



Reimbursement Information for Diagnostic Elastography¹

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This Advisory addresses Medicare coding and payment information for diagnostic ultrasound and associated tissue elastography measurements for hospital outpatient and physician office sites of service. Although information in the Advisory reflects Medicare policies, it may also be applicable to certain private payer reimbursement policies within the United States.^{2,3}

Current Procedural Terminology (CPT) Coding, Definitions and Medicare Payment Rates

Overview

Tissue stiffness is often related to suspicious abnormalities or underlying disease. Using sensitive measurement techniques such as elastography, tissue stiffness can be accurately quantified and stiffness changes assessed over time to better inform physician diagnoses.

The American Medical Association (AMA) has created two CPT codes to describe elastography examinations that pertain to strain elastography and acoustic radiation force impulse (ARFI) & Shear Wave Elastography techniques:

- **0346T** – Ultrasound, elastography (list separately in addition to code for primary procedure)
- **91200** – Liver elastography, mechanically induced shear wave (e.g., vibration), without imaging, with interpretation and report
- CPT code 0346T is classified as a Category III CPT code which is given to examinations considered to be emerging and not yet a standard of care. Unlike the permanent Category I CPT codes, RVU's have not been set and consequently there is not a standard payment when a claim is submitted
- CPT code 91200 is classified as a Category I CPT code which is associated with widespread use and has established relative value units (RVUs) that provide a basis for uniform reimbursement

ACR Coding Guidance

American College of Radiology (ACR) has provided coding guidance for the two elastography CPT codes 91200 and 0346T in their 2018 Ultrasound Coding Users Guide.⁴ The recommendations for reporting procedures are as follows:

- CPT code 91200 should be reported for mechanically induced shear wave technique without imaging for liver studies. Per the 2017 update, code 91200 can be used for all forms of shear wave liver elastography, including both those using mechanical (transient elastography – Fibroscan®) or acoustic (ARFI) techniques to generate the shear waves. The shear wave speed can be reported in meters/second (m/s) or converted to KiloPascals (kPa) making appropriate assumptions
- CPT code 0346T should be reported in conjunction with CPT codes 76536, 76604, 76641, 76642, 76700, 76705, 76770, 76775, 76830, 76856, 76857, 76870, 76872, 76881, and 76882

Coding and Payment Information

The following provides 2018 national Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates for the CPT codes identified in this guide. Payment rates reflect DRA-imposed payment reductions for services that are subject to the regulations. Payment will vary by geographic locality.

Before filing any claims, it is recommended that providers verify current requirements and policies with network payers.

2018 Medicare Reimbursement for Ultrasound Elastography Procedures⁵

(Reflects national rates, unadjusted for locality)

CPT/HCPS code ⁶	Physician		Facility	
	Reimbursement component	Medicare physician fee schedule payment ⁷	APC	Hospital outpatient payment ⁸
0346T Ultrasound Elastography (list separately in addition to code for primary procedure)	Professional (-26)*	Contractor priced	N/A	Bundled procedure. No separate reimbursement
	Technical (-TC)**			
	Global			

Category III CPT code 0346T is an add-on code and should be reported in conjunction with the following ultrasound procedures:

76536 Ultrasound Soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), real-time with image documentation	Professional (-26)	\$28.80	5522	\$114.46
	Technical (-TC)	\$90.72		
	Global	\$119.52		
76604 Ultrasound Chest (includes mediastinum), real-time with image documentation	Professional (-26)	\$27.72	5522	\$114.46
	Technical (-TC)	\$63.72		
	Global	\$91.44		
76641 Ultrasound Breast, unilateral, real-time with image documentation, including axilla when performed; complete	Professional (-26)	\$37.44	5522	\$114.46
	Technical (-TC)	\$72.72		
	Global	\$110.16		
76642 Ultrasound Breast, unilateral, real-time with image documentation, including axilla when performed; limited	Professional (-26)	\$34.92	5521	\$62.12
	Technical (-TC)	\$55.44		
	Global	\$90.36		
76700 Ultrasound Abdominal, real-time with image documentation; complete	Professional (-26)	\$41.40	5522	\$114.46
	Technical (-TC)	\$84.24		
	Global	\$125.64		
76705 Ultrasound Abdominal, real-time with image documentation; limited (e.g., single organ, quadrant, follow-up)	Professional (-26)	\$30.24	5522	\$114.46
	Technical (-TC)	\$63.72		
	Global	\$93.96		
76770 Ultrasound Retroperitoneal (e.g., renal, aorta, nodes), real-time with image documentation; complete	Professional (-26)	\$37.80	5522	\$114.46
	Technical (-TC)	\$78.48		
	Global	\$116.28		

* Technical (-TC) – The technical component is the equipment and technician performing the test. This is identified by adding modifier “TC” to the procedure code identified for the technical component charge.

** Professional (-26) – The professional component is the interpretation of the results of the test. When the professional component is reported separately, the service may be identified by adding modifier “26.”

CPT/HCPS code	Physician		Facility	
	Reimbursement component	Medicare physician fee schedule payment ⁷	APC	Hospital outpatient payment ⁸
76775 Ultrasound Retroperitoneal (eg, renal, aorta, nodes), real-time with image documentation; limited	Professional (-26)	\$29.52	5522	\$114.46
	Technical (-TC)	\$29.88		
	Global	\$59.40		
76830 Ultrasound Transvaginal	Professional (-26)	\$35.64	5522	\$114.46
	Technical (-TC)	\$89.64		
	Global	\$125.28		
76856 Ultrasound Pelvic (nonobstetric), real-time with image documentation; complete	Professional (-26)	\$35.28	5522	\$114.46
	Technical (-TC)	\$77.76		
	Global	\$113.04		
76857 Ultrasound Pelvic (nonobstetric), real-time with image documentation; limited or follow-up (e.g., for follicles)	Professional (-26)	\$25.56	5522	\$114.46
	Technical (-TC)	\$24.12		
	Global	\$49.68		
76870 Ultrasound Scrotum and contents	Professional (-26)	\$32.76	5522	\$114.46
	Technical (-TC)	\$36.72		
	Global	\$69.48		
76872 Ultrasound Transrectal	Professional (-26)	\$34.56	5522	\$114.46
	Technical (-TC)	\$64.44		
	Global	\$99.00		
76881 Ultrasound Extremity, nonvascular, real-time with image documentation; complete	Professional (-26)	\$32.40	5522	\$114.46
	Technical (-TC)	\$71.64		
	Global	\$104.04		
76882 Ultrasound Extremity, nonvascular, real-time with imagedocumentation; limited, anatomicspecific	Professional (-26)	\$25.20	5522	\$114.46
	Technical (-TC)	\$33.84		
	Global	\$59.04		
Liver elastography without imaging				
91200 Liver elastography Mechanically induced shear wave (e.g., vibration), without imaging, with interpretation and report	Professional (-26)	\$14.40	5721	\$136.32
	Technical (-TC)	\$26.64		
	Global	\$41.04		

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.

51 – Multiple Procedures

This modifier is used to inform payers that two or more procedures are being reported on the same day.

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).

The following are modifiers that may pertain to the use of the ultrasound, elastography procedure code 0346T, when used:

52 – Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced.

59 – Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, etc.

76 – Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service.

77 – Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service.

ICD-10-CM and ICD-10-PCS

It is the provider's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-10-CM code based on his or her findings or the pre-service signs, symptoms or conditions that reflect the reason for doing the ultrasound elastography procedure.

There is no specific ICD-10-PCS code for elastography procedures. One would report the corresponding ICD-10-PCS code for ultrasound procedure based on the location on the body that the ultrasound elastography is being performed. Examples are provided of ICD-10-PCS procedure codes that relate to ultrasound procedures are (not an all inclusive list):

BH4CZZZ	Ultrasonography of head and neck
BW4FZZZ	Ultrasonography of neck
BB4BZZZ	Ultrasonography of pleura
BB4CZZZ	Ultrasonography of mediastinum
BH40ZZZ	Ultrasonography of right breast
BH41ZZZ	Ultrasonography of left breast
BH42ZZZ	Ultrasonography of bilateral breasts
BW40ZZZ	Ultrasonography of abdomen
BD42ZZZ	Ultrasonography of stomach
BD48ZZZ	Ultrasonography of appendix
BD49ZZZ	Ultrasonography of duodenum
BD4CZZZ	Ultrasonography of rectum
BF40ZZZ	Ultrasonography of bile ducts
BF42ZZZ	Ultrasonography of gallbladder
BF43ZZZ	Ultrasonography of gallbladder and bile ducts
BF45ZZZ	Ultrasonography of liver
BF47ZZZ	Ultrasonography of pancreas
BW40ZZZ	Ultrasonography of abdomen
BW41ZZZ	Ultrasonography of abdomen and pelvis
B440ZZZ	Ultrasonography of abdominal aorta
B44BZZZ	Ultrasonography of other intra-abdominal arteries
B549ZZZ	Ultrasonography of inferior vena cava, intravascular
BT41ZZZ	Ultrasonography of right kidney
BT42ZZZ	Ultrasonography of left kidney
BT43ZZZ	Ultrasonography of bilateral kidneys
BT40ZZZ	Ultrasonography of bladder
BU40ZZZ	Ultrasonography of right fallopian tube
BU45ZZZ	Ultrasonography of bilateral ovaries
BH47ZZZ	Ultrasonography of upper extremity
BH48ZZZ	Ultrasonography of lower extremity
BW4GZZZ	Ultrasonography of pelvic region

For more information on ICD-10-CM/PCS, please go to:
<https://www.cms.gov/medicare/Coding/ICD10/index.html>

Documentation Requirements

Ultrasound performed using either a compact portable ultrasound or a console ultrasound system are reported using the same CPT codes as long as the studies that were performed meet 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 diagnostic ultrasound or ultrasound-guided procedure must be completed and maintained in the patient record. This should include a description of the structures or organs examined the findings and reason for the ultrasound procedure. Diagnostic ultrasound procedures require the production and retention of image documentation. It is recommended that permanent ultrasound images, either electronic or hard copy, from all ultrasound services be retained in the patient record or other appropriate archive.

Payment Methodologies for Ultrasound Services

Medicare may reimburse 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

Physician Office Setting

In the office setting, a physician who owns the ultrasound equipment and performs the service, or a sonographer who performs the service, may report the global code without a -26 modifier.

Hospital Outpatient

When the ultrasound is performed in the hospital outpatient, physicians may not submit a global charge to Medicare because the global charge includes both the professional and technical components of the service. If the procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the ultrasound service as an outpatient service. The CPT code filed by the hospital will be assigned to a hospital outpatient system Ambulatory Payment Classification (APC) payment system, and payment will be based on the APC grouping. However, for Medicare, the hospital outpatient facility and the physician must report the same CPT code. If the physician is a hospital employee, the hospital may submit a charge for the global service.

Hospital Inpatient Setting

If this service is performed in the inpatient setting, charges for the ultrasound services occurring in the hospital inpatient setting would be considered part of the charges submitted for the inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services regardless.

Note: Medicare may reimburse for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary.

Coverage Information

Procedures may be a covered benefit if such usage meets all requirements established by the particular payer. However, it is advisable that you verify coverage policies with your local Medicare Administrative Contractor. 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 private payer plans will reimburse for ultrasound procedures performed by any physician specialist while other plans will limit ultrasound procedures to specific types of medical specialties. In addition, plans may require providers to submit applications requesting these diagnostic ultrasound and ultrasound-guided services be added to the list of services performed in their practice. It is important that you contact the payer prior to submitting claims to determine their requirements.

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1. Information presented in this document is current as of January 1, 2018. Any subsequent changes which may occur in coding, coverage, and payment are not reflected herein.
2. The Food and Drug Administration (FDA) cleared/approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this Customer Advisory. Some payers in some instances treat a procedure which is not specifically covered by the equipment's FDA-approved/cleared labeling as a non-covered service.
3. 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, certificate of need, and other restrictions may be applicable.
4. 2018 Ultrasound Coding User's Guide, American College of Radiology, Benson JM, Pellerito JS, pg 43.
5. The payment amounts indicated are estimates only based upon data elements derived from various CMS sources. Actual Medicare payment rates may vary based on any deductibles, copayments and sequestration rules that apply.
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7. 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. 82, No. 219 / Wednesday, November 15, 2017. 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.
8. 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. 82, No. 219 / Wednesday, November 15, 2017. 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.

Imagination at work

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