



January 2014

Ultrasound Reimbursement Information



Primary Care

This guide provides coverage and payment information for diagnostic ultrasound and ultrasound guided procedures commonly performed in the primary care setting. 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.

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.

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 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.

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 CPT¹ 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 biopsy or injection 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.

Medicare Reimbursement for AAA Screening

Medicare reimbursement rules for AAA screening are as follows:

- Coverage: Eligible beneficiaries for coverage of ultrasound screening examinations for AAA are those who:
 1. have not been previously furnished a covered AAA screening ultrasound examination under the Medicare program; and
 2. are included in one of the following risk categories:
 - Men and women with a family history of an AAA; or
 - Men age 65 to 75 years who have smoked at least 100 cigarettes in their lifetimes

For 2014 the requirement attached to the beneficiary receiving a referral as part of the Initial Preventative Physical Examination IPPE was removed.

- Coding: Physicians submitting claims for payment for AAA screening exams will submit G0389 - Ultrasound, real time with image documentation; for abdominal aortic aneurysm (AAA) screening.
- Payment: The unadjusted national average 2014 payment for the global service for CPT code G0389 is \$66.27 when the test is performed in the physician office.

Private Insurance Reimbursement for AAA

Several private insurance companies provide coverage for AAA screening for their members who have preventive services in their plan.

- Aetna will cover a one-time ultrasound screening for AAA for men 65 years of age or older. Aetna's policy identifies the use of either CPT code 76770 - complete retroperitoneal ultrasound or CPT code 76775 - limited retroperitoneal ultrasound, as appropriate for the reporting of this service. Payment rates are not publicly available and will depend upon the contract each provider has negotiated with Aetna.
- Cigna will cover a one-time ultrasound screening for AAA for men age 65 - 75 who have ever smoked, male nonsmokers nearing age 65 with a family history of AAA, and female smokers age 70 or older with a family history of AAA. These coverage criteria only apply for those members who have coverage for preventive health services. Cigna's policy also references the limited and complete retroperitoneal ultrasound codes. Payment rates are proprietary and variable as above.
- Several of the Blue Cross Blue Shield companies advise members determined by their physicians to be at risk for AAA to receive screening for AAA, but they note that this service may not be covered under all plans.

In all instances, it is advisable for providers to contact the private insurance companies prior to providing the AAA screening to verify coverage for their individual patients.

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 characterization or identification of a thyroid nodule use CPT code 76536 - Ultrasound of soft tissues of head and neck.
- For evaluation of extremity veins for venous incompetence or deep vein thrombosis, use CPT codes 93970, duplex scan of extremity veins; complete bilateral study or 93971, unilateral or limited study.

- For evaluation of carotid arteries, use CPT codes 93880, duplex scan of extracranial arteries, complete bilateral study or 93882, unilateral or limited study.
- Effective January 1, 2011 two new codes are used to report ultra sound examination of an extremity:
 - 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, the suggested code is 76942 - Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation.
- CPT codes 93306, 93307 and 93308 describe a two-dimensional (2D) evaluation of the heart. As of CPT 2009 specific details on the technical aspects of the studies that must be completed in order to meet the requirements of the CPT code were added. For dates of service on or after 1/1/2009 to report the complete 2D assessment with spectral and color Doppler use 93306. The complete assessment without spectral or color Doppler report 93307. Do not report "add-on" codes +93320, +93321 or +93325 with either 93306 or 93307.
- To report the 2D assessment of a patient for pericardial fluid or left ventricular hypertrophy, code 93308, limited echocardiography, is recommended.
- To report a quantitative evaluation of flow, CPT code +93321 - pulsed and/or continuous wave Doppler - can be reported with limited studies. Limited Doppler, code +93321, is reported in addition to code 93308. Note this code is an "add-on code" and cannot be reported separately. It may be reported in conjunction with 93308, among others.
- 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 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 among others.

General Coverage Information

- For echocardiography and non-invasive vascular studies, check with your local Medicare Carrier for the covered indications and allowable frequencies of reporting. 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 between payers. Payers do not distinguish between limited and complete exams in assessing the frequency of TTEs. Carriers also vary considerably as to which indications will justify the use of echocardiography and non-invasive vascular services.

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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.

CPT Code	CPT Code Descriptor	Medicare Physician Fee Schedule - National Average*		
		Global Payment	Professional Payment	Technical Payment
76536	Ultrasound of soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), real time with image documentation	\$123.59	\$28.66	\$94.93
76705	Ultrasound, abdominal, real time with image documentation); limited (e.g., single organ, quadrant, follow-up)	\$109.98	\$29.73	\$80.24
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	\$91.35	\$32.60	\$58.75
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	\$102.81	\$38.33	\$64.48
76818	Fetal biophysical profile; with non-stress testing	\$123.59	\$53.73	\$69.85
76881	Ultrasound, extremity, nonvascular, real-time with image documentation; complete	\$120.01	\$32.24	\$87.77
76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited	\$36.18	\$25.08	\$11.11
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	\$74.15	\$34.03	\$40.12
93880	Duplex scan of extracranial arteries; complete bilateral study	\$192.01	\$30.45	\$190.84
93882	Duplex scan of extracranial arteries; unilateral or limited study	\$124.31	\$20.78	\$190.84
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
93308	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; follow-up or limited study	\$123.59	\$25.79	\$97.80
+93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display, follow-up or limited	\$31.17	\$7.52	\$23.64
+93325	Doppler echocardiography color flow velocity mapping	\$26.15	\$3.58	\$22.57
G0389	Ultrasound, real time with image documentation; for abdominal aortic aneurysm (AAA) screening.	\$66.27	\$29.37	\$36.90
76775	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation, limited	\$66.27	\$29.37	\$36.90

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		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	\$141.14	\$67.35	0004	\$411.24
20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)	\$48.36	\$36.54	0204	\$202.21
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	\$50.51	\$38.33	0204	\$202.21
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g. shoulder, hip, knee joint, subacromial bursa)	\$60.90	\$47.29	0204	\$202.21

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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.

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.

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