GE Healthcare

Reimbursement Information for Diagnostic Ultrasound Procedures[1] Completed by Obstetricians

January, 2011

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This overview addresses coding, coverage, and payment for diagnostic ultrasound procedures performed with traditional ultrasound as well as diagnostic ultrasound procedures performed with pocket-sized ultrasound visualization tools for obstetrical procedures.[2] While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

Diagnostic Obstetrical Procedures

The following table includes diagnostic ultrasound CPT codes that may apply when obstetrical ultrasound is performed. This information pertains to diagnostic ultrasound procedures. Also included are the 2011 national average Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates for the CPT codes. **Payment will vary in geographic locality.**

Table 1: 2011 Medicare reimbursement for procedures related to traditional diagnostic ultrasound obstetrical procedures.

CPT[3]/HCPCS Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Payment[4]	APC	Hospital Outpatient Payment[5]
General Obstetric Examinations				
CPT 76801 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation	Professional (-26)*	$ 48.93	0266	$ 96.28
	Technical (-TC)**	$ 81.88		
	Global	$ 130.81		
CPT +76802 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	Professional (-26)	$ 41.11	0265	$ 62.25
	Technical (-TC)	$ 29.22		
	Global	$ 70.33		
CPT 76805 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation	Professional (-26)	$ 48.93	0266	$ 96.28
	Technical (-TC)	$ 96.28 (DRA Capped)		
	Global	$ 145.21		
CPT +76810 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	Professional (-26)	$ 48.25	0266	$ 96.28
	Technical (-TC)	$ 49.95		
	Global	$ 98.19		
CPT 76811 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation	Professional (-26)	$ 93.77	0267	$ 152.99
	Technical (-TC)	$ 100.23		
	Global	$ 194.01		

**Professional – is the physician payment.*
***Technical – is the facility payment.*

CPT[3]/HCPCS Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Payment[4]	APC	Hospital Outpatient Payment[5]
CPT +76812 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	Professional (-26)*	$ 87.66	0265	$ 62.25
	Technical (-TC)**	$ 62.25 (DRA Capped)		
	Global	$ 149.91		
CPT 76813 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	Professional (-26)	$ 58.10	0265	$ 62.25
	Technical (-TC)	$ 69.31		
	Global	$ 127.41		
CPT +76814 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)	Professional (-26)	$ 48.59	0265	$ 62.25
	Technical (-TC)	$ 32.62		
	Global	$ 81.20		
CPT 76815 Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	Professional (-26)	$ 31.60	0265	$ 62.25
	Technical (-TC)	$ 60.14		
	Global	$ 91.74		
CPT 76816 Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus	Professional (-26)	$ 42.13	0265	$ 62.25
	Technical (-TC)	$ 62.25 (DRA Capped)		
	Global	$ 104.38		
CPT 76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal	Professional (-26)	$ 37.03	0265	$ 62.25
	Technical (-TC)	$ 62.25 (DRA Capped)		
	Global	$ 99.28		
CPT 76818 Fetal biophysical profile; with non-stress testing	Professional (-26)	$ 51.98	0266	$ 96.28
	Technical (-TC)	$ 71.01		
	Global	$ 122.99		
CPT 76819 Fetal biophysical profile; without non-stress testing	Professional (-26)	$ 38.39	0266	$ 96.28
	Technical (-TC)	$ 54.02		
	Global	$ 92.42		
CPT 76820 Doppler velocimetry, fetal; umbilical artery	Professional (-26)	$ 24.46	0265	$ 62.25
	Technical (-TC)	$ 22.42		
	Global	$ 46.88		
CPT 76821 Doppler velocimetry, fetal; middle cerebral artery	Professional (-26)	$ 35.00	0265	$ 62.25
	Technical (-TC)	$ 62.25 (DRA Capped)		
	Global	$ 97.25		

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CPT[3]/HCPCS Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Payment[4]	APC	Hospital Outpatient Payment[5]
Fetal Echocardiography				
CPT 76825 Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording	Professional (-26)*	$ 81.88	0270	$ 562.15
	Technical (-TC)**	$ 136.25		
	Global	$ 218.13		
CPT 76826 Echocardiography, fetal, cardiovascular system, real time with image documentation (2D), with or without M-mode recording; follow-up or repeat study	Professional (-26)	$ 40.77	0269	$ 402.39
	Technical (-TC)	$ 84.94		
	Global	$ 125.71		
CPT 76827 Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete	Professional (-26)	$ 28.20	0265	$ 62.25
	Technical (-TC)	$ 38.39		
	Global	$ 66.59		
CPT 76828 Doppler echocardiography, fetal, pulsed wave and/ or continuous wave with spectral display; follow-up or repeat study	Professional (-26)	$ 27.52	0265	$ 62.25
	Technical (-TC)	$ 21.41		
	Global	$ 48.93		
Ultrasound Guidance				
CPT 76941 Ultrasonic guidance for intrauterine fetal transfusion or cordocentesis, imaging supervision and interpretation	Professional (-26)	$ 68.97	N/A	Service Packaged into APC.
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
CPT 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Professional (-26)	$ 33.64	N/A	Service Packaged into APC.
	Technical (-TC)	$ 164.45		
	Global	$ 198.08		
CPT 76945 Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation	Professional (-26)	$ 33.98	N/A	Service Packaged into APC.
	Technical (-TC)	Carrier Priced		
	Global	Carrier Priced		
CPT 76946 Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	Professional (-26)	$ 18.69	N/A	Service Packaged into APC.
	Technical (-TC)	$ 19.37		
	Global	$ 38.05		
CPT 76948 Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	Professional (-26)	$ 19.37	N/A	Service Packaged into APC.
	Technical (-TC)	$ 19.37		
	Global	$ 38.73		
Non-obstetrical				
CPT 76856 Ultrasound, pelvic (non-obstetric), real time with image documentation; complete	Professional (-26)*	$ 34.32	0266	$ 96.28
	Technical (-TC)**	$ 91.06		
	Global	$ 125.37		
CPT 76857 Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Professional (-26)	$ 19.71	0265	$ 62.25
	Technical (-TC)	$ 62.25 (DRA Capped)		
	Global	$ 81.96		

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Pocket-sized Ultrasound

Diagnostic Obstetrical Ultrasound Procedures Completed with a Pocket-sized Ultrasound Device

A pocket-sized ultrasound is a small, battery-powered device that fit in a physician's pocket and is intended for use in performing focused, non-invasive diagnostic ultrasound imaging, to assist physicians with real-time, point-of-care visual information at the bedside.

Billing Criteria

The use of a pocket-sized ultrasound device may be billable in certain circumstances. Any use has minimum criteria that have to be met before it can be billed separately from an initial evaluation ultrasound exam. When the pocket-sized ultrasound device is used for a quick look and if it is necessary for a follow up ultrasound to be performed on the patient to determine or conclude the patient's condition, this would be considered part of the initial exam, or Evaluation and Management (E/M) examination being performed.

In addition, if using the pocket-sized ultrasound device as an extension of the patient's physical examination, it would not be appropriate to bill separately for these ultrasound exams. Rather, these ultrasound exams would be included in as an extension of an E/M examination. Refer to your coding manual to select appropriate CPT codes that address E/M examinations.

Diagnostic Use of Pocket-Sized Ultrasound Device

If the pocket-sized ultrasound device is being utilized for a documented appropriate medical necessity, is being performed by appropriately qualified providers and meets all Medicare requirements including documentation and storage of images, it may be possible for it to be billed and considered for coverage and payment by a payer.[6, 7, 8, 9, 10]

Billing Requirements for Pocket-Sized Ultrasound Device

According to many of the local Medicare Contractors, billing for a limited diagnostic ultrasound procedure requires that the following minimum requirements be met:

1. It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
2. It should be done for the same purpose as a reasonable physician would order a standard ultrasound.
3. It must be billed using the CPT code that accurately describes the service performed.
4. The technical quality of the exam must be in keeping with the accepted national standards and not require a follow-up ultrasound to confirm the results.
5. The study must be performed and interpreted by qualified individuals.
6. The medical necessity, images, findings, interpretation and report must be documented in the medical record.[11]

Payers or their local branches and the local Medicare Contractors may have distinct requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer and/or Medicare contractor.

Qualifications of Personnel

The American Medical Association (AMA) policy states:[12]

H-230.960 Privileging for Ultrasound Imaging

(1) AMA affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians;

(2) AMA policy on ultrasound acknowledges that broad and diverse use and application of ultrasound imaging technologies exist in medical practice; and

(3) AMA policy on ultrasound imaging affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staffs and should be specifically delineated on the Department's Delineation of Privileges form; and

(4) AMA policy on ultrasound imaging states that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty. (Res. 802, I-99; Reaffirmed: Sub. Res. 108, A-00)

Payers or their local branches and the local Medicare Contractors may have distinct requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer.

Documentation Requirements

Ultrasound performed using a pocket-sized device, hand-held ultrasound, a compact portable, or a console ultrasound system may be reported using the same CPT codes as long as the studies performed meet the requirements addressed above as well as all the following requirements:

- Medical necessity as determined by the payer
- Completeness
- Documented in the patient's medical record

A separate **written** record of the ultrasound procedure(s) should be maintained in the patient record.[13] This should include a description of the structures or organs examined, the findings, and reason for the ultrasound procedure(s). Images are to be labeled with patient identification, facility identification, examination date, the anatomical site imaged, transducer orientation and the initials of the operator. The use of ultrasound without a thorough evaluation of organ(s) or anatomical region, image documentation, and final written report is not separately reportable.

In order to be separately reportable, diagnostic ultrasound procedures require the production and retention of image documentation. It is recommended that permanent ultrasound images, either electronic or hardcopy, from all ultrasound services be retained in the patient record or other appropriate archive.

If the ultrasound procedure is performed with a pocket-sized ultrasound device and does not meet all of the aforementioned requirements, it would not be considered to be separately reportable. It would be considered part of the physical exam.

The following table pertains to obstetrical ultrasound procedures performed with a pocket-sized ultrasound device when all of the requirements have been meet. Included are the 2011 national average Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates for the CPT codes. **Payment will vary in geographic locality.**

Table 2: 2011 Medicare reimbursement for procedures related to diagnostic ultrasound obstetrical procedures performed with a pocket-sized ultrasound device.

CPT[14]/HCPCS Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Payment[15]	APC	Hospital Outpatient Payment[16]
General Obstetric Examinations				
CPT 76801 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation	Professional (-26)*	$ 48.93	0266	$ 96.28
	Technical (-TC)**	$ 81.88		
	Global	$ 130.81		
CPT +76802 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (list separately in addition to code for primary procedure)	Professional (-26)*	$ 41.11	0265	$ 62.25
	Technical (-TC)**	$ 29.22		
	Global	$ 70.33		
CPT 76815 Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	Professional (-26)	$ 31.60	0265	$ 62.25
	Technical (-TC)	$ 60.14		
	Global	$ 91.74		
CPT 76818 Fetal biophysical profile; with non-stress testing	Professional (-26)	$ 51.98	0266	$ 96.28
	Technical (-TC)	$ 71.01		
	Global	$ 122.99		
CPT 76819 Fetal biophysical profile; without non-stress testing	Professional (-26)	$ 38.39	0266	$ 96.28
	Technical (-TC)	$ 54.02		
	Global	$ 92.42		

**Professional – is the physician payment.*
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CPT[14]/HCPCS Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Payment[15]	APC	Hospital Outpatient Payment[16]
Non-obstetrical				
CPT 76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	Professional (-26)	$ 34.32	0266	$ 96.28
	Technical (-TC)	$ 91.06		
	Global	$ 125.37		
CPT 76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Professional (-26)	$ 19.71	0265	$ 62.25
	Technical (-TC)	$ 62.25 (DRA Capped)		
	Global	$ 81.96		

Payment Methodologies for Ultrasound Services

Medicare reimburses for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary. The following describes the various payment methods by site of service.

Site of Service – Ultrasound Services

Physician Office (Medicare Physician Fee Schedule (MPFS))
In the office setting, a physician who owns the equipment and performs the ultrasound guidance or a sonographer who performs the service may report the global/non-facility code and report the CPT code without any modifier may be reported.

Hospital Outpatient
If the site of service is a hospital outpatient setting and the physician is performing the ultrasound guidance, the –26 modifier (professional service only) should be appended to the CPT code for the imaging service.

Based on the Medicare Outpatient Prospective Payment System (OPPS), the technical component of image guidance for a needle placement procedure that is performed in the hospital outpatient department is considered a packaged service. This means that the payment to the facility for these services is included in the payment for the primary procedure.

Coverage Policies

Use of diagnostic ultrasound services may be a covered benefit if such usage meets all requirements established by that particular payer. It is advisable that you check with your local Medicare Contractor for specific coverage requirements. Also, it is essential that each claim be coded appropriately and supported with adequate documentation in the medical record.

Coverage by private payers varies by payer and by plan with respect to which medical specialties may perform ultrasound services. Some payers will reimburse ultrasound procedures to all specialties while other plans will limit ultrasound procedures to specific types of medical specialties. In addition, there are plans that require providers to submit applications requesting these services be added to the list of services performed in their practice. Also, ultrasound examinations are usually not included in the obstetrical global package and may be billed separately. However, certain payers may bundle the obstetrical ultrasound procedure into the global obstetrical package. It is important that you contact the payer prior to submitting claims to determine their requirements.

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.

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TC-Technical Component
This modifier would be used to bill for services by the owner of the equipment only to report the technical component of the service. This modifier is most commonly used if the service is performed in an Independent Diagnostic Testing Facility (IDTF).

52-Reduced Services
This modifier would be used in certain circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion.

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.

ICD-9-CM Diagnosis Coding

It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-9-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the ultrasound.

Limited vs. Complete Ultrasound

Complete and limited ultrasound studies are defined in the ultrasound introductory section notes of the CPT 2011 code book. According to CPT, the report should contain a description of all elements or the reason that an element could not be visualized. As stated in the guidelines, If less than the required elements for a 'complete' exam are reported (eg, limited number of organs or limited portion of region evaluated), the limited code for that anatomic region should be used once per patient exam session.[17]

Other Considerations

The American Society of Echocardiography (ASE) published a position statement (J Am Soc Echocardiog 2002; 15: 369-73) about hand carried ultrasound in April 2002. This position establishes that "The safety and effectiveness of a diagnostic study should be judged on the medical indications of the study, the qualifications and experience of the providers of service, the quality and completeness of the diagnostic information obtained, and the adherence to published and widely accepted professional standards and processes developed, and not based on the size or cost of the instrumentation used to perform the study."[18]

Furthermore, the ASE document states that the technical capabilities of Hand Carried Ultrasound (HCU) equipment do not themselves serve as a means for distinguishing a complete or limited echocardiogram from an extension of a physical exam.

Therefore, if the appropriate images and data are recorded as follows, the study should be considered an independent diagnostic test rather than an extension of the patient's physical examination.

- a qualified sonographer or physician and interpret the ultrasound exam
- interpreted by a physician with a level 2 (or higher) training in echocardiography (level 2 is described by the American College of Cardiology (ACC) here: (http://www.acc.org/qualityandscience/clinical/competence/echo/III_transthoracic.htm),
- reported in an appropriate manner,
- archived properly,
- and the study was performed for an approved clinical indication.

1 Information presented in this document is current as of January 1, 2011. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

2 The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

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4 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 75, No. 228 November 29, 2010 and updated with data files from Transmittal 828 Emergency Update to the CY 2011 Medicare Physician Fee Schedule (MPFS) Database December 29, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

5 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in the Federal Register, Vol. 75, No. 226, November 24, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

6 CIGNA Government Services. Article Hand-Carried Ultrasound Examinations. http://www.cignagovernmentservices.com/partb/pubs/news/2003/0703/COPE602.html. Publication date 8/1/2003. Accessed 5/5/2010.

7 Noridian Administrative Services LLC. Article for Hand-Carried Ultrasound (A23254). http://www.cms.gov/mcd/viewarticle.asp?article_id=23254&article_version=4&basket=article%3A23254%3A4%3AHand%2DCarried+Ultrasound%3ACarrier%3ANoridian+Administrative+Services%7C%7C+LLC+%2800820%29. Updated on 02/23/2007. Accessed 5/5/2010.

8 Palmetto GBA. Article for Hand-Carried Ultrasound Examinations (A12481). http://www.cms.gov/mcd/viewarticle.asp?article_id=12481&article_version=3&basket=article%3A12481%3A3%3AHand%2DCarried+Ultrasound+Examinations%3ACarrier%3APalmetto+GBA+%2800880%29. Updated on 03/20/2007. Accessed 5/5/2010.

9 Trailblazer Health Enterprises, LLC. Article for Hand-Carried Ultrasound Examinations (A13566). http://www.cms.gov/mcd/viewarticle.asp?article_id=13566&article_version=2&basket=article%3A13566%3A2%3AHAND%2DCARRIED+ULTRASOUND+EXAMINATIONS%3ACarrier%3ATrailBlazer+Health+Enterprises%7C%7C+LLC+%2800904%29. Updated on 09/25/2003. Accessed 5/5/2010.

10 Wisconsin Physicians Service Insurance Corporation. Article for Hand-Carried Ultrasound Examinations (A11626). http://www.cms.gov/mcd/viewarticle.asp?article_id=11626&article_version=3&basket=article%3A11626%3A3%3AHand%2DCarried+Ultrasound+Examinations%3ACarrier%3AWisconsin+Physicians+Service+Insurance+Corporation+%2800951%29. Updated on 09/25/2003. Accessed 5/5/2010.

11 Wisconsin Physicians Service Insurance Corporation. Article for Hand-Carried Ultrasound Examinations (A11626). http://www.cms.gov/mcd/viewarticle.asp?article_id=11626&article_version=3&basket=article%3A11626%3A3%3AHand%2DCarried+Ultrasound+Examinations%3ACarrier%3AWisconsin+Physicians+Service+Insurance+Corporation+%2800951%29. Updated on 09/25/2003. Accessed 5/5/2010.

12 http://www.ama-assn.org/ama1/pub/upload/mm/467/513.doc.

13 Certain Medicare carriers require that the physician who performs and/or interprets some types of ultrasound examinations to prove that they have undergone training through recent residency training or post-graduate CME and experience. For further details, contact your Medicare Contractor.

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15 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and profes sional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 75, No. 228, November 29, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

16 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in the Federal Register, Vol. 75, No. 226, November 24, 2010. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

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18 American Society of Echocardiography Report on Hand Carried Ultrasound (HCU) April 2002 (J Am Soc Echocardiog 2002; 15:369-73).

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ULT-0534-06.11-EN-US