

Anesthesiology

This guide offers information about coverage and payment for diagnostic ultrasound and ultrasound guided procedures related to anesthesiology. The information is meant to help determine appropriate codes and other information for reimbursement. Ultrasonix Medical Corporation makes no guarantees concerning reimbursement or coverage; it is the provider's responsibility to confirm and submit appropriate codes, modifiers and claims for services provided.

Suggested Codes

Procedure	Suggested Code
Ultrasound guidance for a nerve block	Ultrasonic guidance for needle placement, imaging supervision and interpretation: 76942
Ultrasound guidance for vascular access	Ultrasonic guidance of vascular access: +76937

Payment Information

		2011 Medicare Physician Fee Schedule – National Avg			Hospital Outpatient Prospective Payment System (OPPS)	
2011 CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	2011 APC Code	2011 APC Payment
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration injection, localization device), imaging supervision and interpretation	\$198.08	\$33.64	\$164.45	Packaged Service	No Payment
+76937	Ultrasonic 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	\$35.00	\$15.29	\$19.71	Packaged Service	No Payment

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Payment Information Con't

		2011 Medicare Physician Fee Schedule – National Average		Hospital Outpatient Prospective Payment System (OPPS)	
2011 CPC Code	CPT Code Descriptor	Non-Facility Payment	Facility Payment	2011 APC Code	2011 APC Payment
64413	Injection, anesthetic agent; cervical plexus	\$118.58	\$78.83	0206	\$267.40
64415	Injection, anesthetic agent; brachial plexus, single	\$122.32	\$67.27	0206	\$267.40
64417	Injection, anesthetic agent; axillary nerve	\$128.43	\$69.65	0206	\$267.40
64418	Injection, anesthetic agent; suprascapular nerve	\$136.92	\$73.39	0206	\$267.40
64420	Injection, anesthetic agent; intercostal nerve, single	\$135.91	\$66.59	0206	\$267.40
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block	\$195.36	\$91.74	0207	\$522.67
64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves	\$130.47	\$94.11	0206	\$267.40
64445	Injection, anesthetic agent; sciatic nerve, single	\$133.53	\$75.43	0207	\$522.67
64446	Nerve block injection, sciatic continuous infusion	\$82.56	\$85.56	0207	\$522.67
64447	Injection, anesthetic agent; femoral nerve, single	\$118.92	\$65.91	0206	\$267.40
64448	Nerve block injection, femoral continuous infusion	\$73.39	\$73.39	0207	\$522.67

This chart provides payment information based on the national unadjusted Medicare physician fee schedule for ultrasound services described. Payment will vary by geographic region. The column entitled "Global Payment" may be used to estimate reimbursement for services in a physician's office setting. The "Professional Payment" column may be used to estimate reimbursement for services provided by a physician in facility settings.

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Documentation Requirements

Permanently recorded images must be maintained in the patient record for all ultrasound examinations, including diagnostic and those when ultrasound is used to guide a procedure. Images can be stored as printed images, on a tape or electronic medium and kept in the patient record or some other archive (they are not required to be submitted with the claim). Documentation of the study must be available to the insurer when requested.

A written report of all ultrasound studies should be maintained in the patient's record. For ultrasound guidance procedures, the written report may be filed as a separate item in the patient's record or it may be included within the report of the procedure for which the guidance is used.

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Payment Policies for Ultrasound Services

Medicare Part B will reimburse anesthesiologists for medically necessary diagnostic ultrasound services, provided the services are within the scope of the physician's license. Some Medicare Carriers require the physician who performs and/or interprets some types of ultrasound examinations can demonstrate relevant, documented training through recent residency training or post-graduate CME and experience. Please contact your Medicare Part B Carrier for details.

Private insurance payment rules about which specialties may perform and receive reimbursement for ultrasound services vary by payer and plan. Some payers will reimburse providers of any specialty for ultrasound services while others may restrict imaging procedures to specific specialties or providers possessing specific certifications or accreditations. Some insurers require physicians to submit applications requesting ultrasound exams and procedures be added to their list of services performed in their practice. **It is important to contact your private payers before submitting claims to determine their requirements and request that they add ultrasound to your list of services.**

Site of Service – Code Selection

In an office setting, a physician who owns the equipment and personally performs the ultrasound exam or guidance or performs it through an employed or contracted sonographer, may report the global/non-facility code and report the CPT code without any modifier.

If the site of service is the hospital, the –26 modifier, indicating the professional service only was provided, must be added by the physician to the CPT code for the ultrasound service. Payers will not reimburse physicians for the technical component in the hospital setting.

If billing for a biopsy or injection procedure on the same day as an office visit, add modifier -25 to the office visit code to indicate a "significant, separately identifiable evaluation and management service." However, this modifier is not to be used routinely. The E&M service must be "...above and beyond the usual preoperative and postoperative care associated with the procedure that was performed." (CPT Assistant, May 2003.) Be sure to document in the patient's record all components of the E&M service.

Regardless of the type of ultrasound equipment that is used, all ultrasound examinations must:

1. Meet the requirements of medical necessity as set forth by the payer
2. Meet the requirements of completeness for the code that is chosen
3. Be documented in the patient's record

It is the physician's responsibility to select the codes that accurately describe the service performed and the corresponding reason for the study. Under the Medicare program, the physician should select the diagnosis or ICD-9 code based upon test results, with two exceptions. If the test does not yield a diagnosis or was normal, the physician should use the pre-service signs, symptoms and conditions that prompted the study. If the test is a screening examination ordered in the absence of any signs or symptoms of illness or injury, the physician should select "screening" as the primary reason for the service. If there are test results, they should be recorded as additional diagnoses.

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