SonoSite

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Ultrasound Reimbursement Information

Ultrasound use in ICU/CCU

These guidelines have been developed to assist with reporting ultrasound services performed in the hospital ICU and CCU settings. 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.

Ultrasound services in ICU/CCU are typically considered to be covered services as long as medical necessity is properly established and supported by documentation. While ultrasound services are not considered primary procedures and, therefore, do not determine the Medicare DRG assignment, it is still important for physicians to document the performance of these procedures in the patient's record and for the hospital to assign an ICD-9-CM procedure code for the purposes of determining the standardized charge and evaluating the discharge for outlier payment status.

Please note the following with regard to hospital billing of ultrasound procedure codes in the ICU/CCU settings:

- When performing procedures where ultrasonic guidance is used, a separate guidance code does not exist for reporting hospital services. Rather, it is considered included in the primary procedure being performed. Examples of this include: paracentesis (ICD-9-CM procedure code 54.91) or thoracentesis (ICD-9-CM procedure code 34.91).
- ICD-9-CM Procedure code 88.72 (Diagnostic ultrasound of heart) is used for transesophageal echocardiography (TEE) and transthoracic echocardiography (TTE).

Code Selection

The following revenue code is used to report the facility portion of ultrasound services in the ICU/CCU setting:

Revenue Code	Descriptor
402	Other imaging services, ultrasound

The following ICD-9-CM procedure codes are commonly reported for the facility portion when using ultrasound in the inpatient setting:

Area of the Body	ICD-9-CM Procedure Code	Descriptor
Abdomen and retroperitoneum	88.76	Diagnostic ultrasound of abdomen and retroperitoneum
Digestive system	88.74	Diagnostic ultrasound of digestive system
Head and neck	88.71	Diagnostic ultrasound of head and neck (echoencephalography)
Heart	88.72	Diagnostic ultrasound of heart (TEE and TTE)
Other diagnostic	88.79	Other diagnostic ultrasound (multiple sites, total body)
Peripheral vascular system	88.77	Diagnostic ultrasound of peripheral vascular system (DVT scan)
Thorax	88.73	Diagnostic ultrasound of other sites of thorax (aortic arch, breast, lung)
Urinary system	88.75	Diagnostic ultrasound of urinary system
Diagnostic imaging (general)	88.90	Diagnostic imaging, not elsewhere classified

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Coding and Payment Information

Physicians report the professional component of ultrasound services by appending the -26 modifier to the CPT[1] code on the CMS 1500 billing form, The following payment information is based on the unadjusted Medicare physician fee schedule and reflects the reimbursement for the physician's service. The actual payment will vary by location.

CPT Procedure Code	Descriptor	2012 Medicare Physician Fee Schedule – National Average* Professional Payment
75989	Radiological guidance (ie, fluoroscopy, ultrasound or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation	$57.18
76604	Ultrasound, chest, real time with image documentation	$26.55
76705	Ultrasound, abdominal, real time with image documentation; limited	$28.59
76775	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	$28.25
76930	Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	$32.68
+ 76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting	$14.98
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$33.02
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	$64.33
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	$36.76
93306	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; complete, with spectral Doppler and color flow Doppler.	$64.67
93307	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; complete, without spectral Doppler or color flow Doppler.	$45.95
93308	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording when performed; follow-up or limited study	$25.87
93312	Echocardiography, transesophageal, real time with image documentation (2D) with or without M-mode recording; including probe placement, image acquisition, interpretation and report	$106.20
93313	Echocardiography, transesophageal, real time with image documentation (2D) with or without M-mode recording; placement of transesophageal probe only	$41.87
93314	Echocardiography, transesophageal, real time with image documentation (2D) with or without M-mode recording; image acquisition, interpretation and report only	$61.07
+ 93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	$18.72
+ 93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study	$7.49
+ 93325	Doppler echocardiography color flow velocity mapping	$3.74
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	$22.12

*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.

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