Minimum criteria for reimbursement of diagnostic ultrasound tests

First Coast Service Options Inc. (First Coast) recognizes that the miniaturization of electronic devices and advances in technology will lead to the increasing availability of certain real time images to clinicians. Such images may or may not be associated with improved test performance and added value to diagnostic/therapeutic interventions. These evolving devices can range in complexity and capability from lightweight pocket-sized units completely contained within the examiner’s hand to complex equipment systems where only the probe itself is hand-held.

The appropriate assignment of a specific ultrasound Current Procedural Terminology (CPT®) code(s) is not determined by the weight, size or portability of the equipment, but rather by the extent, quality and documentation of the procedure. While Medicare does not endorse any particular machine or device, professional organizations are available to address the functionality of particular machines and accredit laboratories that perform ultrasound studies. CPT® has guidelines addressing radiology coding and descriptors for procedures please see the 2013 CPT® book, radiology section, subsection, diagnostic ultrasounds page(s) 394-395. According to CPT® standards physicians and allied personnel are required to code to specificity and should only submit codes that are clearly separately reportable.

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.

Studies that do not meet these minimum criteria, regardless of the equipment used, should not be billed under diagnostic ultrasound codes or other CPT® codes. For example:

- An emergency room “quick look” ultrasound to assess the chest for the presence of fluid, etc., may be useful as an extension of the physical examination. However, it does not meet the above standards and should not be coded as CPT® code 76604 (Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation).

Interventional pain management procedures address a range of interventions, some with X-ray based imaging included in the procedure or separately coded when indicated. There are certain scenarios in which First Coast may or may not cover ultrasound imaging for CPT® code 76942 (Ultrasound guidance for needle placement (eg, biopsy, aspiration, injection, localization device, imaging supervision and interpretation)) in the following clinical instances (this is not an all-inclusive list). For example:

- An orthopedic surgeon, rheumatologist, or other physician/NPP performing a routine arthrocentesis of the knee for diagnosis and/or therapy (visco supplementation, corticosteroid injection) does not meet the guidelines for this procedure code. Also, LCD 29307 -- Viscosupplementation Therapy for Knee, specifically non-covers ultrasound imaging for viscosupplementation.
- Many episodes of care would not meet the intent of the code or meet the reasonable and necessary threshold for coverage (such as podiatrist or other provider treating Morton’s neuroma, physician/NPP doing trigger point injections, nerve injections, physician/NPP treating symptomatic varicose veins, etc.)
- Ultrasound guidance for needle placement may be payable when clinical circumstance warrants- such as a procedure where anatomy/organ evaluation is necessary; joint procedure where risk of osteomyelitis is significant; and the medical necessity of the service is clearly documented in the medical record (the unique patient has indications that are medically reasonable and necessary, and the images, findings, interpretation and report are separately documented in the medical record).

It is the expectation that physicians utilizing ultrasound guidance for standard office based needle procedures, either not code separately or bill the unlisted code (76999- unlisted ultrasound procedure (eg, diagnostic, interventional)) with an appropriate fee.
• CPT® code 76942 was weighted by the (RUC) to address physician work, practice expense & physician liability. The intra-service time of CPT® code 76942 is 30 minutes.

• Of note, a large joint arthrocentesis is rated for five minutes of intra-service time.

• Not all marginal improvements in the technical aspects of a procedure add complete value (are reasonable and necessary and/or are the established standard of care) nor are such improvements completely addressed in CPT® and the associated Medicare physician fee schedule.

CPT® codes 76881 (Ultrasound, extremity, nonvascular, real-time with image documentation; complete) and 76882 (Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific) describe an ultrasound imaging procedure for the evaluation of muscles, tendons, joints, and/or soft tissue structures generally after a standard radiograph does not determine the diagnosis and other imaging is not indicated (MRI etc.). Use of these procedures codes with aspiration and/or injection procedures would not be expected unless a separate musculoskeletal diagnostic evaluation is indicated and documented as reasonable and necessary.

• Of note, CPT® codes 76881 and 76882 are generally paid if coded and billed correctly by qualified physicians and all other requirements of the Medicare program are satisfied though coverage (the medical record supports the medical necessity of the services). These two codes have 15 minutes intra service time and 11 minutes intra service time respectively unless a separate musculoskeletal diagnostic evaluation is indicated and documented as reasonable and necessary.

Per the Code of Federal Regulations (CFR) section 410.32, all diagnostic tests must be ordered by the physician/nonphysician practitioner who is treating the patient, that is, the physician/nonphysician practitioner who furnishes a consultation or treats a patient for a specific medical problem and who uses the results in the management of the patient’s specific medical problem. Tests not ordered by the physician/nonphysician practitioner who is treating the patient are not reasonable and necessary.

The provider is responsible for ensuring the medical necessity of the diagnostic radiology procedure(s) and maintaining the medical record, which must be available to First Coast Medicare upon request. Diagnostic radiology procedures, including ultrasound, are medically reasonable and necessary only if the outcome will potentially impact the diagnosis or clinical course of the patient. It is also expected that ultrasound services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS
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