GE Healthcare

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

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This overview addresses coding, coverage, and payment for diagnostic ultrasound and ultrasound-guided vascular 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 ultrasound-guided vascular procedures.**

| CPT/HCPCS Code | Physician | | Facility | | |
|---|---|---|---|---|---|
| | Reimbursement Component | Medicare Physician Fee Schedule Amount[3] | APC | Hospital Outpatient Payment[4] | Ambulatory Surgery Center[5] |
| **CPT 76942**<br>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**<br>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 | | | |
| **CPT 93880**<br>Duplex scan of extracranial arteries; complete bilateral study | Professional (-26) | $ 28.92 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 183.66 DRA CAPPED | | | |
| **CPT 93882**<br>Duplex scan of extracranial arteries; unilateral or limited study | Professional (-26) | $ 19.73 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 174.47 DRA CAPPED | | | |
| **CPT 93886**<br>Transcranial Doppler study of the intracranial arteries; complete study | Professional (-26) | $ 47.29 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 202.03 DRA CAPPED | | | |

* *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 93888**<br>Transcranial Doppler study of the intracranial arteries; limited study | Professional (-26)* | $ 30.96 | 0265 | $ 64.57 | Packaged service. No separate payment. |
| | Technical (-TC)** | $ 64.57 DRA CAPPED | | | |
| | Global | $ 95.53 DRA CAPPED | | | |
| **CPT 93925**<br>Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study | Professional (-26) | $ 38.79 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 193.53 DRA CAPPED | | | |
| **CPT 93926**<br>Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study | Professional (-26) | $ 24.50 | 0266 | $ 99.32 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 99.32 | | | |
| | Global | $ 123.82 | | | |
| **CPT 93965**<br>Noninvasive physiologic studies of extremity veins, complete bilateral study (e.g., Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography) | Professional (-26) | $ 17.01 | 0096 | $ 108.61 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 108.87 | | | |
| | Global | $ 125.89 | | | |
| **CPT 93970**<br>Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study | Professional (-26) | $ 34.36 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 189.10 DRA CAPPED | | | |
| **CPT 93971**<br>Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study | Professional (-26) | $ 21.77 | 0266 | $ 99.32 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 95.26 | | | |
| | Global | $ 117.04 | | | |
| **CPT 93975**<br>Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study | Professional (-26) | $ 87.44 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 242.18 DRA CAPPED | | | |
| **CPT 93976**<br>Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study | Professional (-26) | $ 58.52 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 213.26 DRA CAPPED | | | |

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** *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 93978**<br>Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study | Professional (-26) | $ 31.98 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 186.72 DRA CAPPED | | | |
| **CPT 93979**<br>Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study | Professional (-26) | $ 21.09 | 0266 | $ 99.32 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 99.32 DRA CAPPED | | | |
| | Global | $ 120.41 DRA CAPPED | | | |
| **CPT 93980**<br>Duplex scan of arterial inflow and venous outflow of penile vessels; complete study | Professional (-26)* | $ 60.22 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC)** | $ 104.11 | | | |
| | Global | $ 164.33 | | | |
| **CPT 93981**<br>Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study | Professional (-26) | $ 21.09 | 0267 | $ 154.74 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 91.52 | | | |
| | Global | $ 112.62 | | | |
| **CPT 93990**<br>Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow) | Professional (-26) | $ 12.25 | 0266 | $ 99.32 | Packaged service. No separate payment. |
| | Technical (-TC) | $ 99.32 DRA CAPPED | | | |
| | Global | $ 111.57 DRA CAPPED | | | |
| **CPT G0365**<br>Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow) | Professional (-26) | $ 12.25 | 0267 | $ 154.74 | $ 86.83 |
| | Technical (-TC) | $ 154.74 DRA CAPPED | | | |
| | Global | $ 166.99 DRA CAPPED | | | |

* *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.*

## Ultrasound Guidance of Saphenous Vein Ablation

Saphenous Vein Ablation procedures are described by the CPT codes 36457, +36476, 36478 and +36479 depending on the exact procedure performed. These codes are inclusive of imaging guidance. Therefore, ultrasound guidance of these procedures is not separately reportable. The recommended codes for perioperative extremity duplex procedures are 93970 and 93971. It is recommended to check with your local carrier for existing coverage policies as they can vary.

## 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 diagnostic ultrasound and ultrasound-guided vascular 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).

**53-Discontinued Procedure**

The physician may terminate a surgical or diagnostic procedure due to extenuating circumstances. Use this modifier to indicate a procedure was started, but discontinued.

## 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 ICD-9-CM procedure codes that are typically used to report diagnostic ultrasound procedures and ultrasound-guidance commonly performed in vascular procedures:

**00.21** Intravascular imaging of extracranial cerebral vessels
**00.22** Intravascular imaging of intrathoracic vessels
**00.23** Intravascular imaging of peripheral vessels
**00.25** Intravascular imaging of renal vessels
**00.28** Intravascular imaging, other specified vessel(s)
**00.29** Intravascular imaging, unspecified vessel(s)
**88.71** Diagnostic ultrasound of head and neck
**88.76** Diagnostic ultrasound of abdomen and retroperitoneum
**88.77** Diagnostic ultrasound of peripheral vascular system
**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.

## Limited vs. Complete Ultrasound

Complete and limited ultrasound studies are defined in the ultrasound introductory section notes of the CPT 2013 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 (e.g., 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.[6]

## 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.[7] This should include a description of the structures or organs examined, the findings, and reason for the ultrasound procedure(s). Duplex scans requires hard copy output of all data analysis, including bi-directional vascular flow or imaging when provided.

## 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-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.

#### 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 vascular 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 for 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

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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.

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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. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient 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 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 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. The professional component is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units as published in the Federal Register Vol 77, No. 222 published on 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.

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7 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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