Coding and Billing for Ultrasound Examinations

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Introduction

Surgical procedures should be appropriately performed for appropriate indications and documented and then coded/billed. Surgeon-performed ultrasound examinations are the same. Once the surgeon becomes proficient in performing independent ultrasound examinations and the credentialing for performing ultrasound is achieved locally, he or she can consider billing for ultrasound examinations. Table 22.1 is the summary of important points for coding and billing for ultrasound examinations.

Documentation of Ultrasound Findings

Adequate documentation is an essential component to patient care, but it is also required for billing. There should be a permanent record of the ultrasound examination and its interpretation. Comparison with previous relevant imaging studies is helpful and always performed when available. Images of all appropriate areas, both normal and abnormal, should be recorded in appropriate storage format. Variations from normal size or dimension should be accompanied by measurements. Images should be labeled with the examination date, patient identification, and image orientation. A report of the ultrasound findings should be included in the patient's medical record, regardless of where and when the study is performed.

Coding and Billing

For coding, first of all, documentation is essential. In addition to ultrasound findings, appropriate indications for examinations should be documented. For the process of billing, the correct coding with appropriate modifiers must be used. The coding may change, and, therefore, the surgeon should update the coding using the current "CPT" and "ICD." Like all procedures in today's environment, surgeons or their billers must follow up on reimbursement for ultrasound. If appropriate reimbursement is not received, the surgeon should discuss the issue with the insurer and, when necessary, with local or national professional societies.

For all ultrasound examinations, there are professional and technical components. Surgeons performing office ultrasound (e.g., transabdominal ultrasound) by themselves using their own equipment can code for both the professional and the technical components. In such a case, no modifier is required. For surgeons performing ultrasound in a facility or hospital (e.g., ultrasound in the emergency room, intensive care unit, or operating room), the situation is more complex. If a surgeon performs ultrasound examinations (with or without a technician) using the hospital's machine, he or she should use modifier -26 to charge only for the professional component. In a facility or hospital, a surgeon performing ultrasound by himself or herself (without the help of a hospital technician) using his or her own machine can charge only for the professional component for Medicare patients. In this

Table 22.1 Coding and billing for ultrasound examinations

1. Proficiency and credentialing
2. Adequate ultrasound examination for appropriate indications
3. Adequate documentation; indications and ultrasound findings with record of images
4. Use of correct coding and modifier: understanding of professional and technical components
5. Updating of coding using current "CPT" and "ICD"
6. Follow-up of reimbursement

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Table 22.2 Coding for ultrasound examinations frequently performed by surgeons and Medicare reimbursement[a]

		Medicare reimbursement of 2013[b] (average of all states)	
Code	Procedure (ultrasound examination)	Total service	Professional component
76700	US of the abdomen, including the liver, biliary, pancreas, and spleen, *complete*[c]	$235.60	
76705	US of the abdomen, *limited* (e.g., *single organ, quadrant, follow-up)*[c]	$172.77	
76770	US of the retroperitoneum (e.g., renal, aorta, nodes) *complete*[d]	$214.66	
76775	US of the retroperitoneum, *limited*[d]	$162.30	
76856	US of the pelvis (nonobstetric)[e]	$172.77	
76942	US guidance for needle placement (biopsy, aspiration, injection, localization device, etc.)[f]	$235.60	
76970	US study follow-up (for repeat US for follow-up of specific organs)	$125.65	
76975	Gastrointestinal endoscopic US (modifier -26)		$188.48 (modifier -26)
76998	US guidance, intraoperative[g]	$324.61	
76700/76705	Intraoperative abdominal US and laparoscopic US[h]	$235.60	
76940	US guidance for tissue ablation (modifier -26)[i]		$198.95 (modifier -26)

Notes
US ultrasound, *FAST* focused abdominal sonography for trauma
[a]As of March 2014, some procedures listed here have become bundled. Surgeons and billers need to update bundle information
[b]Coding and reimbursement shown here are based on information (Medicare Reimbursement of 2013) as of May 2013
[c]76700 and 76705 are frequently used by surgeons performing abdominal US, including FAST. Use 76705 for US of the abdominal wall (e.g., hernia evaluation)
[d]76770 and 76775 are not commonly used by surgeons. Instead, 76700 and 76705 are used, because the retroperitoneum US is usually performed as part of abdominal US
[e]76856 is not frequently used. A possible utility for surgeons is the pelvic US during evaluation of appendicitis or lower abdominal pain. In such circumstances, 76700 or 76705 may be a better code
[f]US guidance (76942) is just for the US portion of the procedure and is added to the procedure itself
Examples: 49082 and 76942: US-guided paracentesis
47000 and 76942: US-guided percutaneous liver biopsy
47001 and 76942: US-guided open liver biopsy
[g]Intraoperative US guidance (76998) is used when US is performed to guide procedures (e.g., hepatic resection) during surgery. However, for open liver biopsy, it is better to use 76942
[h]Currently, there is no code specific for "intraoperative abdominal US" and "laparoscopic US." For this reason, 76700 or 76705 is used for intraoperative abdominal US and laparoscopic US, as well as transabdominal US. This code is for diagnostic US, and you can add these codes. Example: Laparoscopic US during laparoscopic cholecystectomy is coded as 47562 and 76700 or 76705
[i]When US is used for guidance of tissue ablation, such as radiofrequency thermal ablation and cryoablation, 76940 is used. Do not report 76998 in addition to 76940. For liver ablation procedures (radiofrequency and cryotherapy) themselves, see codes 47370–47382

case, the surgeon must add modifier -26 (they must include this; otherwise, the claim will be rejected) because Medicare pays only for the professional component on the HCFA 1500. For other insurers (such as Blue Cross/Blue Shield), both components may be paid; however, the surgeon should first discuss this issue with a medical director of the insurance company. Otherwise, the modifier -26 should be used for the professional charge only.

Table 22.2 is a list of coding for ultrasound examinations commonly performed in a surgical practice of the abdomen, including office-based ultrasound and hospital-based ultrasound.

Surgeons who evaluate a patient, determine that an ultrasound examination is indicated, and perform the ultrasound by themselves can charge for both the evaluation and management (E/M) service and the ultrasound examination. E/M services are separately payable if the documentation indicates that the visit led to the decision to perform a procedure (the ultrasound examination). Generally, when a procedure is performed (e.g., incision and drainage) after an E/M service, it is reported by adding the modifier -25 to the appropriate level of E/M service. However, it is not necessary to add -25 for an ultrasound examination. For example, if the surgeon is asked (consulted) to evaluate a patient with right upper quadrant abdominal pain and performs ultrasound after E/M service, the codes are as follows:

992XX	Office consultation
76700	Ultrasound of the abdomen

The surgeon should make sure that the information in the documentation is substantive enough to demonstrate medical necessity for the ultrasound examination.

For multiple surgical procedures, generally, the modifier -51 is added. For distinct procedural service, the modifier -59 is added. However, it is not necessary to add -51 or -59 for additional ultrasound coding. For example, when billing for the professional component of intraoperative ultrasound (guidance for hepatic lobectomy), ultrasound guidance for liver biopsy, followed by right hepatic lobectomy, the codes are:

47130	Hepatic lobectomy
47001-51	Open liver biopsy
76700-26	Intraoperative ultrasound or
76998-26	Intraoperative ultrasound guidance
76942-26	Ultrasound guidance for biopsy

Note that newer coding/billing, many procedures have become "bundled", and insurers may not pay for multiple procedures. Surgeons and their billers, therefore, need to update this "bundle" information.

Medicare has been paying physicians for diagnostic and therapeutic ultrasound services regardless of specialty. To receive reimbursement for ultrasound services, it may be necessary to submit documentation of credentialing for performing ultrasound in accordance with the local insurer's policies.

The above guideline regarding coding and billing is applicable to Medicare. Other insurers may use a slightly different coding system, and, therefore, one may have to confirm each insurer's policy regarding ultrasound practice.

Conclusion

Surgeons first need to learn and master ultrasound examinations and then perform ultrasound appropriately with sufficient technical competency for appropriate indications. Once examinations are done in such way, surgeons do not need to hesitate to do billing for reasonable payment. However, precise documentation and accurate coding are critical. For coding and billing of all ultrasound examinations, there are professional and technical components. The coding changes periodically, and, therefore, the surgeon should update the coding with modifiers using the current "CPT" and "ICD." It is imperative for surgeons and their billers to understand and use appropriate and timely coding and billing to obtain suitable payment.

Useful References

Coders' Desk Reference for Procedures 2013, Optum (Ingenix). www.optumcoding.com