Ultrasound reimbursement information

Payment for Ultrasound-Guided Regional Anesthesia 2010

This guide focuses on coding, coverage, and payment for ultrasound guidance for various types of nerve blocks in the hospital outpatient department, ambulatory surgical center, and physician office settings. To the extent that this guide addresses physician payments, it's also applicable to services provided by physicians to hospital inpatients under the Medicare program. Payment amounts are provided for Medicare only, since the amounts paid by private payers vary considerably by payer and by health plan.

Coverage and documentation

Nerve blocks

Under Medicare rules, when a nerve block is administered primarily for anesthesia administration during an operative session, the nerve block is considered to be covered as part of the anesthesia for the procedure, and no separate payment is available. However, when the nerve block is administered post-operatively for pain control or is otherwise distinct from anesthesia administered in conjunction with a surgical procedure, the service may be eligible for separate coverage and payment.

Private payer coverage for nerve blocks varies by payer and by plan.

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Ultrasound guidance

Medicare covers ultrasound guidance when reasonable and necessary for the diagnosis or treatment of a Medicare patient. However, as set forth below, Medicare payment may vary depending on the site of service involved and, in the ambulatory surgical center and hospital outpatient departments; no separate payment for ultrasound guidance may be available.

In order for a procedure to be eligible for coverage, it is critical that a separate written record of the ultrasound visualization procedure be maintained in the patient record. This documentation should include image documentation in either hard copy or electronic format.

Private payer coverage for ultrasound guidance varies by payer and by plan.

Coding

Nerve blocks

When a nerve block is administered 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.

Some examples of CPT codes used to report nerve block procedures that may require ultrasound guidance are included as Attachment A.

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).

Payment

Medicare payment for both nerve blocks and ultrasound guidance varies based on the site of service.

When ultrasound guidance is provided in the physician's office, the applicable CPT code is reported for the global service (technical and professional components). When a nerve block is provided in the physician's office, it is crucial for the correct site of service ("physician's office") to be included on the claim for proper payment to be made. In either case, payment is made under the Physician Fee Schedule.

When a nerve block or ultrasound guidance is provided in the hospital outpatient department or ambulatory surgical center, Medicare payment is made under the Hospital Outpatient Prospective Payment System or under the Ambulatory Surgical Center payment system, respectively.

Certain special limits also may apply. For example, when an imaging service is provided in a physician's office setting, payment for the technical component of the service is limited to the amount that would be paid for the service under the hospital outpatient prospective payment system. Likewise, payment made to an ambulatory surgical center for its facility services is limited to the practice expense payment that would be made to a physician's office providing the same service.

Significantly, no separate payment is made for the ultrasound guidance in either hospital outpatient departments or ambulatory surgical centers. In both of these settings, payment is presumed to be "bundled" into the amount received for the primary procedure.

The following provides 2010 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. Please note that there are new Category III CPT ("tracking") codes for certain chronic pain medicine procedures, and these codes should be used if they more accurately describe the services rendered. Philips Healthcare has available a separate guidance document that addresses these new pain medicine tracking codes, which became effective on January 1, 2010.

2010 Medicare reimbursement for procedures related to diagnostic musculoskeletal ultrasound guidance and ultrasound guidance (reflects national rates, unadjusted for geographic locality):

	Physician office		Facility	
CPT/HCPCS Code	Reimbursement component	Medicare fee schedule amount	Hospital outpatient APC category and payment	ASC payment amount
CPT 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Global Professional** Technical*	$181.87 $33.92 $147.95	Packaged Service No separate payment	Packaged Service No separate payment
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 Professional** Technical*	$33.56 $15.52 $18.04	Packaged Service No separate payment	Packaged Service No separate payment
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	Facility*** Non-facility****	$97.07 $216.987	APC 0207: Level III Nerve Injections $485.34	$295.98
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, Sacra; (caudal)	Facility*** Non-facility****	$91.65 $198.10	APC 0207: Level III Nerve Injections $485.34	$295.98

*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

	Physician office		Facility	
CPT/HCPCS code	Reimbursement component	Physician fee schedule amount	Hospital outpatient APC category and payment	ASC payment amount
CPT 64416 Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)	Facility*** Non-facility****	$81.96 N/A	APC 0207: Level III Nerve Injections $485.34	$288.44
CPT 64446 Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter, (including catheter placement)	Facility*** Non-facility****	$84.08 N/A	APC 0201: Level III Nerve Injections $485.34	$288.44
APC 64448 Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)	Facility*** Non-facility****	$74.33 N/A	APC 0201: Level III Nerve Injections $485.34	$288.44
CPT 64449 Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	Facility*** Non-facility****	$84.80 N/A	APC 0201: Level III Nerve Injections $485.34	$288.44
CPT 64413 Injection, anesthetic agent; cervical plexus	Facility*** Non-facility****	$75.52 $110.06	APC 0206: Level II Nerve Injections $250.89	$54.49
CPT 64415 Injection, anesthetic agent; brachial plexus, single	Facility*** Non-facility****	$70.00 $120.52	APC 0206: Level II Nerve Injections $250.89	$145.08
CPT 64417 Injection, anesthetic agent; axillary nerve	Facility*** Non-facility****	$68.92 $120.88	APC 0206: Level II Nerve Injections $250.89	$145.08
CPT 64418 Injection, anesthetic agent; suprascapular nerve	Facility*** Non-facility****	$71.09 $122.38	APC 0206: Level II Nerve Injections $250.89	$76.14
CPT 64445 Injection, anesthetic agent; sciatic nerve, single	Facility*** Non-facility****	$77.58 $126.66	APC 0206: Level III Nerve Injections $485.35	$68.92
CPT 64447 Injection, anesthetic agent; femoral nerve, single	Facility*** Non-facility****	$66.40 N/A	APC 0206: Level II Nerve Injections $250.89	$149.11

*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

Attachment A

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

CPT3 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:

CPT3 code	Description
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.

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How to reach us
www.philips.com/healthcare
healthcare@philips.com
fax: +31 40 27 64 887

Asia
+852 2821 5888

Europe, Middle East, Africa
+49 7031 463 2254

Latin America
+55 11 2125 0744

North America
+1 425 487 7000
800 285 5585 (toll free, US only)

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