GE Healthcare

Reimbursement Information for Diagnostic Ultrasound and Ultrasound-guided Procedures Performed in the Hospital ICU and CCU Settings[1]

January, 2013

www.gehealthcare.com/reimbursement

This overview addresses coding, coverage and payment for diagnostic ultrasound and ultrasound-guided procedures commonly performed in the hospital Intensive Care Unit (ICU) and Critical Care Unit (CCU) settings. 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)[2] Coding, Definitions and Medicare Payment Rates

The following provides 2013 national Medicare physician fee schedule (MPFS) and facility payment rates for example CPT codes that may be used. **Payment will vary by geographic regions.**

2013 Medicare reimbursement for procedures related to diagnostic ultrasound and ultrasound-guided procedures performed in the hospital ICU and CCU settings.

CPT/HCPCS Code	Reimbursement Component	Medicare Physician Fee Schedule Amount[3]
CPT 75989 Radiological guidance (e.g., fluoroscopy, ultrasound or computed tomography) for percutaneous drainage (e.g., abscess, specimen collection) with placement of catheter, radiological supervision and interpretation	Professional (-26)*	$ 56.48
CPT 76604 Ultrasound, chest (includes mediastinum), real time with image documentation	Professional (-26)	$ 26.54
CPT 76705 Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)	Professional (-26)	$ 28.24
CPT 76775 Ultrasound, retroperitoneal (e.g., renal, aorta, nodes) real time with image documentation; limited	Professional (-26)	$ 27.90
CPT 76930 Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	Professional (-26)	$ 31.30
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)	Professional (-26)	$ 14.63
CPT 76942 Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation	Professional (-26)	$ 32.66

(+ 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 (-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.*

CPT/HCPCS Code	Reimbursement Component	Medicare Physician Fee Schedule Amount
CPT 93304 Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	Professional (-26)	$ 36.06
CPT 93306 Echocardiography, transthoracic, real time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	Professional (-26)	$ 61.92
CPT 93307 Echocardiography, transthoracic, real time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	Professional (-26)	$ 44.23
CPT 93308 Echocardiography, transthoracic, real time with image documentation (2D), includes M-mode recording, when performed; follow-up or limited study	Professional (-26)	$ 24.84
CPT 93312 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report	Professional (-26)	$ 102.07
CPT 93313 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only	Facility**	$ 41.17
CPT 93314 Echocardiography, transesophageal, real time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only	Professional (-26)	$ 58.52
CPT 93318 Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	Professional (-26)	$ 109.55
CPT +93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	Professional (-26)	$ 18.03
CPT +93321 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	Professional (-26)	$ 7.14
CPT +93325 Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	Professional (-26)	$ 3.74
CPT 93971 Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	Professional (-26)	$ 21.77

(+ 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 (-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.*

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 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.

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.

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 ICD-9-CM procedure codes that are typically used to report ultrasound performed in the hospital ICU and CCU settings:

88.71 Diagnostic ultrasound of head and neck
88.72 Diagnostic ultrasound of heart
88.73 Diagnostic ultrasound of other sites of thorax
88.74 Diagnostic ultrasound of digestive system
88.75 Diagnostic ultrasound of urinary system
88.76 Diagnostic ultrasound of abdomen and retroperitoneum
88.77 Diagnostic ultrasound of peripheral vascular system
88.79 Other diagnostic ultrasound
88.90 Diagnostic imaging, not elsewhere classified

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.

Revenue Code

Revenue codes are used for facility billing of ultrasound services in the ICU and CCU settings. The revenue code that applies is **402 Other imaging services, ultrasound.**

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.[4]

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 for Ultrasound Services Performed in the Hospital Inpatient ICU or CCU

Charges for the ultrasound services occurring in the hospital inpatient 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. Note: Medicare may reimburses for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary.

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.

Disclaimer

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 Current Procedural Terminology © 2012 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 the Federal Register, Vol 77, No. 222 published on November 16, 2012 and subsequent updates based on 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.

4 CPT Copyright 2012 American Medical Association. All rights reserved.

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.

www.gehealthcare.com/reimbursement

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

www.gehealthcare.com

imagination at work

ULTP-0559-02.13-EN-US

DOC1160078