



January 2014

Ultrasound Reimbursement Information



Pulmonary Medicine

This guide provides coverage and payment information for diagnostic ultrasound and ultrasound guided procedures commonly performed by a pulmonologist. 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.

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.

Site of Service Payment Rules

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/non-facility fee, and report the CPT¹ code without any modifiers.

If the site of service is hospital (inpatient, outpatient or emergency department) or Ambulatory Surgery Center (ASC) the -26 modifier, indicating the professional service only was provided, must be added to the CPT code for the imaging service. Payers will not reimburse physicians for the technical component in these settings.

In the hospital and ASC sites of service, under the Medicare Outpatient Prospective Payment System (OPPS) the technical component of image guidance procedures and the "add-on" codes for echocardiography are listed as packaged services. When these services are provided in the outpatient department or ASC, the payment for the image guidance is included in the reimbursement for the underlying procedure. Hospitals report the charge for the ultrasound guidance and ASC incorporate the cost into the charge for the procedure. Private payer policies may differ - contact your payers directly for guidance on submitting claims for ultrasound services in this setting.

For additional information on inpatient services, please see our Reimbursement Information for Ultrasound use in the ICU/CCU.

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 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 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-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.

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 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
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	\$89.56	\$27.58	\$61.97	0265	\$90.05

CPT Code	CPT Code Descriptor	Medicare Physician Fee Schedule - National Average		Hospital Outpatient Prospective Payment System (OPPS)	
		Non-Facility Payment	Facility Payment	APC Code	APC Payment
32555	Thoracentesis, needle or catheter, aspiration of the pleural space, with image guidance	\$299.84	\$117.14	0070	\$485.19
32557	Pleural drainage, percutaneous, with insertion of indwelling catheter, with image guidance	\$577.82	\$171.59	0070	\$485.19

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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.

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 ultrasound of the chest, including mediastinum use CPT code 76604. This code is used for the evaluation of the pleural spaces for the presence of fluid and/or masses of the chest, chest wall or mediastinum.
- As of January 1, 2013 CPT revised the description for a thoracentesis, and new code 32555 is used for thoracentesis needle or catheter, aspiration of the pleural space including image guidance. In addition code 32557 is reported for pleural drainage, percutaneous, with insertion of indwelling catheter with image guidance. Under these new codes 76942 is no longer reported in addition to the procedure (e.g., 32555, 32557.)
- If performing a diagnostic chest ultrasound and an ultrasound guided procedure during the same patient encounter both codes may be billed: the diagnostic ultrasound (76604), and the underlying procedure code (e.g., 32555).

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