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Ultrasound Reimbursement Information

Vascular Surgery

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.

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 CPT[1] code without any modifiers.

[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)

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.

Payment Information

The following chart provides payment information that is based on the national unadjusted Medicare physician fee schedule for the ultrasound services discussed in this guide. Payment will vary by geographic region. Use the "Professional Payment" column to estimate reimbursement to the physician for services provided in facility settings.

Ambulatory Payment Classification (APC) codes and payments are used by Medicare to reimburse facilities under the Hospital Outpatient Prospective Payment System (OPPS). Payment is based on the national unadjusted OPPS amounts for facilities. The actual payment will vary by location.

		2021 Medicare Physician Fee Schedule — National Average*			2021 Hospital Outpatient Prospective Payment System (OPPS)†	
CPT Code	CPT Code Descriptor	Global Payment	Professional Payment	Technical Payment	APC Code	APC Payment
76998	Ultrasonic guidance, intraoperative	No Payment	$63.16	No Payment	Packaged Service	No Separate Payment
93880	Duplex scan of extracranial arteries; complete bilateral study	$204.12	$39.08	$165.04	5523	$230.13
93882	Duplex scan of extracranial arteries; unilateral or limited study	$132.94	$24.77	$108.17	5522	$108.97
93886	Transcranial Doppler study of the intracranial arteries complete study	$277.24	$47.11	$230.13	5522	$230.13
93888	Transcranial Doppler study of the intracranial arteries limited study	$134.79	$25.82	$108.97	5522	$108.97
93925	Duplex scan of lower extremity arteries or arterial bypass grafts, complete bilateral study	$259.95	$38.38	$221.57	5523	$230.13
93926	Duplex scan of lower extremity arteries or arterial bypass graft s, unilateral or limited study	$132.70	$23.73	$108.97	5522	$108.97

[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.

93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	$200.29	$33.85	$166.44	5523	$230.13
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	$125.96	$21.98	$103.98	5522	$108.97
93975	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and or retroperitoneal organs; complete study	$284.03	$56.88	$227.15	5523	$230.13
93976	Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and or retroperitoneal organs; limited study	$148.05	$39.08	$108.97	5522	$108.97
93978	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts, complete study	$192.96	$39.43	$153.53	5523	$230.13
93979	Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study	$124.57	$24.08	$100.49	5522	$108.97
93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	$122.82	$61.06	$61.76	5522	$108.97
93981	Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study	$74.67	$21.28	$53.39	5522	$108.97
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	$133.40	$24.43	$108.97	5522	$108.97
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	$269.21	$39.08	$230.13	5523	$230.13
93986	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study	$133.05	$24.08	$108.97	5522	$108.97
76706	Ultrasound, real time with image documentation; for abdominal aortic aneurysm (AAA) screening.	$112.36	$27.57	$84.79	5522	$108.97

*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/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-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/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-fc