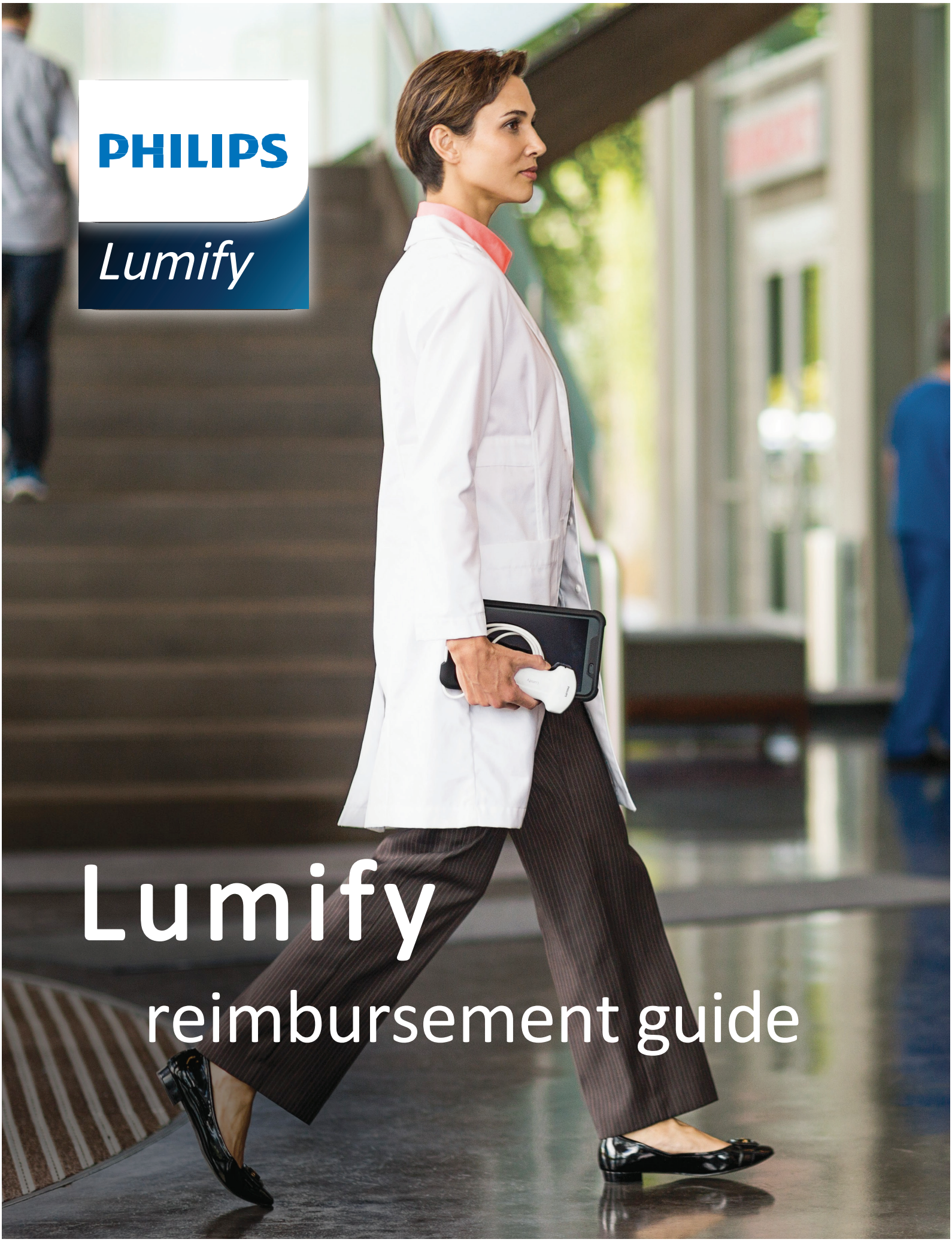

Lumify

reimbursement guide

Contents

Overview

Ultrasound services performed with an Ultra mobile or hand-carried ultrasound system are reported using the same ultrasound codes that are submitted for studies performed with cart-based ultrasound systems so long as all applicable requirements for that code are met. For example, all ultrasound examinations must meet the requirements of medical necessity as set forth by the 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.

The information provided is intended to assist providers in determining appropriate codes and the other information for reimbursement purposes. It represents the information available in the public domain as of the date listed in this document. It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for the services rendered. Before filing any claims, providers should verify current requirements and policies with the applicable payer. Philips makes no guarantees concerning reimbursement or coverage.

How claims are 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 facilities (IDTFs). In order for ultrasound procedures to be paid by a payer, two sets of codes are used: procedure codes and diagnosis codes. Procedure codes describe to the health plan what was done. ICD-10 diagnosis codes describe why it was done.

Procedure codes

Procedures are reported using Current Procedural Terminology (CPT) codes or Common Procedural Coding Systems (HCPCS) Codes. Payments are assigned to procedure codes.

Payments for ultrasound procedures performed in non-hospital settings 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 -26 to the CPT/HCPCS procedure code. When the technical service is reported separately, the service may be identified by adding a -TC modifier to the CPT/HCPCS procedure code. In the case of procedures performed in a hospital, the physician only bills for the professional component (-PC), and the hospital bills for the facility overhead, equipment and staff time as a facility services.

Diagnosis codes

ICD-10 CM diagnostic codes are reported to describe the 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 preventive services that Medicare and private payers are required to cover, under specified circumstances.)

*The reimbursement information in this document does not address hospital inpatient imaging procedures.

Documentation requirements

Ultrasound procedures performed using a handheld or portable ultrasound device or traditional ultrasound system may be reported using the same CPT codes 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

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 using Lumify or any other ultrasound system.

Billing codes for ultrasound:

Non-hospital setting

Codes and payment rates

Generally, the amount allowed by payers for the interpretation of an ultrasound study is the same regardless of the site of service; however, for Medicare (and for many other payers), the amount paid for the image acquisition (the "technical component" or the "facility fee") differs depending on whether the study is performed in a hospital or non-hospital (generally physician office or imaging center (IDTF) setting..

Medicare reimburses for ultrasound procedures performed in a physician's office or imaging center under the Physician Fee Schedule. The payment received in the Physician Fee Schedule is divided into two parts. The first, called the professional fee, is the amount the physician gets for reading and interpreting a test, regardless of the setting or location where the test was done. The second, the technical fee, is the amount the physician receives to cover the costs of equipment, non-physician clinical staff, medical supplies and other practice expenses when the tests are performed in the physician's office, freestanding imaging centers, and Independent Diagnostic Testing Facilities (IDTFs).

Commercial Payers reimburse procedures and services according to the provision of the provider's contract with the health plan. Some commercial payers impose training, certification, or accreditation requirements for providers of ultrasound and refrain from contracting with providers who do not meet these requirements.

The following codes are identified as appropriate for point-of-care ultrasound and that fall within the scope of the labelling for Lumify:

Limited vs Complete:

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.

	2016 Medicare Payment for the Non-hospital Setting		Physician Fee Schedule	
	Rates apply to procedures conducted in the non-hospital setting: a physician's office, imaging center or independent diagnostic testing facility. These are national average payment rates. Actual rates are adjusted by geographic region			
CPT code*	CPT code descriptor	Global payment (if applicable)	Professional payment (-26)	Technical component (TC)
	General ultrasound codes			
76604	Ultrasound chest, real time with image documentation	$89.15	$27.57	$61.58
76705	Ultrasound exam, abdominal, soft tissue limited (e.g., single organ, quadrant, follow-up)	$92.74	$30.08	$62.66
76775	Ultrasound retroperitoneal, abdominal back wall – limited	$58.72	$29.36	$29.36
76857	Ultrasound exam, pelvic, limited (non-OB)	$48.33	$25.42	$22.91
93308	TTE follow-up or limited: Echocardiography, transthoracic, real-time with image documentation (2D) includes m-mode recording, when performed, follow-up or limited study	$126.03	$26.14	$99.89
93971	Extremity study – DVT (vascular)	$122.80	$22.91	$99.89
	Ultrasound Guided Procedure Codes			
76937	Ultrasound guidance vascular access	$31.87	$14.68	$17.19
76942	Ultrasound guidance for biopsy/guided injection	$61.58	$34.01	$27.57
49083	Abdominal paracentesis w/imaging	$299.32	Global Payment	Global Payment
	Musculoskeletal (MSK)			
76882	Ultrasound extremity non-vascular limited	$36.52	$25.06	$11.46
76942	Ultrasound guidance for biopsy/guided injection	$61.58	$34.01	$27.57
20604	Drain/ inject small joint/bursa with ultrasound: e.g. finger, toe	$73.40	Global Payment	Global Payment
20606	Drain/ inject mid-size joint/bursa with ultrasound: e.g. wrist, elbow	$81.28	Global Payment	Global Payment
20611	Drain/ inject large joint/bursa with ultrasound: e.g. hip, knee	$93.09	Global payment	Global Payment
	Soft Tissue			
76536	Ultrasound exam of head and neck (soft tissues – e.g. thyroid)	$117.80	$28.64	$89.15
	Pelvic			
76815	Ultrasound, pregnant uterus – limited (e.g., fetal heart beat, placental location, qualitative amniotic fluid and/or fetal position)	$85.57	$33.30	$52.27
76857	Ultrasound exam, pelvic, limited (non-OB)	$48.33	$25.42	$22.91
	Other			
G0389	Ultrasound exam AAA screen	$121.79	$29.72	$92.07

*CPT codes listed reflect a subset of codes relevant to Point-of-care focused, goal-directed exams

The rates provided above are Medicare 2016 National Average Rates.

Billing codes for ultrasound:

Hospital outpatient department

Codes and payment rates

Generally, the amount allowed by payers for the interpretation of an ultrasound study is the same regardless of the site of service; however, for Medicare (and for many other payers), the amount paid for the image acquisition (the "technical component" or the "facility fee") differs depending on whether the study is performed in a hospital or non-hospital (generally physician office or imaging center (IDTF) setting.

Medicare reimburses for the facility fee associated with ultrasound procedures performed in a hospital outpatient department under the Hospital Outpatient Prospective Payment System. The HOPPS determines payment for diagnostic and therapeutic services that do not require hospitalization. To determine the payment amounts, Medicare uses a classification system called Ambulatory Payment Classifications, or APCs, which groups procedures on the basis of clinical and cost similarity. All services within an APC receive the same payment rate.

Commercial Payers reimburse procedures and services according to the provision of the provider's contract with the health plan.

Physician billing in hospital settings

Medicare rules preclude physicians from billing for the technical component of an examination if the examination is performed in a hospital setting. If Lumify is used in a hospital setting, only the professional component of the examination is eligible to be billed by the physician. In addition, a hospital may limit the physicians who are eligible to bill for the professional component to those physicians who have staff privileges to perform ultrasound procedures.

Limited vs Complete:

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.

The following codes are among the codes that the ACEP has identified as appropriate for point-of-care ultrasound and that fall within the scope of the labelling for Lumify:

*Items and services packaged into APC rates. No separate payment is available for this service as the payment is packaged into the associated primary procedure.

	2016 Medicare Payment for Hospital Outpatient Department		Hospital Outpatient Prospective Payment System	
Rates apply to procedures conducted in the hospital outpatient departments & are paid from the HOPPS schedule. Additionally, these are national average payment rates. Actual rates are adjusted by geographic region.				
CPT code**	**CPT code descriptor**	**Professional payment (-26)**	**APC group**	**APC payment**
	Core Emergency Ultrasound Codes			
76604	Ultrasound chest, real time with image documentation	$27.57	5531	$92.07
76705	Ultrasound exam, abdominal – soft tissue, limited (FAST Exam)	$30.08	5532	$153.58
76775	Ultrasound exam, abdominal back wall limited e.g. (Urinary tract, renal, AAA)	$29.36	5532	$153.58
76815	Ultrasound, pregnant uterus, limited	$33.30	5532	$153.58
76857	Ultrasound exam, pelvic, limited (non-OB)	$25.42	5531	$92.07
93308	TTE follow-up or limited: Echocardiography, transthoracic, real-time with image documentation (2D) includes m-mode recording, when performed, follow-up or limited study	$26.14	5532	$153.58
93971	Extremity study – DVT (vascular)	$22.91	5532	$153.58
	Ultrasound Guided Procedure Codes			
76930	Ultrasound guidance for pericardiocentesis	$33.30	Packaged*	No payment
76937	Ultrasound guidance vascular access (line placement)	$14.68	Packaged*	No payment
76942	Ultrasound guidance for needle placement (biopsy, injection)	$34.01	Packaged*	No payment
49083	Abdominal paracentesis w/imaging	$112.78	5391	$482.83
	MSK (Musculoskeletal)			
76882	Ultrasound extremity non-vascular limited	$25.06	5331	$92.07
76942	Ultrasound guidance for needle placement (biopsy, injection)	$34.01	Packaged*	No payment
20604	Drain/ inject small joint/bursa with ultrasound	$47.26	5441	$223.76
20606	Drain/ inject intermediate joint/bursa with ultrasound	$54.06	5441	$223.76
20611	Drain/ inject major joint/bursa with ultrasound	$63.37	5441	$223.76
	Soft Tissue – Obstetrical + Non-obstetrical			
76536	Ultrasound exam of head and neck (soft tissues – thyroid)	$28.64	5532	$153.58
	Pelvic			
76815	Ultrasound, pregnant uterus – limited	$33.30	5532	$153.58
76857	Ultrasound exam, pelvic, limited	$25.42	5531	$92.07

*Items and services packaged into APC rates. No separate payment is available for this service as the payment is packaged into the associated primary procedure.

**CPT codes listed reflect a subset of codes relevant to Point-of-care focused, goal-directed exams

The rates provided above are Medicare 2016 National Average Rates.

Frequently Asked Questions

Lumify reimbursement FAQs

What's the reimbursement model for App-Based Ultrasound (Lumify)?

No different from any other ultrasound in terms of reimbursement. Philips ultrasound solutions are critical tools in care management.

Can I get reimbursed if I use Lumify?

Lumify is a prescription medical device available for purchase by licensed medical physicians (defined as Doctor or Medicine – MD or Doctor of Osteopathic Medicine – DO) and healthcare providers that employ licensed physicians.

Ultrasound services performed with an Ultra mobile or hand-carried ultrasound system are reported using the same ultrasound codes that are submitted for studies performed with cart-based ultrasound systems so long as all applicable requirements are met. All ultrasound examinations must meet the requirements of medical necessity as set forth by the 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. Consult the CPT for specific instructions.

Diagnostic use

When an app-based ultrasound device such as Lumify is being utilized for a study that is medically necessary, is performed by a qualified provider and meets all documentation, storage, and other applicable requirements, it may be considered for coverage and payment by a payer.

Extension of physical exam

When an app-based ultrasound device such as Lumify is used as an extension of the patient's physical examination, it would not be appropriate to bill separately for these as diagnostic ultrasound exams. Rather, these ultrasound exams would be included as an extension of an Evaluation and Management (E/M) examinations. We would encourage you to refer to your coding manual to select appropriate CPT codes that address E/M examinations.

Since I am NOT a radiologist, can I get reimbursed if I provide 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 payers to confirm their requirements and, if you meet the 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 qualification requirements for the Lumify examinations that you perform, or contact your Medicare Part B Contractor to confirm their requirements.

Do I need to capture/store specific images and a report to be reimbursed?

All diagnostic ultrasound examinations, including ultrasound guidance for a procedure, require that permanently recorded images be maintained. The images can be maintained in the patient record or some other archive, but may not need to be submitted with the claim. Documentation of the study must be available to the payer if requested. Images can be stored on a digital medium or as printed images.

A written report of all ultrasound studies should be maintained in the patient record. The written report for ultrasound 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.

Check the CPT for further guidance on specific examinations.

Resources

1. Medicare Coverage Database
http://www.cms.gov/medicare-coverage-database

2. Medicare Claims Processing Manual Centers for Medicare and Medicaid Services
https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912.html

3. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)
http://www.cdc.gov/nchs/icd/icd10cm.htm

4. http://www.philips.com/lumify

Glossary

Ambulatory Payment Classification (APC)
APC are categories of procedures composed of services which are similar in clinical intensity, resource utilization and cost. Procedures and their associated codes are assigned to an APC that in turn corresponds to a specific payment, reflecting the costs required to support the particular procedures.

Bundling/Packaging
The use of a single payment for a group of related services or surgeries and principle procedures when performed together.

Center for Medicare and Medicaid Services (CMS)
The federal agency that administers the Medicare and Medicaid programs. It is part of the Department of Health and Human Services.

Composite APC
A composite APC pays a fixed amount when certain procedures are performed together. A single payment will be made when two or more designated imaging procedures are performed using the same modality.

CPT
Current Procedural Terminology or "CPT" is a listing of 5 digit codes with narrative descriptions that are used to report medical services or procedures. Codes are updated annually and are effective for use on January 1st of each year. The American Medical Association manages these codes.

Diagnosis Related Group (DRG)
A system of classifying medical cases for payment on the basis of diagnosis. Used under the Medicare's prospective payment system for inpatient Services.

Fee Schedule
A list of predetermined payments for medical services. Medicare Part B reimburses Physicians based on a fee schedule.

ICD-10
A standardized system of describing diagnoses and identifying codes for reporting treatment and diagnosis of health plan enrollees. The coding and terminology provide a uniform language that accurately designates primary and secondary diagnosis and ensures consistent communication on claim forms.

HCPCS Procedure Codes
HCPCS is a standardized alphanumeric coding system that is used primarily to identify products, supplies and services not included in the CPT codes such as new technologies. These codes are managed by CMS.

National Medicare Coverage decisions
A reimbursement decision on an individual healthcare technology that is made by CMS and issued as national policy. The policy is published in CMS regulations, published in the Federal register as a final notice, contained in a CMS ruling, or issued as a program instruction, these decisions are binding on all Medicare contractors and must be applied.

Hospital Outpatient Prospective Payment System (HOPPS)
Medicare payment system which utilizes an Ambulatory Patient Classification (APC) system, which provides a fixed rate of payments for categories of hospital outpatient services.

Physician Fee Schedule (PFS)
Medicare payment system which establishes payments for physicians and independent imaging centers based on resources, costs associated with physician work, practice expense, and professional liability insurance.

Resource based Relative Value Scale
A government mandated relative value system that is used for calculating national fee schedules for services provided to Medicare patients. Physicians are paid on Relative Value Units (RVUs) for procedures and services. The three components of each established value include: work RVU, practice expense RVU and Malpractice expense RVU.

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