January 2008

SonoSite

# Ultrasound Reimbursement Information

# Obstetrics and Gynecology

*This guide provides coverage and payment information for diagnostic ultrasound and ultrasound guided procedures related to obstetrics and gynecology. 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 permanently recorded images. The images can be stored in hardcopy or electronic format. 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 procedure report for which the guidance was utilized.

## Third Party Insurance Payment Policies

- Assuming medical necessity is documented and the coverage indications met, ultrasounds are typically not included in the global obstetrical package and should be billed separately. However, some insurers may bundle payment for an obstetrical ultrasound in a routine pregnancy into the global maternity package, so it is advisable to contact the companies directly for their policies.
- Private insurance payment policies vary by payer and plan with respect to which specialties may perform ultrasound services. Some payers may restrict imaging procedures to specific specialties or providers possessing specific certifications. 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.
- The "Original Medicare Plan," also referred to as traditional Medicare Part B, will reimburse obstetrician-gynecologists 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).

## Coverage Guidelines

- Medically indicated conventional 2D 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.

## 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 studies meet the requirements of medical necessity as set forth by the payer, the requirements of completeness for the code that is chosen and are documented in the patient's record.

- It is the physician's responsibility to select the CPT code that most accurately describes the elements of the ultrasound service that is performed. The equipment used to conduct the ultrasound services must have the functionality required to perform the study described by the CPT descriptor.
- Under the Medicare program, the physician should select the diagnosis or ICD-9 code based on the interpretation/results of the ultrasound study. If the ultrasound study does not yield a diagnosis or was normal, the physician should select an ICD-9 code that represents the pre-service signs, symptoms and conditions that prompted the study.
- An E&M service that is distinct and separate from the interpretation of the ultrasound may be reported separately. The E&M service must be documented separately from the radiological findings and interpretation.

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## 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.
- In the hospital setting, the –26 modifier, indicating that only the professional service was provided, must be added to the CPT code. Payers will not reimburse physicians for the technical component in the hospital setting.
- If billing for a surgical 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.

## 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* | | | Hospital Outpatient Prospective Payment System (OPPS)† | |
|---|---|---|---|---|---|---|
| 2008 CPT Code | CPT Code Descriptor | Global Payment | Professional Payment | Technical Payment | 2008 APC Code | 2008 APC Payment |
| **Obstetrical** | | | | | | |
| 76801 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation | $132.54 | $46.85 | $85.70 | 0266 | $96.14 |
| +76802 | each additional gestation (List separately in addition to code for primary procedure) | $78.08 | $39.99 | $38.09 | 0265 | $60.96 |
| 76805 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks, 0 days), transabdominal approach; single or first gestation | $142.99‡ | $46.85 | $96.14‡ | 0266 | $96.14 |
| +76810 | each additional gestation (List separately in addition to code for primary procedure) | $100.55 | $46.47 | $54.08 | 0266 | $96.14 |

*continued*

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| 2008 CPT Code | CPT Code Descriptor | 2008 Medicare Physician Fee Schedule – National Average* Global Payment | Professional Payment | Technical Payment | Hospital Outpatient Prospective Payment System (OPPS)† 2008 APC Code | 2008 APC Payment |
|---|---|---|---|---|---|---|
| **Obstetrical** | | | | | | |
| 76811 | Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation | $222.05 | $90.65 | $131.40 | 0267 | $151.54 |
| +76812 | each additional gestation (List separately in addition to code for primary procedure) | $145.89‡ | $84.93 | $60.96‡ | 0265 | $60.96 |
| 76813 | Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation | $131.02 | $56.75 | $74.27 | 0266 | $96.14 |
| +76814 | each additional gestation (List separately in addition to code for primary procedure.) | $84.17 | $46.09 | $38.09 | 0265 | $60.96 |
| 76815 | Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses | $91.41 | $30.85 | $60.56 | 0265 | $60.96 |
| 76816 | Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus | $101.71‡ | $40.75 | $60.96‡ | 0265 | $60.96 |
| 76817 | Ultrasound, pregnant uterus, real time with image documentation, transvaginal | $96.38‡ | $35.42 | $60.96‡ | 0265 | $60.96 |
| 76818 | Fetal biophysical profile; with non-stress testing | $121.12 | $50.27 | $70.84 | 0266 | $96.14 |
| 76819 | Fetal biophysical profile; without non-stress testing | $97.88 | $36.94 | $60.94 | 0266 | $96.14 |
| 76820 | Doppler velocimetry, fetal, umbilical artery | $67.41 | $24.38 | $43.04 | 0096 | $93.56 |
| **Non-Obstetrical** | | | | | | |
| 76830 | Ultrasound, transvaginal | $114.26 | $33.14 | $81.13 | 0266 | $96.14 |
| 76831 | Hysterosonography, with or without color flow Doppler | $114.64 | $33.90 | $80.74 | 0267 | $151.54 |
| 76856 | Ultrasound, pelvic (non-obstetric), real time with image documentation; complete | $114.64 | $33.14 | $81.51 | 0266 | $96.14 |
| 76857 | limited or follow-up (e.g., for follicles) | $79.24‡ | $18.28 | $60.96‡ | 0265 | $60.96 |
| **Procedure Guidance** | | | | | | |
| 76941 | Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation | No Payment | $63.99 | No Payment | Packaged Service | No Payment |
| 76942 | Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation | $176.34 | $32.37 | $143.97 | Packaged Service | No Payment |
| 76945 | Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation | No Payment | $31.61 | No Payment | Packaged Service | No Payment |
| 76946 | Ultrasonic guidance for amniocentesis, imaging supervision and interpretation | $57.13 | $17.90 | $39.23 | Packaged Service | No Payment |
| 76948 | Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation | $56.75 | $17.52 | $39.23 | Packaged Service | No Payment |



*Federal Register, November 27, 2007, revised December 4, 2007. †Federal Register, November 27, 2007.

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.