

Ultrasound Guidance of Regional Anesthesia in the ASC

This guide provides coverage and payment information for ultrasound guided procedures such as nerve blocks performed by anesthesiologists in an Ambulatory Surgery Center (ASC). 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 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.

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.

Payment for Physician Fees

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.
- Generally Medicare will reimburse anesthesiologists for medically necessary 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.

Professional Services

In the Ambulatory Surgery Center (ASC) the –26 modifier, indicating the billing is only for the professional service, must be added to the CPT¹ code for the imaging service. Payers will not reimburse physicians for the technical component in these settings.

ASC Fees

In the ASC site of service, under the Medicare Outpatient Prospective Payment System (OPPS) for 2010, the technical component of image guidance procedures is listed as a packaged service. When these services are provided in the ASC, the payment for the image guidance is included in the reimbursement for the underlying procedure. The Medicare program instructs the ASC to incorporate the cost of packaged services into the charge for the nerve block procedure and not to report packaged services separately.

- Private payer policies may differ – contact your payers directly for guidance on submitting claims for ultrasound services in this setting.



Ambulatory Surgery Centers – Ultrasound Guidance

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 “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 ASCs under the Hospital Outpatient Prospective Payment System (OPPS). Payment is based on the national unadjusted OPPS amounts for ASC. 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	Professional Payment	2012 APC Code	2012 APC Payment
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	\$33.02	Packaged Service	No Payment

		2012 Medicare Physician Fee Schedule – National Average	Hospital Outpatient Prospective Payment System (OPPS) for ASC	
2012 CPT Code	CPT Code Descriptor	Physician at Facility Payment	2012 APC Code	2012 ASC Payment
64413	Injection, anesthetic agent; cervical plexus	\$123.56	0206	\$272.74
64415	Injection, anesthetic agent; brachial plexus, single	\$124.24	0206	\$272.24
64417	Injection, anesthetic agent; axillary nerve	\$133.09	0206	\$272.24
64418	Injection, anesthetic agent; suprascapular nerve	\$138.87	0206	\$272.24
64420	Injection, anesthetic agent; intercostal nerve, single	\$125.94	0206	\$272.24
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	\$177.68	0207	\$522.87
64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	\$134.35	0206	\$272.74
64445	Injection, anesthetic agent; sciatic nerve, single	\$136.15	0207	\$522.87
64446	Nerve block injection, sciatic continuous infusion	\$81.69	0207	\$522.87
64447	Injection, anesthetic agent; femoral nerve, single	\$124.24	0206	\$272.74
64448	Nerve block injection, femoral continuous infusion	\$72.84	0207	\$522.87

CPT® five digit codes, nomenclature and other data are Copyright 2011 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 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.

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.