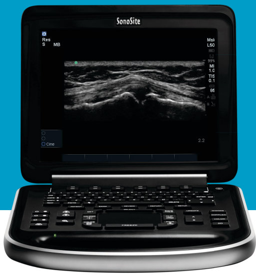

January 2014

Ultrasound Reimbursement Information

Emergency Medicine

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

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.

Site of Service Payment Rules

In the hospital emergency department setting, the physician who performs the interpretation of an ultrasound exam may submit a charge for the professional component of the ultrasound service, using a modifier -26 appended to the ultrasound code.

The facility will submit charges for the technical component of the ultrasound service. To do so, the facility and the physician must report the same CPT[1] code. In connection with the hospital's Medicare technical component services, the CPT code will be assigned to an APC (Ambulatory Payment Classification) and result in payment to the facility for the use of the ultrasound equipment as well as related labor and supplies.

In the hospital setting, physicians may not submit a "global" charge to Medicare, or otherwise bill Medicare for the technical component.

Under the Medicare Outpatient Prospective Payment system (OPPS) if a facility provides two or more imaging services that are categorized within a family of services on the same date of service, Medicare will assign those CPT codes to a composite APC and pay the facility a single payment regardless of the number of services provided. The services included in the ultrasound family are as follows:

Family 1 - Ultrasound	Code Description
76604	Ultrasound exam, chest
76700	Ultrasound exam, abdominal, complete
76705	Ultrasound exam, abdominal, limited
76770	Ultrasound exam, abdominal back wall complete
76775	Ultrasound exam, abdominal back wall limited
76776	Ultrasound exam, kidney transplant w/Doppler
76831	Ultrasound exam, uterus
76856	Ultrasound exam, pelvic, complete
76857	Ultrasound exam, pelvic, limited
76870	Ultrasound exam, scrotum

Under the Medicare Outpatient Prospective Payment System (OPPS) the technical components of image guidance procedures are listed as packaged services. When these services are provided in the outpatient department, the payment for the image guidance is included in the reimbursement for the underlying procedure. Please see payment chart on page 3 of this guide.

Private insurers typically have not implemented the Medicare APC payment method. Facilities are paid according to the type of contractual agreement between the insurer and the facility. Generally, these arrangements will not permit emergency medicine physician practices to bill the payer for the technical component of services.

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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.

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.

SonoSite's reimbursement staff suggests the following specific coding advice. (Complete descriptors for codes referenced in the following paragraphs are listed in the attached chart.)

- The recommended code for Focused Abdominal Sonography for Trauma (FAST) exam is the limited abdominal ultrasound code - 76705.
- To code for the evaluation of pain in the right upper quadrant, use the limited abdominal ultrasound code - 76705.
- If an ultrasound examination is used to evaluate an extremity for the presence of a foreign body, code 76882 is recommended.
- For ultrasound guidance of placement of a central venous catheter, use code +76937 - Ultrasonic guidance for vascular access. Using ultrasound to guide a pericardiocentesis is coded appropriately using 76930 - Ultrasonic guidance for pericardiocentesis.
- To assess a patient for pericardial fluid, code 93308, limited echocardiography, is recommended.
- Correct coding of female pelvic ultrasound studies depends upon whether the patient's pregnancy status is known prior to the ultrasound.
- If a patient is known to be pregnant prior to the ultrasound examination and the ultrasound is undertaken to determine some aspect of the pregnancy, such as whether the pregnancy is intrauterine or to check viability, use code 76815, limited ultrasound, pregnant uterus, transabdominal approach. If that same study is performed using a transvaginal technique, use code 76817.
- If pregnancy status is unknown and the ultrasound is completed to assess a non-obstetric, but pelvic condition, such as abnormal bleeding or pelvic pain, code 76857, limited pelvic ultrasound, would be appropriate. If the examination reveals that the patient is pregnant, 76857 is still the appropriate code, because the patient's pregnancy was not the cause for performing the ultrasound examination. 76830 - Ultrasound transvaginal should be used if the study described above is performed using the transvaginal technique.
- If an ultrasound examination is completed on a pregnant patient to evaluate conditions unrelated to pregnancy, the obstetrical codes would not be used in this instance, either.

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. 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.

		Medicare Physician Fee Schedule - National Average*	Hospital Outpatient Prospective Payment System (0PPS)†	
CPT Code	CPT Code Descriptor	Professional Payment	APC Code	APC Payment
76705	Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)	$29.73	0266	$134.57
76775	Ultrasound retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	$29.37	0266	$134.57
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	$32.60	0265	$90.05
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	$38.33	0265	$90.05
76830	Ultrasound, transvaginal	$35.11	0266	$134.57
76857	Ultrasound, pelvic (non-obstetric), or real time with image documentation; limited or follow-up (e.g., for follicles)	$19.34	0265	$90.05
76930	Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	$32.60	Packaged Service	No Payment
+76937	Ultrasonic guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real time ultrasound visualization of vascular needle entry, with permanent recording and reporting	$15.40	Packaged Service	No Payment
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection localization device), imaging supervision and interpretation	$34.03	Packaged Service	No Payment
93308	Echocardiography, transthoracic, real time with image documentation (2D)	$25.79	0697	$250.67

CPT® five digit codes, nomenclature and other data are Copyright 2013 American Medical Association. All rights reserved. No fee schedule, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

*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.

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[1]Current Procedural Terminology (CPT®) Copyright 2013 American Medical Association

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