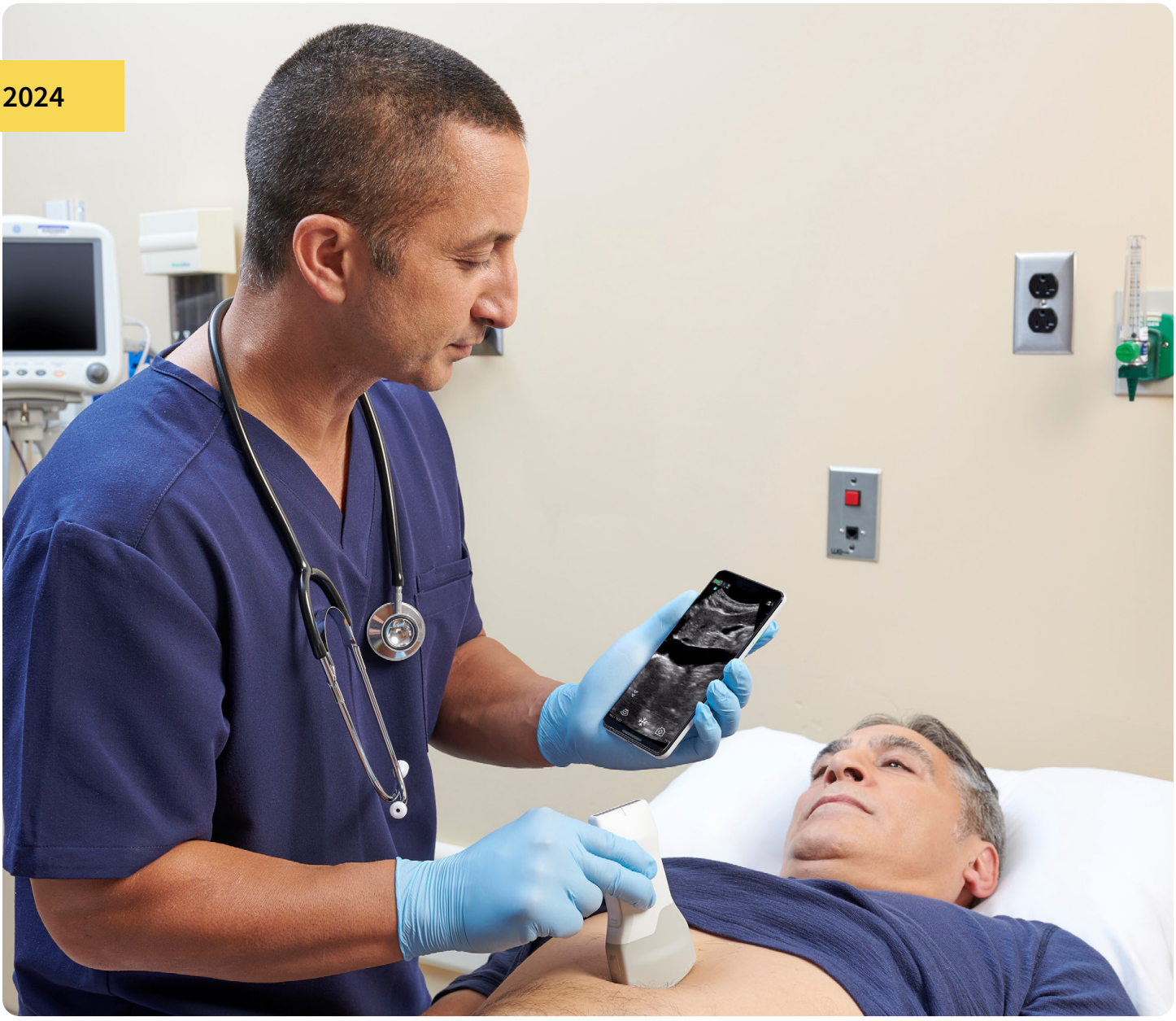
GE HealthCare

Reimbursement information for diagnostic ultrasound procedures completed with a Vscan™ Family ultrasound device[1]

2024



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This overview addresses coding, coverage, and payment for diagnostic ultrasound procedures performed with pocket-sized ultrasound visualization tools in the general practitioner and family practice physician office settings.[2] A pocket-sized ultrasound is a small, battery-powered device that fits in a physician's pocket and is intended for use in performing focused, non-invasive diagnostic ultrasound imaging, to assist physicians with real-time, point-of-care visual information at the bedside. 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®)[3] coding, definitions, and Medicare reimbursement

The following tables provide CPT coding and 2024 Medicare national average reimbursement for the physician facility and non-facility settings of care. Payment will vary by geographic location. Physician Non-facility values are shown as the Global value along with the Professional Component (PC –26) and Technical Component (TC).

▶ New CPT code
▶ Updated CPT description

A2 — Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
G2 — Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
J8 — Device-intensive procedure; paid at adjusted rate.
N1 — Packaged service/item; no separate payment made.
P3 — Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PE RVUs; payment based on MPFS non-facility PE RVUs.
Z2 — Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3 — Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS non-facility PE RVUs.

Anesthesiology

CPT	Description	Physician Non-facility payment**[4]	APC code[5]	APC payment[5]	ASC payment indicator	ASC payment[6]
76942	Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation	**Global:** $57.92 **Professional:** $29.63 **Technical:** $28.29	Packaged. No extra payment.		N1	Packaged. No extra payment.
76937	Ultrasonic 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)	**Global:** $38.28 **Professional:** $13.65 **Technical:** $24.63	Packaged. No extra payment.		N1	Packaged. No extra payment.

CPT	Description	Non-facility payment*	Facility payment*	APC code	APC payment	ASC payment indicator	ASC payment
▶ 64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	$75.56	$52.59	5441	$282.20	P3	$36.95
▶ 64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	$133.82	$68.57	5443	$868.45	A2	$472.76
▶ 64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed	$160.11	$63.25	5443	$868.45	A2	$472.76
▶ 64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	$86.22	$54.92	5442	$658.90	P3	$45.60
▶ 64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	$97.87	$57.59	5442	$658.90	A2	$358.69

Anesthesiology cont.

CPT	Description	Non-facility payment	Facility payment	APC code	APC payment	ASC payment indicator	ASC payment
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (list separately in addition to code for primary procedure)	$33.29	$24.63	5443	$868.45	A2	$472.76
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	$110.52	$53.93	5442	$658.90	P3	$73.90
64445	"Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed	$158.45	$71.24	5442	$658.90	P3	$107.51
64446	"Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	n/a	$74.23	5443	$868.45	G2	$472.76
64447	"Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	$115.84	$62.25	5442	$658.90	P3	$67.57
64448	"Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	n/a	$70.90	5443	$868.45	J8	$646.31
64450	"Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	$75.23	$41.61	5442	$658.90	P3	$47.27

Ultrasound Guidance of Regional Anesthesia in the ASC

CPT	Description	Professional payment	APC code	APC payment	ASC payment indicator	ASC payment
76942	Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$29.63	Packaged. No extra payment.		N1	Packaged. No extra payment.
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	$68.57	5443	$868.45	A2	$472.76
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed	$63.25	5443	$868.45	A2	$472.76
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	$54.92	5442	$658.90	P3	$45.60
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	$57.59	5442	$658.90	A2	$358.69
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (list separately in addition to code for primary procedure)	$24.63	5443	$868.45	A2	$472.76
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	$53.93	5442	$658.90	P3	$73.90
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed	$71.24	5442	$658.90	P3	$107.51
64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	$74.23	5443	$868.45	G2	$472.76
64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	$62.25	5442	$658.90	P3	$67.57
64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed	$70.90	5443	$868.45	J8	$646.31
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	$41.61	5442	$658.90	P3	$47.27

Echocardiograph

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
93304	Transthoracic echocardiography for congenital cardiac anomalies, follow-up or limited	**Global:** $155.12 **Professional:** $34.95 **Technical:** $120.17	5524	$525.63	Not listed on ASC fee schedule.	

Emergency Medicine

CPT	Description	Professional payment	APC code	APC payment	ASC payment indicator	ASC payment
76604	Ultrasound, chest (includes mediastinum), real-time with image documentation	$26.63	5522	$104.75	N1	Packaged. No extra payment.
76705	Ultrasound, abdominal, real-time with image documentation; limited (e.g. single organ, quadrant, follow-up)	$27.30	5522	$104.75	Z2	$57.02
76775	Ultrasound retroperitoneal (e.g. renal, aorta, nodes), real-time with image documentation; limited	$26.96	5522	$104.75	N1	Packaged. No extra payment.
76815	Ultrasound, pregnant uterus, real-time with image documentation, limited (e.g. fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	$30.29	5522	$104.75	N1	Packaged. No extra payment.
76857	Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up (e.g. for follicles)	$22.97	5522	$104.75	Z3	$31.63
76937	Ultrasonic 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)	$13.65	Packaged. No extra payment.		N1	Packaged. No extra payment.
76942	Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection localization device), imaging supervision and interpretation	$29.63	Packaged. No extra payment.		N1	Packaged. No extra payment.
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	$24.30	5523	$233.47	Not listed on ASC fee schedule.	

Endocrinology

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
76536	Ultrasound, soft tissues of head and neck (e.g. thyroid, parathyroid, parotid), real-time with image documentation	**Global:** $110.18 **Professional:** $26.30 **Technical:** $83.88	5522	$104.75	N1	Packaged. No extra payment.
76942	Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation	**Global:** $57.90 **Professional:** $29.63 **Technical:** $28.29	Packaged. No extra payment.		N1	Packaged. No extra payment.

Endocrinology cont.

CPT	Description	Non-facility payment	Facility payment	APC code	APC payment	ASC payment indicator	ASC payment
10005	Fine needle aspiration biopsy; including ultrasound guidance; first lesion	$134.15	$71.90	5071	$670.36	G2	$364.93
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (list separately in addition to code for primary procedure)	$59.92	$49.27	Packaged. No extra payment.		N1	Packaged. No extra payment.
60100	Biopsy, thyroid, percutaneous core needle	$109.52	$75.23	5071	$670.36	P3	$51.93

Musculoskeletal Applications — Ultrasound Services

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
76881	Ultrasound, complete joint (i.e. joint space and periarticular soft tissue structure(s)) real-time with image documentation	**Global:** $53.59 **Professional:** $42.61 **Technical:** $10.99	5522	$104.75	Z3	$21.97
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (e.g. joint space, periarticular tendon(s), muscle(s), nerve(s), other soft tissue structure(s), or soft tissue mass[es]) real-time with image documentation	**Global:** $63.25 **Professional:** $32.29 **Technical:** $30.96	5522	$104.75	N1	Packaged. No extra payment.
76942	Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation	**Global:** $57.92 **Professional:** $29.63 **Technical:** $28.29	Packaged. No extra payment.		N1	Packaged. No extra payment.
76883	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity	**Global:** $71.24 **Professional:** $56.92 **Technical:** $14.31	5522	$104.75	Not listed on ASC fee schedule.	

Musculoskeletal Applications — Procedures that include ultrasound guidance

CPT	Description	Non-facility payment	Facility payment	APC code	APC payment	ASC payment indicator	ASC payment
20526	Injection, therapeutic (e.g. local anesthetic, corticosteroid), carpal tunnel	$82.55	$56.59	5441	$282.20	P3	$45.60
20527	Injection, enzyme (e.g. collagenase), palmar fascial cord (i.e. Dupuytren's contracture)	$87.88	$65.58	5441	$282.20	P3	$48.27
20550	Injection(s) single tendon sheath, or ligament, aponeurosis (e.g. plantar “fascia”)	$57.92	$38.60	5441	$282.20	P3	$29.62
20551	Injection(s); single tendon origin/insertion	$57.59	$38.28	5441	$282.20	P3	$29.62
20552	Injection(s), single to multiple trigger point(s), one or two muscle(s)	$52.59	$36.62	5441	$282.20	P3	$27.97
20553	Injection(s), single to multiple trigger point(s), three or more muscle(s)	$60.58	$41.61	5441	$282.20	P3	$32.62

Musculoskeletal Applications — Procedures that include ultrasound guidance cont.

CPT	Description	Non-facility payment	Facility payment	APC code	APC payment	ASC payment indicator	ASC payment
20612	Aspiration and/or injection of ganglion cyst(s), any location	$65.24	$40.94	5441	$282.20	P3	$38.61
10005	Fine needle aspiration biopsy; including ultrasound guidance; first lesion	$134.15	$71.90	5071	$670.36	G2	$364.93
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (list separately in addition to code for primary procedure)	$59.92	$49.27	Packaged. No extra payment.		N1	Packaged. No extra payment.
20604	Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g. fingers, toes) with ultrasound guidance, with permanent recording and reporting	$82.89	$45.27	5441	$282.20	P3	$49.94
20606	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g. temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) with ultrasound guidance, with permanent recording and reporting	$90.21	$51.60	5442	$658.90	P3	$52.60
20611	Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g. shoulder, hip, knee joint, subacromial bursa) with ultrasound guidance, with permanent recording and reporting	$99.53	$58.59	5441	$282.20	P3	$57.92

Obstetrics and Gynecology

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
Obstetrical						
76801	Ultrasound, pregnant uterus, real-time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation	**Global:** $117.17 **Professional:** $46.27 **Technical:** $70.90	5522	$104.75	Z2	$57.02
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (list separately in addition to code for primary procedure)	**Global:** $59.92 **Professional:** $38.95 **Technical:** $20.97	Packaged. No extra payment.		N1	Packaged. No extra payment.
76805	Ultrasound, pregnant uterus, real-time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks, 0 days), transabdominal approach; single or first gestation	**Global:** $135.48 **Professional:** $46.60 **Technical:** $88.88	5522	$104.75	Z2	$57.02
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (list separately in addition to code for primary procedure)	**Global:** $87.21 **Professional:** $45.94 **Technical:** $41.28	Packaged. No extra payment.		N1	Packaged. No extra payment.
76815	Ultrasound, pregnant uterus, real-time with image documentation, limited (e.g. fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	**Global:** $80.89 **Professional:** $30.29 **Technical:** $50.60	5522	$104.75	N1	Packaged. No extra payment.
76816	Ultrasound, pregnant uterus, real-time with image documentation, follow-up (e.g. re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus	**Global:** $109.85 **Professional:** $39.95 **Technical:** $69.90	5522	$104.75	N1	Packaged. No extra payment.
76818	Fetal biophysical profile; with non-stress testing	**Global:** $118.50 **Professional:** $49.27 **Technical:** $69.24	5522	$104.75	Z2	$57.02
76819	Fetal biophysical profile; without non-stress testing	**Global:** $85.55 **Professional:** $35.95 **Technical:** $49.60	5522	$104.75	Z3	$58.59

Obstetrics and Gynecology cont.

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
Non-Obstetrical						
76856	Ultrasound, pelvic (non-obstetric), real-time with image documentation; complete	**Global:** $105.19 **Professional:** $31.96 **Technical:** $73.23	5522	$104.75	Z2	$57.02
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (e.g. for follicles)	**Global:** $49.27 **Professional:** $22.97 **Technical:** $26.30	5522	$104.75	Z3	$31.63
Procedure Guidance						
76942	Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation	**Global:** $57.92 **Professional:** $29.63 **Technical:** $28.29	Packaged. No extra payment.		N1	Packaged. No extra payment.
76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	**Global:** $33.29 **Professional:** $17.98 **Technical:** $15.31	Packaged. No extra payment.		N1	Packaged. No extra payment.

Pain Management

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
76942	Ultrasonic guidance for needle placement (e.g. biopsy, aspiration injection, localization device), imaging supervision and interpretation	**Global:** $57.92 **Professional:** $29.63 **Technical:** $28.29	Packaged. No extra payment.		N1	Packaged. No extra payment.

CPT	Description	Non-facility payment	Facility payment	APC code	APC payment	ASC payment indicator	ASC payment
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	$75.56	$52.59	5441	$282.20	P3	$36.95
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	$133.82	$68.57	5443	$868.45	A2	$472.76
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed	$160.11	$63.25	5443	$868.45	A2	$472.76
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	$86.22	$54.92	5442	$658.90	P3	$45.60
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	$97.87	$57.59	5442	$658.90	A2	$358.69
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (list separately in addition to code for primary procedure)	$33.29	$24.63	5443	$868.45	A2	$472.76
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	$110.52	$53.93	5442	$658.90	P3	$73.90
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed	$158.45	$71.24	5442	$658.90	P3	$107.51
64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	$115.84	$62.25	5442	$658.90	P3	$67.57

Pain Management cont.

CPT	Description	Non-facility payment	Facility payment	APC code	APC payment	ASC payment indicator	ASC payment
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	$75.23	$41.61	5442	$658.90	P3	$47.27
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	$146.47	$76.56	5443	$868.45	A2	$472.76

Pulmonary Medicine

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
76604	Ultrasound, chest (includes mediastinum), real-time with image documentation	**Global:** $56.92 **Professional:** $26.63 **Technical:** $30.29	5522	$104.75	N1	Packaged. No extra payment.

CPT	Description	Non-facility payment	Facility payment	APC code	APC payment	ASC payment indicator	ASC payment
32555	Thoracentesis, needle or catheter, aspiration of the pleural space, with image guidance	$311.24	$106.52	5181	$598.55	G2	$325.84
32557	Pleural drainage, percutaneous, with insertion of indwelling catheter, with image guidance	$652.43	$145.47	5182	$1,525.93	G2	$619.11

Surgery

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
76536	Ultrasound, soft tissues of head and neck (e.g. thyroid, parathyroid, parotid), real-time with image documentation	**Global:** $110.18 **Professional:** $26.30 **Technical:** $83.88	5522	$104.75	N1	Packaged. No extra payment.
76641	Ultrasound, breast unilateral, real-time with image documentation including axilla when performed; complete	**Global:** $102.53 **Professional:** $34.29 **Technical:** $68.24	5522	$104.75	N1	Packaged. No extra payment.
76642	Ultrasound, breast unilateral, real-time with image documentation including axilla when performed; limited.	**Global:** $84.88 **Professional:** $31.96 **Technical:** $52.93	5521	$86.58	N1	Packaged. No extra payment.
76705	Ultrasound, abdominal, real-time with image documentation limited (e.g. single organ, quadrant, follow-up)	**Global:** $86.88 **Professional:** $27.30 **Technical:** $59.59	5522	$104.75	Z2	$57.02
76942	Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation	**Global:** $57.92 **Professional:** $29.63 **Technical:** $28.29	Packaged. No extra payment.		N1	Packaged. No extra payment.
76998	Ultrasonic guidance, intraoperative	**Global:** No payment **Professional:** $45.94 **Technical:** No payment	Packaged. No extra payment.		N1	Packaged. No extra payment.

Surgery cont.

CPT	Description	Non-facility payment	Facility payment	APC code	APC payment	ASC payment indicator	ASC payment
10005	Fine needle aspiration biopsy; including ultrasound guidance; first lesion	$134.15	$71.90	5071	$670.36	G2	$364.93
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (list separately in addition to code for primary procedure)	$59.92	$49.27	Packaged. No extra payment.		N1	Packaged. No extra payment.
19000	Puncture aspiration of cyst of breast	$100.20	$41.61	5071	$670.36	P3	$68.57
19083	Biopsy, breast, with placement of breast localization device(s) when performed and imaging of biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	$492.66	$150.79	5072	$1,544.75	G2	$682.83
19084	Biopsy, breast, with placement of breast localization device(s) (e.g. clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure)	$373.82	$75.23	Packaged. No extra payment.		N1	Packaged. No extra payment.
19285	Placement of breast localization device(s) (e.g. clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	$363.17	$82.22	5071	$670.36	N1	Packaged. No extra payment.
19286	Placement of breast localization device(s) (e.g. clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure)	$296.59	$41.28	Packaged. No extra payment.		N1	Packaged. No extra payment.
60100	Biopsy, thyroid, percutaneous, core needle	$109.52	$75.23	5071	$670.36	P3	$51.93

Vascular Access

CPT	Description	Physician payment	APC code	APC payment	ASC payment indicator	ASC payment
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)	**Global:** $38.28 **Professional:** $13.65 **Technical:** $24.63	Packaged. No extra payment.		N1	Packaged. No extra payment.

Vascular Surgery

CPT	Description	Physician Non-facility payment	APC code	APC payment	ASC payment indicator	ASC payment
76998	Ultrasonic guidance, intraoperative	**Global:** No payment **Professional:** $45.94 **Technical:** No payment	Packaged. No extra payment.		N1	Packaged. No extra payment.
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	**Global:** $106.52 **Professional:** $25.63 **Technical:** $80.89	5522	$104.75	Not listed on ASC fee schedule.	

Billing criteria

The use of a pocket-sized ultrasound device may be billable in certain circumstances. Any use has minimum criteria that have to be met before it can be billed separately from an initial evaluation ultrasound exam. When the pocket-sized ultrasound device is used for a quick look, and if it is necessary for a follow-up ultrasound to be performed on the patient to determine or conclude the patient's condition, this would be considered part of the initial exam, or Evaluation and Management (E/M) examination being performed.

In addition, if the pocket-sized ultrasound device is used as an extension of the patient's physical examination, it would not be appropriate to bill separately for these ultrasound exams. Rather, these ultrasound exams would be included as an extension of an E/M examination. Refer to your coding manual to select appropriate CPT codes that address E/M examinations.

Diagnostic Use of Pocket-Sized Ultrasound Device

If use of the pocket-sized ultrasound device is medically necessary, it should be well documented in the patient's medical record, be performed by a qualified provider, and meet all Medicare requirements, including documentation and storage of images. In such cases, it may be possible for it to be billed and considered for coverage and payment by a payer.

Billing requirements for pocket-sized ultrasound device

According to many local Medicare contractors, billing for a limited diagnostic ultrasound procedure requires that the following minimum requirements be met:

- It should be done for the same purpose as a reasonable physician would order a standard ultrasound.
- It must be billed using the CPT code that accurately describes the service performed.
- The technical quality of the exam must be in keeping with the accepted national standards and not require a follow-up ultrasound to confirm the results.
- The study must be performed and interpreted by qualified individuals.
- The medical necessity, images, findings, interpretation, and report must be documented in the medical record.
- It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.

Qualifications of personnel

The American Medical Association (AMA) policy states:[3]

H-230.960 Privileging for Ultrasound Imaging

1. AMA affirms that ultrasound imaging is within the scope of practice of appropriately trained physicians
2. AMA policy on ultrasound acknowledges that broad and diverse use and application of ultrasound imaging technologies exist in medical practice
3. AMA policy on ultrasound imaging affirms that privileging of the physician to perform ultrasound imaging procedures in a hospital setting should be a function of hospital medical staffs and should be specifically delineated on the Department's Delineation of Privileges form
4. AMA policy on ultrasound imaging states that each hospital medical staff should review and approve criteria for granting ultrasound privileges based upon background and training for the use of ultrasound technology and strongly recommends that these criteria are in accordance with recommended training and education standards developed by each physician's respective specialty. (Res. 802, I-99; Reaffirmed: Sub. Res. 108, A-00 / Reaffirmed: CMS Rep. 6, A-10)

Documentation requirements

Ultrasound performed using a pocket-sized device, a handheld ultrasound, a compact portable, or a console ultrasound system may be reported using the same CPT codes as long as the studies performed meet the requirements addressed above, as well as 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 ultrasound procedure(s) should be maintained in the patient record.4 This should include a description of the structures or organs examined, the findings, and reason for the ultrasound procedure(s). Images are to be labeled with patient identification, facility identification, examination date, the anatomical site imaged, transducer orientation, and the initials of the operator. The use of ultrasound without a thorough evaluation of organ(s) or anatomical region, image documentation, and final written report is not separately reportable.

In order to be separately reportable, diagnostic ultrasound procedures require the production and retention of image documentation. It is recommended that permanent ultrasound images, either electronic or hard copy, from all ultrasound services be retained in the patient record or other appropriate archive.

Coverage policies

Use of diagnostic ultrasound services may be a covered benefit if such usage meets all requirements established by that particular payer. It is advisable that you check with your local Medicare contractor for specific coverage requirements. 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.

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 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).

52: Reduced Services

This modifier would be used in certain circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion.

76: Repeat Procedure by Same Physician

This modifier is defined as a repeat procedure by the physician on the same date of service or patient session. The CPT defines "same physician" as not only the physician doing the procedure, but also as a physician of the same specialty working for the same medical group/employer.

77: Repeat Procedure by Another Physician

This modifier is defined as a repeat procedure by another physician on the same date of service or patient session. "Another physician" refers to a physician in a different specialty or one who works for a different group/employer. Medical necessity for repeating the procedure must be documented in the medical record in addition to the use of the modifier.

ICD-10-CM diagnosis coding

It is the physician's ultimate responsibility to select the codes that appropriately represent the service performed, and to report the ICD-10-CM code based on his or her findings or the pre-service signs, symptoms, or conditions that reflect the reason for performing the ultrasound.

Limited vs. complete ultrasound

Complete and limited ultrasound studies are defined in the ultrasound introductory section notes of the CPT 2023 procedural code book. According to CPT, the report should contain a description of all elements or the reason that an element could not be visualized. As stated in the guidelines:

"If less than the required elements for a 'complete' exam are reported (e.g. limited number of organs or limited portion of region evaluated), the limited code for that anatomic region should be used once per patient exam session." [5]

Other considerations

The American Society of Echocardiography (ASE) published a position statement (J Am Soc Echocardiog 2002; 15: 369-73) about hand-carried ultrasound in April 2002. This position establishes that:

"The safety and effectiveness of a diagnostic study should be judged on the medical indications of the study, the qualifications and experience of the providers of service, the quality and completeness of the diagnostic information obtained, and the adherence to published and widely accepted professional standards and processes developed, and not based on the size or cost of the instrumentation used to perform the study." [6]

Furthermore, the ASE document states the technical capabilities of Hand Carried Ultrasound (HCU) equipment do not themselves serve as a means for distinguishing a complete or limited echocardiogram from an extension of a physical exam. Therefore, if the appropriate images and data are recorded as follows, the study should be considered an independent diagnostic test, rather than an extension of the patient's physical examination.

Therefore, if the appropriate images and data are recorded as follows, the study should be considered an independent diagnostic test, rather than an extension of the patient's physical examination:

- A qualified sonographer or physician interprets the ultrasound exam
- Interpreted by a physician with a level 2 (or higher) training in echocardiography (level 2 is described by the American College of Cardiology (ACC) here: www.acc.org/~/media/non-clinical/files-pdfs-excel-ms-word-etc/ guidelines/2015/031315_cocats4_unified_document.pdf
- Reported in an appropriate manner
- Archived properly
- The study was performed for an approved clinical indication

Disclaimer

The information provided with this notice is general reimbursement information only; it is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. It is always the provider's responsibility to determine and submit appropriate codes, charges, modifiers and bills for the services that were rendered. This information is provided as of January 1st, 2024. All coding and reimbursement information is subject to change without notice. Payers or their local branches may have distinct coding and reimbursement requirements and policies. Before filing any claims, providers should verify current requirements and policies with the
local payer.

Third party reimbursement amounts and coverage policies for specific procedures will vary including by payer, time period and locality, as well as by type of provider entity.
This document is not intended to interfere with a health care professional's independent clinical decision making. Other important considerations should be taken into account when making decisions, including clinical value. The health care provider has the responsibility, when billing to government and other payers (including patients), to submit claims or invoices for payment only for procedures which are appropriate and medically necessary. You should consult with your reimbursement manager or healthcare consultant, as well as experienced legal counsel.

1. Information presented in this document is current as of January 1st, 2024. 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. https://policysearch.ama-assn.org/policyfinder/detail/Ultrasound%20imaging?uri=%2FAMADoc%2FHOD.xml-0-1591.xml
4. Certain Medicare carriers require that the physician who performs and/or interprets some types of ultrasound examinations prove that they have undergone training through recent residency training or postgraduate CME and experience. For further details, contact your Medicare contractor.
5. 2023 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.
6. American Society of Echocardiology Report on Hand Carried Ultrasound (HCU) - April 2002 (J AM Soc Echocardiog 2002; 15:369-73).
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 88/November 18th, 2022. These changes are effective for services provided from 1/1/2023 through 12/31/2023. 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.
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 88/November 18th, 2022. These changes are effective for services provided from 1/1/2023 through 12/31/2023. 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.

* Physician 'Facility' = Procedure done in a facility other than the physician's office.
'Physician Non-facility' = Physician's office.

** Professional is the physician payment (–26). Technical is the facility payment (TC).

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