SonoSite

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Ultrasound Reimbursement Information

Urology

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

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's 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 studies, 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 reimburse urologists for medically necessary diagnostic ultrasound services, provided the services are within the scope of the physician's license. Some Medicare Carriers 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 Carrier for details.
- 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 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 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.

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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 transrectal evaluation of the prostate, use CPT code 76872 – Ultrasound, transrectal.
- For needle core biopsy of the prostate, use CPT code 55700.
- For ultrasound guidance of a prostate biopsy, use CPT code 76942 – Ultrasonic guidance for needle placement. Report 76942 in addition to the code for the biopsy.
- If performing a diagnostic prostate ultrasound evaluation and an ultrasound guided needle procedure during the same patient encounter, all three codes may be billed: the diagnostic ultrasound (76872), the ultrasound guidance (76942) and the biopsy (55700). Medicare CCI edits do not, at present, bundle the prostate ultrasound and the ultrasound guidance of the biopsy, but some private payers may. It is recommended to check quarterly CCI updates and to check with each payer.
- The American Urological Association recommends that measurement of post-void residual urine volume be reported using CPT code 51798 – Measurement of post void residual urine, regardless of whether or not the ultrasound system used provides an image.
- CPT code 76770 – Ultrasound, retroperitoneal may be used to report an evaluation of the urinary tract, including the kidneys, ureters and urinary bladder.
  - CPT explanatory notes recommend that CPT code 76857, limited pelvic ultrasound, be used to report a study of the urinary bladder only.

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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 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.

		2012 Medicare Physician Fee Schedule – National Average*			Hospital Outpatient Prospective Payment System (OPPS)†	
2012 CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	2012 APC Code	2012 APC Payment
76857	Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up (e.g., for follicles)	$81.98‡	$19.06	$62.92‡	0265	$62.92
76870	Ultrasound, scrotum and contents	$126.96	$31.31	$95.65	0266	$96.31
76872	Ultrasound, transrectal	$130.35‡	$34.04	$96.31‡	0266	$96.31
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning	$172.55‡	$76.24	$96.31‡	0266	$96.31
76770	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; complete	$132.39‡	$36.08	$96.31‡	0266	$96.31
76775	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	$112.32	$28.25	$84.07	0266	$96.31
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$206.61	$33.02	$173.59	Packaged Service	No Payment

		2012 Medicare Physician Fee Schedule – National Average		Hospital Outpatient Prospective Payment System (OPPS)	
2012 CPT Code	CPT Code Descriptor	Non-Facility Payment	Facility Payment	2012 APC Code	2012 APC Payment
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	$19.40	$19.40	0340	$45.64
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	$224.31	$140.23	0184	$968.17

*Federal Register November 28, 2011. +Federal Register November 1, 2011. ‡Deficit Reduction Act of 2005 Adjustment.

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.