EMERGENCY ULTRASOUND FREQUENTLY ASKED QUESTIONS

1. What documentation is necessary for the coding of Emergency Department ultrasounds?

Proper documentation of ultrasound studies performed in the Emergency Department should include or indicate the following: (ref IV. A)

- A separately identifiable written report for each test performed. This may be an independent report or may be incorporated within the patient treatment record.
- Who performed the study
- Scope of the examination (limited vs. complete, including any modifiers)
- The indication (medical necessity) for the examination
- A description of the structures or organs studied and an interpretation of the findings
- Signed by physician
- An order for the test
- Archiving the image

2. Do I have to meet American College of Radiology standards for documentation in order to code for an ultrasound interpretation?

No, there are no CMS (agency formerly known as HCFA) requirements that documentation adhere to any specialty society guidelines. CMS opinion has primarily addressed X-ray and EKG interpretation and can be reviewed in the "HCFA Final Rule on X-ray/EKG Interpretations" and "HCFA memo regarding X-ray/EKG Interpretations in the ED" (both found at www.acep.org). While these documents do not directly address ultrasound interpretation and reports, our opinion is that general principles of X-ray interpretation by Emergency Physicians would be similar to ultrasound examination and interpretation by Emergency Physicians.

Reports must be complete and similar to that usually prepared by a specialist in the field. Reports need not specifically follow the American College of Radiology guidelines.

When multiple bills are submitted for the same report, CMS will pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. The interpretation and report paid will usually be that provided contemporaneous with the patient's visit and without consideration of the reporting physician's specialty. (IV. A).

3. What code should I use for the FAST exam?

The FAST examination is not a single ultrasound procedure, but a clinical approach to the traumatically injured or hypotensive patient that utilizes two distinct limited examinations currently described by CPT. The components of this clinical approach have been outlined by both ACEP publications as well as the joint AIUM and ACEP document: Guideline for the Performance of the FAST exam. The CPT codes are (1) limited transthoracic echocardiogram (93308-26) and (2) limited abdominal ultrasound (76705-26). If one performs a focused chest ultrasound, the CPT for a limited chest ultrasound may be added (76604-26) (ref II.A.1). Decreased reimbursement is expected for limited abdomen and limited chest as these are in the same ultrasound family as categorized in Multiple Procedural Payment Reduction by CMS.

4. If I perform a diagnostic ultrasound and a related ultrasound-guided procedure during a single patient encounter, how do I code?

As long as the diagnostic code is not subsumed in the procedural code, the diagnostic and procedural codes can be billed separately. If one performs a limited cardiac ultrasound and diagnoses pericardial tamponade, then performs an ultrasound-guided pericardiocentesis, the codes would be: 1. diagnostic transthoracic echocardiogram (93308-26) 2. ultrasound-guided pericardiocentesis (76930-26), and 3. the surgical procedure for pericardiocentesis (33010, pericardiocentesis; initial). (ref. II.A.7).

5. If the Emergency Physician and a Trauma Surgeon both perform a FAST exam, can both physicians code and bill for their respective examinations?

Physicians with the same group Medicare provider number are considered to be the same physician from a billing perspective. If the "same physician" repeats an examination, then the -76 modifier is utilized (I.C.4,5).

A second physician with a different group Medicare provider number may code and bill a repeat examination for the same patient on the same date. However, the second physician should utilize the -77 CPT code modifier. Both physicians must document the medical necessity for each examination performed. The indications for a repeat FAST examination during the same patient encounter might include such factors as the development of hemodynamic instability, a falling hematocrit, or development of increased abdominal pain/tenderness in a patient who had a negative initial FAST examination. Repeating a FAST examination to simply confirm the finding of another provider may be clinically reasonable, but would not warrant the coding of a separate study.

6. Can an Emergency Physician code a limited examination and a Radiologist code a complete examination on the same patient encounter?

Two physicians can code a limited examination and a complete examination, of the same anatomic description, on the same date of service, if two separate procedures are performed and are medically necessary. On some occasions, an initial limited examination by an Emergency Physician will be inconclusive or demonstrate an unexpected finding requiring a complete examination or follow-up examination by a consulting Radiologist. What is required is that each examination, limited or complete, stand on its own merit as a medically necessary study. A repeat examination of the exact same type by a second physician with a different group Medicare provider number would require a -77 modifier.

The planned sequencing of a limited examination by one provider (Emergency Physician) followed by a complete examination by a second provider (Radiologist), both coding for the procedure, would not constitute proper or compliant coding.

A single provider would not code a limited exam followed by a complete examination of the same anatomic description, as the initial limited exam would be included in the more comprehensive complete code.

7. If I use transabdominal and transvaginal ultrasound to evaluate a pregnancy or a possible complication of pregnancy, how should I code the study?

When the patient is (1) known to be pregnant, including knowledge of a positive pregnancy test and (2) the physician is utilizing ultrasound to evaluate the pregnancy or a suspected complication of pregnancy, then the obstetric pelvic codes would be utilized (e.g. 76815-26). When these two criteria are met, the obstetric codes are utilized regardless of the study result. Thus the obstetric pelvic codes would apply to the "known pregnant patient" even in the absence of an identified intrauterine pregnancy and if the patient was found to have an ectopic pregnancy, spontaneous abortion, molar pregnancy, ovarian torsion or a non-pregnancy related condition (ref. II. A. 2).

If transabdominal and transvaginal examinations are medically necessary and performed, both can be coded. The planned sequencing of a transabdominal and transvaginal ultrasound for every patient, regardless of the information obtained on transabdominal ultrasound would not be appropriate. As stated earlier, the medical indication for each exam should be documented (II. A. 2).

8. Can hospital based Emergency Physicians own the US machine and code a global CPT based on ownership of the equipment?

No. In the hospital setting, ultrasound charges are divided between the professional component and the technical component instead of having a global fee assigned. The professional component of the ultrasound service, indicated by the -26 modifier, is reported by the physician for professional services that include interpretation and report of the study results. The technical component, designated by a –TC modifier, is charged by the facility (i.e. hospital) and includes reimbursement for the cost of equipment, service and maintenance, supplies, and technician salaries.

If physicians are hospital employees and the hospital owns the ultrasound machine, the hospital must still separate the ultrasound billing into professional and technical charges. The physician service is submitted on the HCFA form 1500 and the technical component is submitted to the Medicare fiscal intermediary on a form UB 92.

Equipment purchase is not typically a cost sustained by hospital-based physicians, and hospital Emergency Physician groups do not typically receive revenue from equipment ownership. Financial relationship between physicians who utilize hospital services that entail using the physicians' own equipment are addressed by multiple fraud and abuse statutes and regulations. Physicians contemplating such arrangement are advised to seek competent specialized legal counsel (ref I. C. 1).

9. Are midlevel providers allowed to perform Emergency Department ultrasounds?

Midlevel providers (ie. PAs and NPs) are subject to state defined scope of practice. Depending on how the state-guidelines above are interpreted, the midlevel providers would also have to be credentialed by the hospital to be performing the ultrasound procedure. Their credentialing process would be expected to meet the same requirements as an Emergency Physician.

The following resources are available for more specific information:

PA scope of practice
http://www.aapa.org/gandp/statelaw.html

NP scope of practice
http://www.aanp.org/Publications/AANP+Position+Statements/Position+Statements+and+Papers.asp

ACEP's FAQs link for mid-level providers
http://www.acep.org/practres.aspx?id=30478

If the scope of practice criteria is met and the hospital credentials the midlevel provider, the PA or NP is able to bill for procedures. Medicare typically pays 85% of what they would pay for a physician performing the same procedure if a

physician is not involved in a mid-level provider case. Non-Medicare payers have different contractual agreements for fee schedules.

Mid-level providers are not inclusive of registered nurses. Nurses are not billing for "professional" services found in the professional CPT guidelines.

10. What are some resources for me to appeal payment rejections for emergency ultrasounds?

Form letter: http://www.acep.org/content.aspx?id=30434

ACEP Billlling Hassle Log: http://www.acep.org/Content.aspx?ekfrm=43460