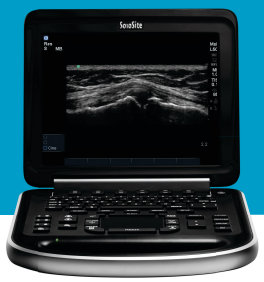

January 2014

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.

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.

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 Contractors 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 Contractor 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 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.

An evaluation and management (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.

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 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 for the ultrasound service. 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 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. 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 under the Hospital Outpatient Prospective Payment System (OPPS). Payment is based on the national unadjusted OPPS amounts for facilities. The actual payment will vary by location.

		Medicare Physician Fee Schedule - National Average*			Hospital Outpatient Prospective Payment System (0PPS)†	
CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
Obstetrical						
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks O days), trans abdominal approach; single or first gestation	$127.89	$49.79	$78.09	0266	$134.57
+76802	each additional gestation (List separately in addition to code for primary procedure)	$68.06	$42.27	$25.79	0265	$90.05
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks, 0 days), trans abdominal approach; single or first gestation	$147.95	$50.15	$97.80	0266	$134.57
+76810	each additional gestation (List separately in addition to code for primary procedure)	$98.15	$49.79	$48.36	0266	$134.57
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, trans abdominal approach; single or first gestation	$187.35	$96.72	$90.63	0267	$190.84
+76812	each additional gestation (List separately in addition to code for primary procedure)	$181.04‡	$90.99	$90.05‡	0265	$90.05
76813	Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, trans abdominal or transvaginal approach; single or first gestation	$121.51	$60.18	$62.33	0265	$90.05
+76814	each additional gestation (List separately in addition to code for primary procedure.)	$80.60	$50.51	$30.09	0265	$90.05
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	$91.35	$32.60	$58.75	0265	$90.05
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., revaluation 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), trans abdominal approach, per fetus	$117.86	$43.35	$74.51	0265	$90.05

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		Medicare Physician Fee Schedule - National Average*			Hospital Outpatient Prospective Payment System (0PPS)†	
CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
Obstetrical						
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	$102.81	$38.33	$64.48	0265	$90.05
76818	Fetal biophysical profile; with non-stress testing	$123.59	$53.73	$64.48	0266	$134.57
76819	Fetal biophysical profile; without non-stress testing	$90.63	$39.41	$51.23	0266	$134.57
76820	Doppler velocimetry, fetal, umbilical artery	$49.44	$25.43	$24.00	0265	$90.05
Non-Obstetrical						
76830	Ultrasound, transvaginal	$127.89	$35.11	$92.78	0266	$134.57
76831	Hysterosonography, with or without color flow Doppler	$125.38	$36.90	$88.48	0267	$190.84
76856	Ultrasound, pelvic (non-obstetric), real time with image documentation; complete	$125.74	$34.75	$90.99	0266	$134.57
76857	limited or follow-up (e.g., for follicles)	$54.45	$19.34	$35.11	0265	$90.05
Procedure Guidance						
76941	Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	No Payment	$70.93	No Payment	Packaged Service	No Payment
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$74.15	$34.03	$40.12	Packaged Service	No Payment
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation	No Payment	$35.11	No Payment	Packaged Service	No Payment
76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	$32.60	$19.34	$13.25	Packaged Service	No Payment
76948	Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	$33..32	$20.06	$13.25	Packaged Service	No Payment

*Federal Register December 10, 2013 †Federal Register December 10, 2013 ‡ Deficit Reduction Act of 2005 Adjustment

Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a conversion factor of $35.8228.

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.

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