



January 2014

Ultrasound Reimbursement Information



Echocardiography

This guide provides coverage and payment information for commonly performed echocardiography procedures. 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 regarding reimbursement or coverage. Please feel free to contact the SonoSite reimbursement staff if you have any questions at 1-888-482-9449.

Documentation Requirements

A final written interpretation of all echocardiography studies must be kept in the patient's record. The rationale for performing the study must be clearly documented or understood in the medical record.

Echocardiography codes require the production and retention of image documentation. Permanent images, either electronic or hardcopy must be retained in the patient's record or some other archive in order to meet the requirements of billing these CPT¹ codes.

Third Party Insurance Payment Policies

Private insurance payment rules vary by payer and plan with respect to which specialties may receive reimbursement for echocardiography services. Some payers will reimburse providers of any specialty while others may restrict echocardiography procedures to specific specialties or providers only. Some private plans require physicians to submit applications requesting echocardiography 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.

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.

A limited number of Medicare Part B Contractors require that physicians performing and/or interpreting echocardiography studies attain Level 2 competency as defined by the American Heart Association (AHA) and the American College of Cardiology (ACC). Others require that the provider who performs the interpretation possess the knowledge, skills, training and experience minimally necessary for this component of the service. (This determination is based upon accepted community standards and State scope of practice limitations.) Check with your local Part B for is requirements.

If the technical component of the echocardiography study is performed by a sonographer, some Medicare Part B Contractors require in the relevant Local Coverage Determination that the sonographer be credentialed as either a Registered Diagnostic Cardiac Sonographer (RDCS) through the American Registry of Diagnostic Medical Sonographers or as a Registered Cardiac Sonographer (RCS) through the Cardiovascular Credentialing International; or the service is performed at a laboratory (e.g. office, IDTF), credentialed by the Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL).

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).

Site of Service Payment Information

In the office setting, a physician who owns the ultrasound equipment and performs the service him or herself or through an employed or contracted sonographer, may bill the global fee, which is represented by the CPT code without any modifiers.

If the site of service is the hospital (inpatient, outpatient or ED), a Skilled Nursing Facility, or an IRF, the physician must add the -26 modifier, indicating that only the professional service was provided, to the CPT code for the ultrasound service. Payers will not reimburse physicians for the technical component in these settings.

A physician who provides echocardiography services to a Medicare patient admitted for a Part A stay in a Skilled Nursing Facility (SNF) may bill the professional component directly to the Medicare Part B Contractor. However, the physician must bill the SNF for the technical component. Under the consolidated billing requirements, the SNF is responsible for providing many medical services that a SNF resident receives, either directly or under arrangements.

Under the Medicare Outpatient Prospective Payment System (OPPS) the technical components of "add-on" codes +93320, +93321 and +93325 are listed as packaged services. When these services are provided in the outpatient department, the payment for the "add-on" services is included in the reimbursement for the 2D echocardiography service.

Allowable Frequency of Studies and Indications for Use

Many Medicare Carriers provide guidelines on the frequency with which transthoracic echocardiography (TTE) studies will be reimbursed depending on the condition of the patient. Generally speaking, allowable frequencies vary according to the indication for performing the exam and according to the payer to whom the claim is being submitted. Typically, acute symptoms will justify payment. Chronic conditions will fall under frequency guidelines, which vary significantly between payers. Payers do not distinguish between limited and complete exams in assessing the frequency of TTEs. Carriers also vary considerably as to which diagnoses are covered indications for echocardiography services. Check with your local carrier for clinical indications and allowable frequencies of use.

Code Selection

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

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):

- CPT code 93306 - for dates of service on or after 1/1/2009 this code represents a complete echocardiogram, including 2D, M-mode recording, when performed, and spectral and color Doppler.
- CPT code 93307 - for dates of service on or after 1/1/2009 this code represents the complete 2D study without spectral or color Doppler.
- Do not report "add-on" codes +93320, +93321 or +93325 with either CPT code 93306 or 93307.
- CPT code 93308 represents the limited or follow up 2D echocardiography including M-mode recording when performed.
- To report a color Doppler examination of the flow of blood through the heart's chambers and valves, report CPT code +93325 in addition to some of the codes for 2D echocardiography. Note that code +93325 is an "add-on" code and cannot be reported separately. It can be used in conjunction with 93308 and 93350, among others.
- To report a quantitative evaluation of flow, CPT codes +93320 and +93321 - pulsed and/or continuous wave Doppler - can be reported for complete studies and limited studies respectively. Limited Doppler, code +93321, is typically used with the Limited 2D code, 93308.
- Note that codes +93320 and +93321 are "add-on codes" and cannot be reported separately. They may be reported in conjunction with 93308 and 93350, among others.
- For stress echocardiography, whether exercise or pharmacologically induced, report CPT code 93350. If color Doppler and spectral Doppler are also performed, those codes may be reported also. However, the components of 93306, 93307 and/or 93308 are included in 93350. Therefore, neither 93307 nor 93308 should be reported in addition to 93350. The appropriate cardiovascular stress test codes should also be reported along with 93350.

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.

Echocardiography

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. Payment rates shown in the attached chart reflect DRA-imposed payment for services that are subject to the cap. 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.

CPT Code	CPT Code Descriptor	Medicare Physician Fee Schedule — National Average*			Hospital Outpatient Prospective Payment System (OPPS)†	
		Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
93306	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; complete, with spectral Doppler and color flow Doppler.	\$229.27	\$64.48	\$164.78	0269	\$427.27
93307	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; complete, without spectral Doppler or color flow Doppler.	\$132.54	\$45.85	\$86.69	0269	\$427.27
93308	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; follow up or limited	\$123.59	\$25.79	\$97.80	0697	\$250.67
93303	Transthoracic echocardiography for congenital cardiac anomalies, complete	\$239.30	\$64.48	\$174.82	0270	\$594.41
93304	Transthoracic echocardiography for congenital cardiac anomalies, follow-up or limited	\$158.70	\$37.26	\$121.44	0269	\$427.27
93350	Echocardiography, transthoracic, real-time with image documentation (2D, with or without M-mode recording), during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	\$242.16	\$72.36	\$169.80	0269	\$427.27
93015	Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report.	Non-facility payment \$75.94	NA	NA	NA	NA
+93320	Doppler Echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for 2D echocardiographic imaging); complete.	\$54.81	\$18.63	\$36.18	Packaged Service	No Payment
+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.	\$31.17	\$7.52	\$23.64	Packaged Service	No Payment
+93325	Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	\$26.15	\$3.58	\$22.57	Packaged Service	No Payment

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*Federal Register December 10, 2013 †Federal Register December 10, 2013.

Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a conversion factor of \$35.8228.

¹Current Procedural Terminology (CPT®) Copyright 2013 American Medical Association.