

Ultrasound Reimbursement Information

Vascular Surgery

This guide provides coverage and payment information for select diagnostic ultrasound and non-invasive vascular duplex procedures. 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 and non-invasive vascular duplex scans require permanently recorded images. In the case of duplex scans, CPT requires hard copy output of all data analysis, including bidirectional vascular flow or imaging when provided. The images can be kept in the patient's record or some other archive – they do not need to be submitted with the claim. 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 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.

Site of Service Payment Rules

- In the office setting, a physician who owns the ultrasound 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 (inpatient, outpatient or ED), or an IRF, physicians may not submit a global charge to payers, or otherwise bill third party payers for the technical component. Payers will not reimburse physicians for the technical component in these settings.
- A physician who provides non-invasive vascular duplex scans to a Medicare patient admitted for a Part A stay in a Skilled Nursing Facility (SNF) may bill the professional component directly to the Medicare Part B carrier. However, the physician must bill the SNF for the technical component. Under the consolidated billing requirements, the SNF is responsible for providing many medical services that a SNF resident receives, either directly or under arrangements.

Use of Modifiers

- To report the professional component only of an ultrasound or non-invasive vascular service the -26 modifier must be added to the CPT code for the primary service.
- If reporting 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 all components of the E&M service in the patient's record.

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.

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- **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 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 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.)

Non-Invasive Vascular Studies

- For evaluation of carotid arteries, use CPT¹ codes 93880, duplex scan of extracranial arteries, complete bilateral study or 93882, unilateral or limited study.
- To report a transcranial Doppler study (TCD), use CPT codes 93886 and 93888. Explanatory Notes in CPT regarding transcranial Doppler studies indicate the following: "A complete transcranial Doppler study includes evaluation of the right and left anterior circulation territories and the posterior circulation territory (to include vertebral arteries and basilar artery). In a limited TCD study (93888) there is ultrasound evaluation of two or fewer of these territories. For TCD, ultrasound evaluation is a reasonable and concerted attempt to identify arterial signals through an acoustic window."
- 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.
- Medicare has created code G0365 to be used for vessel mapping performed in conjunction with the creation of an autogenous fistula for hemodialysis access. The code includes evaluation of the relevant arterial and venous vessels.
- The limited venous extremity code (93971) is used for all other vein mapping. Check with your payers for coverage guidelines on this procedure. In some cases it is not paid in the absence of a previous condition such as severe varicose veins or previous deep vein thrombosis.
- To evaluate the functioning of an existing hemodialysis graft or fistula, use CPT code 93990. Medicare has published specific coverage guidelines for this procedure – review the Local Coverage Determination for specifics.

Intraoperative Ultrasound

- Completion duplex of the carotid artery to verify that proper flow has been established and to evaluate the anastomosis may be billed using code 76998.

Ultrasound Guidance of Saphenous Vein Ablation

- The following CPT codes are used to describe saphenous vein ablation procedures using the radiofrequency and laser methods: 36475, +36476, 36478 and +36479. The new codes are inclusive of all imaging guidance; ultrasound guidance of these procedures is not separately reportable. Although carrier policies vary, typically, preoperative extremity duplex to identify and characterize the venous incompetence can still be reported separately. The recommended codes for that procedure are 93970 and 93971– Duplex scan of extremity veins, depending upon whether the study is complete and bilateral or limited and unilateral.

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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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 CPT Code	CPT Code Descriptor	2008 Medicare Physician Fee Schedule – National Average*			Hospital Outpatient Prospective Payment System (OPPS)†	
		Global Payment	Professional Payment	Technical Payment	2008 APC Code	2008 APC Payment
76998	Ultrasonic guidance, intraoperative	No Payment	\$59.80	No Payment	Packaged Service	No Payment
93880	Duplex scan of extracranial arteries; complete bilateral study	\$180.87*	\$29.33	\$151.54*	0267	\$151.54
93882	Duplex scan of extracranial arteries; unilateral or limited study	\$168.73	\$19.81	\$148.92	0267	\$151.54
93886	Transcranial Doppler study of the intracranial arteries; complete study	\$197.63*	\$46.09	\$151.54*	0267	\$151.54
93888	Transcranial Doppler study of the intracranial arteries; limited study	\$91.81*	\$30.85	\$60.96*	0265	\$60.96
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	\$179.72*	\$28.18	\$151.54*	0267	\$151.54
93926	Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study	\$115.18*	\$19.04	\$96.14*	0266	\$96.14
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	\$185.06*	\$33.52	\$151.54*	0267	\$151.54
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	\$118.23*	\$22.09	\$96.14*	0266	\$96.14
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and or retroperitoneal organs; complete study	\$240.28*	\$88.74	\$151.54*	0267	\$151.54
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and or retroperitoneal organs; limited study	\$209.81*	\$58.27	\$151.54*	0267	\$151.54
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts, complete study	\$183.91*	\$32.37	\$151.54*	0267	\$151.54
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study	\$117.85*	\$21.71	\$96.14*	0266	\$96.14
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	\$178.25	\$61.32	\$116.93	0267	\$151.54
93981	Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study	\$136.75	\$21.33	\$115.02	0267	\$151.54
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	\$108.71*	\$12.57	\$96.14*	0266	\$96.14
G0365	Vessel mapping of vessels for hemodialysis access (Services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)	\$163.73*	\$12.19	\$151.54*	0267	\$151.54
G0389	Ultrasound, real time with image documentation; for abdominal aortic aneurysm (AAA) screening.	\$115.40	\$28.18	\$87.22	0266	\$96.14

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*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.