GE Healthcare

Reimbursement Information for Diagnostic Musculoskeletal Ultrasound and Ultrasound-guided Procedures[1]

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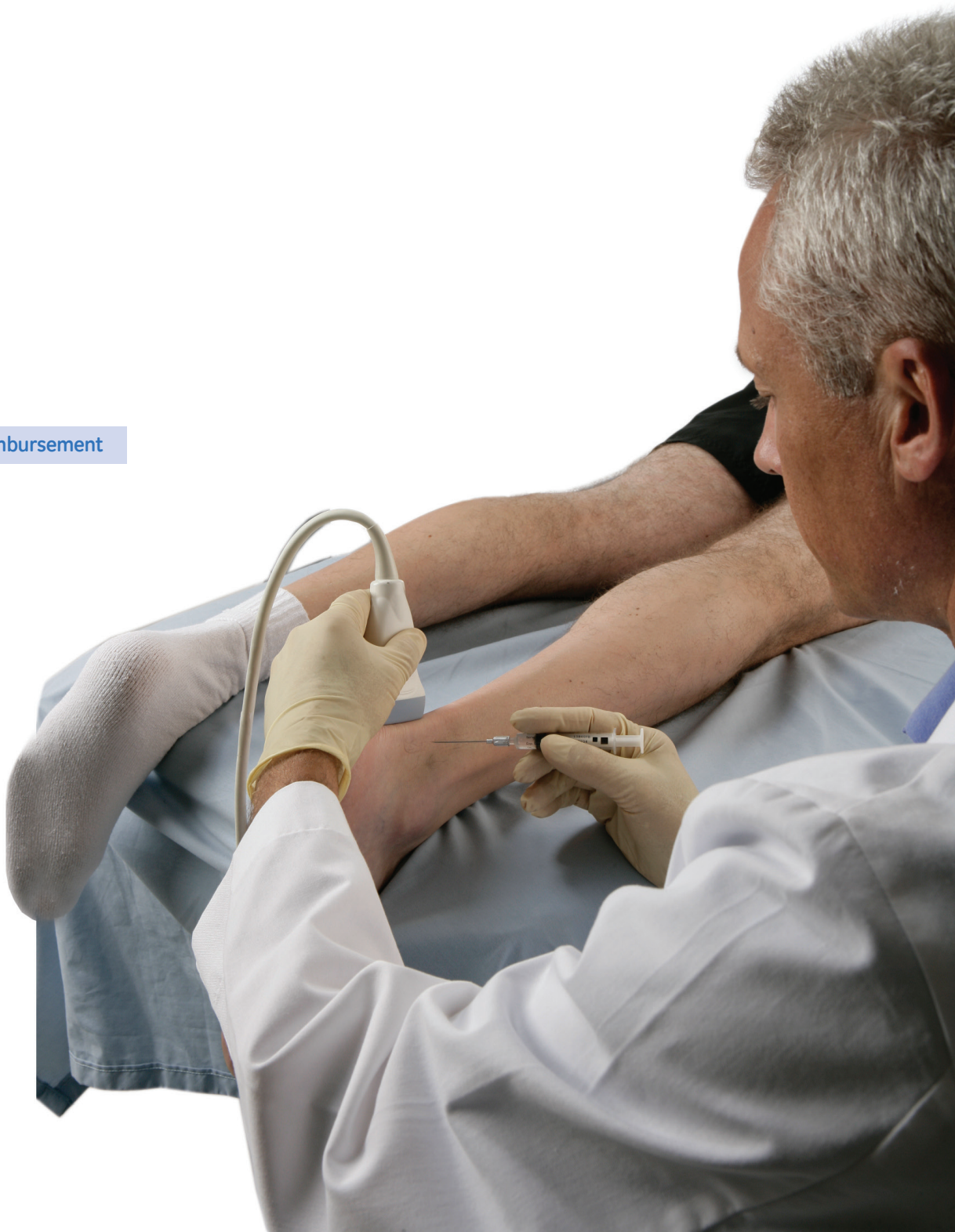

This overview addresses coding, coverage, and payment for diagnostic ultrasound and related ultrasound guidance procedures when performed in the hospital outpatient department and the physician office.[2] While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country. For appropriate code selection, contact your local payer prior to claims submittal.

Current Procedural Terminology (CPT)[3] Coding, Definitions and Medicare Payment Rates

The following provides 2013 national Medicare Physician Fee Schedule (MPFS), the Hospital Outpatient Ambulatory Payment Category (APC) and the Ambulatory Surgery Center (ASC) payment rates for the CPT codes identified in this guide. Payment rates reflect DRA-imposed payment reductions for services that are subject to the regulations. **Payment will vary in geographic locality.**

2013 Medicare reimbursement for procedures related to diagnostic musculoskeletal ultrasound and ultrasound guidance.

CPT/HCPCS Code	Physician		Facility		
Ultrasound Codes	Reimbursement Component	Medicare Physician Fee Schedule Payment[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
CPT 76942 Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Professional (-26)*	$ 32.66	N/A	Packaged Service. No separate payment.	Packaged Service. No separate payment.
	Technical (-TC)**	$ 175.90			
	Global	$ 208.56			
CPT 76881 Ultrasound, extremity, nonvascular, real time with image documentation; complete	Professional (-26)	$ 30.96	0266	$ 99.32	$ 55.73
	Technical (-TC)	$ 93.56			
	Global	$ 124.52			
CPT 76882 Ultrasound, extremity, nonvascular, real time with image documentation; limited, anatomic specific	Professional (-26)	$ 23.82	0265	$ 64.57	$ 8.25
	Technical (-TC)	$ 11.57			
	Global	$ 35.38			

* *Professional (-26) - The professional component is the interpretation of the results of the test. When the professional component is reported separately the service may be identified by adding modifier 26.*

** *Technical (-TC) - The technical component is the equipment and technician performing the test. This is identified by adding modifier "TC" to the procedure code identified for the technical component charge.*

CPT/HCPCS Code **Musculoskeletal Procedure Codes**	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount	APC	Hospital Outpatient Payment	Ambulatory Surgery Center
CPT 10022 Fine needle aspiration; with imaging guidance	Facility***	$ 64.64	0004	$ 345.52	$ 193.88
	Non-facility****	$ 141.20			
CPT 20552 Injection(s); single or multiple trigger point(s), one or two muscle(s)	Facility	$ 38.11	0204	$ 182.61	$ 22.75
	Non-facility	$ 55.80			
CPT 20553 Injection(s); single or multiple trigger point(s), three or more muscle(s)	Facility	$ 42.87	0204	$ 182.61	$ 27.00
	Non-facility	$ 64.98			
CPT 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)	Facility	$ 35.04	0204	$ 182.61	$ 16.50
	Non-facility	$ 47.29			
CPT 20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromicoclavicular, wrist, elbow or ankle, olecranon bursa)	Facility	$ 52.74	0204	$ 182.61	$ 20.75
	Non-facility	$ 65.66			
CPT 20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	Facility	$ 45.93	0204	$ 182.61	$ 21.50
	Non-facility	$ 60.56			
CPT 64999 Unlisted procedure, nervous system	Facility	Carrier Priced for Prof, Tech and Global	0204	$ 182.61	Not on approved ASC list - no payment associated with this code
	Non-facility				

**** Facility – is the payment made to the physician when the procedure is performed in a hospital or ASC.*

***** Non-facility – is the payment to the physician when the procedure is performed in the physician's office. Fields in this column populated with 'N/A' indicate that CMS has not developed a PE RVU in the non-facility setting for services because it is typically performed in the hospital setting. If there is an 'N/A' in the non-facility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.*

CPT/HCPCS Code **Category III CPT Codes**	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount	APC	Hospital Outpatient Payment	Ambulatory Surgery Center
CPT 0213T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level	Facility***	Carrier Priced^	0207	$ 565.75	$ 317.46
	Non-facility****	Carrier Priced			
CPT 0214T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)	Facility	Carrier Priced	0204	$ 182.61	$ 102.47
	Non-facility	Carrier Priced			
CPT 0215T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	Facility	Carrier Priced	0204	$ 182.61	$ 102.47
	Non-facility	Carrier Priced			
CPT 0216T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level	Facility	Carrier Priced	0207	$ 565.75	$ 317.46
	Non-facility	Carrier Priced			
CPT 0217T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)	Facility	Carrier Priced	0204	$ 182.61	$ 102.47
	Non-facility	Carrier Priced			
CPT 0218T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	Facility	Carrier Priced	0204	$ 182.61	$ 102.47
	Non-facility	Carrier Priced			

Category III Codes[7]

Category III codes are a set of temporary codes used to report emerging technology, services, and procedures; and allow for data collection for these services/procedures. If a Category III code exists for the procedure described, it must be reported instead of the unlisted CPT code from the Category I section. As with the unlisted CPT codes, CPT III codes do not have Relative Value Units (RVUs) associated with them.

CPT III codes sunset after five years if the code has not been accepted for placement in the Category I section of CPT, unless demonstrated that a Category III code is still needed.

**** Facility – is the payment made to the physician when the procedure is performed in a hospital or ASC.*
***** Non-facility – is the payment to the physician when the procedure is performed in the physician's office. Fields in this column populated with 'N/A' indicate that CMS has not developed a PE RVU in the non-facility setting for services because it is typically performed in the hospital setting. If there is an 'N/A' in the non-facility PE RVU column, and the contractor determines that this service can be performed in the non-facility setting, the service will be paid at the facility PE RVU rate.*
^Carrier Priced – this means that coverage and payment is determined by individual carrier.

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 for musculoskeletal procedures.

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

TC-Technical Component
This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

Hospital Inpatient – ICD-9-CM Procedure Coding

ICD-9-CM procedure codes are used to report procedures performed in a hospital inpatient setting. The following are the ICD-9-CM procedure codes that are typically used to report diagnostic ultrasound and related ultrasound-guided procedures commonly:

88.79 Other diagnostic ultrasound
88.78 Diagnostic ultrasound of gravid uterus

Limited vs. Complete Ultrasound

Complete and limited ultrasound studies are defined in the ultrasound introductory section notes of the CPT 2013 code book. According to CPT, the report should contain a description of all elements or the reason that an element could not be visualized. As stated in the guidelines, If less than the required elements for a 'complete' exam are reported (eg, limited number of organs or limited portion of region evaluated), the limited code for that anatomic region should be used once per patient exam session.[8]

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 ultrasound visualization procedure should be maintained in the patient record.[9] 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

Physician Office Setting

In the office setting, a physician who owns the ultrasound equipment and performs the service, or a sonographer who performs the service, may report the global code without a –26 modifier.

Hospital Outpatient or an Ambulatory Surgery Center (ASC)

When the ultrasound is performed in the hospital outpatient or in an ASC, 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 procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the ultrasound service as an outpatient service.

The CPT code filed by the hospital 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 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.

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 Medicare 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.

1 Information presented in this document is current as of January 1, 2013. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

2 The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

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4 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 the Federal Register (Vol. 77, No. 222/ November 16, 2012) and subsequent updates based upon legislation enacted by CMS. These changes are effective for services provided from 1/1/13 through 12/31/13. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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 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. The payment amounts indicated are based upon data elements published in the Federal Register Vol 77, No. 221 published on November 15, 2012. These changes are effective for services provided from 1/1/13 through 12/31/13. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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.

6 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. If the procedure is not listed on the ASC covered procedure listing, no technical or professional payment is listed. The technical payment is a payment amount assigned to an APC based payment rate under the ambulatory surgical center prospective payment system as published in Federal Register Vol 77, No. 221 published on November 15, 2012. These changes are effective for services provided from 1/1/13 through 12/31/13. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA.

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9 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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GE Healthcare
9900 Innovation Drive
Wauwatosa, WI 53226
U.S.A.

www.gehealthcare.com

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