FUJIFILM
Value from Innovation

SonoSite January 2019
Ultrasound Reimbursement Information

Anesthesiology

This guide provides coverage and payment information for diagnostic ultrasound and related ultrasound guided procedures. This information was obtained from third-party sources and is subject to change without notice, as Medicare and other payers may change their reimbursement policies at any time. This document is for educational purposes only. It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for service rendered and to ensure any services provided to patients and submitted for reimbursement are medically necessary. Fujifilm SonoSite makes no guarantees concerning reimbursement or coverage. If you have questions related to how to bill for these services appropriately, please contact your own reimbursement staff or the patient's insurer, as Fujifilm SonoSite cannot provide specific reimbursement guidance.

Documentation Requirements

All diagnostic ultrasound examinations, including those when ultrasound is used to guide a procedure, require that permanently recorded images, with measurements, when such measurements are clinically indicated be maintained in the patient's 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. For those anatomic regions that have complete or limited ultrasound codes, note the elements that comprise a complete exam. The report should contain a description of these elements or the reason that an element could not be visualized. If less than the required elements of a complete exam are reported, the limited code for that anatomic should be used once per patient exam session. A limited exam of an anatomic region should not be reported for the same exam session as a complete exam of the same region.

In the case of ultrasound guidance procedures, 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.

Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable. [1]

Third Party Insurance Payment Policies

Effective May 22, 2007, Medicare has a National Coverage Determination ("NCD") regarding ultrasound diagnostic procedures.[2] Per this policy, Medicare will generally reimburse physicians for medically necessary diagnostic ultrasound services, provided the services are within the scope of the physician's license and for the indications outlined in the NCD. Some Medicare Administrative Contractors ("MACs") 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. Prior to performing ultrasound procedures, physicians should contact your Part B MAC for details. We recommend also checking for any local coverage determinations ("LCDs") for the service(s) you intend to provide. Some MACs do have policies regarding ultrasound studies of the extremities or ultrasound guidance of certain injections or both.

Payment rules for other non-Medicare payers (*e.g.*, commercial/private payers, Medicare Advantage, Medicaid) vary by payer and plan. Payer rules and guidance should be reviewed, as some plans indicate, for example, what qualifications or credentials are required or which specialties may perform and receive reimbursement for ultrasound services. Some insurers require physicians to submit applications requesting ultrasound be added to their list of services performed in their practice.

Additional requirements may apply, so providers should contact the appropriate plan before submitting claims for ultrasound studies to determine their requirements and request that they add ultrasound to the list of services in your contract.

Use of Modifiers

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 generally bill the global fee, which is represented by the CPT[1] code without any modifiers.

If the site of service is the hospital, the -26 modifier, indicating the professional service only was provided, must be added by the physician to the CPT code for the ultrasound service. Payers will not reimburse physicians for the technical component in the hospital or ASC setting.[3]

Providers should review plan guidance to determine whether any additional modifiers may be required depending on the service provided.

---

[1] CPT 2019 Professional Edition, American Medical Association, Page 493.

[2] Medicare National Coverage Determinations Manual, Ch. 1, Part 4, § 220.5,*Ultrasound Diagnostic Procedures* (Effective May 22, 2007) (Rev. 173, Issued: 09-04-14, Effective: Upon Implementation: of ICD-10, Implementation: Upon Implementation of ICD-10), (*available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)

[3] 2017 Ultrasound Coding Users Guide, American College of Radiology, page 55.

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 CPT and ICD-10 codes that accurately describe the service performed and the corresponding reason for the study.

National Correct Coding Initiative Edits

The National Correct Coding Initiative (NCCI) sets correct coding methodologies for Medicare, as well as many other payers. Under the NCCI, one unit of service is allowed for CPT code 76942 in a single patient encounter regardless of the number of needle placements performed. Per NCCI, "The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.[4]

As of January 2017, Evaluation of an anatomic region and guidance for a needle placement procedure in that anatomic region by the same radiologic modality at the same or different patient encounter(s) on the same date of service are not separately reportable. For example, a physician should not report a diagnostic ultrasound CPT code and CPT code 76942 (ultrasonic guidance for needle placement...) when performed in the same anatomic region on the same date of service. Physicians should not avoid these edits by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service. [5]

Providers should review the NCCI to determine whether additional coding edits will apply to the services provided.

Payment Information

The following chart provides payment information that is based on the 2019 national unadjusted Medicare physician fee schedule for ultrasound services regarding musculoskeletal health. Payment will vary by geographic region. Use the "Professional Payment" column to estimate reimbursement to the physician for services provided in a facility setting – i.e. a hospital or ASC.

Ambulatory Payment Classification (APC) codes and payments are used by Medicare under the Hospital Outpatient Prospective Payment System (OPPS). Payment is based on the 2019 national Medicare unadjusted OPPS amounts. The actual payment will vary by location.

		2019 Medicare Physician Fee Schedule — National Average*			2019 Hospital Outpatient Prospective Payment System (OPPS)†	
CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration injection, localization device), imaging supervision and interpretation	$58.02	$32.80	$25.23	Packaged Service	No Payment
+76937	Ultrasonic guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting	$34.60	$14.78	$19.82	Packaged Service	No Payment
93308	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording; when performed, follow up or limited study	$100.19	$26.31	$73.88	5523	$230.56
+93321	Doppler Echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for 2D echocardiographic imaging); follow up or limited study	$27.39	$7.57	$19.82	Packaged Service	No Payment
+93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	$25.59	$3.24	$22.34	Packaged Service	No Payment

[4] National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) Effective January 1, 2017, page IX-19

[5] National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) Effective January 1, 2017, page IX-22.

CPT Code	CPT Code Descriptor	Non-Facility Payment	Facility Payment	APC Code	APC Payment
64405	Injection, anesthetic agent; occipital nerve	$85.41	$55.50	5441	$247.48
64413	Injection, anesthetic agent; cervical plexus	$129.74	$84.33	5442	$598.81
64415	Injection, anesthetic agent; brachial plexus, single	$121.81	$67.39	5443	$764.84
64417	Injection, anesthetic agent; axillary nerve	$135.51	$72.80	5443	$764.84
64418	Injection, anesthetic agent; suprascapular nerve	$97.67	$59.10	5442	$598.81
64420	Injection, anesthetic agent; intercostal nerve, single	$113.52	$69.20	5442	$598.81
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	$160.73	$95.14	5443	$764.84
64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	$141.63	$98.03	5442	$598.81
64445	Injection, anesthetic agent; sciatic nerve, single	$140.19	$75.32	5442	$598.81
64446	Nerve block injection, sciatic continuous infusion	N/A	$82.17	5442	$598.81
64447	Injection, anesthetic agent; femoral nerve, single	$124.70	$68.83	5442	$598.81
64448	Nerve block injection, femoral continuous infusion	N/A	$73.88	5443	$764.84
64450	Nerve block injection, other peripheral nerve or branch	$78.93	$46.13	5442	$598.81

*Source of Information: Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2019 release, RVU19A file

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a 2019 conversion factor of $36.0391

†Source: CMS OPPS - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-CN2.html

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.

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.