

Ultrasound Use in ICU/CCU

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. 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.

Documentation Requirements

All diagnostic ultrasound examinations, including those when ultrasound is used to guide a procedure, require that permanently recorded images, with measurements, when such measurements are clinically indicated be maintained in the patient's record. The images can be kept in the patient record or some other archive - they do not need to be submitted with the claim. Images can be stored as printed images, on a tape or electronic medium. Documentation of the study must be available to the insurer upon request.

A final, written report of all ultrasound studies should be issued for inclusion in the patient's medical record. For those anatomic regions that have "complete" or "limited" ultrasound codes, note the elements that comprise a "complete" exam. The report should contain a description of these elements or the reason that an element could not be visualized (eg, obscured by bowel gas, surgically absent). If less than the required elements of a "complete" exam are reported (eg, limited number of organs or limited portion of region evaluated), the "limited" code for that anatomic should be used once per patient exam session. A "limited" exam of an anatomic region should not be reported for the same exam session as a complete exam of the same region.

Ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized.

Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable.¹

Third Party Insurance Payment Policies

Effective May 22, 2007, Medicare has a National Coverage Determination ("NCD") regarding ultrasound diagnostic procedures.² Per this policy, Medicare will generally reimburse physicians for medically necessary diagnostic ultrasound services, provided the services are within the scope of the physician's license and for the indications outlined in the NCD. Some Medicare Administrative Contractors ("MACs") require that the physician who performs and/or interprets some types of ultrasound examinations be capable of demonstrating relevant, documented training through recent residency training or post-graduate CME and experience. Prior to performing ultrasound

procedures, physicians should contact your Part B MAC for details. We recommend also checking for any local coverage determinations ("LCDs") for the service(s) you intend to provide. Some MACs do have policies regarding ultrasound studies of the extremities or ultrasound guidance of certain injections or both.

Payment rules for other non-Medicare payers (e.g., commercial/private payers, Medicare Advantage, Medicaid) vary by payer and plan. Payer rules and guidance should be reviewed, as some plans indicate, for example, what qualifications or credentials are required or which specialties may perform and receive reimbursement for ultrasound services. Some insurers require physicians to submit applications requesting ultrasound be added to their list of services performed in their practice.

Additional requirements may apply, so providers should contact the appropriate plan before submitting claims for ultrasound studies to determine their requirements and request that they add ultrasound to the list of services in your contract.

¹ CPT 2021 Professional Edition, American Medical Association, page 535.

² Medicare National Coverage Determinations Manual, Ch. 1, Part 4, § 220.5, *Ultrasound Diagnostic Procedures* (Effective May 22, 2007) (Rev. 173, Issued: 09-04-14, Effective: Upon Implementation: of ICD-10, Implementation: Upon Implementation of ICD-10), (available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf)

Use of Modifiers

In the office setting, a physician who owns the equipment and performs the service him or herself or through an employed or contracted sonographer, may generally bill the global fee, which is represented by the CPT₁ code without any modifiers.

If the site of service is the hospital, the -26 modifier, indicating the professional service only was provided, must be added by the physician to the CPT code for the ultrasound service. Payers will not reimburse physicians for the technical component in the hospital or ASC setting.³

Providers should review plan guidance to determine whether any additional modifiers may be required depending on the service provided.

Code Selection

Ultrasound services performed with hand-carried ultrasound systems are reported using the same ultrasound codes that are submitted for studies performed with cart-based ultrasound systems so long as the usual requirements are met. All ultrasound examinations must meet the requirements of medical necessity as set forth by the payer, must meet the requirements of completeness for the code that is chosen, and must be documented in the patient's record, regardless of the type of ultrasound equipment that is used.

It is the physician's responsibility to select the CPT and ICD-10 codes that accurately describe the service performed and the corresponding reason for the study.

National Correct Coding Initiative Edits

The National Correct Coding Initiative (NCCI) sets correct coding methodologies for Medicare, as well as many other payers.

Under the NCCI, one unit of service is allowed for CPT code 76942 in a single patient encounter regardless of the number of needle placements performed. Per NCCI, "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."⁴

As of January 2017, Evaluation of an anatomic region and guidance for a needle placement procedure in that anatomic region by the same radiologic modality at the same or different patient encounter(s) on the same date of service are not separately reportable. For example, a physician should not report a diagnostic ultrasound CPT code and CPT code 76942 (ultrasonic guidance for needle placement...) when performed in the same anatomic region on the same date of service. Physicians should not avoid these edits by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service.⁵

Providers should review the NCCI to determine whether additional coding edits will apply to the services provided.

Code and Payment Information

Physicians report the professional component of ultrasound services by appending the -26 modifier to the CPT₁ code on the CMS 1500 billing form. The following payment information is based on the unadjusted Medicare physician fee schedule and reflects the reimbursement for the physician's service. The actual payment will vary by location.

CPT Code	Descriptor	2021 Medicare Physician Fee Schedule - National Average* Professional Payment
75989	Radiological guidance (ie, fluoroscopy, ultrasound or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation	\$56.88
76604	Ultrasound, chest, real time with image documentation	\$28.61
76705	Ultrasound, abdominal, real time with image documentation; limited	\$29.31
76775	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	\$28.96
+ 76937	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	\$13.96
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	\$31.40
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	\$62.81
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	\$36.99
93306	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; complete, with spectral Doppler and color flow Doppler.	\$70.83
93307	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; complete, without spectral Doppler or color flow Doppler.	\$45.36

³ 2017 Ultrasound Coding Users Guide, American College of Radiology, page 55.

⁴ National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) Effective January 1, 2017, page IX-19

⁵ National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) Effective January 1, 2017, page IX-22.

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3308	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording when performed; follow-up or limited study	\$25.47
93312	Echocardiography, transesophageal, real time with image documentation (2D) with or without M-mode recording; including probe placement, image acquisition, interpretation and report	\$109.22
93313	Echocardiography, transesophageal, real time with image documentation (2D) with or without M-mode recording; placement of transesophageal probe only	\$11.51
93314	Echocardiography, transesophageal, real time with image documentation (2D) with or without M-mode recording; image acquisition, interpretation and report only	\$91.42
+ 93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	\$18.14
+ 93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study	\$7.33
+ 93325	Doppler echocardiography color flow velocity mapping	\$3.14
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	\$21.98

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*Source of Information: Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – Final Rule, Addendum B
<https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-federal-regulation-notices/cms-1734-f>

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

†Source: CMS OPPS - <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-fc>

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.