GE Healthcare

Reimbursement Information for Ultrasound-guided Vascular Access Device Placement Procedures[1]

January, 2013

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This overview addresses coding, coverage and payment for ultrasound guidance for the placement of a vascular access device. 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 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 by geographic locality.**

2013 Medicare reimbursement for procedures related to ultrasound-guided vascular access procedures.

CPT[2]/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[3]	APC	Hospital Outpatient Payment[4]	Ambulatory Surgery Center[5]
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	N/A	Packaged service. No separate payment.	Packaged service. No separate payment.
	Technical (-TC)**	$ 21.77			
	Global	$ 36.40			

(+ 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.*

** *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.*

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 guidance for the placement of a vascular access device.

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 is an ICD-9-CM procedure code that is typically used to report ultrasound guidance for the placement of a vascular access device:

88.79 Other diagnostic ultrasound

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.

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-guided procedure must be completed and maintained in the patient record.[6] 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 fee without a –26 modifier.

Hospital Outpatient Setting
When the ultrasound is performed in the hospital outpatient 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 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.

Hospital Inpatient Setting
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 reimburses for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary.

Coverage

Use of 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 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 11/16/12 Federal Register (Vol. 77, No. 222 / 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 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 in 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 make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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 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. The professional component is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published 11/16/12 in Federal Register (Vol. 77, No. 222 / 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 and subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

6 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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ULTP-0551-02.13-EN-US

DOC1160069