



January 2014

Ultrasound Reimbursement Information



Surgery

This guide provides coverage and payment information for diagnostic ultrasound and ultrasound guided procedures commonly performed by general surgeons. SonoSite provides this information as a courtesy to assist providers in determining 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 with any questions at 1-888-482-9449.

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 kept 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, 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

The "Original Medicare Plan," also referred to as traditional Medicare Part B, will generally reimburse physicians for medically necessary diagnostic ultrasound services, provided the services are within the scope of the physician's license. Some Medicare Contractors 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 Contractor for details. Also we recommend checking for any local coverage determinations for the service(s) you intend to provide.

Payment policies for beneficiaries enrolled in Medicare Part C, known as the Medicare Advantage plans, will reflect those of the private insurance administrator. The Medicare Advantage plan may be either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO).

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.

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 CPT¹ code without any modifiers.

In the hospital setting, physicians typically may only submit the professional component of the service to payers. The hospital submits the charge for the technical component or facility fee. Under the Medicare Outpatient Prospective Payment System (OPPS) the technical components of image guidance procedures are listed as packaged services. When these services are provided under OPPS packaging rules, facilities should report all packaged services. In the outpatient department the payment for the image guidance is included in the reimbursement for the underlying procedure.

In the Ambulatory Surgery Center (ASC), the Medicare rules provide reimbursement for radiological services provided in conjunction with a surgical procedure. However, under the Medicare rules payment for all image guided services are packaged into reimbursement for the underlying procedure. The ASC incorporates the cost of the ultrasound guided service into the charge for the underlying procedure and does not report the packaged service separately. Private payer policies may differ - contact your payers directly for guidance on submitting claims for ultrasound services in this setting.

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.

SonoSite's reimbursement staffs suggest the following specific coding advice. (Complete descriptors for codes referenced in the following paragraphs are listed in the attached chart.)

Breast Ultrasound

For characterization of a breast nodule the recommended CPT code is 76645 (Breast ultrasound).

For performing a line needle aspiration with imaging guidance use code 10022. A cyst drainage may be reported using 19000.

For breast biopsy, with placement of breast localization device(s) when performed and imaging of biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance use CPT code 19083 for the first lesion and if performed and +19084 for each additional lesion. Ultrasound guidance for these percutaneous procedures described above is included.

If performing a diagnostic breast ultrasound evaluation and an ultrasound guided needle procedure during the same patient encounter both codes may be billed: the diagnostic ultrasound (76645) and the ultrasound guided biopsy. Medicare CCI edits do not, at present, bundle the breast ultrasound and the ultrasound guidance of the biopsy, but some private payers may.

Thyroid Ultrasound

For characterization or identification of a thyroid nodule use CPT code 76536 (Soft tissues of head and neck ultrasound).

For percutaneous needle core biopsy, use code 60100. Image-guided, fine needle aspirations may be billed using 10022.

For ultrasound guidance of a thyroid biopsy or cyst aspiration use CPT code 76942. Report 76942 in addition to the code for the primary procedure (e.g., 60100, 10022).

Medicare CCI edits do not currently bundle the thyroid ultrasound and the ultrasound guidance of the biopsy, but some private payers may.

Abdominal Ultrasound and FAST Exam

To bill for the evaluation of a single organ within the abdomen use code 76705 (abdominal ultrasound, limited or follow-up). To bill for Focused Abdominal Sonography for Trauma (FAST) exam, also use code 76705.

Vascular Ultrasound

For evaluation of carotid arteries, use codes 93880, duplex scan of extracranial arteries, complete bilateral study or 93882, unilateral or limited study.

For evaluation of extremity veins for venous incompetence or deep vein thrombosis, use codes 93970, duplex scan of

extremity veins; complete bilateral study or 93971, unilateral or limited study.

Medicare has created code G0365 to be used for vessel mapping performed in conjunction with the creation of an autogenous fistula for hemodialysis access. The code includes evaluation of the relevant arterial and venous vessels.

The limited extremity venous duplex code (93971) is used for all other vein mapping. Check with your payers for coverage guidelines on this procedure. In some cases it is not paid in the absence of a previous condition such as severe varicose veins or previous deep vein thrombosis.

CPT codes 36475, +36476, 36478, +36479 are used to describe saphenous vein ablation procedures using the radiofrequency and laser methods. These codes are inclusive of all imaging guidance; ultrasound guidance of these procedures is not separately reportable. Although carrier policies vary, typically preoperative extremity duplex to identify and characterize the venous incompetence can still be reported separately. The recommended codes for that procedure are 93970 and 93971 - Duplex scan of extremity veins, depending upon whether the study is complete and bilateral or limited and unilateral.

If the technical component services of the vascular studies are performed by sonographers, some Medicare Contractors require that the sonographers have specific vascular ultrasound credentials. Check your local contractor non-invasive vascular ultrasound coverage policy to learn their requirements. The credentialing requirement does not apply if the physician performs the technical component of the vascular study.

Intraoperative Ultrasound

Completion duplex of the carotid artery to verify that proper flow has been established and to evaluate the anastomosis may be billed using CPT code 76998.

Use of Modifiers

If the site of service is the hospital or the ASC, the -26 modifier, indicating that only the professional service was provided, must be attached to the CPT code for the ultrasound service. Payers will not reimburse physicians for the technical component in the hospital setting.

If reporting a surgical procedure such as a biopsy on the same day as an office visit, add modifier -25 to the office visit code to indicate a "significant, separately identifiable evaluation and management service." However, this modifier is not to be used routinely. The E/M service must be "...above and beyond the usual preoperative and postoperative care associated with the procedure that was performed." (CPT Assistant, May 2003.) Be sure to document in the patient's record all components of the E&M service.

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.

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.

		Medicare Physician Fee Schedule - National Average*			Hospital Outpatient Prospective Payment System (OPPS)†	
CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
76536	Ultrasound of soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), real time with image documentation	\$123.59	\$28.66	\$94.93	0266	\$134.57
76645	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation	\$99.95	\$27.94	\$72.00	0265	\$90.05
76705	Ultrasound, abdominal, real time with image documentation limited (e.g., single organ, quadrant, follow-up)	\$109.98	\$29.73	\$80.24	0266	\$134.57
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	\$74.15	\$34.03	\$40.12	Packaged Service	No Payment
76998	Ultrasonic guidance, intraoperative	No Payment	\$65.91	No Payment	Packaged Service	No Payment
93880	Duplex scan of extracranial arteries; complete bilateral study	\$192.01	\$30.45	\$161.56	0267	\$190.84
93882	unilateral or limited study	\$124.31	\$20.78	\$103.53	0267	\$190.84
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	\$188.79	\$35.82	\$152.96	0267	\$190.84
93971	unilateral or limited study	\$114.63	\$22.93	\$91.71	0266	\$134.57
G0365	Vessel mapping of vessels for hemodialysis access (Services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)	\$203.38‡	\$12.54	\$190.84‡	0267	\$190.84

		Medicare Physician Fee Schedule - National Average*		Hospital Outpatient Prospective Payment System (OPPS)†	
CPT Code	CPT Code Descriptor	Non-Facility Payment	Facility Payment	APC Code	APC Payment
10022	Fine needle aspiration; with imaging guidance	\$141.14	\$67.35	0004	\$411.24
19000	Puncture aspiration of cyst of breast	\$113.20	\$45.14	0004	\$411.24
19083	Biopsy, breast, with placement of breast localization device(s) when performed and imaging of biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	\$677.14	\$100.71	0005	\$702.08
+19084	each additional lesion	\$543.43	\$83.83	Included	No Payment
19285	Placement of breast localization device(s), percutaneous; first lesion, including ultrasound guidance	\$472.14	\$89.92	0420	\$98.25
+19286	each additional lesion	\$395.84	\$43.35	Included	No Payment
60100	Biopsy, thyroid, percutaneous core needle	\$114.99	\$81.68	0004	\$411.24

CPT® five digit codes, nomenclature and other data are Copyright 2013 American Medical Association. All rights reserved. No fee schedule, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

*Federal Register December 10, 2013 †Federal Register December 10, 2013 ‡ Deficit Reduction Act of 2005 Adjustment. Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a conversion factor of \$35.8228.