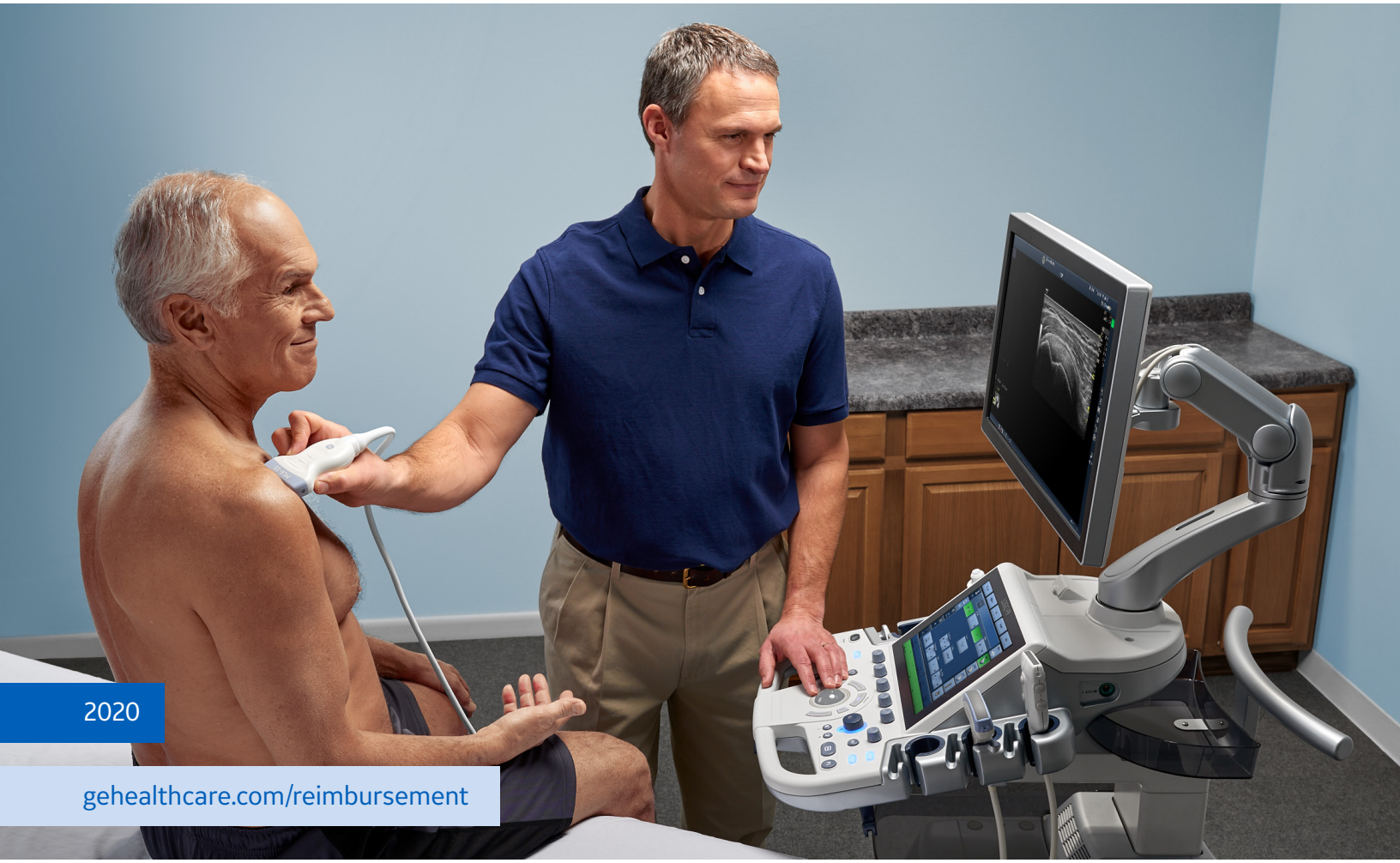
Reimbursement Information for Point of Care Ultrasound Procedures[1]



2020

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This overview addresses coding, coverage, and payment for point of care ultrasound procedures when performed in the hospital outpatient department, the physician office and ambulatory surgery center setting.[2] This advisory focuses on Medicare program policies. Non-Medicare payers may have different rules and guidelines for coding, coverage and reimbursement for the procedures discussed in this document. For appropriate code selection, contact your local payer prior to claims submittal.

Current Procedural Terminology (CPT®)[3] Coding, Definitions and Medicare Payment Rates

The following provides 2020 national Medicare Physician Fee Schedule (MPFS), the Hospital Outpatient Ambulatory Payment Category (APC) and the Ambulatory Surgery Center (ASC) 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 in geographic locality.

2020 Medicare Reimbursement for Point of Care Ultrasound Procedures

CPT Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Payment[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Ultrasound Guidance					
76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Professional	$32.48	N/A	Packaged service/ item; no separate payment made	Packaged service/ item; no separate payment made
	Technical	$25.98			
	Global	$58.47			
Emergency Medicine and Critical Care					
76705 Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	Professional	$29.95	5522	$112.08	$56.63
	Technical	$62.80			
	Global	$92.75			
76706 Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	Professional	$28.15	5522	$112.08	Not on ASC list of approved procedures
	Technical	$87.70			
	Global	$115.85			
76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Professional	$25.26	5522	$112.08	$23.82
	Technical	$24.18			
	Global	$49.44			
93308 Echocardiography, transthoracic, real time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	Professional	$26.35	5523	$233.04	Not on ASC list of approved procedures
	Technical	$874.34			
	Global	$100.69			
Pain Management and Anesthesia					
64405 Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	Facility	$55.94	5441	$261.77	$33.20
	Non-Facility	$74.71			
64415 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus	Facility	$66.04	5443	$812.05	$410.32
	Non-Facility	$116.21			
64416 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)	Facility	$66.77	5443	$6812.05	$410.32
	Non-Facility	N/A			

CPT Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Payment[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Pain Management and Anesthesia *(cont.)*					
64417 Injection(s), anesthetic agent(s) and/or steroid; axillary nerve	Facility	$63.16	5443	$812.05	$410.20
	Non-Facility	$140.39			
64418 Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	Facility	$59.19	5442	$662.05	$43.31
	Non-Facility	$87.34			
64447 Injection(s), anesthetic agent(s) and/or steroid; femoral nerve	Facility	$55.20	5442	$662.05	$48.36
	Non-Facility	$91.31			
64448 Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)	Facility	$63.88	5443	$812.05	$410.20
	Non-Facility	N/A			
64486 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	Facility	$58.47	N/A	Packaged service/ item; no separate payment made	Packaged service/ item; no separate payment made
	Non-Facility	$114.40			
Musculoskeletal Medicine					
20526 Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	Facility	$59.55	5441	$261.77	$41.50
	Non-Facility	$81.20			
20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar fascia)	Facility	$40.78	5441	$261.77	$25.98
	Non-Facility	$56.30			
20551 Injection(s); single tendon origin/insertion	Facility	$41.50	5441	$261.77	$27.43
	Non-Facility	$57.74			
20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	Facility	$40.06	5441	$261.77	$30.30
	Non-Facility	$57.38			
20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	Facility	$47.64	5441	$261.77	$42.95
	Non-Facility	$78.31			

CPT Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Payment[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Musculoskeletal Medicine *(cont.)*					
20606 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	Facility	$54.86	5442	$625.05	$46.56
	Non-Facility	$86.62			
20611 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	Facility	$62.44	5441	$261.77	$52.33
	Non-Facility	$96.72			
76881 Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real time with image documentation	Professional	$32.12	5522	$112.08	$46.56
	Technical	$46.92			
	Global	$79.04			
76882 Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real time with image documentation	Professional	$24.90	5522	$112.08	Packaged service/ item; no separate payment made
	Technical	$33.20			
	Global	$58.10			
Breast Surgery, Endocrinology and Vein Therapy					
19000 Puncture aspiration of cyst of breast	Facility	$45.47	5071	$610.01	$77.95
	Non-Facility	$112.24			
60100 Biopsy thyroid, percutaneous core needle	Facility	$81.20	5071	$610.01	$53.77
	Non-Facility	$114.76			
60300 Aspiration and/or injection, thyroid cyst	Facility	$51.25	5071	$610.01	$78.68
	Non-Facility	$116.93			
76536 Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	Professional	$28.87	5522	$112.08	Packaged service/ item; no separate payment made
	Technical	$89.14			
	Global	$118.01			

CPT Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Payment[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Breast Surgery, Endocrinology and Vein Therapy *(cont.)*					
76642 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Professional	$34.65	5521	$79.81	Packaged service/ item; no separate payment made
	Technical	$54.50			
	Global	$89.14			
93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	Professional	$35.37	5523	$233.04	Not on ASC list of approved procedures
	Technical	$163.49			
	Global	$198.85			
93971 Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	Professional	$22.74	5522	$112.08	Not on ASC list of approved procedures
	Technical	$101.41			
	Global	$123.84			
36475 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Facility	$291.96	5183	$2,771.28	$1,341.23
	Non-Facility	$1,404.97			
36478 Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Facility	$290.88	5183	$2,771.28	$1,341.23
	Non-Facility	$1,092.07			
Vascular Access and Renal Dialysis					
93990 Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	Professional	$25.62	5522	$112.08	Not on ASC list of approved procedures
	Technical	$112.24†			
	Global	$137.86†			

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 guidance 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.

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).

59 – Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier (-59) is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.

Hospital Inpatient – ICD-10-PCS Procedure Coding

ICD-10-PCS procedure codes are used to report procedures performed in a hospital inpatient setting. The following are possible ICD-10-PCS procedure codes that may be used to report to ultrasound-guided procedures commonly performed (not all inclusive list):

B04BZZZ	Ultrasonography of Spinal Cord
BW41ZZZ	Ultrasonography of Abdomen and Pelvis
3E0S305	Introduction of Other Antineoplastic into Epidural Space, Percutaneous Approach
3E0U305	Introduction of Other Antineoplastic into Joints, Percutaneous Approach
3E0U3BZ	Introduction of Anesthetic Agent into Joints, Percutaneous Approach
3E0U3GC	Introduction of Other Therapeutic Substance into Joints, Percutaneous Approach
3E0T3BZ	Introduction of Anesthetic Agent into Peripheral Nerves and Plexi, Percutaneous Approach
3E0X3BZ	Introduction of Anesthetic Agent into Cranial Nerves, Percutaneous Approach
3E0R3BZ	Introduction of Anesthetic Agent into Spinal Canal, Percutaneous Approach
3E0S3BZ	Introduction of Anesthetic Agent into Epidural Space, Percutaneous Approach

ICD-10-CM Diagnosis Coding

Because of the vast array of diagnoses related to the aforementioned procedures, please check with your payer regarding appropriate ICD-10-CM diagnosis code selection.

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.[7] This should include a description of the structures or organs examined and the findings and reason for the ultrasound procedure(s). 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.

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 (Medicare Physician Fee Schedule (MPFS))

In the office setting, a physician who owns the equipment and performs the ultrasound guidance may report the global/nonfacility code and report the CPT code without any modifier.

Hospital Outpatient or Ambulatory Surgery Center (ASC)

If the site of service is a hospital outpatient setting or an ASC 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 or in the ASC 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

Use of ultrasound-guided procedures may be a covered benefit if such usage meets all requirements established by the particular payer. In many cases, because the use of ultrasound guidance is an emerging technology, it may be considered investigational and may not be a covered procedure. It is advisable that you check with your local Medicare 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 reimbursement for 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

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References

1. Information presented in this document is current as of February 27th, 2020. 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 inoffice 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. 2020 Current Procedural Terminology (CPT®) Professional Edition. CPT is a registered trademark of the 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.
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 on 11/15/19 in the (Federal Register / Vol. 84, No. 221 / Wednesday, November 15, 2019 and subsequent updates. These changes are effective for services provided from 1/1/2020 through 12/31/2020. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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. 84, No. 218 / Monday, November 12, 2019 and subsequent updates based on legislation enacted by CMS. These changes are effective for services provided from 1/1/2020 through 1/1/2020. CMS may make adjustments to any or all of the data inputs from time to time. 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. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. Ambulatory Surgery Center Prospective Payment System, as published in the Federal Register/ Vol. 84, No. 218/Tuesday, November 12, 2019 and subsequent updates based on legislation enacted by CMS. These changes are effective for services provided from 1/1/2020 through 12/31/2020. CMS may make adjustments to any or all of the data inputs from time to time. 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.
7. 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.

† OPPS capped payment amount-Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of certain diagnostic imaging procedures and the TC portions of the global diagnostic imaging services. This cap is based on the Outpatient Prospective Payment System (OPPS) payment. To implement this provision, the physician fee schedule amount is compared to the OPPS payment amount and the lower amount is used in the formula to calculate payment.

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