Subject: ED echos

January 24, 2016
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BOG:

One of my colleagues passed this along to me (see below)

1. Does anyone know the billing guidelines for echoes performed in E.R.

2. Does the ACC or Society of Echocardiography have/ or should have , any authoritative jurisdiction over echocardiography performed by the E. R.

January 24, 2016
Lawrence Rudski, MD, CM, FACC (Lawrence.rudski@gmail.com)

I cannot answer the first question for you, as I work in Quebec, but in Quebec, ED MDs can bill a different code.

For the second question, as a former ASE Board of Directors member, this was a hot topic. We came up with a joint "consensus" document that was quite contentious. There is NO "jurisdiction" as performance of medical acts and the authorization to do them does not lie within a society, but via governmental licensing and billing authorities.
The best any organization can strive for is to try to lobby to ensure quality of the equipment and training of the person using it. In Quebec, at least, it is a completely different billing code that has no bearing on the cardiologist's ability to perform and bill for an echo.

January 25, 2016
Debra Mariani, ACC Staff (dmariani@acc.org)

Hello Dr. Moutsatsos,

Here is some coding guidance from CMS regarding Diagnostic Procedures. Echos have NCCI (National Correct Coding Iniative) indicator of "1" which means only one service/procedure can be billed on the same patient on the same day but it may be possible that initial and follow-up echocardiographic exams of the same recipient on the same date of service can be reimbursable if an explanation of medical necessity is included with the claim but we think that Medicare will not pay for more than one interpretation of the same imaging service unless it changes diagnosis or care plan. Here is the guidance I have found:

CPT-4 Codes 93306 and 93307	CPT-4 codes 93306 and 93307 are not reimbursable when billed for the same recipient, on the same date of service, by any provider.
CPT-4 Codes 93307 and 93350 of service.	CPT-4 codes 93307 and 93350 are mutually exclusive. These codes are not both reimbursable if billed for the same recipient on the same date

CPT-4 Codes 93308, 93320 and 93321

CPT-4 codes 93308, 93320 and 93321 may be reimbursed for either:

- One professional component (modifier 26) plus one technical component (modifier TC) for the same date of service, any provider; or
- Both the professional and technical components (no modifier)

for the same date of service, same provider.

Transesophageal Echocardiography (TEE) Codes

Transesophageal echocardiography (TEE) services are billed with CPT-4 codes 93312, 93315 and 93318. For services billed by any provider, the following policies apply:

- Only one of the following CPT-4 codes may be reimbursed for claims on the same date of service: 93312, 93315 or 93318. Subsequent claims must have the same procedure code and appropriate modifier, or they will be denied.
- CPT-4 codes 93312, 93315 and 93318 must be billed with the appropriate modifiers: 26 (professional component) or TC (technical component). When billing for both the professional and technical components, a modifier is neither required nor allowed.
- The frequency restriction for CPT-4 codes 93312, 93315 and 93318 is four per year, per recipient, by any provider.

Here is some guidance from the CMS Claims Manual for Diagnostic Procedures which would be the same for echos, example are provided below:

The professional component of a diagnostic procedure furnished to a beneficiary in a hospital includes an interpretation and written report for inclusion in the beneficiary's medical record maintained by the hospital. (See 42 CFR 415.120(a).)

Carriers generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service. This is because the review is already included in the emergency department evaluation and management (E/M) payment. For example, a notation in the medical records saying "fx-tibia" or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An "interpretation and report" should address the findings, relevant clinical issues, and comparative data (when available).

Generally, carriers must pay for only one interpretation of an EKG or x-ray procedure furnished to an emergency room patient. They pay for a second interpretation (which may be identified through the use of modifier "-77") only under unusual circumstances (for which documentation is provided) such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure.

When carriers receive only one claim for an interpretation, they must presume that the one service billed was a service to the individual beneficiary rather than a quality control measure and pay the claim if it otherwise meets any applicable reasonable and necessary test.

When carriers receive multiple claims for the same interpretation, they must generally pay for the first bill received. Carriers must pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. Consideration is not given to physician specialty as the primary factor in deciding which interpretation and report to pay regardless of when the service is performed. Consideration is not given to designation as the hospital's "official interpretation" as a factor in determining which claim to pay. Carriers pay for the interpretation billed by the cardiologist or radiologist if the interpretation of the procedure is performed at the same time as the diagnosis and treatment of the beneficiary. (This interpretation may be an oral report to the treating physician that will be written at a later time.)
If the first claim received is from a radiologist, carriers generally pay the claim because they would not know in advance that a second claim would be forthcoming. When carriers receive the claim from the emergency room (ER) physician and can identify that the two claims are for the same interpretation, they must determine whether the claim from the ER physician was the interpretation that contributed to the diagnosis and treatment of the patient and, if so, they pay that claim. In such cases, carriers must determine that the radiologist's claim was actually quality control and institute recovery action.
The two parties should reach an accommodation about who should bill for these interpretations.

The following examples apply to carriers:

EXAMPLE A:
A physician sees a beneficiary in the ER on January 1 and orders a single view chest x-ray. The physician reviews the x-ray, treats, and discharges the beneficiary. A carrier
receives a claim from a radiologist for CPT code 71010-26 indicating an interpretation with written report with a date of service of January 3. The carrier will pay the radiologist's claim as the first bill received. Carriers do not have to develop the claim to determine whether the interpretation was a quality control service.
EXAMPLE B:
Same circumstances as Example A, except that the physician who sees the beneficiary in the ER also bills for CPT code 71010-26 with a date of service of January 1. The carrier will pay the first claim received. If the first claim is from the treating physician in the ER, and there is no indication the claim should not be paid, e.g., no reason to think that a complete, written interpretation has not been performed, payment of the claim is appropriate. The carrier will deny a claim subsequently received from a radiologist for the same interpretation as a quality control service to the hospital rather than a service to the individual beneficiary.
EXAMPLE C:
Same as Example B except that the claim from the radiologist uses modifier "-77" and indicates that, while the ER physician's finding that the patient did not have pneumonia was correct, there was also a suspicious area of the lung suggesting a tumor that required further testing. In such situations, the carrier pays for both claims under the fee schedule.
EXAMPLE D:
The carrier receives separate claims for CPT code 71010-26 from a radiologist and a physician who treated that patient in the ER, both with a date of service of January 1. The first claim processed in the system is paid and the second claims will be identified and denied as a duplicate. If the denied "provider" is the radiologist and he raises an issue the carrier will develop the claim to determine whether the findings of the radiologist's interpretation were conveyed to the treating physician (orally or in writing) in time to contribute to the diagnosis and treatment of the patient. If the radiologist's interpretation was furnished in time to serve this purpose, that claim should be paid, and the claim from the other physician should be denied as not reasonable and necessary.

I am also checking with ASE to see if they have any further guidance.