

University of Florida Critical Care Ultrasound Curriculum (Updated 5/1/17)

Billing/Coding:

The goal of this document is to show what billing codes we can use and what is required on the documentation form to be able to bill for a particular procedure.

Current Procedural Terminology = CPT

Sometimes the CPT code is an “add-on” code, which means it is billed in conjunction with the procedure for the type of procedure done, which typically includes codes in the 36555-36585 range.

Practitioners must provide documentation via the physical examination to support diagnostic scans as well. While the medical record or ultrasound report is not submitted with the claim, third party payors may request to review this material at any time. Meticulous documentation is required to support claims and, in case of an audit, to avoid refunds and/or penalties. In all reporting of ultrasound services in the hospital setting, the physician’s professional service is identified by appending the -26 modifier to the appropriate CPT code, i.e., 36556, 76937-26. This indicates to the payers that you have provided the professional component of the ultrasound service, which encompasses the supervision and interpretation elements (see after table for more info on coding).

CPT Code and description	Medicare Physician Fee Schedule Amount
CPT 76937: Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting	15.52
CPT 76604: Ultrasound, chest (includes mediastinum), real time with image documentation	27.42
CPT 76942: Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation This is billed with either: 32421 - Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent OR 32422 -Thoracentesis, with insertion of tube, includes water seal (e.g., for pneumothorax), when performed (separate procedure)	33.92

<p>CPT 75989: Radiological guidance (i.e., fluoroscopy, ultrasound or computed tomography) for percutaneous drainage (e.g., abscess, specimen collection)</p> <p>This is billed with either: 32550 – Insertion of indwelling tunneled pleural catheter with cuff <i>OR</i> 32551 – Tube thoracostomy, includes water seal (e.g., for abscess, hemothorax, empyema), when performed (separate procedure)</p>	60.26
CPT 76705: Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)	29.59
CPT 76775: Ultrasound, retroperitoneal (e.g., renal, aorta, nodes) real time with image documentation; limited	29.95
CPT 76930: Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation	35.36
CPT 93308: Echocardiography, transthoracic, real time with image documentation (2D), includes M-mode recording, when performed; follow-up or limited study	28.15
CPT 93313: Echocardiography, transesophageal; real time with image documentation (2D) (with or without M mode recording); placement of transesophageal probe only (facility)	41.5
CPT 93314: Echocardiography, transesophageal; real time with image documentation (2D) (with or without M mode recording); image acquisition, interpretation, and report only	64.59
CPT 93318: Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2 dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis	115.11
CPT 93971: Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	23.45

32554 : thoracentesis without ultrasound

32555: thoracentesis with ultrasound

32556: pleural drainage with indwelling cath without ultrasound

32557: pleural drainage with indwelling cath with ultrasound

If image guidance is used 75989 with modifier 26 should be use

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 ultrasound procedures.

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.

52-Reduced Services

When, under certain circumstances, a service is partially reduced or eliminated at the physician's discretion, the (-52) modifier is used.

76-Repeat Procedure by Same Physician

This modifier is defined as a repeat procedure by the physician on the same date of service or patient session. The CPT defines "same physician" as not only the physician doing the procedure but also as a physician of the same specialty working for the same medical group/employer.

77-Repeat Procedure by Another Physician

This modifier is defined as a repeat procedure by another physician on the same date of service or patient session. "Another physician" refers to a physician in a different specialty or one who works for a different group/employer. Medical necessity for repeating the procedure must be documented in the medical record in addition to the use of the modifier.

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 ultrasound performed in the hospital ICU and CCU settings:

88.71 Diagnostic ultrasound of head and neck

88.72 Diagnostic ultrasound of heart

88.73 Diagnostic ultrasound of other sites of thorax

88.74 Diagnostic ultrasound of digestive system

88.75 Diagnostic ultrasound of urinary system

88.76 Diagnostic ultrasound of abdomen and retroperitoneum

88.77 Diagnostic ultrasound of peripheral vascular system

88.79 Other diagnostic ultrasound

88.90 Diagnostic imaging, not elsewhere classified

Revenue Code

Revenue codes are used for facility billing of ultrasound services in the ICU and CCU settings. The revenue code that applies is **402 Other imaging services, ultrasound.**

Payment for Ultrasound Services Performed in the Hospital Inpatient ICU or CCU

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 reimburses for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary.

References:

<http://www.sonosite.com/sales/reimbursement>

http://emergencyultrasoundteaching.com/assets/us_coding.pdf

http://www.healthcare.philips.com/pwc_hc/us_en/support/assets/Reimbursement_ICU_CCU_L2.pdf