

REIMBURSEMENT FAQ's for NONINVASIVE VASCULAR STUDIES

Submit claims using the HCFA 1500 claim form, either electronically or on paper.

Fill in all applicable fields of the 1500 form (see example) or electronic equivalent.

For the provider *performing* the test:

- The referring provider must be listed in field 17, and the supplying provider in field 31. Be sure to supply the appropriate NPIs.
- Use the "TC" modifier in field 24D to indicate that you have performed the technical component of the test.

For the provider *reading* the test:

- The provider's name should be listed as the supplying provider in field 31. The referring provider in field 17 is the provider who performed the test. Be sure to supply appropriate NPIs.
- Use the "26" modifier code in field 24D to indicate that you have performed the professional component of the test.
- Per CMS document MM6375 (eff. 1/4/10), the date of service should be the actual date that the provider performed the interpretation, not the date the test was administered.

When one provider is billing for services rendered by another provider (*Purchased or Anti-Markup Services*):

- It is not appropriate to bill these services globally. Separate claims must be filed when billing Medicare, using appropriate modifiers (TC or 26) to indicate the portion of the service which was purchased.
- Per CMS document MM6371 (eff. 7/1/09) Anti-Markup claims should be completed as follows:
 - Field 17 should indicate the provider who ordered the test, or requested the interpretation.
 - Field 20 should indicate "yes" and the actual amount that was charged for the purchased service.
 - All claim line items, including billed amount, correct codes, and modifiers should be included.
 - Field 31 should be signed by the billing provider.
 - Field 32 should identify the provider who performed the purchased service.
 - Field 33 should identify the billing provider.

General Information:

- Payers will not reimburse for screening of non-symptomatic patients. All appropriate ICD-9 codes that relate to the patient should be entered into HCFA 1500 field 21. The Medicare LCD (Local Coverage Determination) for your carrier includes a list of ICD-9 codes that they consider adequate to support medical necessity. Providers should use the most specific code available which describes the patient's condition.
- Medicare (and many commercial payers) requires that a signed physician's order be included in the medical record for any diagnostic test. This order should indicate the physician's intention that the patient receive the specific test, give the reason test is indicated, and include a physician's signature. (handwritten or electronic signatures are acceptable, stamped are not) The ordering physician should be one who is treating the patient, and for Medicare purposes, must be a registered Medicare provider.

Other notes:

It is always advisable to have the patient sign a medical records release, and an assignment of benefits form.

Medicare pays 80% of the allowable amount for any code. The 20% balance is billable to the patient or the patient's supplemental insurance. Only amounts designated "patient responsibility" by Medicare can be billed to the patient.

In the event you receive a denial, double check the original claim for these common errors:

- Incorrect spelling or incomplete patient information
- Missing policy or group ID's (check for transposed digits)
- Missing referring or providing physicians' information, including NPIs
- Inappropriate CPT & ICD-9 codes (check for transposed digits)
- Missing signature on claim form
- Incorrect place of service entered

The payer may ask for evidence to support the medical necessity of performing the test. This should not be a problem if your physician has documented the patient's record. In the event records are requested, be sure to include the order for specific test, documentation of test performed, the test results, and any plan of care which was decided upon.

If you are billing for 93924, this code includes both the pre-exercise and the post-exercise test. It is not appropriate to bill a 93923 AND a 93924.

The test site and the reader must both use the appropriate modifiers. If one site leaves off the modifier, the other site may receive a denial stating the claim is a duplicate.