

Reimbursement Information for Diagnostic Ultrasound and Ultrasound-guided Procedures¹ Performed by Emergency Medicine Physicians

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This overview addresses coding, coverage and payment for diagnostic ultrasound and related ultrasound guidance procedures commonly performed by emergency medicine physicians. While this advisory focuses on Medicare program policies, these policies may also be applicable to select private payers throughout the country. For appropriate code selection, contact your local payer prior to claims submittal.

Current Procedural Terminology (CPT) Coding, Definitions and Medicare Payment Rates

The following provides 2010 national Medicare physician fee schedule (MPFS) and hospital outpatient facility payment rates for the diagnostic ultrasound and related ultrasound guidance procedures CPT codes commonly performed by emergency medicine physicians. **Payment will vary by geographic regions.**

2010 Medicare reimbursement for diagnostic ultrasound and ultrasound-guided procedures commonly performed by emergency medicine physicians (reflects national rates, unadjusted for locality).

CPT ² /HCPCS Code	Physician	Facility	
	Medicare Physician Fee Schedule Amount ^{3*}	APC	Hospital Outpatient Payment ⁴
CPT 76604 Ultrasound, chest (includes mediastinum), real-time with image documentation	\$ 27.42	0265	\$ 62.47
CPT 76705 Ultrasound, abdominal, real-time with image documentation; limited (e.g., single organ, quadrant, follow-up)	\$ 29.59	0266	\$ 97.29
CPT 76775 Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real-time with image documentation; limited	\$ 29.95	0266	\$ 97.29
CPT 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	\$ 31.75	0265	\$ 62.47
CPT 76817 Ultrasound, pregnant uterus, real-time with image documentation, transvaginal	\$ 37.17	0265	\$ 62.47
CPT 76830 Ultrasound, transvaginal	\$ 34.28	0266	\$ 97.29
CPT 76857 Ultrasound, pelvic (nonobstetric), real-time with image documentation; limited or follow-up (e.g., for follicles)	\$ 19.85	0265	\$ 62.47

*Professional Component using a -26 modifier.

CPT ² /HCPCS Code	Physician	Facility	
	Medicare Physician Fee Schedule Amount ^{3*}	APC	Hospital Outpatient Payment ⁴
CPT 76870 Ultrasound exam, scrotum and contents	\$ 32.48	0266	\$ 97.29
CPT 76880 Ultrasound, extremity, nonvascular, real-time with image documentation	\$ 28.87	0266	\$ 97.29
CPT 76930 Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	\$ 35.36	N/A	Packaged service. No separate payment.
CPT +76937 Ultrasound 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 (list separately in addition to code for primary procedure)	\$ 15.52	N/A	Packaged service. No separate payment.
CPT 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	\$ 33.92	N/A	Packaged service. No separate payment.
CPT 93308 Echocardiography, transthoracic, real-time with image documentation (2D) with or without M-mode recording; follow-up or limited study	\$ 28.15	0697	\$ 264.39
CPT 93971 Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	\$ 23.45	0266	\$ 97.29
CPT 93976 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	\$ 61.34	0267	\$ 155.07

+ Indicates that the CPT code is considered an add-on code.

Add-on codes are reported in conjunction with the primary procedure and may not be reported as a stand-alone code.

*Professional Component using a -26 modifier.

Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Here are some common modifiers related to the use of ultrasound by emergency medicine physicians.

26-Professional Component

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

52-Reduced Services

When, under certain circumstances, a service is partially reduced or eliminated at the physician's discretion, the (-52) modifier is used.

76-Repeat Procedure by Same Physician

This modifier is defined as a repeat procedure by the physician on the same date of service or patient session. The CPT defines "same physician" as not only the physician doing the procedure but also as a physician of the same specialty working for the same medical group/employer.

77-Repeat Procedure by Another Physician

This modifier is defined as a repeat procedure by another physician on the same date of service or patient session. "Another physician" refers to a physician in a different specialty or one who works for a different group/employer. Medical necessity for repeating the procedure must be documented in the medical record in addition to the use of the modifier.

ICD-9-CM Diagnosis Coding

It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-9-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the ultrasound.

Medicare Multiple Imaging Payment Rules for Hospital Outpatient Facilities

The Centers for Medicare & Medicaid Services (CMS) has established five imaging composite Ambulatory Payment Classification (APC) groups, (APCs 8004, 8005, 8006, 8007, and 8008) that are based on the families of codes used for the multiple imaging procedure payment reduction policy under the Medicare Physician Fee Schedule (MPFS). Medicare provides a single APC composite payment when two or more imaging procedures using the same imaging modality are provided in a single session. The following chart lists the **ultrasound family of services**, which are paid under Medicare's Ultrasound Composite **APC 8004**.

Ultrasound Family (APC 8004)

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

A single payment would be made if an emergency department provides one or more imaging services that are categorized within the ultrasound family chart listed above and performed on the same date of service. The 2010 national average Medicare hospital outpatient **payment rate for the Ultrasound Composite (APC 8004) is \$191**.

Documentation Requirements

Ultrasound performed using either a compact portable ultrasound or a console ultrasound system are reported using the same CPT codes as long as the studies that were performed meet all the following requirements:

- Medical necessity as determined by the payer
- Completeness
- Documented in the patient's medical record

A separate **written** record of the diagnostic ultrasound or ultrasound-guided procedure must be completed and maintained in the patient record.⁵ This should include a description of the structures or organs examined, the findings, and reason for the ultrasound procedure(s).

Diagnostic ultrasound procedures require the production and retention of **image** documentation. It is recommended that permanent ultrasound images, either electronic or hardcopy, from all ultrasound services be retained in the patient record or other appropriate archive.

Payment Methodologies for Ultrasound Services

Medicare reimburses for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary. The following describes the various payment methods by site of service.

Site of Service

Hospital Emergency Department Setting (Outpatient)

When the ultrasound is performed in the hospital emergency department setting, physicians may not submit a "global" charge to Medicare because the global charge includes both the professional and technical components of the service.

If the patient is discharged from the emergency department then the emergency department may bill for the technical component of the ultrasound service as an outpatient service.

The CPT code filed by the emergency department will be assigned to a hospital outpatient system Ambulatory Payment Classification (APC) payment system, and payment will be based on the APC grouping. However, for Medicare, the hospital outpatient facility (emergency department) and the physician must report the same CPT code. If the physician is a hospital employee, the hospital may submit a charge for the global service.

Hospital Admittance (Inpatient)

If the patient is admitted as an inpatient, charges for the ultrasound services occurring in the emergency department setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services regardless. Medicare does not prohibit emergency medicine physicians from billing ultrasound CPT codes. However, the service must be medically necessary and within the scope of the physician's license. In some Medicare contractor jurisdictions, the physician who performs and/or interprets the study must be capable of demonstrating relevant training and experience. Contact your Medicare contractor for further details.

Based on the Medicare Hospital Outpatient Prospective Payment System (HOPPS), the technical components of all **image-guidance** procedures that are performed in the hospital outpatient department are considered a packaged service. This means that the payment to the facility for these services is included in the payment for the primary procedure.

Coverage

Use of diagnostic ultrasound and ultrasound-guided procedures may be a covered benefit if such usage meets all requirements established by the particular payer. However, for coverage of other indications, it is advisable that you verify coverage policies with your local Medical Contractor. Also, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record.

Coverage by private payers varies by payer and by plan with respect to which medical specialties may perform ultrasound services. Some private payer plans will reimburse ultrasound procedures performed by any physician specialist while other plans will limit ultrasound procedures to specific types of medical specialties. In addition, plans may require providers to submit applications requesting these diagnostic ultrasound and ultrasound-guided services be added to the list of services performed in their practice. It is important that you contact the payer prior to submitting claims to determine their requirements.

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- 1 Information presented in this document is current as of January 1, 2010. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.
- 2 Current Procedural Terminology © 2009 American Medical Association. All Rights Reserved. No fee schedules, 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.
- 3 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 74, No. 226, November 25, 2009 and the Federal Register, Vol. 74, No. 236, December 10, 2009, and updated as per Transmittal R1887CP, dated January 6, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
- 4 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in Federal Register, Vol. 74, No. 223, November 20, 2009. The professional component is generally paid based on the Medicare physician fee schedule, but for Category III CPT codes, local Medicare contractors determine the payment rate. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
- 5 Certain Medicare carriers require that the physician who performs and/or interprets some types of ultrasound examinations to prove that they have undergone training through recent residency training or post-graduate CME and experience. For further details, contact your Medicare Contractor.

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