This guide provides coverage and payment information for diagnostic ultrasound and ultrasound guided procedures most likely to be performed by emergency medicine physicians. SonoSite provides this information as a courtesy to assist providers in determining appropriate codes and other information for reimbursement purposes. It is the provider’s responsibility to determine and submit appropriate codes, modifiers, and claims for services rendered. SonoSite makes no guarantees concerning reimbursement or coverage. Please feel free to contact the SonoSite reimbursement staff if you have any questions at 1-888-482-9449 or send email to reimbursement@sonosite.com.

Emergency Medicine

Documentation Requirements

- All diagnostic ultrasound examinations, including those when ultrasound is used to guide a procedure, require permanently recorded images. Images can be stored as hardcopy or in electronic format. Documentation of the study must be available to the insurer upon request.
- A written interpretation of all ultrasound studies should be maintained in the patient’s record. In the case of ultrasound guidance studies, the written report may be filed as a separate item in the patient’s record or it may be included within the report of the procedure for which the guidance is utilized.

Third Party Insurance Payment Policies

- The “Original Medicare Plan,” also referred to as traditional Medicare Part B, will reimburse emergency medicine physicians for medically necessary diagnostic ultrasound services, provided the services are within the scope of the physician's license. Some Medicare Carriers require that the physician who performs and/or interprets some types of ultrasound examinations be capable of demonstrating relevant, documented training through recent residency training or post-graduate CME and experience. Contact your Medicare Part B Carrier for details.
- Payment policies for beneficiaries enrolled in Medicare Part C, known as the Medicare Advantage plans, will reflect those of the private insurance administrator. The Medicare Advantage plan may be either a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO).
- Private insurance payment rules vary by payer and plan with respect to which specialties may perform and receive reimbursement for ultrasound services. Some payers will reimburse providers of any specialty for ultrasound services while others may restrict imaging procedures to specific specialties or providers possessing specific certifications or accreditations. Some insurers require physicians to submit applications requesting ultrasound be added to their list of services performed in their practice.
- Contact your private payers before submitting claims to determine their requirements and request that they add ultrasound to your list of services.

Site of Service Payment Rules

- In the hospital emergency department setting, the physician who performs the interpretation of an ultrasound exam may submit a charge for the professional component of the ultrasound service, using a modifier (-26) appended to the ultrasound code.
- The facility will submit charges for the technical component of the ultrasound service. To do so, the facility and the physician must report the same CPT® code. In connection with the hospital’s Medicare technical component services, the CPT code will be assigned to an APC (Ambulatory Payment Classification) and result in payment to the facility for the use of the ultrasound equipment.
- Ultrasound systems are not eligible for additional pass-through payments under the Medicare Hospital Outpatient Prospective Payment System (OPPS).
- In the hospital setting, physicians may not submit a “global” charge to Medicare, or otherwise bill Medicare for the technical component.
- Under the Medicare Outpatient Prospective Payment System (OPPS) for 2008 the technical component of image guidance procedures are listed as packaged services. This means that when these services are provided in the outpatient department, the payment for the image guidance is included in the reimbursement for the underlying procedure. However, the technical component for diagnostic ultrasound services is separately reimbursed to the facility. Please see payment chart on page 3 of this guide.
- Private insurers typically have not implemented the Medicare APC payment method. Facilities are paid according to the type of contractual agreement between the insurer and the facility. Generally, these arrangements will not permit emergency department practices to bill the payer for the technical component services.
The information in this handout is intended to assist providers in determining appropriate codes and the other information for reimbursement purposes. It represents the information available to SonoSite as of the date listed above. Subsequent guidance might alter the information provided. SonoSite disclaims any responsibility to update the information provided. The only persons authorized by SonoSite to supply information regarding any reimbursement matter not reflected in a circular such as this are members of SonoSite’s reimbursement staff.

January 2008
Ultrasound Reimbursement Information

Emergency Medicine

Code Selection

Ultrasound services performed with hand-carried ultrasound systems are reported using the same ultrasound codes that are submitted for studies performed with cart-based ultrasound systems so long as the studies meet the requirements of medical necessity as set forth by the payer, the requirements of completeness for the code that is chosen and are documented in the patient's record.

It is the physician's responsibility to select the codes that accurately describe the service performed and the corresponding reason for the study. Under the Medicare program, the physician should select the diagnosis or ICD-9 code based upon the test results, with two exceptions. If the test does not yield a diagnosis or was normal, the physician should use the pre-service signs, symptoms and conditions that prompted the study. If the test is a screening examination ordered in the absence of any signs or symptoms of illness or injury, the physician should select “screening” as the primary reason for the service and record the test results, if any, as additional diagnoses.

SonoSite's reimbursement and coding advisors have suggested the following specific coding advice. (Complete descriptors for codes referenced in the following paragraphs are listed in the attached chart.)

- The recommended code for Focused Abdominal Sonography for Trauma (FAST) exam is the limited abdominal ultrasound code – 76705.
  This code is recommended since it is unlikely the physician will be doing a complete visualization of all the anatomical structures within the abdomen in this kind of examination.
- To code for the evaluation of pain in the right upper quadrant, use the limited abdominal ultrasound code – 76705.
- Correct coding of female pelvic ultrasound studies depends upon whether the patient's pregnancy status is known prior to the ultrasound. If a patient is known to be pregnant prior to the ultrasound examination and the ultrasound is undertaken to determine some aspect of the pregnancy, such as whether the pregnancy is intrauterine or to check viability, use code 76815, limited ultrasound, pregnant uterus, transabdominal approach. If that same study is performed using a transvaginal technique, use code 76817.
- If pregnancy status is unknown and the ultrasound is completed to assess a non-obstetric, but pelvic condition, such as abnormal bleeding or pelvic pain, code 76857, limited pelvic ultrasound, would be appropriate. If the examination reveals that the patient is pregnant, 76857 is still the appropriate code, because the patient's pregnancy was not the cause for performing the ultrasound examination.
- If an ultrasound examination is completed on a pregnant patient to evaluate conditions unrelated to pregnancy, the obstetrical codes would not be used in this instance, either.
- For ultrasound guidance of placement of a central venous catheter, use code +76937 – Ultrasonic guidance for vascular access. Using ultrasound to guide a pericardiocentesis is coded appropriately using 76930 – Ultrasonic guidance for pericardiocentesis.
- To assess a patient for pericardial fluid, code 93308, limited echocardiography, is recommended.
- If transvaginal approach is used for the study described above, use CPT code 76830.
Payment Information
The following chart provides payment information that is based on the national unadjusted Medicare physician fee schedule for the ultrasound services discussed in this guide. Payment will vary by geographic region. Use the "Professional Payment" column to estimate reimbursement to the physician for services provided in facility settings.

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.

<table>
<thead>
<tr>
<th>2008 CPT Code</th>
<th>CPT Code Descriptor</th>
<th>2008 Medicare Physician Fee Schedule – National Average*</th>
<th>Hospital Outpatient Prospective Payment System (OPPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>76705</td>
<td>Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)</td>
<td>$28.57</td>
<td>0266</td>
</tr>
<tr>
<td>76775</td>
<td>Ultrasound retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited</td>
<td>$28.18</td>
<td>0266</td>
</tr>
<tr>
<td>76815</td>
<td>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</td>
<td>$30.85</td>
<td>0265</td>
</tr>
<tr>
<td>76817</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, transvaginal</td>
<td>$35.42</td>
<td>0265</td>
</tr>
<tr>
<td>76830</td>
<td>Ultrasound, transvaginal</td>
<td>$33.14</td>
<td>0266</td>
</tr>
<tr>
<td>76857</td>
<td>Ultrasound, pelvic (non-obstetric), or real time with image documentation; limited or follow-up (e.g., for follicles)</td>
<td>$18.28</td>
<td>0265</td>
</tr>
<tr>
<td>76930</td>
<td>Ultrasound guidance for pericardiocentesis, imaging supervision and interpretation</td>
<td>$34.28</td>
<td>Packaged Service</td>
</tr>
<tr>
<td>76937</td>
<td>Ultrasonic guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting</td>
<td>$14.95</td>
<td>Packaged Service</td>
</tr>
<tr>
<td>76942</td>
<td>Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation</td>
<td>$32.37</td>
<td>Packaged Service</td>
</tr>
<tr>
<td>93308</td>
<td>Echocardiography, transthoracic, real time with image documentation (2D) with or without M-mode recording; limited</td>
<td>$27.42</td>
<td>0697</td>
</tr>
</tbody>
</table>

CPT® five digit codes, nomenclature and other data are Copyright 2007 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.


Reimbursement rates shown for payment of services under the Physician’s Fee Schedule reflect a conversion factor of $38.0870 as provided for in the Medicare, Medicaid, and SCHIP Extension Act of 2007, which was signed into law on December 29, 2007.