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SonoSite

Ultrasound Reimbursement Information

Family Practice

This guide provides coverage and payment information for diagnostic ultrasound and ultrasound guided procedures most likely to be performed in family practice. 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. Documentation of the study must be available to the insurer upon request.
- A written interpretation 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 physicians 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 by the phystian to the CPT code for the primary 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

The Centers for Medicare and Medicaid Services (CMS) released the final rule on November 1, 2006, for the coding, coverage and payment of the new AAA screening benefit.

- Coverage: Eligible beneficiaries for coverage of ultrasound screening examinations for AAA are those who:
  1. have received a referral for an ultrasound screening as a result of an initial preventive physical examination (IPPE);
  2. have not been previously furnished a covered AAA screening ultrasound examination under the Medicare program; and
  3. 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
- 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 2008 payment for the global service for CPT code G0839 is $115.40 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 if the member's plan provides coverage for such services. Aetna's policy identifies CPT code 76770 - complete retroperitoneal ultrasound and CPT code 76775 - limited retroperitoneal

ultrasound. 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 famiy 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 has been suggested by SonoSite's reimbursement and coding advisors. (Complete descriptors for codes referenced in the following paragraphs are listed in the attached chart.)

- To report a limited obstetrical ultrasound, the recommended CPT code is 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. If the transvaginal approach is used, the recommended code is 76817 – Ultrasound, pregnant uterus, real time with image documentation, transvaginal.
- For characterization or identification of a thyroid nodule use CPT code 76536 – Ultrasound of soft tissues of head and neck.
- For evaluation of carotid arteries, use CPT codes 93880, duplex scan of extracranial arteries, complete bilateral study or 93882, unilateral or limited study.
- To report diagnostic ultrasound scans of muscles, tendons, joints and soft tissue in the extremities, including the shoulders, the recommended code is 76880 – Ultrasound, extremity, non-vascular, real time with image documentation.
- 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 93307 and 93308 describe a two-dimensional (2D) evaluation of the heart. CPT 2007 contains specific detail on the technical aspects of the studies that must be completed in order to meet the requirements of the CPT code. To report the 2D assessment of a patient for pericardial fluid or left ventricular hypertrophy, code 93308, limited echocardiography, is recommended.
- 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 93307, and 93308 among others.
- To report a quantitative evaluation of flow, CPT codes +93320 and +93321 – pulsed and/or continuous wave Doppler – can be reported for complete studies and limited studies respectively. Limited Doppler, code +93321, is typically used with the Limited 2D code, 93308. Note that codes +93320 and +93321 are "add-on codes" and cannot be reported separately. They may be reported in conjunction with 93307 and 93308, among others.

General Coverage Information

- Medically indicated conventional 2D obstetrical ultrasound is a covered service by most insurance plans. However, ultrasound examinations to determine fetal gender or to provide a keepsake image of the fetus are considered not medically necessary and are, therefore, not a covered service by most insurers.
- To the extent that ultrasound is used to guide antepartum services such as amniocentesis, cordocentesis, chorionic villus sampling, etc. and the indications for coverage state that these procedures are covered outside of the global maternity service package, the ultrasound guidance procedure should be billed separately.
- 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.

Family Practice

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. Payment rates shown in the attached chart reflect DRA-imposed payment reductions for services that are subject to the cap. 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.

		2008 Medicare Physician Fee Schedule – National Average*		
2008 CPT Code	CPT Code Descriptor	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	$103.98	$26.28	$77.70
76705	Ultrasound, abdominal, real time with image documentation); limited (e.g., single organ, quadrant, follow-up)	$99.41	$28.57	$70.84
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	$91.41	$30.85	$60.56
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	$96.38‡	$35.42	$60.96‡
76818	Fetal biophysical profile; with non-stress testing	$121.12	$50.27	$70.84
76880	Ultrasound, extremity, non-vascular, real time with image documentation	$115.40	$28.18	$87.22
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$176.34	$32.37	$143.97
93880	Duplex scan of extracranial arteries; complete bilateral study	$180.87‡	$29.33	$151.54‡
93882	Duplex scan of extracranial arteries; unilateral or limited study	$168.73	$19.81	$148.92
93307	Echocardiography, transthoracic, real time with image documentation (2D) with or without M-mode recording; complete	$191.96	$47.23	$144.73
93308	Echocardiography, transthoracic, real time with image documentation (2D) with or without M-mode recording; follow-up or limited study	$114.26	$27.42	$86.84
+93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	$84.93	$19.42	$65.51
+93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited	$42.28	$8.00	$34.28
+93325	Doppler echocardiography color flow velocity mapping	$79.22	$3.81	$75.41
G0389	Ultrasound, real time with image documentation; for abdominal aortic aneurysm (AAA) screening.	$115.40	$28.18	$87.22

*Federal Register, November 27, 2007, revised December 4, 2007. †Federal Register, November 27, 2007. ‡Deficit Reduction Act of 2005 adjustment

Reimbursement rates shown for payment of services under the Physician's Fee Schedule reflect a conversion factor of $38.0870 as provided for in the Medicare, Medicaid, and SCHIP Extension Act of 2007, which was signed into law on December 29, 2007.