronic medical record (EMR) in CMS's Value-Based Purchasing (VBP) program suggests that digital images in a picture archiving and communication system (PACS) or vendor-neutral archive (VNA) is the preferred option. There is no defined credentialing or competency parameters defined by CMS to bill for CUS exams, however most health systems will require that physicians be appropriately trained to bill for CUS exams.⁶

References:

1. American College of Emergency Physicians. Ultrasound guidelines: Emergency, point-of-care, and clinical ultrasound guidelines in medicine. [policy statement]. <https://www.acep.org/patient-care/policy-statements/ultrasound-guidelines-emergency-point-of-care-and-clinical-ultrasound-guidelines-in-medicine/> Accessed 8.21.19
2. ACEP US Reimbursement FAQs. <https://www.acep.org/administration/reimbursement/reimbursement-faqs/ultrasound-faqs/> (Accessed 8/22/19).
3. Coding for Chest Medicine: A Coding and Billing Update (2016 ed.)
4. CMS Local Coverage Determinations Process. <https://www.cms.gov/medicare/coverage/determinationprocess/LCDs.html>
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6. Reimbursement for Office-Based or Outpatient Ultrasound Imaging H-385.934 <https://policysearch.ama-assn.org/policyfinder/detail/H-385.934?uri=%2FAMADoc%2FHOD.xml-0-3253.xml> (Accessed 8/22/19).