REIMBURSEMENT POLICY STATEMENT
INDIANA MEDICAID

Original Issue Date	Next Annual Review		Effective Date
01/01/2017	03/22/2018		01/01/2017
Policy Name			**Policy Number**
Transthoracic Echocardiogram			PY-0183
Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Contents of Policy

A. SUBJECT

Transthoracic Echocardiogram

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

CareSource will reimburse participating providers, for transthoracic echocardiograms (TTE) rendered to CareSource members, as set forth in this policy.

C. DEFINITIONS

- Transthoracic Echocardiogram (TTE) - is a type of echocardiogram in which an ultrasound probe (or ultrasonic transducer) is placed on the chest or abdomen of the patient to obtain various views of the heart.

D. POLICY

I. CareSource does not require a prior authorization for a transthoracic echocardiogram (TTE).

II. A transthoracic echocardiogram may be reimbursed according to Centers for Medicare and Medicaid Services (CMS) LCD 33577 guidelines using appropriate CPT and modifier codes (if applicable).

III. A transthoracic echocardiogram may be reimbursed according to Medicaid guidelines using appropriate CPT and/or HCPCS and modifier codes (if applicable).

IV. Reimbursement is based on submitting a claim with the appropriate ICD-10 diagnosis code to match the transthoracic echocardiogram CPT code.

V. If the appropriate ICD-10 diagnosis code is not submitted with the CPT code, the claim will be denied.

Note: Although a transthoracic echocardiogram does not require a prior authorization, compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting CMS approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the Indiana Medicaid fee schedule http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/maxfee_search.asp

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/01/2017	New Policy.
Date Revised	04/02/2019	Removed code table – CareSource follows the LCD referenced in the table.
Date Effective	01/01/2017	

H. REFERENCES

1. IHCP Fee-For-Service Fee Schedule. (2017, February 25). Retrieved from http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/maxfee_search_results.asp#results
2. Echocardiogram: MedlinePlus Medical Encyclopedia. (2015, April 20). Retrieved 2/6/2017from https://medlineplus.gov/ency/article/003869.htm
3. Current Procedural Terminology (CPT) and National Uniform Billing Committee (NUBC) Licenses. (2016, October 1). Retrieved 2/6/2017 from https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33577

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.