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SonoSite

January 2016

Ultrasound Reimbursement Information

Frequently Asked Questions

This guide provides general information for ultrasound reimbursement. SonoSite provides this information as a courtesy to assist providers. 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.

Are there separate CPT[1] codes for hand-carried ultrasound?

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 usual requirements are met. All ultrasound examinations must meet the requirements of medical necessity as set forth by the payer, must meet the requirements of completeness for the code that is chosen, and must be documented in the patients record regardless of the type of ultrasound equipment that is used.

What are the requirements for image documentation and reporting?

All diagnostic ultrasound examinations, including those when ultrasound is used to guide a procedure, require that permanently recorded images be maintained in the patient record. The images can be maintained in the patient record or some other archive - they do not need to be submitted with the claim. Images can be stored as printed images, on a tape or electronic medium. Documentation of the study must be available to the insurer upon request.

A written report of all ultrasound studies should be maintained in the patients record. In the case of ultrasound guidance studies, the written report may be filed as a separate item in the patients record or it may be included within the report of the procedure for which the guidance is utilized.

I am a physician, but not a radiologist; will I get reimbursed for providing ultrasound services?

Private insurance payment policies vary by payer and plan with respect to which specialties may perform ultrasound services. Some payers may restrict imaging procedures to specific specialties or providers with specific credentials only Contact your private payers before submitting claims to determine their requirements and request that they add ultrasound to your list of services.

Medicare does not differentiate by medical specialty with respect to billing 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 postgraduate CME and experience. Contact your Medicare Part B Carrier for details.

When I contact my private payers, what do I ask the Provider Representative to determine whether or not I can obtain payment for ultrasound services?

You need to ask the following questions (Have the list ready of ultrasound codes you will be reporting.)

- What do I need to do to have ultrasound added to my practices contract or list of services?
- Are there any specific training requirements that I must meet or credentials that I must obtain in order to be privileged to perform ultrasound in my office?
- Do I need to send a letter or can I submit the request verbally?
- Is there an application that must be completed?
- If there is a privileging program, how long will it take after submission of the application before we are accepted?
- What is the fee schedule associated with these codes?
- Are there any bundling edits in place covering any of the services I am considering performing? (Be prepared to provide the codes for any non-ultrasound services you will be performing in conjunction with the ultrasound services.)
- Are there any preauthorization requirements for specific

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Are there any specific certifications that the sonographer who performs the study needs to obtain?

Some Medicare Carriers require that sonographers performing non-invasive vascular or echocardiography studies be credentialed in those specific applications. Check the carriers website for those policies or contact your provider representative by telephone.

Some private payers have specific requirements as a part of an imaging privileging program or a diagnostic imaging accreditation program. Contact the provider representative for information.

If I take my ultrasound system to the hospital or an Ambulatory Surgery Center (ASC), can I submit a global charge or bill for technical component services?

Ultrasound codes are a combination of two components: the professional component and the technical component. The two components together make up the "global" service. The professional component indicated by appending the "-26" modifier includes the physician work such as a written interpretation and supervision of the ultrasound study The technical component indicated by appending the "-TC" modifier covers all costs associated with the actual performance of the study such as equipment, non-physician labor costs and supplies.

The physician cannot bill third party payers for technical services provided in the hospital or ASC setting. In these settings, the physician may only submit the professional component indicated by appending the -26 modifier to the ultrasound CPT code.

Private payer policies may be different - contact your payers directly for guidance on submitting claims for ultrasound services in this setting.

If I take my ultrasound system to a Skilled Nursing Facility (SNF) can I submit global charges for imaging services that I provide there?

You can bill the professional component of the imaging services directly to Medicare Part B. However; for Medicare patients admitted under a Part A stay you must bill the SNF for the technical component. Under the consolidated billing requirements, the SNF is responsible for providing, either directly or through contract with another provider; many of the medical services that a SNF patient requires. The physician should develop a contract with the SNF to outline the terms under which the SNF will pay for the services rendered that are included in the facility's consolidated billing.

Do I need to add any modifiers to the ultrasound codes for services provided in my office?

No modifiers are required for ultrasound studies performed in your office. In the office setting, a physician who owns the equipment and performs both components of the service him or herself or through an employed or contracted sonographer may report the global service, which is represented by the CPT code without any modifiers.

[1] Current Procedural Terminology (CPT®) Copyright 2015 American Medical Association.