Reimbursement Information for Diagnostic Ultrasound Procedures[1] Completed with a Vscan Family Pocket Sized Ultrasound Device by Primary Care Physicians

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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.

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 using the pocket-sized ultrasound device 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 in 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 the pocket-sized ultrasound device is being utilized for a documented appropriate medical necessity, is being performed by appropriately qualified providers and meets all Medicare requirements including documentation and storage of images, 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 of the local Medicare Contractors, billing for a limited diagnostic ultrasound procedure requires that the following minimum requirements be met:

1. It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
2. It should be done for the same purpose as a reasonable physician would order a standard ultrasound.
3. It must be billed using the CPT code that accurately describes the service performed.
4. 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.
5. The study must be performed and interpreted by qualified individuals.
6. The medical necessity, images, findings, interpretation and report must be documented in the medical record.

Payers or their local branches and the local Medicare Contractors may have distinct requirements and policies. Before filing any claims, providers should verify current requirements and policies with the local payer and/or Medicare contractor.

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; and
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; and
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, 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 2020 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.

- A qualified sonographer or physician and interpret 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: (https://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

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Current Procedural Terminology (CPT) Coding, Definitions and Medicare Payment Rates

2020 Reimbursement Rates

If the ultrasound procedure is performed with a pocket-sized ultrasound device and does not meet all of the aforementioned requirements, it would not be considered to be separately reportable. It would be considered part of the physical exam.

The following are diagnostic ultrasound CPT codes that may apply depending on where on the body the ultrasound was performed. Also included are the 2020 national average Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Ambulatory Payment Category (APC) payment rates for the CPT codes. Payment will vary in geographic locality.

Not all codes apply to every product in the Vscan pocket sized ultrasound family – please see Indications for Use and/or User Manual for applications by product.

2020 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician office setting.

CPT[7] Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Amount[8]	APC	Hospital Outpatient Payment[9]
Chest Ultrasound				
76604 Ultrasound, chest (includes mediastinum), real-time with image documentation	Professional (-26)	$29.59	5522	$112.08
	Technical (-TC)	$50.89		
	Global	$80.48		
OB/GYN				
76815 Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	Professional (-26)	$33.20	5522	$112.08
	Technical (-TC)	$52.33		
	Global	$85.53		
76946 Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	Professional (-26)	$19.13	N/A	Bundled service. No separate payment
	Technical (-TC)	$13.71		
	Global	$32.84		
Primary Care Ultrasound				
76705 Ultrasound, abdominal, real-time with image documentation; limited (eg, single organ, quadrant, follow-up)	Professional (-26)	$29.95	5522	$112.08
	Technical (-TC)	$62.80		
	Global	$92.75		
76775 Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real-time with image documentation; limited	Professional (-26)	$29.59	5522	$112.08
	Technical (-TC)	$30.32		
	Global	$59.91		
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 (-26)	$24.90	5522	$112.08
	Technical (-TC)	$33.20		
	Global	$58.10		
76999 Unlisted ultrasound procedure (eg, diagnostic, interventional)	Professional (-26)	Carrier priced	5521	$79.81
	Technical (-TC)	Carrier priced		
	Global	Carrier priced		
76857 Ultrasound, pelvic (nonobstetric), real-time with image documentation; limited or follow-up (eg, for follicles)	Professional (-26)	$25.26	8004	$112.08
	Technical (-TC)	$24.18		
	Global	$49.44		
93304 Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	Professional (-26)	$37.53	5524	$481.58
	Technical (-TC)	$125.59		
	Global	$163.12		
93308 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-Mode recording, when performed, follow-up or limited study[†]	Professional (-26)	$26.35	5523	$233.04
	Technical (-TC)	$74.34		
	Global	$100.69		

2020 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician office setting. *(cont.)*

CPT[5] Code	Physician		Facility	
	Reimbursement Component	Medicare Physician Fee Schedule Amount	APC	Hospital Outpatient Payment
Primary Care Ultrasound (cont.)				
93882 Duplex scan of extracranial arteries; unilateral or limited study	Professional (-26)	$25.98	5522	$112.08
	Technical (-TC)	$105.38		
	Global	$131.37		
Image Guidance				
76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Professional (-26)	$32.48	N/A	Bundled Service. No Separate Payment
	Technical (-TC)	$25.98		
	Global	$58.47		
Vascular/Vascular Access				
93971 Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited	Professional (-26)	$22.74	5522	$112.08
	Technical (-TC)	$101.41		
	Global	$124.15		
93979 Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study	Professional (-26)	$25.26	5522	$112.08
	Technical (-TC)	$98.16		
	Global	$123.43		
Urology				
51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	Facility	$10.47	5733	$55.01
	Non-Facility	$10.47		

References

1. Information presented in this document is current as of February 24, 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 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 to prove that they have undergone training through recent residency training or postgraduate CME and experience. For further details, contact your Medicare Contractor.
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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. 84, No. 221/Wednesday, November 15, 2019. 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. 84, No. 218/ Tuesday, November 12, 2019. 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.

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