



Ultrasound Reimbursement Information

Vascular Access

This guide provides coverage and payment information for the ultrasound guidance of the placement of a vascular access device. SonoSite provides this information as a courtesy to assist providers in determining the appropriate coding and other information for reimbursement purposes. It is the provider's responsibility to determine and submit appropriate codes, modifiers and claims for services rendered. SonoSite makes no guarantees concerning reimbursement or coverage. Please feel free to contact the SonoSite reimbursement staff if you have any questions at 1-888-482-9449 or send email to reimbursement@sonosite.com.

The CPT code that is recommended for reporting ultrasound guidance of the placement of a vascular access device is:

+76937 – Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting.

In order to meet the requirements of reporting this CPT code, providers must produce and retain permanent images of the ultrasound study. The images may be maintained in either electronic or hardcopy format. Additionally, a written report of the study should be maintained in the patient record, either as a separate item or within the report for the line placement itself.

The 2008 national average Medicare payment amounts from the Physician's Fee Schedule, as printed in the Federal Register on November 27, 2007, are as follows:

- National average payment for 2008 for the global procedure is \$35.80. The global procedure is the combination of the professional and technical services and is typically reported in the physician's office when all elements of both parts of the service are performed and the physician owns the equipment.
- Payment for the professional service alone is \$14.85, indicated by appending the –26 modifier to the CPT code. Physicians in the hospital inpatient and outpatient settings typically report the professional service.
- Medicare coverage for +76937 is indicated only for venous access procedures, not arterial access.

Under the Medicare Hospital Outpatient Prospective Payment System for 2008, code +76937 is listed as a packaged service meaning that payment for the facility portion of this service is included in payment for the line placement procedure.

Private payers' payment policies and fee schedules are not publicly available. Check with provider representatives to ascertain payment information for this service.

Reimbursement rates shown for payment of services under the Physician's Fee Schedule reflects a conversion factor of \$38.0870 as provided for in the Medicare, Medicaid, and SCHIP Extension Act of 2007, which was signed into law December 29, 2007.

The information in this handout is intended to assist providers in determining appropriate codes and the other information for reimbursement purposes. It represents the information available to SonoSite as of the date listed above. Subsequent guidance might alter the information provided. SonoSite disclaims any responsibility to update the information provided. The only persons authorized by SonoSite to supply information regarding any reimbursement matter not reflected in a circular such as this are members of SonoSite's reimbursement staff.

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. SonoSite makes no guarantees concerning reimbursement or coverage. A provider should not rely on any information provided by SonoSite in submitting any claim for payment, without confirming that information with an authoritative source.