FUJIFILM
Value from Innovation

SonoSite

January 2016

Ultrasound Reimbursement Information

Musculoskeletal Applications

This guide provides coverage and payment information for diagnostic musculoskeletal ultrasound and related ultrasound guided 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 service 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.

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. Some Medicare contractors have policy regarding either the diagnostic study or ultrasound guidance of certain injections or both.

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 perform and 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 possessing specific certifications or accreditations. 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.

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 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 setting.

If billing for a procedure 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.

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-10 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 diagnostic extremity ultrasound exams there are two coding options:
  - CPT code 76881 - Ultrasound, extremity, nonvascular, real-time with image documentation; complete
  - CPT code 76882 - Ultrasound, extremity, nonvascular, real-time with image documentation; limited.
- CPT® describes a complete ultrasound examination of an extremity (76881) as consisting of real time scans of a specific joint that includes examination of the muscles, tendons, joint, and other soft tissue structures and any identifiable abnormality. CPT code 76882 describes a limited examination of the extremity where a specific anatomic structure such as a tendon or a muscle is assessed or the code could be used to evaluate a soft-tissue mass.
- To report the use of ultrasound to guide injections or aspirations, the suggested code is 76942 - Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation. Report 76942 in addition to the code for the underlying procedure.

Under the National Correct Coding Initiative, NCCI, which sets CMS payment policy as well as many private payers, 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.

Effective January 1, 2015 three new codes are used to report arthrocentesis services with ultrasound guidance:

-CPT code 20604 – Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes), with ultrasound guidance, with permanent recording and reporting

-CPT code 20606 - Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) with ultrasound guidance, with permanent recording and reporting

- CPT code 20611 - Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g. shoulder, hip, kneejoint, subacromial bursa) with ultrasound guidance, with permanent recording and reporting

This means is that CPT code 76942 - Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation is NO LONGER reported with this series of CPT codes and codes 20600, 20605 and 20610 now have the language "without ultrasound guidance".

Please note the CPT code 76942 is still an active code and could and should be reported with other aspiration or injection services as appropriate. Please see page 3 for such examples.

General Coverage Information

Generally speaking, medically indicated ultrasound studies are covered by most insurance plans. Diagnostic ultrasound of the extremities is typically a covered procedure for effusion of joints and swelling in limbs. In the case where ultrasound is used to guide the performance of a procedure such as an injection or aspiration, the coverage for the injection or aspiration will usually determine the coverage for the ultrasound guidance. A small number of local Medicare contractors have published policy pertaining to ultrasound services. Check with your local Medicare contractor for the covered indications for reporting these codes. It is advisable to also check with your individual private payers directly.

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 under the Hospital Outpatient Prospective Payment System (OPPS). Payment is based on the national unadjusted OPPS amounts. The actual payment will vary by location.

Ultrasound Services

		Medicare Physician Fee Schedule - National Average*			Hospital Outpatient Prospective Payment System (0PPS)†	
CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	$116.80	$32.25	$84.55	5532	$153.58
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited	$36.54	$25.08	$11.46	Packaged Service	No Payment
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$61.98	$34.04	$27.95	Packaged Service	No Payment

Procedures that may be ultrasound guided (report 76942 in addition)

		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
20526	Injection, therapeutic (eg local anesthetic, corticosteroid), carpal tunnel	$79.18	$59.47	5441	$223.76
20527	Injection, enzyme (eg collagenase) palmar fascial cord (Dupuytren's cord) post enzyme injection	$86.70	$69.15	5441	$223.76
20550	Injection(s) single tendon sheath, or ligament, aponeurosis (eg plantar "fascia")	$60.07	$42.91	5441	$223.76
20551	Injection(s) single tendon sheath, or ligament, aponeurosis (eg plantar "fascia") single tendon origin/insertion	$61.50	$43.98	5441	$223.76
20552	Injection(s), single to multiple trigger point(s) one or two muscle(s)	$55.78	$38.62	5441	$223.76
20553	Injection(s), single to multiple trigger point(s) three or more muscle(s)	$64.72	$43.98	5441	$223.76
20612	Aspiration and/or injection of ganglion(s) cyst any location	$61.86	$42.91	5441	$223.76

Procedures that include ultrasound guidance (Do NOT report 76942 in addition)

		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	$142.95	$67.36	5072	$480.64
20604	Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes) with ultrasound guidance, with permanent recording and reporting	$73.81	$47.29	5441	$223.76
20606	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) with ultrasound guidance, with permanent recording and reporting	$81.69	$54.46	5441	$223.76
20611	Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g. shoulder, hip, knee joint, subacromial bursa) with ultrasound guidance, with permanent recording and reporting	$93.51	$63.42	5441	$223.76

*Federal Register November 2015 †Federal Register November, 2015.

Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a conversion factor of $35.8279

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.

[1]Current Procedural Terminology (CPT®) Copyright 2015 American Medical Association