GE Healthcare

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

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This overview addresses coding, coverage, and payment for diagnostic ultrasound and related ultrasound-guided breast procedures. 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)[2] 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 ultrasound and related ultrasound-guided breast procedures.

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[3]	APC	Hospital Outpatient Payment[4]	Ambulatory Surgery Center[5]
CPT 76645 Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation	Professional (-26)*	$ 26.54	0265	$ 64.57	$ 36.23
	Technical (-TC)**	$ 64.57 DRA Capped			
	Global	$ 91.11 DRA Capped			
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 76998 Ultrasonic guidance, intraoperative	Professional (-26)	$ 63.96	N/A	Packaged service. No separate payment.	Packaged service. No separate payment.
	Technical (-TC)	Carrier Priced			
	Global	Carrier Priced			

* *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	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 19000 Puncture aspiration of cyst of breast	Facility	$ 42.87	0004	$ 345.52	$ 60.25
	Non-facility	$ 113.98			
CPT 19001 Puncture aspiration of cyst of breast; each additional cyst (list separately in addition to code for primary procedure)	Facility	$ 21.43	0002	$ 122.62	$ 7.75
	Non-facility	$ 26.54			
CPT 19100 Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	Facility	$ 69.07	0004	$ 345.52	$ 193.88
	Non-facility	$ 155.49			
CPT 19101 Biopsy of breast; open, incisional	Facility	$ 223.19	0028	$ 1862.77	$ 1045.25
	Non-facility	$ 351.46			
CPT 19102 Biopsy of breast; percutaneous, needle core, using imaging guidance	Facility	$ 100.37	0005	$ 625.24	$ 350.84
	Non-facility	$ 217.41			
CPT 19103 Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance	Facility	$ 188.15	0037	$ 1118.54	$ 627.64
	Non-facility	$ 565.46			
CPT 19290 Preoperative placement of needle localization wire, breast	Facility	$ 62.94	0340	$ 49.64 Packaged APC payment if billed on same date of service as a HCPCS code assigned status indicator S, T, V or X. (Q1 Status Indicator)	Packaged service. No separate payment.
	Non-facility	$ 159.91			
CPT 19295 Image-guided placement, metallic localization clip, percutaneous, during breast biopsy (list separately in addition to code for primary procedure)	Facility	$ N/A	0340	$ 49.64 Packaged APC payment if billed on same date of service as a HCPCS code assigned status indicator S, T, V or X. (Q1 Status Indicator)	Packaged service. No separate payment.
	Non-facility	$ 95.60			
CPT 60100 Biopsy thyroid, percutaneous core needle	Facility	$ 78.25	0004	$ 345.52	$ 39.75
	Non-facility	$ 112.28			
CPT 60300 Aspiration and/or injection, thyroid cyst	Facility	$ 49.33	0004	$ 345.52	$ 61.75
	Non-facility	$ 120.44			

*** *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.*[10]

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 breast procedures.

25-Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service

A physician may indicate that on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable evaluation and management (E/M) service above and beyond the other service provided.

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 the ICD-9-CM procedure code that is typically used to report ultrasound of the breast procedures:

88.73 Diagnostic ultrasound of other sites of thorax

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 diagnostic ultrasound or 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 may reimburse 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 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-guided** 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.

Ambulatory Surgery Center (ASC)

Under Medicare guidelines, payment for all image-guided procedures is packaged into the reimbursement for the underlying procedure. The cost of the ultrasound-guided service is incorporated into the charge for the underlying procedure. Therefore, this cannot be reported separately.

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 may reimburse 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 on 11/16/12 in the 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. Only national rates unadjusted for local wage and cost differences are provided. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in the Federal Register, Vol 77, No. 221 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). 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 in the Federal 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.

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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