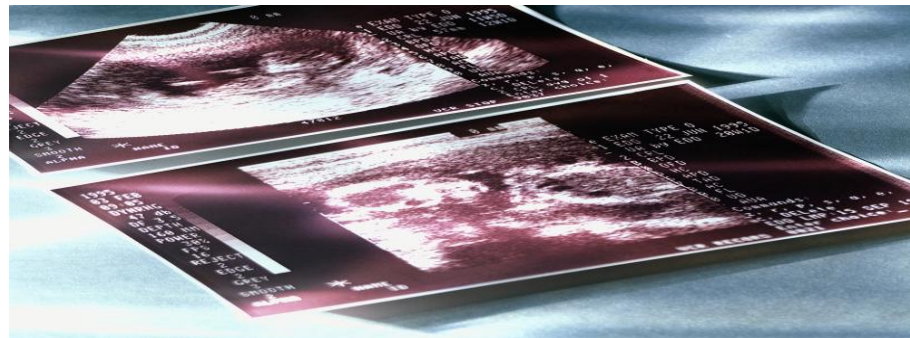


# *Ultrasound Obstetrical Care Services*

**BUREAU OF MEDICAID SERVICES**



# *Objectives*

- Present an overview of key Medicaid obstetrical ultrasound services policies.
- Gain an understanding of the need for submitting **appropriate documentation** when submitting ultrasound claims to Medicaid for medical review.
- Increase understanding of the value of submitting claims with **correct modifiers**.

# *Presentation Topics*

- Medical Necessity
- Ultrasounds General Policy
- Ultrasounds for Multiple Gestations
- Ultrasound Service Limitations
- Pricing Modifiers and appropriate documentation
- Handbooks and Resources

## *Medical Necessity*

- Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's services.
- The services must meet the following criteria per 59G-1.010 (166), F.A.C.:
  - Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

## *Medical Necessity, cont'd*

- Individualized services, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Consistent with accepted professional medical standards;
- Not experimental or investigational;

## ***Medical Necessity, cont'd***

- Reflective of the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

## ***AHCA Determines Medical Necessity***

- Medicaid makes the **final determination** whether a service is medically necessary.
- The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods, or services medically necessary, or a covered service.

# *Ultrasounds General Policy*

General policy governing ultrasound services is found in the ***Physician Services Coverage and Limitations Handbook*** that describes service specific policy information.

- Obstetrical Care Services
- Appendix C – Diagnosis Code List for additional ultrasounds for pregnant women.

## *Online Information*

All Medicaid handbooks, fee schedules, forms, provider notices, and other important Medicaid information are available on the Medicaid fiscal agent's Web Portal at:

**<http://mymedicaid-florida.com/>**

Click on Public Information for Providers, then on Provider Support, and then click on Provider Handbooks, Fee Schedules, Forms, or Provider Notices.

## *Ultrasounds: General Policy*

- One ultrasound (procedure code **76801** or **76805**) is reimbursable **per** pregnancy, regardless of pregnancy risk factors.
- A claim with modifier 22 with procedure codes 76801 or 76805 will be denied.



## *Ultrasounds: General Policy*

Follow-up ultrasounds (procedure code 76815 or 76816) are reimbursable for recipients who have a **diagnosis listed** on the Diagnosis Code List for Additional Ultrasounds for Pregnant Women (Appendix C).

Source: Medicaid Physician Coverage and Limitations Handbook

**APPENDIX C****DIAGNOSIS CODE LIST FOR ADDITIONAL ULTRASOUNDS  
FOR PREGNANT WOMEN**

• Baby with Known or Suspected Genetic Disorder	655.23
• Systemic Malignancy	199.0, 199.1
• Age 35 years and above	659.53, 659.63
• Diabetes Mellitus, Including Gestational Diabetes	648.03, 648.83
• Hyperthyroidism	648.13
• Asthma Requiring Medication	493.00-493.91
• HIV Positive	V08
• Acquired Immune Deficiency Syndrome	042
• Seizure Disorders	345.00-345.91
• Hemoglobinopathies, Including Sickle Cell	282.0-282.9
• Severe Anemia (less than 8 grams Hgb. or 24% Hct.)	648.23
• Cardiac Disease	648.53, 648.63
• Thromboembolic Disease	671.23, 671.33, 671.53
• Pre-Eclampsia or Eclampsia	642.43, 642.53, 642.63, 642.73
• Hypertension	642.03, 642.13, 642.23, 642.33

## ***Ultrasounds: General Policy***

- A maximum of three follow-up ultrasounds may be reimbursed with a diagnosis code on Appendix C with no documentation of medical necessity.
- If the diagnosis code is not on the list, the provider must bill with a modifier 22 and submit documentation.
- The claim will be reviewed for payment by a Medicaid medical consultant.

## *Ultrasounds General Policy*

- If more than three follow-up ultrasounds are required, the additional ultrasound(s) must be billed with a modifier 22.
- A report documenting medical necessity and a plan of care must be submitted with the claim. Without **all components of this requirement**, claims will be denied.

## *Ultrasounds: General Policy*

- For professional services rendered to a recipient in the inpatient, outpatient hospital, or other facility, the provider must bill the professional component only.
- The maximum fee is intended to pay the physician for performing the complete procedure, including both the technical and professional components and can be billed only when all parts of the procedure are provided in the physician's office.

# *Ultrasounds Multiple Gestations*

The following CPT codes billed with any of these diagnosis codes require the addition of **modifier TH**:

CPT codes	Modifier	Diagnosis codes
76816	TH	651.03, 651.13, 651.23, 651.83, or 651.93
76818	TH	651.03, 651.13, 651.23, 651.83, or 651.93
76819	TH	651.03, 651.13, 651.23, 651.83, or 651.93

For multiple gestations **up to four fetuses** medical documentation is not required with these diagnosis codes

# Ultrasounds Multiple Gestations

If more than four fetuses:

CPT codes	Modifier	Modifier	Diagnosis codes
76816	TH	22	651.03, 651.13, 651.23, 651.83, or 651.93
76818	TH	22	651.03, 651.13, 651.23, 651.83, or 651.93
76819	TH	22	651.03, 651.13, 651.23, 651.83, or 651.93

Supporting medical documentation **must be attached** to the claim documenting the **number** of fetuses

## ***Ultrasounds for Multiple Gestations***

- CPT codes 76802, 76810, and 76812 may be billed without medical documentation when using any of these diagnosis codes (651.03, 651.13, 651.23, 651.83, or 651.93) for multiple gestations up to four fetuses.
- The codes above must be billed with their primary CPT codes 76801, 76805, or 76811, respectively.

# *Transvaginal Ultrasound*

A transvaginal ultrasound is billable in addition to other obstetrical ultrasounds if medical necessity is **documented on the ultrasound report as a separate identifiable procedure with findings that are submitted with the claim.**

This ultrasound is limited to three per pregnancy with the following diagnosis codes:

- ✓ 632
- ✓ 634.91
- ✓ 640.03
- ✓ 641.03
- ✓ 641.13
- ✓ 654.53
- ✓ 654.63

# *Transvaginal Ultrasound*

- If more than three transvaginal ultrasounds are required, the additional ultrasound(s) must be billed with a modifier 22.
- A **report** must be submitted with the claim that **documents** the medical necessity for the additional transvaginal ultrasound(s) and the result of the study.

# *Transvaginal Ultrasound*

- If the diagnosis code is not included in the list on slide 18, the code must be billed with a modifier 22 and a **report submitted that indicates medical necessity and the result of the study.**
- Transvaginal ultrasounds are not reimbursable as a predictor of preterm labor.

## ***Fetal Biophysical Profile***

- A fetal biophysical profile (code 76818 or 76819) and a non-stress test (code 59025) are not reimbursable for the same recipient, same provider, on the same date of service.
- Biophysical profiles are limited to two per pregnancy.
- If more than two biophysical profiles are required, the additional biophysical profiles must be billed with a modifier 22.

## ***Fetal Biophysical Profile***

- A report must be submitted with the claim that documents medical necessity for the biophysical profile and the result of each component.
- Without documentation of all these components the claim will be denied.

## *Fetal Velocimetry*

- Procedure code 76820 is reimbursable twice per pregnancy for the growth restricted fetus.
- Procedure code 76821 is reimbursable twice per pregnancy to evaluate fetal anemia.

## ***Fetal Echocardiography***

- Procedure codes 76825 and 76827 are reimbursable once per pregnancy for a fetus with a high-risk diagnosis code, including an abnormality of the heart structure or rhythm or is in a high-risk group for fetal heart disease.
- Follow-up or repeat fetal echocardiograms are billed using procedure code 76826 or 76828 with a confirmed high-risk diagnosis code.
- Each of these procedure codes are limited to two per pregnancy.

## ***Ultrasound Service Limitations***

- CPT code 76811 includes a detailed fetal anatomic examination.
- This code is limited to physician provider specialties 47 (radiology) and 65 (maternal/fetal).
- CPT code 76811 is limited to one procedure per pregnancy.

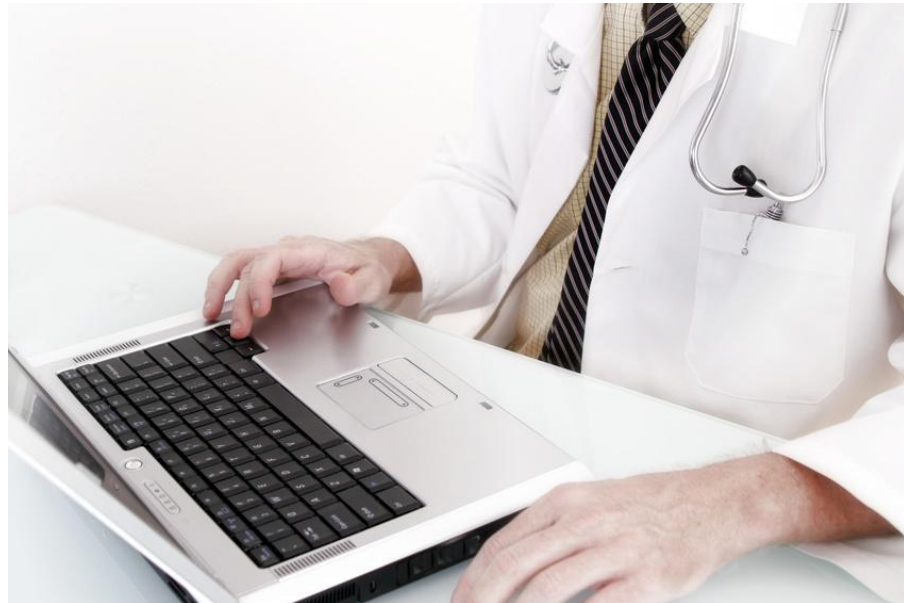
# *Ultrasound Codes*

Only **one** of the following ultrasound procedure codes is reimbursed on the same **date of service** for the same **recipient**:

- ✓ 76801
- ✓ 76805
- ✓ 76811
- ✓ 76815
- ✓ 76816
- ✓ 76818, or
- ✓ 76819

# *Ultrasound Key Points*

- Submit appropriate medical documentation to support a diagnosis for a high risk pregnancy.
- Even if the patient has been referred by another provider, obtain the necessary medical documentation to support the billing claim.



## *What is a Modifier?*

A modifier is a two-digit code that is used with a procedure code to **more fully describe** the procedure performed so that accurate payment may be determined.

There are two different types of modifiers that physicians use: **pricing** modifiers and **local-code** modifiers.

## *Pricing Modifiers*

- Pricing modifiers are used with the procedures listed in the fee schedule to affect the procedure code's fee or cause a claim to pend for review.
- The pricing modifiers are:
  - 22, 24, 25, 26, 50, 51, 52, 54, 55, 56, 59, 62, 66, 76, 77, 78, 79, 80, and 99, LT/RT, QK, QS, and TC.

## *Modifier 22: Unusual Services*

- Modifier 22 is used when a service(s) exceeds the usual service as described in the CPT.
- Modifier 22 requires claim **review** by a Medicaid medical consultant for appropriate pricing.
- The provider ***must submit appropriate documentation*** justifying additional services.

## *Modifier 22: Appropriate Documentation*

Examples of medical documentation that support the diagnosis listed on the CMS-1500 claim item 21:

- **Medical Reports**
- **Plan of Care**
- **Consultations**
- **Test Results**
- **Laboratory Results**
- **Medications**

Even if the patient was referred by another health care provider, the billing provider should submit along with the CMS- 1500 claim the appropriate medical documentation to justify additional services.

## *Modifier 22: Unusual Services*

- Examples include an explanation of increased complexity of the service or unexpected complications during a service.
- **Inadequate documentation** can result in:
  - A claim denial,
  - A request for more information, or
  - No increase in reimbursement or no reimbursement

## *Professional Component (PC) Fee*

- The PC is intended to reimburse the physician for the *interpretation* and *report* of certain procedures.
- A modifier **26** is appended to the procedure code to indicate the professional component.
- For professional services rendered to a recipient in the inpatient or outpatient hospital or other facility, the provider may only bill for reimbursement of the PC.

## *Professional Component Fee*

- Professional services rendered in the office may be billed with the PC **only** when the provider does not provide the technical component.
- The professional component and technical component may not be **billed separately** if the same provider performed **both** the technical and professional components. Instead, bill the maximum fee.



## ***Technical Component***

The technical component is intended to reimburse the physician for the equipment, supplies, and technician services utilized during a procedure or diagnostic test. The modifier TC is appended to the procedure code to indicate the technical component.

## *Technical Component (TC)*

- The provider may bill a separate TC for procedures that are in the radiology range (70000-79999) .
- For procedures other than those in the radiology code range (70000 - 79999), the physician may only bill a separate TC if the recipient is eligible for both Medicare and Medicaid (Medicare cross-over claims).

## *Modifier TC : Technical Component*

- Use this modifier when the radiological technical component is reported separately.
- Procedure codes billable for technical component are identified in the “TC” column in the radiology fee schedule.
- Do not bill the technical component separately, if the same provider performs both the technical and professional components. Instead, bill the maximum fee.

## *Modifier TC : Technical Component*

- Certain procedures are a combination of a professional component and a technical component.
- Procedure codes reimbursable with a technical component are **radiology procedure codes** (70000-79999) in the physician office setting only.
- A separate TC modifier for other procedure codes is only reimbursable for Medicare cross-over claims.

## *Maximum Fee*

The maximum fee is intended to pay the physician for performing the complete procedure including both the technical and professional components.

The maximum fee may be billed only when the same provider performs all **technical and professional** components.

## *Maximum Fee*

The physician may not bill the maximum fee when the procedure is performed in the hospital, outpatient hospital, emergency department, ambulatory surgery center, or other facility to which Medicaid reimburses a facility fee.

In order to bill the maximum fee for office procedures, the physician **must personally supervise and be responsible** for the operation of the practice on a daily basis.

## ***Modifier 26: Professional Component***

- Certain procedures are a combination of a professional component and a technical component. For professional services rendered in the hospital, outpatient hospital, emergency room, or ambulatory surgery center, the provider may bill **only** the professional component.
- Use this modifier when the professional component is reported separately. If all components are rendered by the same provider, do not bill the components separately.
- Acceptable procedure codes billable for professional component are identified in the “**PC**” **column in the fee schedule**.

# *Handbooks and Resources*



# *Handbooks that Govern Physician Services*

- 1) ***Provider General Handbook***: Describes the Florida Medicaid Program.
- 2) ***Reimbursement Handbook, CMS-1500***: Describes how to complete and file claims for reimbursement from Medicaid.
- 3) ***Physician Services Coverage and Limitations Handbook***: Describes service-specific policy information.

The Physician Radiology Services **Fee Schedule** lists the ultrasounds covered for Medicaid recipients.

**Physician Radiology Services Fee Schedule**  
Effective January 1, 2010

The fees below are reimbursed for services provided to adults age 21 and over. For services provided to children under the age of 21, there is a 4% increase over the adult fee. To calculate reimbursement for services to children, multiply the base fee by 1.04. Example: \$83.39 X 1.04 = \$86.73.

In addition to the 4% increase noted above, the following physician specialty types receive a 24% increase for services provided to children under 21: 02, 03, 04, 05, 08, 10, 14, 15, 17, 21, 23, 29, 30, 31, 36, 37, 38, 39, 43, 46, 51, 53, 55, 57, 58, 60, 62. To calculate the specialty fee, multiply the base fee by 1.04, as noted above for children, and then multiply that result by 1.24. Example: \$83.39 X 1.04 = \$86.73 X 1.24 = \$107.54. The same method applies to the Base PC Fee and Base TC Fee. Fees are rounded to the nearest hundredth.

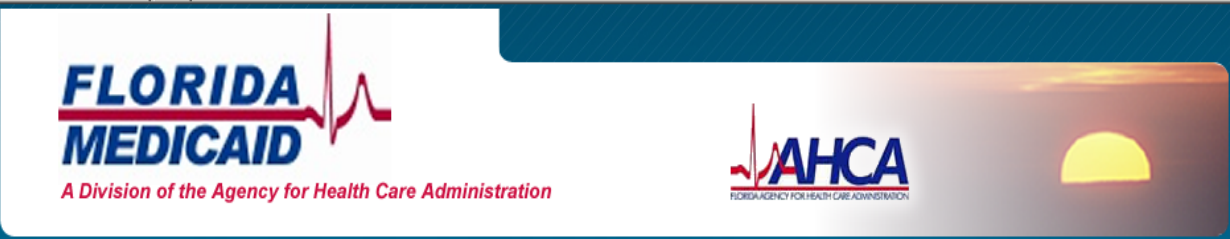
Note: Reimbursement increases noted above do not apply to the following services: Regional Perinatal Intensive Care Center services, injectable medications, immunizations, supplies, devices, and laboratory/pathology services.

Code	Report	Base Fee	Base PC Fee	Base TC Fee	Units	Modifiers				
70010		83.39	33.08	50.32	1	TC	Q6	26	59	77
70015		82.41	33.86	48.55	1	TC	Q6	26	59	76 77
70030		15.86	4.89	10.96	1	TC	LT RT Q6	26	59	76 77
70100		16.44	4.89	11.55	1	TC	Q6	26	59	76 77
70110		21.53	6.85	14.68	1	TC	Q6	26	59	76 77
70120		17.82	4.89	12.92	1	TC	Q6	26	59	76 77
70130		30.54	9.40	21.14	1	TC	Q6	26	59	76 77
70134		25.64	9.59	16.05	1	TC	Q6	26	59	76 77
70140		15.27	5.09	10.18	1	TC	Q6	26	59	76 77
70150		22.71	7.05	15.66	1	TC	Q6	26	59	76 77
70160		17.62	4.70	12.92	1	TC	Q6	26	59	76 77
70170		28.60	8.42	20.18	1	TC	Q6	26	59	76 77
70190		19.18	5.87	13.31	1	TC	Q6	26	59	76 77
70200		23.69	7.63	16.05	1	TC	Q6	26	59	77
70210		15.46	4.50	10.96	1	TC	Q6	26	59	76 77

# *Regularly Check for Provider Alerts Online*

To subscribe to the automated alert system, from the Fiscal Agent Website at: <http://mymedicaid-florida.com/>

- Go to Public Information for Providers
- Go to the right side corner of the panel, under **Quick Links**,
- Click on **Florida Medicaid Health Care Alerts Subscription**
  - Complete the online form.
  - A confirmation e-mail will be sent to your mailbox.
  - Subscribers must return the confirmation e-mail to complete their subscription.



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  - [Help](#) COMING SOON
  - [Provider Directory Search](#) COMING SOON
  - [Recipient Notices](#) COMING SOON
- Secure Information for Recipients** COMING SOON
- Recipient Messages
  - Child Health Check-up (CHCUP) Informing Letter
  - Child Health Check-up (CHCUP) Recommendations
  - Explanation of Medicaid Benefits (EOMB)
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  - Replacement Medicaid Identification Card
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A Division of the Agency for Health Care Administration

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## Provider Home

### Web Portal Alert

#### Known Issues List

Please review the [Known Issues and Informational Items List](#) (Updated 3/26/2010) for details related to the MMIS.

#### Web Portal Claims with Attachments

We are currently experiencing intermittent issues affecting the system's identification that an attachment was sent for a Web Portal submitted claim. In some cases, claims improperly deny for no paper attachment received within 21 days, when in fact an attachment was submitted. Please be advised that we are working diligently to resolve this issue as quickly as possible, and we apologize for any inconvenience this may cause.

If your claim is impacted by this issue because it was initially submitted electronically, we ask that providers resubmit the claim hard-copy (paper) with the attachment. Providers will be notified when this issue has been resolved. We apologize for this temporary inconvenience.

#### Eligibility Verification

REMINDER: When performing an eligibility verification on the secure Web Portal, the response may include references that state "limited to family planning benefit." That statement is referring to the Family Planning Waiver benefit. As a reminder, in cases where a recipient has eligibility in multiple benefit plans, with one of the plans having a higher level of benefit (for

## Contact Us

- Provider Relations Phone Number: 800-289-7799
- Field Services: Option 7
- Provider Enrollment: Option 4
- Support Services Contact Center: Option 7
- EDI: 866-586-0961

## Quick Links

- [Centers for Medicare and Medicaid Services](#)
- [Florida Discount](#)

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- Nursing Home Transition
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- Quality in Managed Care
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- Reimbursement Workgroups
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## Florida Medicaid Health Care Alerts

The Florida Medicaid program has an e-mail alert system to supplement the present method of receiving Provider Alerts information and to notify registered providers or interested parties of "late-breaking" health care information. An e-mail will be delivered to your mailbox when Medicaid policy clarifications or other health care information is available that is appropriate for your selected provider type.

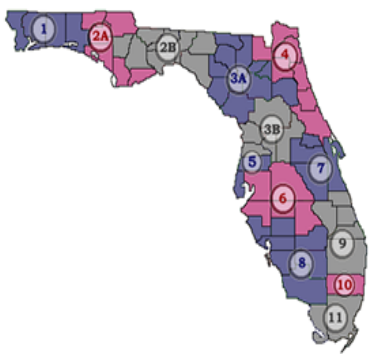
To subscribe to the automated alert system, complete the online form below. A confirmation e-mail will be sent to your mailbox to avoid fraudulent subscription requests. **Subscribers must return the confirmation e-mail to complete their subscription.**

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First Name

Last Name

\*Area  
 All Areas  
 Area 1  
 Area 2  
 Area 3  
 Area 4  
 Area 5



From: State of Florida Agency for Health Care Administration [medicaid\_alert@ahca.myflorida.com]  
To: Sacipa, Yolanda  
Cc:  
Subject: Out-of-State Authorization - Revised

**Example of a Provider Alert**

help protect your privacy, Outlook prevented automatic download of some pictures in this message.

Better Health Care for All Floridians



Health Care Alerts & Provider Alerts Messages  
March 2010

General Providers/All Providers

Out-of-State Authorization - Revised

MediPass providers - Per the Agreement for Participation in MediPass and the Medicaid Provider General Handbook, you are reminded that should a recipient require services that cannot be provided in Florida, the PCP may refer the recipient for out-of-state care. **Prior-authorization for out-of-state services requires a unique authorization granted by the Medicaid Services/Medicaid Prior-Authorization Unit within the Agency for Health Care Administration (AHCA). Do not provide your MediPass authorization number to providers for out-of-state services, as these providers will not be paid without the AHCA issued unique authorization number.**

Should you need to refer a MediPass patient for out-of-state care, you should:

1. Complete the out-of-state request packet which should include the following:
  - a. Completed prior-authorization form (PA01), available in the Medicaid Provider General Handbook, filled out by the recipient's Florida Medicaid primary care or specialist physician (cover page).
  - b. Documentation that justifies the need for the service, such as medical history, lab reports, etc.
  - c. Documentation from the requesting physician indicating the requested service(s) is/are not available in the state of Florida.
  - d. Contact information for the requesting primary care or specialist physician.
  - e. Name and address of the out-of-state facility.
  - f. Name and telephone number of the out-of-state facility's contact.