GE Healthcare

Ultrasound Reimbursement Information for Anesthesiology[1]

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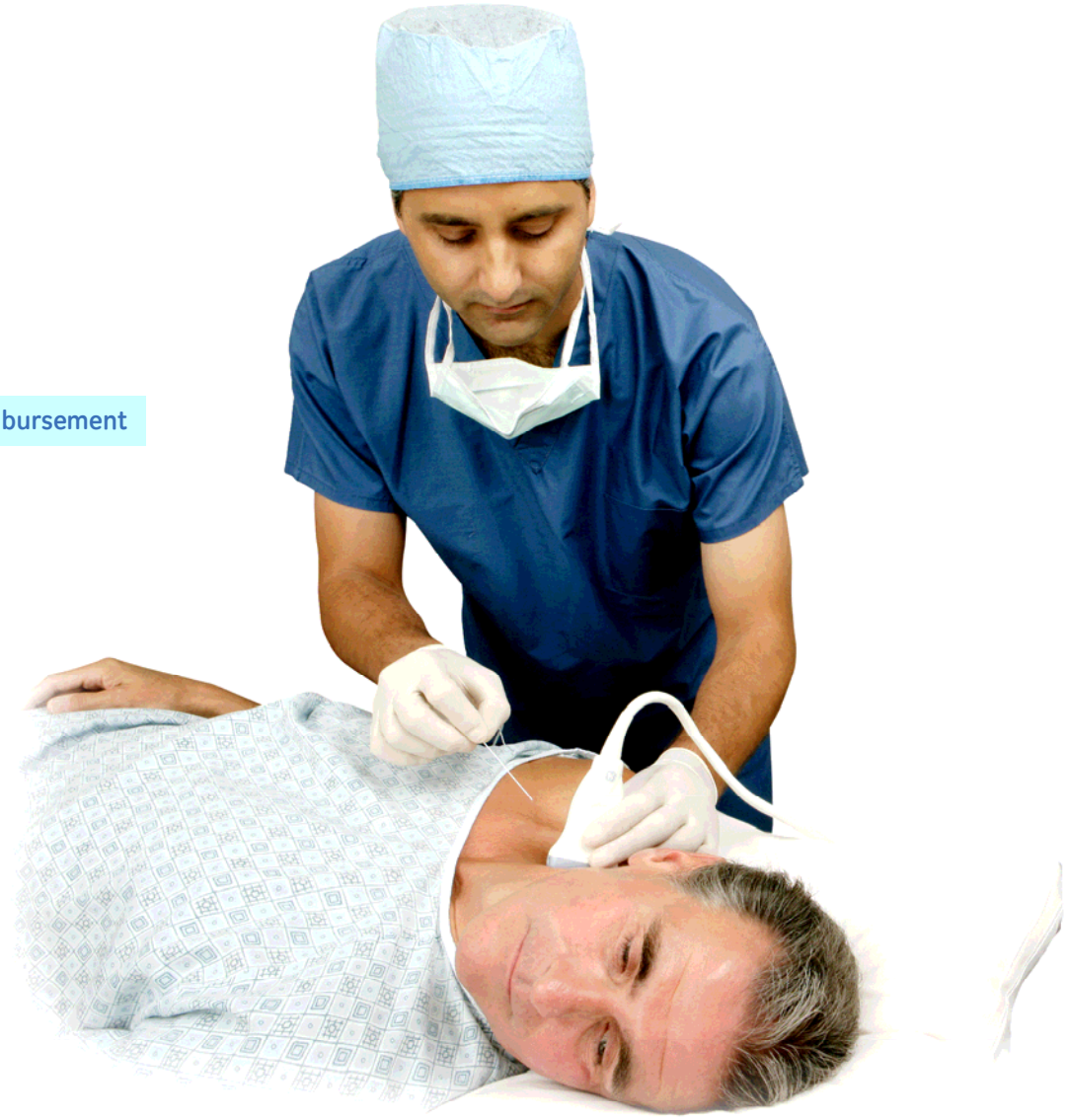

This overview addresses coding, coverage, and payment for ultrasound guidance with continuous and single shot nerve blocks when performed in the hospital outpatient department, physician office and ambulatory surgery center setting.[2] In most instances, ultrasound guidance is performed by anesthesiologists. While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

Current Procedural Terminology (CPT) Coding

Nerve Blocks

Medicare will cover an anesthesia provider performing a nerve block, but proper coding and payment for the procedure will depend on the particular circumstances. 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.

The following codes are examples of CPT codes for musculoskeletal procedures in which ultrasound guidance is used:

CPT[3] Code	Description
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substance, 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
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substance, 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)
64416	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)
64446	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement)
64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)
64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

The following codes are examples of CPT codes that may be used to report single shot nerve blocks:

64413	Injection, anesthetic agent; cervical plexus
64415	Injection, anesthetic agent; brachial plexus, single
64417	Injection, anesthetic agent; axillary nerve
64418	Injection, anesthetic agent; suprascapular nerve
64445	Injection, anesthetic agent; sciatic nerve, single
64447	Injection, anesthetic agent; femoral nerve, single

For appropriate code selection, contact your payer prior to claims submittal.

Ultrasound guidance

If ultrasound guidance is necessary to administer a nerve block, continuous or single injection, the following CPT code may be reported:

CPT Code	Description
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation.

For ultrasound guidance for the placement of a vascular access device, the following CPT code may be reported:

CPT Code	Description
+ 76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure).

Documentation Requirements

A separate written record of the ultrasound visualization procedure should be maintained in the patient record.[4]

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.

Payment Methodologies for Ultrasound Services

Medicare reimburses anesthesia providers 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 (inpatient, outpatient or emergency department) 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), beginning in 2008, 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.

Payment Changes Resulting from the Deficit Reduction Act[5] (DRA) of 2005

Effective January 1, 2007, Medicare capped the payment for the technical component (-TC) of imaging services billed under the physician's fee schedule. This applies to physician offices, freestanding imaging centers and independent diagnostic testing facilities (IDTF). The lesser of the reimbursement rate under the physician's fee schedule or the hospital outpatient prospective payment system will be the payment for the technical component.

Reimbursement

The following provides 2009 national physician Medicare fee schedule (MFS) and facility payment rates for the CPT codes identified earlier in this guide. Payment rates reflect DRA-imposed payment reductions for services that are subject to the regulations. **Payment will vary by geographic region.**

2009 Medicare reimbursement for procedures related to diagnostic musculoskeletal ultrasound guidance and ultrasound guidance (reflects national rates, unadjusted for geographic locality).[6]

CPT[7]/HCPCS Code	Physician Office		Facility	
	Reimbursement Component	Medicare Fee Schedule Amount[8]	Hospital Outpatient APC Category and Payment[9]	ASC Payment Amount[10]
CPT 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Global	$183.94	Packaged Service No separate payment	Packaged Service No separate payment
	Professional	$34.26		
	Technical	$149.68		
CPT 76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	Global	$36.79	Packaged Service No separate payment	Packaged Service No separate payment
	Professional	$15.87		
	Technical	$20.92		
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	$95.58	**APC 0207:** Level III Nerve Injections **$473.78**	$307.09
	Non-facility	$212.79		
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	$89.45	**APC 0207:** Level III Nerve Injections **$473.78**	$307.09
	Non-facility	$192.60		

* Technical- is the facility payment

**Professional- is the physician payment

***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

CPT[7]/HCPCS Code	Physician		Facility	
	Reimbursement Component	Medicare Fee Schedule Amount[8]	Hospital Outpatient[9] APC Category and Payment	ASC[10] Payment Amount
CPT 64416 Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	Facility	$89.45	**APC 0207:** Level III Nerve Injections **$473.78**	$289.48
	Non-facility	N/A		
CPT 64446 Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement)	Facility	$88.00	**APC 0203:** Level IV Nerve Injections **$949.39**	$580.08
	Non-facility	N/A		
CPT 64448 Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	Facility	$77.90	**APC 0206:** Level II Nerve Injections **$241.11**	$147.32
	Non-facility	N/A		
CPT 64449 Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	Facility	$86.56	**APC 0207:** Level III Nerve Injections **$473.78**	$289.48
	Non-facility	N/A		
CPT 64413 Injection, anesthetic agent; cervical plexus	Facility	$71.41	**APC 0206:** Level II Nerve Injections **$241.11**	$51.94
	Non-facility	$105.31		
CPT 64415 Injection, anesthetic agent; brachial plexus, single	Facility	$69.25	**APC 0206:** Level II Nerve Injections **$241.11**	$141.43
	Non-facility	$119.74		
CPT 64417 Injection, anesthetic agent; axillary nerve	Facility	$68.89	**APC 0206:** Level II Nerve Injections **$241.11**	$141.43
	Non-facility	$121.18		
CPT 64418 Injection, anesthetic agent; suprascapular nerve	Facility	$68.17	**APC 0206:** Level II Nerve Injections **$241.11**	$72.85
	Non-facility	$122.99		
CPT 64445 Injection, anesthetic agent; sciatic nerve, single	Facility	$75.38	**APC 0206:** Level II Nerve Injections **$241.11**	$67.44
	Non-facility	$124.43		
CPT 64447 Injection, anesthetic agent; femoral nerve, single	Facility	$66.00	**APC 0206:** Level II Nerve Injections **$241.11**	$147.32
	Non-facility	N/A		

*Technical- is the facility payment

**Professional- is the physician payment

***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

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 plan 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.

[1] Information presented in this document is current as of January 1, 2009. 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] CPT codes and descriptions only are copyright © 2008 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

[4] 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.

[5] Federal Register/Vol. 71, No. 231/Friday, December 1, 2006.

[6] 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.

[7] Current Procedural Terminology © 2008 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.

[8] 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 Federal Register, Vol. 73, No. 224, November 19, 2008. 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] 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. 73, No. 223, November 18, 2008. 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.

[10] 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. If the procedure is listed on the ASC covered procedure listing, the technical payment is a payment amount assigned to an APC based payment rate under the ambulatory surgical center prospective payment system published in Federal Register, Vol. 73, No. 223, November 18, 2008. 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. 73, No. 224, November 19, 2008. 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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9900 West Innovation Drive,
Wauwatosa, WI 53226
U.S.A.

www.gehealthcare.com

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