Reimbursement Guidelines For Diagnostic Ultrasound Services By Portable Ultrasound Devices Performed By Primary Care Physicians

This guideline addresses coding, coverage, and payment for diagnostic ultrasound and related ultrasound guidance procedures when performed with the SONIMAGE P3 portable ultrasound device when by Primary Care Physicians. This guideline mainly focuses on Medicare program policies; however, these policies may also apply to selected private payers as well. It is always recommended to check with your payer for specific coding, coverage and payment requirements.

When using a hand held/portable diagnostic ultrasound device as an extension of the patient’s physical exam, this would be considered part of the Evaluation and Management (E/M) or office visit. It would not be appropriate to bill separately for the diagnostic ultrasound service. Please refer to the current CPT® coding manual for the E/M code series that would pertain to this type of service.

Diagnostic Ultrasound CPT Codes

The SONIMAGE P3 is a portable ultrasound system that may be utilized for diagnostic ultrasound services for various applications. The use of the SONIMAGE P3 may be billable in certain situations. The following CPT codes may be used to report possible diagnostic ultrasound imaging services when certain billing requirements are met:

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>76604</td>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
</tr>
<tr>
<td>76705</td>
<td>Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)</td>
</tr>
<tr>
<td>76775</td>
<td>Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited</td>
</tr>
<tr>
<td>76815</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses</td>
</tr>
<tr>
<td>76857</td>
<td>Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)</td>
</tr>
<tr>
<td>76882</td>
<td>Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific</td>
</tr>
</tbody>
</table>

93304    Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study
93308    Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study

Modifiers

CPT codes may be modified under certain circumstances to more accurately represent the service(s) rendered. Modifiers are used to add information or change the description of service in order to improve accuracy or specificity. The documentation of the service provided must support the use of the modifier. Below are common modifiers that may apply to the use of diagnostic ultrasound services:

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
Under certain circumstances, a charge may be made for the technical component alone. In this instance, the technical component charge is identified by adding modifier ‘TC’ to the CPT code. Technical component charges are institutional charges and not billed separately by physicians.

76-Repeat Procedure by Same Physician
This modifier indicates that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This may be reported by adding modifier 76 to the repeated procedure or service.

77-Repeat Procedure by Another Physician
This modifier indicates that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This may be reported by adding modifier 77 to the repeated procedure or service. Medical necessity for repeating the procedure must be documented and included in the medical record.
Billing Requirements

As mentioned above, if using a hand held/portable diagnostic ultrasound device as an extension of the patient's physical exam, it is important to note that this would be considered part of the Evaluation and Management (E/M) or office visit. It would not be appropriate to bill separately for the diagnostic ultrasound service. Please refer to the current CPT® coding manual for the E/M code series that would pertain to this type of service.

As with any diagnostic imaging service, a diagnostic ultrasound service that is performed with the SONIMAGE P3 must meet the applicable medical necessity as well as the specified requirements in place by Medicare. There are specific requirements that address documentation, storage of images, and qualifications of providers of diagnostic ultrasound services that are enforced by some Medicare contractors and that are recommended by the American Medical Association (AMA). The AMA has its own policy that addresses their opinions for what qualifies a physician to perform ultrasound imaging. This list can be found here http://www.ama-assn.org/resources/doc/PolicyFinder/policyfiles/HnE/H-230.960.HTM.

According to an article published by First Coast, a Medicare contractor, to be reimbursable by Medicare, a diagnostic ultrasound test must meet at least these minimum criteria (this is not an all-inclusive list):

• It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
• It is expected that these services would be performed as indicated by current medical literature and/or current standards of practice.
• It must be billed using the CPT® code that accurately describes the service performed including the intent of the code based on American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) established average intra service time and practice expense.
• The technical quality of the exam must be in keeping with accepted national standards and not require a follow-up ultrasound examination to confirm the results.
• The study must be done for an accepted clinical indication by a properly trained examiner and interpreted by qualified individuals within their scope of practice (weekend courses may not demonstrate expertise)
• The medical necessity, images, findings, interpretation and report must be documented in the medical record.
• An examination that does not meet the standards required for a complete diagnostic ultrasound examination will not be recognized as a valid diagnostic ultrasound service and will be non-covered.

Documentation Requirements

Ultrasound services that are performed using either a hand-carried ultrasound device or a portable ultrasound device may be 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.

Many ultrasound codes require the production and retention of image documentation. It is recommended that permanent images, either electronic or hardcopy, from all ultrasound services be retained in the patient record or some other archive, even in those instances where the CPT code descriptor does not specifically require it.

Limited vs. Complete Ultrasound Examinations

Certain CPT codes specify ‘complete’ or ‘limited’ examinations in their descriptions. According to AMA, a ‘limited’ examination is comprised of less than the required elements for a ‘complete’ examination. For example, if a limited number of organs or a limited portion of an organ are viewed and evaluated. The ‘limited’ code for that anatomic region should be used only once per patient exam session.
## Payment Rates

The following provides 2013 estimate National Average Medicare Physician Fee Schedule (MPFS) as well as National Average facility payment rates for the CPT codes identified above. Payment rates may vary based on geographic region.

2013 Medicare reimbursement for procedures related to diagnostic ultrasound services performed Primary Care Physicians (reflects national rates, unadjusted for locality).

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Reimbursement Component</th>
<th>Medicare Fee Schedule Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT 76604</td>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
<td>Professional</td>
<td>$26.54</td>
</tr>
<tr>
<td>CPT 76705</td>
<td>Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)</td>
<td>Professional</td>
<td>$28.24</td>
</tr>
<tr>
<td>CPT 76775</td>
<td>Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited</td>
<td>Professional</td>
<td>$27.90</td>
</tr>
<tr>
<td>CPT 76815</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses</td>
<td>Professional</td>
<td>$30.96</td>
</tr>
<tr>
<td>CPT 76857</td>
<td>Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)</td>
<td>Professional</td>
<td>$18.71</td>
</tr>
<tr>
<td>CPT 93304</td>
<td>Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study</td>
<td>Professional</td>
<td>$36.06</td>
</tr>
<tr>
<td>CPT 93308</td>
<td>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study</td>
<td>Professional</td>
<td>$24.84</td>
</tr>
</tbody>
</table>

## ICD-9-CM Diagnosis Codes

Because there are many different diagnoses related to the aforementioned procedures, it would be difficult to list them all here in this document. It is recommended that you check with your payer regarding appropriate ICD-9-CM diagnosis code selection.

## Coverage

Use of diagnostic ultrasound procedures may be a covered benefit if such usage meets all requirements established by the particular payer. Coverage requirements may vary by individual payers. Therefore, it is always recommended that you check with your local Medicare Payer to verify their individual requirements for coding, coverage and reimbursement. It is necessary that each claim be coded accurately and supported with documentation in the medical record.

Private payers coverage requirements for diagnostic ultrasound services will vary depending on the payer and on the individual plans. Some payers will reimburse ultrasound procedures to all specialties while other plans may limit ultrasound services to specific specialties. In addition, there are plans that require providers to submit applications requesting these services be added to the list of services performed in their practice. As stated throughout this document, it is advised that you contact the payer prior to submitting claims to determine their requirements.
Reimbursement Guidelines For Diagnostic Ultrasound Services By Portable Ultrasound Devices Performed By Primary Care Physicians (continued)

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1 Information presented in this document is current as of September 1, 2013. Any subsequent changes, which may occur in coding, coverage and payment, are not reflected herein.

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3 First Coast Local Coverage Article: Minimum criteria for reimbursement of diagnostic ultrasound tests (A52248) http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52248&ver=2&ContrId=197&ContrVer=1&SearchType=Advanced&CoverageSelection=Local&ArticleType=SAD%7cEd&PolicyType=-Final&ss=All&KeyWord=76604&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAABABABAAAA%3d%3d

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5 Federal Register / Vol. 77, No. 222 / Friday, November 16, 2012. The payment amounts indicated are based upon the Federal Register dated 11/16/12, and subsequent legislation and updates issued 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.

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