GE Healthcare

Reimbursement Guidelines for Diagnostic Musculoskeletal Ultrasound and Ultrasound Guided Procedures[1]

January, 2009

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This overview addresses coding, coverage, and payment for diagnostic ultrasound and related ultrasound guidance procedures when performed in the hospital outpatient department and the physician office.[2] While this advisory focuses on Medicare program policies, these policies may also be applicable to selected private payers throughout the country.

Current Procedural Terminology (CPT) Coding

The following CPT code may be used to report diagnostic ultrasound scans of muscles, joints, tendons and soft tissue in the extremities:

CPT[3] Code	Description
76880	Ultrasound, extremity, nonvascular, real time with image documentation

If ultrasound guidance is necessary to guide injections or aspirations, the following CPT code may be reported:

76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Ultrasound guidance procedures that are performed using either a hand-carried ultrasound or a cart-based 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

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

CPT Code	Description
10022	Fine needle aspiration; with imaging guidance
20552	Injection(s); single or multiple trigger point(s), one or two muscle(s)
20553	Injection(s); single or multiple trigger point(s), three or more muscle(s)
20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromicoclavicular, wrist, elbow or ankle, olecranon bursa)
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

For appropriate code selection, contact your payer prior to claim submittal.

Modifiers

Modifiers explain that a procedure or service was changed without changing the definition of the CPT code set. Modifiers may also indicate that a procedure or service was a significant and separately identifiable service, such as modifier -25. In certain cases when modifier –25 is used, the payer may ask for a report and/or documentation be submitted to support the service(s) billed. The report or documentation should be complete, describing in detail the complexity of the patient's problems and/or physical findings, as well as a completed description of any therapeutic or diagnostic procedures. It is always advisable to check with you payer prior to using modifier -25.

ICD-9-CM Diagnosis Coding

Because of the vast array of diagnoses related to the aforementioned procedures, please check with your payer regarding appropriate ICD-9-CM diagnosis code selection.

Documentation Requirements

A separate written record of the ultrasound visualization procedure should be maintained in the patient record.[4]

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.

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
(Medicare Outpatient Prospective Payment System (OPPS))
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), beginning in 2008, 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.

Payment Changes Resulting from the Deficit Reduction Act[5] (DRA) of 2005

Effective January 1, 2007, Medicare capped the payment for the technical component (-TC) of imaging services billed under the physician's fee schedule. This applies to physician offices, freestanding imaging centers and independent diagnostic testing facilities (IDTF). The lesser of the reimbursement rate under the physician's fee schedule or the hospital outpatient prospective payment system will be the payment for the technical component.

Reimbursement

The following provides 2009 national Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) 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 locality.**

2009 Medicare reimbursement for procedures related to diagnostic musculoskeletal ultrasound guidance and ultrasound guidance (reflects national rates, unadjusted for geographic locality).

CPT[6]/HCPCS Code	Physician Office		Hospital Outpatient
	Reimbursement Component	Medicare Physician Fee Schedule (MPFS Payment)[7]	Medicare APC Category and Payment[8]
CPT 76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Global	$ 183.94	Packaged Service No separate payment.
	Professional	$ 34.26	
	Technical	$ 149.68	
CPT 76880 Ultrasound, extremity, nonvascular, real time with image documentation	Global	$ 124.43	$ 97.77
	Professional	$ 29.21	
	Technical	$ 95.22	
CPT 20552 Injection(s); single or multiple trigger point(s), one or two muscle(s)	Facility	$ 34.26	$ 164.30
	Non-facility	$ 47.97	
CPT 10022 Fine needle aspiration; with imaging guidance	Facility	$ 64.20	$ 295.46
	Non-facility	$ 130.20	
CPT 20553 Injection(s); single or multiple trigger point(s), three or more muscle(s)	Facility	$ 37.87	$ 164.30
	Non-facility	$ 53.38	
CPT 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)	Facility	$ 38.23	$ 164.30
	Non-facility	$ 50.49	
CPT 20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromicoclavicular, wrist, elbow or ankle, olecranon bursa)	Facility	$ 39.67	$ 164.30
	Non-facility	$ 54.10	
CPT 20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	Facility	$ 47.61	$ 164.30
	Non-facility	$ 69.97	

**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.*

Coverage

Use of diagnostic musculoskeletal ultrasound and ultrasound guided procedures may be a covered benefit if such usage meets all requirements established by the particular payer. In many cases, diagnostic ultrasound of the extremities is indicated for the detection of cysts, abscesses, tumors and effusion of arms and legs. If ultrasound guidance is used in conjunction with another procedure, such as aspiration or injection, coverage for the ultrasound guidance will be determined by the coverage for the primary procedure. However, for coverage of other indications, it is advisable that you check with your local Medical 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 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. It is important that you contact the payer prior to submitting claims to determine their requirements.

Disclaimer

1 Information presented in this document is current as of January 1, 2009. 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.

3 CPT codes and descriptions only are copyright © 2008 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

4 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.

5 Federal Register/Vol. 71, No. 231/Friday, December 1, 2006.

6 Current Procedural Terminology © 2008 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

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. 73, No. 224, November 19, 2008. 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. 73, No. 223, November 18, 2008. 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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imagination at work

BlueCross BlueShield of Tennessee Medical Policy Manual

Trigger Point Injections

Does not apply to BlueCare

DESCRIPTION

Trigger points are well defined, hyperirritable foci in muscles often found in a firm, taut band of skeletal muscle. The cause may be acute trauma or repetitive microtrauma and is described by individuals as persistent pain; either diffuse or localized, and may result in decreased range of motion (ROM). Laboratory tests and imaging techniques are not useful in diagnosing trigger points. The diagnosis is made following a comprehensive pain history, identification of clinical characteristics, and physical examination with findings of a palpable taut, hypersensitive bundle of muscles.

Myofascial pain syndrome (MPS) is a chronic condition affecting the connective tissue surrounding the muscle and is characterized by pain and inflammation. A key feature of MPS is the identification of one or more myofascial trigger points.

Symptoms that persist for extended periods of time (generally greater than 3 months) and fail to be alleviated with conservative approaches may be treated with injections of local anesthetics, anti-inflammatory drugs, and/or corticosteroid in an attempt to deactivate the trigger point. Dry needling is a variant of trigger point injections in which the trigger point is isolated and stimulated by the insertion of a needle without injection of any medication.

POLICY

- Trigger point injections with local anesthetics, with or without steroids, are considered ***medically necessary.*** No more than four (4) trigger point injections are considered appropriate in a one year period.
- Ultrasound guidance of trigger point injections is considered ***not medically necessary*****.**
- Dry needling for the treatment of trigger points is considered ***investigational*****.**
- Any device or agent utilized for this procedure must have FDA approval specific to the indication, otherwise it will be considered ***investigational.***

See also: Prolotherapy for Musculoskeletal Disorders

IMPORTANT REMINDERS

- Any specific products referenced in this policy are just examples and are intended for illustrative purposes only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available. These examples are contained in the parenthetical e.g. statement.
- We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the Medical Policy and a health plan, the express terms of the health plan will govern.

ADDITIONAL INFORMATION

Injections should not be used in isolation as sole method of treatment. They should facilitate mobilization by providing pain relief and assist in application of non-invasive modalities, e.g., physical therapy, medications, and other alternate therapies that address muscle strengthening, flexibility, and functional restoration.

Appropriate utilization dictates that responsiveness to prior trigger point injections with improvement in pain and functional status must have occurred before repeat injections are medically necessary. The number of trigger point injections in a given year should not exceed four (4) to minimize the risks associated with corticosteroids.

There are limited comparative studies available in peer-reviewed journals to determine efficacy or utility of “dry needling” in the treatment of trigger points.

Palpation remains the standard of care for the diagnosis of trigger points and the technique utilized in the guidance of the TPI.

SOURCES

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ORIGINAL EFFECTIVE DATE: 7/14/2012

MOST RECENT REVIEW DATE: 12/12/2013

ID_BT

PT code 76942

Thank you for your responses.

Per CCI guidelines (version 15.3, Radiology G3) this is what I finally found:

3. CPT codes 76942, 77002, 77003, 77012, and 77021 describe radiologic guidance for needle placement by different modalities. CMS payment policy allows one unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.