



Related MLN Matters Article #: MM5608

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Related CR #: 5608

Ultrasound Diagnostic Procedures

Key Words

MM5608, CR5608, R76NCD, Ultrasound, Diagnostic, Procedures

Provider Types Affected

Physicians and other providers who bill Medicare carriers, Fiscal Intermediaries (FIs), and Part A/B Medicare Administrative Contractors (A/B MACs) for ultrasound diagnostic procedures

Key Points

- The effective date of the instruction is May 22, 2007.
- The implementation date is September 28, 2007.
- Change Request (CR) 5608 announces the following:
 - Effective for claims with dates of service on and after May 22, 2007, the Centers for Medicare & Medicaid Services (CMS) has determined that esophageal Doppler monitoring of cardiac output for ventilated patients in the intensive care unit (ICU) and for operative patients with a need for intra-operative fluid optimization is reasonable and necessary; and
 - The previous national non-coverage of cardiac output Doppler monitoring is removed.
- In CR5608, CMS amends the *Medicare National Coverage Determination (NCD) Manual*, Chapter 1 (Coverage Determinations), Section 220.5 (Ultrasound Diagnostic Procedures), by:
 - Adding, "Monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization," to Category I (covered procedures), and
 - Deleting, "Monitoring of cardiac output (Doppler)," from Category II (non-covered procedures).

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Use of Common Procedural Terminology (CPT) Codes

- There is no specific CPT code for this service. CPT code 76999 is for unlisted ultrasound procedures.
- When performed in a hospital setting for ventilated patients in the ICU or for operative patients with a need for ultrasound diagnostic procedures, the professional services only are separately payable when billed using CPT code 76999 with the modifier -26 to show the professional component.
- Such services, when globally billed in a hospital setting with code 76999, will be returned as unprocessable to the provider with a reason code such as 58, "Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."
- When such services are billed in a hospital setting as technical services with the code 76999-TC (technical component), Medicare will deny the services with the 58 reason code and an M77 remark code to show "Missing/Incomplete/Invalid place of service."
- When performed in an ambulatory surgery center (ASC), ultrasound diagnostic procedures are covered when performed by an entity other than the ASC, if globally billed using code 76999, or the technical and professional components may be separately billed using codes 76999-TC and 76999-26, respectively.
- Ultrasound diagnostic procedures professional services billed using codes 76999, 76999-TC, and 76999-26 are carrier-priced.
- Medicare contractors will not search their files to identify and adjust claims processed prior to the implementation of this change, which are for services

Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5608.pdf> on the CMS website.

Providers can find more information about the coverage of esophageal Doppler monitoring of cardiac output by going to CR5608, located at <http://www.cms.hhs.gov/Transmittals/downloads/R76NCD.pdf> on the CMS website.

Providers will find the amended *Medicare NCD Manual*, Chapter 1 (Coverage Determinations), Section 220.05 (Ultrasound Diagnostic Procedures), as an attachment to that CR.

If providers have any questions, they may contact their carrier, FI, or MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.