Ultrasound Reimbursement Information for Emergency Medicine

Payment Criteria

When the ultrasound device is being utilized for a documented appropriate medical necessity, is being performed by appropriately qualified providers, and meets all Medicare requirements including documentation and storage of images, it may be possible for it to be billed and considered for coverage and payment by a payer.

AMA policy on ultrasound imaging states that each hospital medical staff and medical practice should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty.

Documentation Requirements

Ultrasound performed using a pocket-sized device, hand held ultrasound, a compact portable or a console ultrasound system may be reported using the same CPT codes as long as the studies performed meet the requirements addressed above as well as 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 procedure(s) should be maintained in the patient record. This should include a description of the structures or organs examined, the findings, and reason for the ultrasound procedure(s). Images are to be labeled with patient identification, facility identification, examination date, the anatomical site imaged, transducer orientation and the initials of the operator. The use of ultrasound without a thorough evaluation of organ(s) or anatomical region, image documentation, and final written report is not separately reportable.

In order to be separately reportable, 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.

National Correct Coding Initiative Edits

The National Correct Coding Initiative (NCCI) sets correct coding methodologies for Medicare, as well as many other payers. Under the NCCI, one unit of service is allowed for CPT code 76942 in a single patient encounter regardless of the number of needle placements performed. Per NCCI, "The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.4

As of January 2017, Evaluation of an anatomic region and guidance for a needle placement procedure in that anatomic region by the same radiologic modality at the same or different patient encounter(s) on the same date of service are not separately reportable. For example, a physician should not report a diagnostic ultrasound CPT code and CPT code 76942

Konica Minolta Healthcare Americas, Inc.
411 Newark Pompton Turnpike
Wayne, NJ 07470 1-800-934-1034

(ultrasonic guidance for needle placement...) when performed in the same anatomic region on the same date of service. Physicians should not avoid these edits by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service. 5

Providers should review the NCCI to determine whether additional coding edits will apply to the services provided. The following chart provides payment information that is based on the national unadjusted Medicare physician's fee schedule for the ultrasound services. **Payment will vary by geographic region.**

Limited vs. Complete Ultrasound

Complete and limited ultrasound studies are defined in the ultrasound introductory section notes of the CPT 2011 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 (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.

Emergency Medicine Ultrasound CPT Codes and Descriptions

		2018 Medicare Physician Fee Schedule – National Average*	2018 Hospital Outpatient Prospective Payment System (0PPS)	
CPT Code	**Description**	**Professional Component**	**APC Code**	**APC Payment**
76604	Ultrasound, chest, (includes mediastinum) real time with image documentation.	$27.71	5522	$114.46
76705	Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)	$30.23	5522	$114.46
76775	Ultrasound retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	$29.51	5522	$114.46
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	$33.47	5522	$114.46
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	$38.87	5522	$114.46
76830	Ultrasound, transvaginal	$35.63	5522	$114.46
76857	Ultrasound, pelvic (non-obstetric), or real time with image documentation; limited or follow-up (e.g., for follicles)	$25.55	5522	$114.46

76930	Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	$33.83	Packaged Service	No Payment
+76937	Ultrasonic 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	$14.76	Packaged Service	No Payment
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection localization device), imaging supervision and interpretation	$33.11	Packaged Service	No Payment
93308	Echocardiography, transthoracic, real time with image documentation (2D)	$26.27	5523	$232.31

1. *Professional Component: use to estimate reimbursement to the physician.*
2. *Ambulatory Payment Classification (APC) codes and payments are used by Medicare to reimburse facilities for the technical component under the Hospital Outpatient Prospective Payment System (OPPS). Payment rates are also based on the national unadjusted Hospital OPPS amounts. The actual payment will vary by location.*

Konica Minolta Healthcare Americas, Inc.
411 Newark Pompton Turnpike
Wayne, NJ 07470 1-800-934-1034

*Source of Information: Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2018 release, RVU18A file

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU18A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending

Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a 2018 conversion factor of $35.99

†Source: CMS OPPS - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2018-January-Addendum-B.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

Disclaimer

'THE INFORMATION PROVIDED WITH THIS NOTICE DEALS ONLY WITH GENERAL REIMBURSEMENT ISSUES. IT IS NOT LEGAL ADVICE; NOT IS IT ADVICE ABOUT HOW TO CODE, COMPLETE, OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. IT IS ALWAYS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT THE PROPER CODES, CHARGES, MODIFIERS AND BILLS FOR THE SERVICES RENDERED. THIS INFORMATION IS PROVIDED AS OF JANUARY 2018 AND IS CURRENT AS OF THAT DATE. ALL CODING AND REIMBURSEMENT INFORMATION IS SUBJECT TO CHANGE WITHOUT NOTICE. ADDITIONALLY, PAYERS OR THEIR LOCAL BRANCHES MAY HAVE DISTINCT CODING AND REIMBURSEMENT REQUIREMENTS AND POLICIES. BEFORE FILING ANY CLAIM, PROVIDERS MUST VERIFY CURRENT REQUIREMENTS AND POLICIES WITH THE LOCAL PAYER. THIRD PARTY REIMBURSEMENT AMOUNTS AND COVERAGE POLICIES FOR SPECIFIC PROCEDURES WILL VARY BY PAYER, TIME PERIOD, LOCALITY AND THE TYPE OF PROVIDER. THIS DOCUMENT IS NOT INTENDED TO INFLUENCE IN ANY WAY A HEALTH CARE PROFESSIONAL'S INDEPENDENT CLINICAL DECISION MAKING. THE HEALTH CARE PROVIDER HAS THE RESPONSIBILITY, WHEN BILLING TO GOVERNMENT AND OTHER PAYERS (INCLUDING PATIENTS), TO SUBMIT CLAIMS OR INVOICES FOR PAYMENT ONLY FOR PROCEDURES WHICH ARE APPROPRIATE AND MEDICALLY NECESSARY. IF THERE IS ANY QUESTION AS TO WHETHER A CLAIM OR INVOICE IS APPROPRIATE, THE HEALTH CARE PROVIDER SHOULD CONSULT WITH THEIR REIMBURSEMENT MANAGER OR HEALTHCARE CONSULTANT AND EXPERIENCED LEGAL COUNSEL.'