SonoSite

January 2012

Ultrasound Reimbursement Information

Nephrology

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[1] 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).
- If the vascular ultrasound is performed by a sonographer, some Medicare Part B carriers require in the relevant Local Coverage Determination that the sonographer maintains one of the following credentials: Registered Vascular Specialist (RVS) provided by Cardiovascular Credentialing International (CCI), Registered Vascular Technologist (RVT) provided by The American Registry of Diagnostic Medical Sonographers (ARDMS) or Vascular Sonographer (VS) provided by The American Registry of Radiologic Technologists, Sonography (ARRT) (S). Alternatively the office would need to be credentialed under American College of Radiology (ACR) Vascular Ultrasound Accreditation Program or the Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL).
- 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 covered 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 ultrasound 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.

Nephrology

Medicare Reimbursement for AAA Screening

Medicare reimbursement rules for AAA screening are as follows:

- 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 2012 payment for the global service for CPT code G0389 is $112.12 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. Aetna's policy identifies the use of either CPT code 76770 – complete retroperitoneal ultrasound or CPT code 76775 – limited retroperitoneal ultrasound, as appropriate for the reporting of this service. 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 is suggested by SonoSite's reimbursement staff. (Complete descriptors for codes referenced in the following paragraphs are listed in the attached chart.)

- A kidney can be evaluated as a part of a larger exam, or by itself. If it is part of a larger exam, use the CPT code 76770 - Ultrasound, retroperitoneal e.g. renal, aorta, nodes, real time with image documentation; complete. According to CPT a complete ultrasound examination of the retroperitoneum consists of B mode scans of kidneys, abdominal aorta, common iliac artery origins, and inferior vena cava, including any demonstrated retroperitoneal abnormality. Alternatively, if clinical history suggests urinary tract pathology, complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound. Otherwise, a limited exam is reported with CPT code 76775. A limited study evaluates a single area or organ of interest.
- For the evaluation of a transplanted kidney with duplex report CPT code 76776, without duplex CPT code 76775.
- 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.
- 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.

Nephrology

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.

		Medicare Physician Fee Schedule – National Average*			Hospital Outpatient Prospective Payment System (OPPS)†	
CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
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
76776	Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation	$133.07‡	$36.76	$96.31‡	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	$0.00
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and or retroperitoneal organs; complete study.	$240.97‡	$88.84	$152.13‡	0267	$152.13
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and or retroperitoneal organs; limited study.	$211.36‡	$59.23	$152.13‡	0267	$152.13
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow).	$108.90‡	$12.59	$96.36‡	0266	$96.31
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).	$164.38‡	$12.25	$152.13‡	0267	$152.13

*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.