Ultrasound Use in Caring for COVID-19 Patients

This guide provides coverage and payment information for diagnostic ultrasound and related ultrasound-guided procedures. This information was obtained from third-party sources and is subject to change without notice, as Medicare and other payers may change their reimbursement policies at any time. This document is for educational purposes only. Fujifilm Sonosite is not responsible for correct code assignment. It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for service rendered and to ensure any services provided to patients and submitted for reimbursement are medically necessary. Fujifilm Sonosite makes no guarantees concerning reimbursement or coverage. If you have questions related to how to bill for these services appropriately, please contact your own reimbursement staff or the patient's insurer, as Fujifilm Sonosite cannot provide specific reimbursement guidance.

<table>
<thead>
<tr>
<th>Organ System Evaluation</th>
<th>COVID-19 Complications</th>
<th>Ultrasound Application</th>
<th>CPT Code</th>
<th>Descriptor</th>
<th>2021 Medicare Reimbursement for a Physician</th>
<th>2021 Medicare Reimbursement for Hospital Outpatient Setting, including ER*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen</td>
<td>Hepatitis</td>
<td>Assessment for hepatomegaly</td>
<td>76705</td>
<td>Ultrasound, abdominal, real time with image documentation; limited</td>
<td>$29.31</td>
<td>$108.97</td>
</tr>
<tr>
<td></td>
<td>Kidney Injury</td>
<td>Renal Resistive Index</td>
<td>76775</td>
<td>Ultrasound, retroperitoneal (e.g. renal, aorta, nodes) real time with image documentation; limited</td>
<td>$28.96</td>
<td>$108.97</td>
</tr>
<tr>
<td>Arterial Line Placement</td>
<td>Difficulty with arterial access</td>
<td>Safe and efficient line placement with a high rate of first-pass success</td>
<td>+76937</td>
<td>Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry with permanent recording and reporting (list separately in addition to code for primary procedure)</td>
<td>$13.96</td>
<td>Packaged, no separate payment</td>
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<tr>
<td>Blood Vessels</td>
<td>Deep Vein Thrombosis</td>
<td>Direct clot visualization of upper and lower Extremities</td>
<td>93925</td>
<td>Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study</td>
<td>$38.38</td>
<td>$230.13</td>
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<tr>
<td></td>
<td></td>
<td>Compressibility of veins</td>
<td>93926</td>
<td>Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study</td>
<td>$23.73</td>
<td>$108.97</td>
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<td>93970</td>
<td>Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study</td>
<td>$33.85</td>
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<td>93971</td>
<td>Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study</td>
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<td>$108.97</td>
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<tr>
<td>Brain</td>
<td>Ischemic Stroke</td>
<td>Transcranial Doppler</td>
<td>93886</td>
<td>Transcranial Doppler study or the intracranial arteries; complete study</td>
<td>$47.11</td>
<td>$230.13</td>
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<td>Diagnosis</td>
<td>Procedure Description</td>
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<td>RVU</td>
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<tr>
<td>Hemorrhagic Stroke</td>
<td>Intracranial pressure assessment using optic nerve sheath diameter</td>
<td>93888</td>
<td>$25.82</td>
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<td>76512</td>
<td>$31.05</td>
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<tr>
<td></td>
<td>Transcranial Doppler study or the intracranial arteries; limited study</td>
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<td>Cardiac</td>
<td>Cardiac ejection fraction</td>
<td>93308</td>
<td>$25.47</td>
<td>$230.13</td>
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<tr>
<td></td>
<td>Echocardiography, transthoracic, real-time with image documentation (2D), when performed, follow-up or limited study</td>
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<tr>
<td>Pericarditis</td>
<td>Pericardial effusion</td>
<td>+93321</td>
<td>$7.33</td>
<td>Packaged, no separate payment</td>
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<tr>
<td></td>
<td>Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study (list separately in addition to CPT code 93308, if performed)</td>
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<tr>
<td>Myopericarditis</td>
<td>Regional wall motion abnormalities</td>
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<td>$3.14</td>
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<tr>
<td>Myocardial Infarction</td>
<td>Right/left ventricular function</td>
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<td>Doppler echocardiography, color flow velocity mapping (list separately in addition to CPT code 93308, if performed)</td>
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<tr>
<td>Central Venous Catheterization</td>
<td>Iatrogenic pneumothorax, hematomas, carotid artery puncture, central-line associated blood vessel complications</td>
<td>36556</td>
<td>$85.84</td>
<td>$2,861.66</td>
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<td></td>
<td>Safer and faster CVC placement, confirmation of accurate placement, lower rate of complications compared to landmark techniques, reduced infection risk</td>
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<td>Endotracheal Tube Placement</td>
<td>Intubation Confirmation</td>
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<td>$28.61</td>
<td>$108.97</td>
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<tr>
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<td>Visualization of ETT and bilateral lung sliding to confirm</td>
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<td></td>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
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<tr>
<td>Hemodynamics</td>
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<td>Diagnose type of shock</td>
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<td></td>
<td>Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study</td>
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<tr>
<td>Septic Shock</td>
<td>Evaluate intravascular volume status and fluid responsiveness</td>
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<td>$7.33</td>
<td>Packaged, no separate payment</td>
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<td></td>
<td>Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study (list separately in addition to CPT code 93308, if performed)</td>
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<tr>
<td></td>
<td>Inferior vena cava collapsibility</td>
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<td>$3.14</td>
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<td></td>
<td>Doppler echocardiography, color flow velocity mapping (list separately in addition to CPT code 93308, if performed)</td>
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<tr>
<td></td>
<td>Respiratory variation on Doppler flow across left ventricular outflow tract/peripheral arteries</td>
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<td>$28.61</td>
<td>$108.97</td>
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<td></td>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
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<tr>
<td>Procedure</td>
<td>Description</td>
<td>CPT Code</td>
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<tr>
<td>Ultrasound, retroperitoneal (e.g., renal, aorta, nodes) real time with image documentation; limited</td>
<td>76775</td>
<td>$28.96</td>
<td>$108.97</td>
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<tr>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
<td>76604</td>
<td>$28.61</td>
<td>$108.97</td>
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<tr>
<td>Lung COVID Viral Pneumonia</td>
<td>Identification of pulmonary edema (B-lines)</td>
<td>76609</td>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
<td>76604</td>
<td>$28.61</td>
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<tr>
<td>Acute Respiratory Distress Syndrome</td>
<td>Subpleural consolidations</td>
<td>76609</td>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
<td>76604</td>
<td>$28.61</td>
<td>$108.97</td>
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<tr>
<td>Pneumothorax</td>
<td>Pleural effusions</td>
<td>76609</td>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
<td>76604</td>
<td>$28.61</td>
<td>$108.97</td>
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<tr>
<td>Pleural Effusion</td>
<td>Lung sliding</td>
<td>76609</td>
<td>Ultrasound, chest (includes mediastinum), real time with image documentation</td>
<td>76604</td>
<td>$28.61</td>
<td>$108.97</td>
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<tr>
<td>Paracentesis</td>
<td>Bleeding complications</td>
<td>49083</td>
<td>Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance</td>
<td>107.47</td>
<td>$809.60</td>
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<tr>
<td>Pericardiocentesis</td>
<td>Direct needle damage to the heart</td>
<td>33016</td>
<td>Pericardiocentesis, including imaging guidance, when performed</td>
<td>240.41</td>
<td>$1,406.14</td>
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<tr>
<td>Surgical Procedures</td>
<td>General anesthesia requires intubation and aerosolization of Coronavirus</td>
<td>Varies</td>
<td>Anesthesiology Codes</td>
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<tr>
<td>Thoracentesis</td>
<td>Pneumothorax, increased length of stay and higher costs</td>
<td>32555</td>
<td>Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance</td>
<td>112.36</td>
<td>$541.62</td>
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</tr>
</tbody>
</table>

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Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a 2021 conversion factor of $34.8931


When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage.

Dietary services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.

The CARES Act provided for a 20% add-on to the inpatient prospective payment system (PPS) DRG rate for COVID-19 patients for the duration of the public health emergency. CMS states that it will identify discharges of an individual diagnosed with COVID-19 using the following ICD-10 diagnosis codes: U07.1 (COVID-19) for discharges occurring on or after April 1, 2020 B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after Jan 27, 2020 and on or before April 30, 2021. Further coding guidance is available for discharges on or after April 1 and prior to April 1.

For discharges with the diagnosis codes above, CMS will apply an adjustment factor to increase the DRG weight by 20% when determining inpatient PPS operating payments. Inpatient PPS claims for COVID-19 discharges on or after Jan. 27 that are received by CMS before April 21 will be automatically reprocessed to reflect the payment increase. Claims received on or after April 21, 2020 will be processed reflective of the 20% increase.

The information in this handout is intended to assist providers in determining appropriate codes and the other information for reimbursement purposes. It represents the information available to Sonosite as of the date listed above. Subsequent guidance might alter the information provided. Sonosite disclaims any responsibility to update the information provided.

It is the provider’s responsibility to determine and submit appropriate codes, modifiers, and claims for the services rendered. Before filing any claims, providers should verify current requirements and policies with the applicable payer. Sonosite makes no guarantees concerning reimbursement or coverage. A provider should not rely on any information provided by Sonosite in submitting any claim for payment, without confirming that information with an authoritative source.

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