2014 Update: The Latest Changes to Cardiovascular Ultrasound Reimbursement and Its Impact to You

A Washington Update

Diane Millman, ASE Washington Counsel
And
Judy Rosenbloom, ASE Coding Contractor

Q&A

Q: In order to charge for stress testing with supervision, where exactly does the physician need to be (ie, in the room, in the suite, etc...)?

Direct supervision is required in order to bill for stress testing with supervision. According to Medicare, direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed. (Medicare Benefit Policy Manual)

Q: When performing an echocardiogram for congenital heart defects we use these codes 93303, 93320 and 99325. If the study reveals a normal cardiac structure does the code have to be changed to 93306?

Codes 93303-93304 and 93315-93317 should not be used when congenital heart disease is suspected but not found during echocardiographic evaluation. In such circumstances, the non-congenital echocardiography codes should be reported. (CPT Assistant, August 2013)

Q: Also the new code 99351 for a tress echo is paying a lot less than the older three codes we use to bill. Can we use any other code?

Code 93351 is inclusive of stress test and stress echo procedures. Physicians report 93351 when the same physician provides all components (the stress echo and stress test supervision/ interpretation). 93351 is reported by the hospital when both stress echo and stress testing is performed (without contrast). The AHA Coding Clinic has also given guidance that 93351 is the applicable code to report, regardless if the stress test and stress echo is done in different departments. there are no alternative codes that may be reported.

Q: Why does the new bundled code 93306 pay much less thna the old code with 93307, 93320 and 93325?

Payment is based on the Relative Value Units (RVU) assigned to the code. The current national Medicare

payment for 93306 is $229 physician office, $427 HOPD. The current National Medicare payment for 93307 + 93320 + 93325 is $213 physician office, $427 HOPD.

Q: I perform a pediatric echo study for a child with a murmur, but is there a way to bill for the congenital study performed as the 93303, 03320 and 93320 code, even if the final diagnosis is only a murmur and on heart defect was detected?

Codes 93303-93304 and 93315-93317 should not be used when congenital heart disease is suspected but not found during echocardiographic evaluation. In such circumstances, the non-congenital echocardiography codes should be reported. (CPT Assistant, August 2013)

Q: Will physicians' office still be able to perform diagnostic imaging if they are owned by a hospital?

It depends. The changes that are under consideration would preclude physicians' offices that provide ADVANCED diagnostic imaging (MRI, CT and nuclear procedures, but not echo) from relying on the in office ancillary services ("IOASE") exception to the Stark Law. This is the exception that physicians' offices generally rely on, since this exception is one of the few that protects ***both*** *physician* ***ownershp*** *of, and physician c****ompensation*** *relationships with, entities that provide advanced imaging (ie. their practices) When a hospital owns the practice--and the physicians have no ownership interest--it may not be necessary to rely on the IOASE exception: Rather, it may be possible to rely on different exceptions--exceptions that provide protection for physicians' compensation relationships with --but not for their ownership of--entities that provide advanced imaging. Nothing in the legislation under consideration would impact these compensation-only exceptions. Therefore, some hospital-owned practices may be OK even if they can't rely on the IOASE, if they meet the requirements of these compensation exceptions. Advice of counsel should be sought.*

Q: Are vascular tests also being scrutinized in the same way as echo?

Vascular testing is subject to explicit coverage criteria, including credentialing recommendations and requirements.

Q: Please review outpatient Stress echo coding, Doppler add-on? Use of Mod 59?

Doppler (93320) may be reported with the stress echo code. It is not necessary to append modifier -59 to the Doppler code. Although payment for Doppler is packaged (not paid separately), in the hospital outpatient setting, the stress echo and Doppler code should be reported.

Q: If a bubble study is done can you bill for the saline in a hospital setting for IP and/or OP?

Payment for the saline is packaged (not paid separately) in the HOPD and inpatient setting. For reporting purposes, the code is A4216, Sterile water, saline and/or dextrose, diluent/flush, 10 ml but it will not be separately paid.

Q: Where do we stand on reimbursement, prior approval, and indications for 3D code 76376 for both TTE and TEE?

RE: prior approval: Medicare does not prior authorize procedures. Check with your commercial payers to determine if prior authorization is required. For Medicare, coverage requirements for 3D may vary by carrier. Palmetto, a local Medicare contractor has a coverage policy (LCD) which notes that CPT codes 76376 and 76377 may be considered medically unnecessary and denied if equivalent information to that

obtained from the test has already been provided by another procedure (magnetic resonance imaging, ultrasound, angiography, etc.) or could be provided by a standard CT scan (two-dimensional) without reconstruction. Based on the following policy language, 3D rendering of echocardiography may covered by Palmetto:
One of the following diagnosis codes must accompany a primary diagnosis code. The use of these diagnosis codes implies that the medical necessity of the 3-D rendering, and interpretation is documented in the medical record with a written request for the study from the referring physician and is available upon request.
Covered secondary diagnoses:
793.0 nonspecific (abnormal) findings on radiological and other examination of skull and head
793.11 solitary pulmonary nodule
793.19 other nonspecific abnormal finding of lung field
793.2 nonspecific (abnormal) findings on radiological and other examination of other intrathoracic organs
793.4 nonspecific (abnormal) findings on radiological and other examination of gastrointestinal tract
793.5 nonspecific (abnormal) findings on radiological and other examination of genitourinary organs
793.6 nonspecific (abnormal) findings on radiological and other examination of abdominal area, including retroperitoneum
793.7 nonspecific (abnormal) findings on radiological and other examination of musculoskeletal system
3D codes 76376 and 76377 are paid under the Medicare Part B Physician fee schedule. As such, the services are eligible for payment to the physician. Other payers may also separately reimburse. Medicare does not separately reimburse for 3D for hospital outpatients. Rather, the payment is bundled into the base procedure. However, it is important that hospitals continue to establish charges and report these procedures to maintain accurate future rate-setting by Medicare. In addition, the reporting of these services is necessary for maintaining reimbursement with private payers (who may separately ***reimburse).***

Q: V codes are not being accepted by Medicaid in PA. Eg V17.49 for family history of heart defects for a fetal echocardiogram. Any thoughts?
Policies vary so it is advised to seek information from your Medicaid carrier as to the conditions of coverage for fetal echocardiography. There are other conditions that may support medical necessity that are not reported with V codes, e.g. 655.23: Hereditary disease in family possibly affecting fetus

Q: If a patient's script states murmur, can you use MR to bill after the fact?
A diagnosis of MR may be billed if the echo examination confirms MR and is documented in the report as a definitive diagnosis.

Q: How do we code for screening due to family history of bicuspid aortic valve or HOCM?
Relevant available codes for family history of cardiovascular disorders are as follows:
V17.3 Family history of ischemic heart disease
V17.41 Family history of sudden cardiac death (scd)
V17.49 Family history of other cardiovascular diseases
V19.5 Family history of congenital anomalies

There is no specific code for family history of bicuspid aortic valve or HOCM. These would be reported with one of the above codes.

Q: Would you use a limited echo for a TDS patient that you cannot see all structures on?

A complete echocardiogram is one that includes multiple views of 2D, all chambers, valves, pericardium, and portions of the aorta, and appropriate measurements. M mode examinations should also be included, if performed. Additional anatomy such as pulmonary veins, artery, pulmonic valve, and inferior vena cava may be included. The inability to visualize or measure clinically relevant anatomy should be documented; a complete echocardiogram may be coded if visualization of all relevant structures was attempted.

A limited examination is usually a follow-up or focused study that does not evaluate all the structures required for a comprehensive or complete echocardiographic exam. The purpose of this exam is best described as a focused clinical exam.

Q: Can you please speak about reimbursement for 3D Echo, both TEE and TTE. Is there additional reimbursement for it being performed?

Physician

3D codes 76376 and 76377 are paid under the Medicare Part B Physician fee schedule. As such, the services are eligible for payment. Other payers may also separately reimburse.

Hospital Outpatient

Medicare does not separately reimburse for 3D (76376/76377) for hospital outpatients. Rather, the payment is bundled into the base procedure. However, it is important that hospitals continue to establish charges and report these procedures to maintain accurate future rate-setting by Medicare. In addition, the reporting of these services is necessary for maintaining reimbursement with private payers (who may separately reimburse).Note 3D codes are reported in addition to the primary echocardiography procedure code (e.g., 93306)

Q: In the hospital setting can you get payment for recover and or observation of patients that are sedated?

According to CPT, Moderate (Conscious) Sedation includes:

Assessment of the patient, establishment of IV access, administration of agent(s), maintenance of sedation, monitoring of oxygen saturation, heart rate, and blood pressure, and recovery. Recovery is not separately reported/reimbursed.

Q: Is there any coding and reimbursement for facility fee?

There is no "facility fee" for echocardiography alone. If the patient has an echocardiogram in the context of other care (e.g. an ED visit), there may be coding/reimbursement for the encounter, depending upon services provided.

Q: For contrast, does the C8928 code apply to both TTE and also SE?

C8928 is reported for a stress echo with contrast, but not for TTE without stress. There are numerous codes that may be reported for contrast echocardiography in the HOPD:

C8921 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete
C8922 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; follow-up or limited study
C8923 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, complete, without spectral or color doppler echocardiography
C8924 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, follow-up or limited study
C8925 Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, real time with image documentation (2d) (with or without m-mode recording); including probe placement, image acquisition, interpretation and report
C8926 Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927 Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report
C8929 Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography
C8930 Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision

Q: When a patient comes back after an ASD or PDA device placed, the child needs to have follow up echoes (TTE) per device protocol-once a year for the first few years. They do not have an ASd any more and they do not have a heart defect, even though a congenital echo study is done. What ICD9 can we use?
V13.65 - Personal history of (corrected) congenital malformations of heart and circulatory system

Q: When will we know (best guess) if there will be a leveling of the playing field between office and hospital echo?
Now that this issue has been raised, it may be with us for quite some time. It is possible that a "level

playing field" proposal could be included in a package to repeal and replace the SGR, which likely will be considered at the end of this year or the beginning of next year (likely in or around March 2015). However, even if we succeed in convincing Congress not to include the proposal in SGR-related legislation, it is possible and in fact likely that the level playing field idea will recur the next time Congress needs health care savings.

Q: Is there a limited TEE code? Example we do limited TEE pre ablations to look at function and appendage.

There is no "limited" code for TEE. The TEE codes were not established based on the distinction of complete or limited, and the Introductory CPT language does not specify what is considered a complete or limited for these procedures. There is no CPT guidance as to what anatomy is included in a TEE exam.

Q: I cover a HOPPS diagnostic center and hospital depart. Do I utilize the Hospital reimbursement for both scenarios?

If the service is provided in the hospital outpatient department, reimbursement is under the OPPS system. The same is true for a diagnostic center that is a hospital outpatient site of service.

Q: Does a patent foramen ovale finding on TTE qualify for congenital TTE?

The CPT manual is not specific, but the August 2013 CPT Assistant does state: congenital heart disease, which includes defects such as atrial and ventricular septal defects, patent ductus arteriosis, Tetralogy of Fallot, transposition of the great arteries, single ventricle, and congenital defects of the cardiac valves

Q: Does a bicuspid aortic valve finding on TTE qualify for congenital TTE?

The CPT manual is not specific, but the August 2013 CPT Assistant does state: *congenital heart disease, which includes defects such as atrial and ventricular septal defects, patent ductus arteriosis, Tetralogy of Fallot, transposition of the great arteries, single ventricle, and congenital defects of the cardiac valves*

Q: Interested in know if the cost for an echo would be the same for a HOPPS center and the in patient lab.

There is no separate reimbursement for an inpatient echocardiogram. Payment for the echo is packaged into the DRG payment. Conversely, outpatient echo is reimbursed separately under the Outpatient Prospective Payment System. Please see the webinar slides for HOPD payment rates.

Q: Is there a facility fee that we could bill for office based echo procedure?

No. Office based echocardiography is billed under the physician fee schedule for the echo CPT codes only.

Q: Thank you for info on 3d echo. However if I do an inpatient 3D TEE can I bill for 3D with 76376 or 76377?

3D codes 76376 and 76377 are paid under the Medicare Part B Physician fee schedule. As such, the services are eligible for payment for physician services, when provided in any site of service (e.g., for an inpatient, outpatient, etc.). Other payers may also separately reimburse. There is no separate payment to the hospital for 3D by Medicare.

Q: Could office based echo procedure bill for facility fee?

No. Office based echocardiography is billed under the physician fee schedule for the echo CPT codes only.

Q: Can we bill for saline injection in the outpatient clinic setting?

Payment for the saline is packaged (not paid separately) in the HOPD setting. For reporting purposes, the code is A4216, Sterile water, saline and/or dextrose, diluent/flush, 10 ml but it will not be separately paid.