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## Musculoskeletal Ultrasound Reimbursement Information

This guide provides coverage and payment information to assist providers in determining appropriate codes and other information for reimbursement purposes for diagnostic musculoskeletal ultrasound and related ultrasound guided procedures.

## Disclaimer

Terason has used reasonable efforts to provide accurate coding advice, but this advice should not be construed as providing legal advice, clinical advice, dictating reimbursement policy or substituting for the judgment of a practitioner. The information provided with this notice is general reimbursement information only. This information is not intended to increase or maximize reimbursement by any payers, nor is it advice about how to code, complete or submit any particular claim for payment.

It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that are rendered. Payers and their local branches may have distinct coding and reimbursement requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer. The provider is responsible for verifying coverage with the patient's insurance carrier.

Terason assumes no responsibility for the timeliness, accuracy and completeness of the information contained herein. All coding and reimbursement information is subject to change without notice. Since reimbursement laws, regulations and payer policies change frequently, it is recommended that providers consult with their payors, coding specialists and/or legal counsel regarding coverage, coding and payment issues.



77 Terrace Hall Avenue Burlington, MA 01803 www.terason.com 781.270.4143 866.837.2766 Fax: 781.270.4145

## Modifiers and payments

The payment for ultrasound procedures and many other diagnostic services are separated into a physician component and a technical component. The CPT codes for these procedures have separate entries in the MPFS for the professional component (CPT modifier -26), the technical component (CPT modifier –TC), as well as for the "global service" (no CPT modifier).

- The professional component is the portion of the procedure or service performed by a physician, which includes the interpretation, analysis, and a detailed signed written report of the results of the procedure or service.

- The technical component of the radiology service includes the work of the radiology technician, the overhead costs associated with the radiology service and equipment, and physician supervision. The technical component does not involve any direct physician care. When the procedure is performed in an institution (hospital or free standing ambulatory surgical center) the payment for the technical component is included in the facility fee for the treatment procedures(s) performed in the institution as described below.

- Global service refers to procedures that include both the professional and technical components. A physician who both performs and interprets an ultrasound procedure in his own office would report the CPT procedure codes with neither modifier.

Non-diagnostic procedure payments are not separated into technical and professional components; however, for procedures that can be performed in the office, the MPFS will provide different payment amounts according to whether the procedure is performed in an institution (the "facility fee") or in the office ("non-facility" fee).

When a procedure is performed in an institution, the institution is compensated for the use of its resources according to the hospital inpatient prospective payment system (IPPS) the hospital outpatient prospective payment system (OPPS), or the ambulatory surgery center (ASC) payment system. Procedures performed in an independent diagnostic test facility (IDTF) are paid according to the technical component of the MPFS.

Note that the payment amounts in this document represent averages that do not include various adjustments that Medicare or other payers make for geographic location and other factors. Also, some payments are subject to multiple procedure discounts when performed on the same day.



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## CPT Codes and Modifiers for Musculoskeletal Applications of Ultrasound

The following tables include CPT codes may be used to report diagnostic ultrasound scans of muscles, joint, tendons and soft tissue in the extremities and the associated Medicare payments (***payment amounts are inclusive of the 20% patient co-pay***).

| | | 2015 Medicare Physician Fee Schedule National Average | | | 2015 Institutional Payment | |
|---|---|---|---|---|---|---|
| **2015 CPT Code** | **CPT Code Descriptor** | **Global Payment** | **Professional Payment (-26 modifier)** | **Technical Payment (-TC modifier)** | **Hospital Outpatient Facility Payment** | **ASC Facility Payment (-SC modifier)** |
| 76881 | Ultrasound, extremity, nonvascular, real-time with image documentation; complete | 117.63 | 32.18 | 85.45 | 134.85 | 73.89 |
| 76882 | Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific | 36.47 | 25.03 | 11.44 | 91.69 | NA |

## Ultrasonic Guidance Procedures

| | | 2015 Medicare Physician Fee Schedule National Average | | | 2015 Institutional Payment | |
|---|---|---|---|---|---|---|
| **2015 CPT Code** | **CPT Code Descriptor** | **Global Payment** | **Professional Payment (-26 modifier)** | **Technical Payment (-TC modifier)** | **Hospital Outpatient Facility Payment** | **ASC Facility Payment** |
| 76942 | Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation<br>**Notes:**<br>(Do not report 76942 in conjunction with 10030, 19083, 19285, 20604, 20606, 20611, 27096, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 64479-64484, 64490-64495, 76975, 0213T-0218T, 0228T-0231T, 0232T, 0249T, 0301T)<br><br>(For injection(s) of platelet rich plasma, use 0232T) | 60.78 | 33.61 | 27.17 | The technical component of this procedure is “bundled” into the facility payment for the associated procedure(s). | |



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## Surgical procedures that can use ultrasound guidance:

| | | 2015 Medicare Physician Fee Schedule National Average | | 2015 Institutional Payment | |
|---|---|---|---|---|---|
| **2015 CPT Code** | **CPT Code Descriptor** | **Non-Facility Payment** | **Facility Payment** | **Hospital Outpatient Facility Payment** | **ASC Facility Payment (-SC modifier)** |
| 10022 | Fine needle aspiration; with imaging guidance injections(s) | 143.73 | 67.93 | 487.34 | 92.96 |
| 20550 | Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia") | 60.07 | 42.91 | 211.21 | 30.03 |
| 20551 | Injection(s); single tendon origin/insertion | 61.50 | 43.98 | 211.21 | 31.46 |
| 20552 | Injection(s), single to multiple trigger point(s) one or two muscle(s) | 55.78 | 38.62 | 211.21 | 30.03 |
| 20553 | Injection(s), single to multiple trigger point(s) three or more muscle(s) | 64.72 | 43.98 | 211.21 | 35.40 |
| **20604** | Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting | 73.30 | 47.20 | 211.21 | 37.90 |
| **20606** | Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting | 81.16 | 53.99 | 211.21 | 41.12 |
| **20611** | Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting | 93.68 | 63.64 | 211.21 | 48.27 |

## Insurance Coverage Policies

Coverage policies and payment amounts are specific to the insurance carrier (Medicare, Medicaid, and private plans) and are specific to the point of service (office, hospital inpatient, hospital outpatient, IDTF, Ambulatory Surgical Center. Pre-certification based on medical necessity will assist in verification of coverage and payment in all settings. Medicare reimburses for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary. Medicare carriers may require that the physician who performs and/ or interprets some types of ultrasound examinations prove that they have undergone appropriate recent residency training or post-graduate CME and experience.

In general, ultrasound studies should meet all of the requirements of:

- Medical necessity (as determined by the payer)
- Completeness
- Proper documentation in the patient's medical record



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## Documentation Requirements

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

The existence of a code does not guaranty reimbursement – coding, medical coverage policy criteria, National Correct Coding Initiative (NCCI) edits and prior authorization requirements all impact reimbursement for any procedure.

***Source: Centers for Medicare and Medicaid Services (CMS)***