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Reimbursement Information for Ultrasound-guided Procedures Performed by Anesthesiologists[1]

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This overview addresses coding, coverage, and payment for ultrasound guidance with continuous and single shot nerve blocks when performed in the hospital outpatient department, physician office and ambulatory surgery center setting.[2] In most instances, ultrasound guidance is performed by anesthesiologists. 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

Nerve Blocks and Ultrasound Guidance

Medicare may cover an anesthesia provider performing a nerve block. Each particular circumstance will require proper coding. When a catheter or nerve block is placed primarily for anesthesia administration during an operative session, only the anesthesia CPT code (0XXXX) is reported. If the catheter or nerve block is for post-operative pain control and is not placed as the anesthetic for a surgical procedure, both the anesthesia CPT code (0XXXX) and the CPT code for the pain management procedure (CPT codes 62318 or 62319 or a CPT code from the 644XX series) is reported. Some payers will require a modifier –59 *Distinct Procedural Service* appended to the pain management procedure. If ultrasound guidance is necessary to administer a nerve block, continuous or single injection, CPT code 76942 or +76937 may be reported. **For appropriate code selection, contact your payer prior to claims submittal.**

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 ultrasound guidance with continuous and single shot nerve blocks.[3]

CPT[4]/HCPCS Code **Ultrasound Guidance**	Physician		Facility	
	Reimbursement Component	Medicare Fee Schedule Amount[5, 6]	Hospital Outpatient[7] Payment	ASC[8] Payment Amount
CPT 76942 Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Professional (-26)*	$ 32.66	Packaged Service. No separate payment.	Packaged Service. No separate payment.
	Technical (-TC)**	$ 175.90		
	Global	$ 208.56		
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	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.*

CPT/HCPCS Code **Single-shot Nerve Blocks**	Physician			Facility	
	Reimbursement Component	Medicare Fee Schedule Amount	APC	Hospital Outpatient Payment	ASC Payment Amount
CPT 64413 Injection, anesthetic agent; cervical plexus	Facility***	$ 82.00	0206	$ 291.74	$ 54.00
	Non-facility****	$ 128.61			
CPT 64415 Injection, anesthetic agent; brachial plexus, single	Facility	$ 64.30	0206	$ 291.74	$ 163.70
	Non-facility	$ 121.12			
CPT 64417 Injection, anesthetic agent; axillary nerve	Facility	$ 70.43	0206	$ 291.74	$ 163.70
	Non-facility	$ 132.35			
CPT 64418 Injection, anesthetic agent; suprascapular nerve	Facility	$ 75.87	0206	$ 291.74	$ 70.25
	Non-facility	$ 145.28			
CPT 64445 Injection, anesthetic agent; sciatic nerve, single	Facility	$ 72.13	0207	$ 565.75	$ 60.50
	Non-facility	$ 139.15			
CPT 64447 Injection, anesthetic agent; femoral nerve, single	Facility	$ 64.98	0206	$ 291.74	$ 47.50
	Non-facility	$ 121.46			
CPT 64450 Injection, anesthetic agent; other peripheral nerve or branch	Facility	$ 45.25	0206	$ 291.74	$ 39.50
	Non-facility	$ 81.31			

The above table is not an all inclusive list of diagnostic or therapeutic injection/introduction of anesthetic agent CPT codes. It is your provider's responsibility to determine the applicable CPT code based on the information included in the individual patient's records. It is recommended to check with your payer for existing coverage determinations that instruct on applicable coding and coverage requirements.

Single-injection Lumbar Plexus Block

There is no specific code for single-injection lumbar plexus block in the 2013 edition of the CPT Manual published by the American Medical Association (AMA). However, the American Society of Regional Anesthesia (ASRA) January 2011 E-News, (www.asra.com/e-news.php), provides the following coding options for single-injection lumbar plexus block: 64520-Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic), 64450-Injection, anesthetic agent; other peripheral nerve or branch, and 64999-Unlisted procedure, nervous system. In addition, the use of 64483-Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level, is not recommended unless imaging with computed tomography (CT) or fluoroscopy is performed.[9]

*** *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]

CPT/HCPCS Code **Continuous Nerve Blocks**	Physician			Facility	
	Reimbursement Component	Medicare Fee Schedule Amount	APC	Hospital Outpatient APC Category and Payment	ASC Payment Amount
CPT 62318 Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	Facility***	$ 101.05	0207	$ 565.75	$ 317.46
	Non-facility****	$ 244.63			
CPT 62319 Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)	Facility	$ 97.65	0203	$ 856.68	$ 480.71
	Non-facility	$ 175.90			
CPT 64416 Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	Facility	$ 78.25	0207	$ 565.75	$ 317.46
	Non-facility	$ N/A			
CPT 64446 Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement)	Facility	$ 78.59	0207	$ 565.75	$ 317.46
	Non-facility	$ N/A			
CPT 64448 Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	Facility	$ 70.43	0207	$ 565.75	$ 317.46
	Non-facility	$ N/A			
CPT 64449 Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	Facility	$ 82.34	0207	$ 565.75	$ 317.46
	Non-facility	$ N/A			

The above table is not an all inclusive list of diagnostic or therapeutic injection/introduction of anesthetic agent CPT codes. It is your provider's responsibility to determine the applicable CPT code based on the information included in the individual patient's records. It is recommended to check with your payer for existing coverage determinations that instruct on applicable coding and coverage requirements.

*** *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.*

Transversus Abdominis Plane (TAP) Blocks

According to ASRA, while the current CPT book does not specify a code for TAP blocks, the table below lists possible suggestions for TAP block coding.[11]

CPT/HCPCS Code **Transversus Abdominis Plane (TAP) Blocks**	Physician			Facility	
	Reimbursement Component	Medicare Fee Schedule Amount	APC	Hospital Outpatient Payment	ASC Payment Amount
CPT 64425 Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	Facility***	$ 96.29	0206	$ 291.74	$ 52.50
	Non-facility****	$ 138.47			
CPT 64421 Injection, anesthetic agent; intercostal nerves, multiple, regional block	Facility	$ 95.94	0207	$ 565.75	$ 317.46
	Non-facility	$ 159.23			
CPT 64450 Injection, anesthetic agent; other peripheral nerve or branch	Facility	$ 45.25	0206	$ 291.74	$ 39.50
	Non-facility	$ 81.31			

*** *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.*

Paravetebral Blocks (PVB)

There are no longer specific CPT codes for PVB without image guidance. Category III codes for cervical/thoracic and lumbar/sacral PVB with ultrasound guidance became effective January 1, 2011. The codes are as follows:

CPT/HCPCS Code **Paravetebral Blocks (PVB)**	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount	APC	Hospital Outpatient Payment	ASC Payment Amount
CPT 0213T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level	Facility***	Carrier Priced^	0207	$ 565.75	$ 317.46
	Non-facility****	Carrier Priced			
CPT 0214T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)	Facility	Carrier Priced	0204	$ 182.61	$ 102.47
	Non-facility	Carrier Priced			
CPT 0215T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	Facility	Carrier Priced	0204	$ 182.61	$ 102.47
	Non-facility	Carrier Priced			
CPT 0216T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level	Facility	Carrier Priced	0207	$ 565.75	$ 317.46
	Non-facility	Carrier Priced			
CPT 0217T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)	Facility	Carrier Priced	0204	$ 182.61	$ 102.47
	Non-facility	Carrier Priced			
CPT 0218T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	Facility	Carrier Priced	0204	$ 182.61	$ 102.47
	Non-facility	Carrier Priced			

*** *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.*

^ *Carrier Priced – this means that coverage and payment is determined by individual carrier.*

Category III Codes

Category III codes[12] are a set of temporary codes used to report emerging technology, services, and procedures; and allow for data collection for these services/procedures. If a Category III code exists for the procedure described, it must be reported instead of the unlisted CPT code from the Category I section. As with the unlisted CPT codes, CPT III codes do not have Relative Value Units (RVUs) associated with them.

CPT III codes sunset after five years if the code has not been accepted for placement in the Category I section of CPT, unless demonstrated that a Category III code is still needed.

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 anesthesiologists.

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.

59-District Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

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 the ICD-9-CM procedure codes that are typically used to report diagnostic ultrasound and related ultrasound-guided procedures commonly performed by anesthesiologists:

88.79 Other diagnostic ultrasound
88.78 Diagnostic ultrasound of gravid uterus
03.90 Insertion of catheter into spinal canal for infusion of therapeutic or palliative substances
03.91 Injection of anesthetic into spinal canal for analgesia
03.92 Injection of other agent into spinal canal
04.81 Injection of anesthetic into peripheral nerve for analgesia

ICD-9-CM Diagnosis Coding

Because of the vast array of diagnoses related to the aforementioned procedures, please check with your payer regarding appropriate ICD-9-CM diagnosis code selection.

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 visualization procedure should be maintained in the patient record.[13] 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 - Ultrasound Services

Office

In the office setting, a physician, who owns the equipment and performs the ultrasound guidance, may report the global/non-facility code and report the CPT code without any modifier.

Hospital Outpatient or Ambulatory Surgery Center (ASC)

If the site of service is a hospital or an ASC and the anesthesia provider is performing the ultrasound guidance, the **–26 modifier** (professional service only) should be appended to the CPT code for the imaging service.

Based on the Medicare Outpatient Prospective Payment System (OPPS), the technical component of image guidance procedures that are performed in the hospital outpatient department or in the ASC 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.

Coverage

Use of ultrasound guidance with continuous and single shot nerve blocks may be a covered benefit if such usage meets all requirements established by the particular payer. 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 payers will reimburse ultrasound procedures to all specialties while other plans will limit ultrasound procedures to specific types of medical specialties. In addition, there are plans that require anesthesia providers to submit applications requesting these 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.

CRNA Providers

The final rule, which is in effect as of January 1, 2013, will allow CRNAs to bill Medicare directly for performing chronic pain management services such as nerve blocks, pain injections, and maintenance of implanted devices in states where medical scope-of-practice laws allow them to perform these services. For more information on this, please refer to the Federal Register Vol. 77, No. 222 dated Friday, November 16, 2012.

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 The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

3 Payment can be made for medical or surgical services provided by non-medically directed qualified anesthetists if they are allowed to furnish these services under state law.

4 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.

5 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 / 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 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. Federal Register, Vol. 75, No. 228 November 29, 2010, p. 73628.

7 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 under the hospital outpatient prospective payment system, as published in the 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. 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.

8 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 / November 15, 2012. The professional component is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published 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 any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

9 E-News January 2011, American Society of Regional Anesthesia and Pain Medicine. www.asra.com/e-news.php.

10 Federal Register, Vol. 75, No. 228 November 29, 2010, p. 73628.

11 ASRA E-News. http://www.asra.com/e-news.php?id=2

12 CPT is a registered trademark of the American Medical Association. Copyright 2012 - American Medical Association. All rights reserved. www.ama-assn.org/ama1/pub/upload/mm/362/cptcat3codes.pdf.

13 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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