SonoSite

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Ultrasound Reimbursement Information

Ultrasound Guidance for Pain Management

This guide provides coverage and payment information for ultrasound guided procedures such as nerve blocks performed for pain management. SonoSite provides this information as a courtesy to assist providers in determining appropriate codes 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.

Documentation Requirements

- All diagnostic ultrasound examinations, including those when ultrasound is used to guide a procedure, require that permanently recorded images be maintained in the patient record. The images can be maintained in the patient record or some other archive – they do not need to be submitted with the claim. Images can be stored as printed images, on a tape or electronic medium. Documentation of the study must be available to the insurer upon request.
- A written report of all ultrasound studies should be maintained in the patient's record. In the case of ultrasound guidance studies, the written report may be filed as a separate item in the patient's record or it may be included within the report of the procedure for which the guidance is utilized.

Third Party Insurance Payment Policies

- Private insurance payment rules vary by payer and plan with respect to which specialties may receive reimbursement for ultrasound services. Some payers will reimburse providers of any specialty for ultrasound services while others may restrict imaging procedures to specific specialties or providers only. Some insurers require physicians to submit applications requesting ultrasound be added to their list of services performed in their practice.
- Contact your private payers before submitting claims to determine their requirements and request that they add ultrasound to your list of services.
- Medicare will reimburse anesthesiologists for medically necessary diagnostic ultrasound services, provided the services are within the scope of the physician's license. Some Medicare Carriers require that the physician who performs and/or interprets some types of ultrasound examinations be capable of demonstrating relevant, documented training through recent residency training or post-graduate CME and experience. Contact your Medicare Part B Carrier for details.

Site of Service Payment Rules

- In the office setting, a physician who owns the equipment and performs the service him or herself or through an employed or contracted sonographer, may bill the global/non-facility fee, and report the CPT[1] code without any modifier.
- If the site of service is a facility, hospital (inpatient, outpatient or emergency department) or Ambulatory Surgery Center (ASC) physicians must append the –26 modifier, indicating the professional service only was provided, to the CPT code for the imaging service. Payers will not reimburse physicians for the technical component in these settings.
- In the above settings, the facility reports charges for the technical component for diagnostic ultrasound services.
- In the hospital and ASC sites of service, under the Medicare Outpatient Prospective Payment System (OPPS), the technical component of image guidance procedures and the "add-on" codes for Doppler echocardiography are listed as packaged services. When these services are provided in the outpatient department or ASC, the payment for the image guidance is included in the reimbursement for the underlying procedure. Hospitals are required to submit CPT codes for packaged services. ASC's do not report CPT codes for packaged services. ASC's incorporate the cost of packaged services into the charge for the nerve block procedure.

Code Selection

Ultrasound services performed with hand-carried ultrasound systems are reported using the same ultrasound codes that are submitted for studies performed with cart-based ultrasound systems so long as the usual requirements are met. All ultrasound examinations must meet the requirements of medical necessity as set forth by the payer, must meet the requirements of completeness for the code that is chosen, and must be documented in the patient's record, regardless of the type of ultrasound equipment that is used.

It is the physician's responsibility to select the codes that accurately describe the service performed and the corresponding reason for the study. Under the Medicare program, the physician should select the diagnosis or ICD-9 code based upon the test results, with two exceptions. If the test does not yield a diagnosis or was normal, the physician should use the pre-service signs, symptoms and conditions that prompted the study. If the test is a screening examination ordered in the absence of any signs or symptoms of illness or injury, the physician should select "screening" as the primary reason for the service and record the test results, if any, as additional diagnoses.

The following specific coding advice is suggested by SonoSite's reimbursement staff. (Complete descriptors for codes referenced in the following paragraphs are listed in the attached chart.)

- For ultrasound guidance of nerve block procedures, the recommended CPT code is 76942 – Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation. Report CPT code 76942 in addition to the code for the nerve block itself. Medicare Correct Coding Initiative (CCI) edits do not, at present, bundle the nerve block and ultrasound guidance of the nerve block. It is recommended to check with each private payer regarding their policies on this service.

[1] Current Procedural Terminology (CPT®) Copyright 2011 American Medical Association.

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Payment Information

The following chart provides payment information that is based on the national unadjusted Medicare physician fee schedule for the ultrasound services discussed in this guide. Payment will vary by geographic region. Use the column entitled "Global Payment" to estimate reimbursement for services in the physician office setting. Use the "Professional Payment" column to estimate reimbursement to the physician for services provided in facility settings.

Ambulatory Payment Classification (APC) codes and payments are used by Medicare to reimburse facilities for the technical component under the Hospital Outpatient Prospective Payment System (OPPS). Payment rates are also based on the national unadjusted Hospital OPPS amounts. The actual payment will vary by location.

		2012 Medicare Physician Fee Schedule – National Average*			Hospital Outpatient Prospective Payment System (OPPS)†	
2012 CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	2012 APC Code	2012 APC Payment
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$206.61	$33.02	$173.59	Packaged Service	No Payment

		2012 Medicare Physician Fee Schedule – National Average		Hospital Outpatient Prospective Payment System (OPPS)	
2012 CPT Code	CPT Code Descriptor	Non-Facility Payment	Facility Payment	2012 APC Code	2012 APC Payment
64405	Injection, anesthetic agent; greater occipital nerve	$97.01	$61.95	0206	$272.74
64413	Injection, anesthetic agent; cervical plexus	$123.56	$80.33	0206	$272.74
64415	Injection, anesthetic agent; brachial plexus, single	$124.24	$66.71	0206	$272.74
64417	Injection, anesthetic agent; axillary nerve	$133.09	$71.14	0206	$272.74
64418	Injection, anesthetic agent; suprascapular nerve	$138.87	$74.20	0206	$272.74
64420	Injection, anesthetic agent; intercostal nerve, single	$125.94	$68.08	0206	$272.74
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	$177.68	$94.28	0207	$522.87
64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	$134.45	$95.31	0206	$272.74
64445	Injection, anesthetic agent; sciatic nerve, single	$136.15	$74.20	0207	$522.87
64447	Injection, anesthetic agent; femoral nerve, single	n/a	$66.37	0206	$272.74
64510	Injection, anesthetic agent; stellate ganglion	$135.13	$72.50	0207	$522.87

*Federal Register November 28, 2011. +Federal Register November 1, 2011.

Reimbursement rates shown for payment of services under the Physician's Fee Schedule reflect a conversion factor of $34.0376 as provided for in the Temporary Payroll Tax Cut Continuation Act of 2011 which became law on December 23, 2011.