Reimbursement Information for General Imaging Ultrasound[1]

March 2022

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This overview addresses coding, coverage, and payment for ultrasound procedures when performed in the physician's office, hospital outpatient department, and ambulatory surgery center settings.[2] This advisory focuses on Medicare program policies. Medicare Payments listed in this advisory are 2022 national average payments. Non-Medicare payers may have different guidelines for coding, coverage and reimbursement for the procedures discussed in this document. For appropriate code selection, it is recommended that you contact your local payer prior to claims submittal.

Current Procedural Terminology (CPT®)[3] Coding, Definitions and Medicare Reimbursement

The following table provides CPT[3] coding for general ultrasound procedures, with 2022 Medicare national average payment for the physician, hospital outpatient and ambulatory surgery center (ASC) settings of care. Payment will vary by geographic location.

CPT®[3] Code / Description	Physician		Facility		
		Medicare Physician Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Abdomen Ultrasound					
76700 Ultrasound, abdominal, real-time with image documentation; complete	Professional (-26)*	$39.45	5522	$111.19	$56.34
	Technical (-TC)**	$82.71			
	Global	$122.16			
76705 Ultrasound, abdominal, real-time with image documentation; limited (e.g., single organ, quadrant, follow-up)	Professional (-26)*	$29.07	5522	$111.19	$56.34
	Technical (-TC)**	$62.29			
	Global	$91.36			
76706 Ultrasound, abdominal aorta, real-time with image documentation, screening study for dominal aortic aneurysm (AAA)	Professional (-26)*	$26.99	5522	$111.19	NA
	Technical (-TC)**	$84.09			
	Global $115.85	$111.09			
76770 Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real-time with image documentation; complete	Professional (-26)*	$35.99	5522	$111.19	$56.34
	Technical (-TC)**	$77.17			
	Global	$113.16			
76775 Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real-time with image documentation; limited	Professional (-26)*	$28.38	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$31.49			
	Global	$59.87			
76776 Ultrasound, transplanted kidney, real-time and duplex Doppler with image documentation	Professional (-26)*	$37.03	55228	$111.19	$56.34
	Technical (-TC)**	$118.35			
	Global	$155.38			
Bone Density					
76977 Ultrasound bone density measurement and interpretation, peripheral site(s), any method	Professional (-26)*	$2.77	5522	$111.19	$4.15
	Technical (-TC)**	$4.50			
	Global	$7.27			
Breast/Chest Ultrasound					
76641 Ultrasound, breast, unilateral, real-time with image documentation, including axilla when performed; complete	Professional (-26)*	$35.64	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$71.63			
	Global	$107.28			
76642 Ultrasound, breast, unilateral, real-time with image documentation, including axilla when performed; limited	Professional (-26)*	$33.22	5521	$82.61	Packaged. No extra payment.
	Technical (-TC)**	$54.68			
	Global	$87.90			
76604 Ultrasound, chest (includes mediastinum), real-time with image documentation	Professional (-26)*	$29.38	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$31.84			
	Global	$60.21			

CPT[3] Coding, Definitions and Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
		Medicare Physician Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Elastography Ultrasound					
76981 Ultrasound, elastography; parenchyma (e.g., organ)	Professional (-26)*	$29.42	5522	$111.19	$56.34
	Technical (-TC)**	$78.90			
	Global	$108.32			
76982 Ultrasound, elastography; first target lesion	Professional (-26)*	$24.92	5522	$111.19	$56.34
	Technical (-TC)**	$38.41			
	Global	$97.59			
+76983 Ultrasound, elastography; each additional target lesion (List separately in addition to code for primary procedure)	Professional (-26)*	$24.92	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$38.41			
	Global $60.27	$63.33			
Endoscopic Ultrasound					
76975 Gastrointestinal endoscopic ultrasound, supervision and interpretation	Non-facility	$41.18	5523	$235.00	Packaged. No extra payment.
	Facility	$41.18			
Extremities Ultrasound					
76881 Ultrasound, complete joint (i.e., joint space and peri-articular soft-tissue structures), real-time with image documentation	Professional (-26)*	$30.80	5522	$111.19	$29.07
	Technical (-TC)**	$29.42			
	Global	$60.21			
76882 Ultrasound, limited, joint or other nonvascular extremity structure(s) (e.g., 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)*	$23.53	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$34.26			
	Global	$57.59			
76885 Ultrasound, infant hips, real-time with imaging documentation; dynamic (requiring physician or other qualified health care professional manipulation)	Professional (-26)*	$36.34	5521	$82.61	Packaged. No extra payment.
	Technical (-TC)**	$106.93			
	Global	$143.27			
76886 Ultrasound, infant hips, real-time with imaging documentation; limited, static (not requiring physician or other qualified health care professional manipulation)	Professional (-26)*	$30.45	5521	$82.61	Packaged. No extra payment.
	Technical (-TC)**	$74.40			
	Global	$104.86			
Head/Neck/Spine Ultrasound					
76536 Ultrasound, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), real-time with image documentation	Professional (-26)*	$28.03	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$88.59			
	Global	$116.92			
76800 Ultrasound, spinal canal and contents	Professional (-26)*	$60.56	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$91.01			
	Global	$151.58			

CPT[3] Coding, Definitions and Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
		Medicare Physician Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Genitalia: Male and Female Ultrasound					
76830 Ultrasound, transvaginal	Professional (-26)*	$33.91	5522	$111.19	$56.34
	Technical (-TC)**	$91.01			
	Global	$124.93			
76856 Ultrasound, pelvic (nonobstetric), real-time with image documentation; complete	Professional (-26)*	$33.91	5522	$111.19	$56.34
	Technical (-TC)**	$76.48			
	Global	$110.39			
76857 Ultrasound, pelvic (nonobstetric), real-time with image documentation; limited or follow-up (e.g., for follicles)	Professional (-26)*	$23.88	5522	$111.19	$24.92
	Technical (-TC)**	$25.26			
	Global $49.44	$49.14			
76870 Ultrasound, scrotum and contents	Professional (-26)*	$31.49	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$73.71			
	Global	$105.20			
76872 Ultrasound, transrectal	Professional (-26)*	$32.88	5522	$111.19	$56.34
	Technical (-TC)**	$178.57			
	Global	$211.44			
76873 Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)	Professional (-26)*	$77.17	5522	$111.19	$56.34
	Technical (-TC)**	$102.09			
	Global	$179.26			
Imaging Guidance Ultrasound					
76936 Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)	Professional (-26)*	$96.21	5722	$270.29	$136.94
	Technical (-TC)**	$175.11			
	Global	$271.31			
+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 (List separately in addition to code for primary procedure)	Professional (-26)*	$13.84	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$26.65			
	Global	$40.49			
76940 Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	Non-facility	$101.40	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Facility	$101.40			

CPT[3] Coding, Definitions and Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
		Medicare Physician Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Obstetrics /Gynecology Ultrasound					
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	Professional (-26)*	$48.10	5522	$111.19	$56.34
	Technical (-TC)**	$73.71			
	Global	$121.81			
+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)	Professional (-26)*	$40.84	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$22.15			
	Global	$62.98			
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	Professional (-26)*	$48.45	5522	$111.19	$56.34
	Technical (-TC)**	$91.71			
	Global	$140.16			
+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)	Professional (-26)*	$47.76	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$43.26			
	Global	$91.01			
76811 Ultrasound, pregnant uterus, real-time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation	Professional (-26)*	$93.09	5523	$235.00	$85.13
	Technical (-TC)**	$86.52			
	Global	$179.61			
+76812 Ultrasound, pregnant uterus, real-time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	Professional (-26)*	$87.55	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$112.47			
	Global	$200.02			
76813 Ultrasound, pregnant uterus, real-time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	Professional (-26)*	$57.74	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$64.37			
	Global	$122.16			
+76814 Ultrasound, pregnant uterus, real-time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)	Professional (-26)*	$48.79	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$29.42			
	Global	$78.21			

CPT[3] Coding, Definitions and Medicare Reimbursment *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
		Medicare Physician Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Obstetrics /Gynecology Ultrasound (cont.)					
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), 1 or more fetuses	Professional (-26)*	$31.84	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$52.60			
	Global	$84.44			
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	Professional (-26)*	$41.87	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$71.98			
	Global	$113.85			
76817 Ultrasound, pregnant uterus, real-time with image documentation, transvaginal	Professional (-26)*	$37.03	5522	$111.19	Packaged. No extra payment.
	Technical (-TC)**	$59.52			
	Global	$96.55			
Targeted Dynamic Microbubble Sonographic Contrast Characterization Ultrasound					
76978 Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	Professional (-26)*	$79.25	5571	$182.43	$92.43
	Technical (-TC)**	$230.13			
	Global	$309.38			
+76979 Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)	Professional (-26)*	$41.53	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$163.34			
	Global	$204.87			
Unlisted Ultrasound					
76999 Unlisted ultrasound procedure (eg, diagnostic, interventional)	Non-facility	Carrier priced	5521	$82.61	Packaged. No extra payment.
	Facility	Carrier priced			

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Ablation					
19105 Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	$216.63	$2,534.56	5091	$3,225.00	$1,746.00
50250 Ablation, open, 1 or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound guidance and monitoring, if performed	$1,229.56	NA	NA	Inpatient only	Inpatient only
50542 Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed	$1,179.38	NA	5362	$9,096.46	NA
58674 Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	$837.82	NA	5362	$9,096.46	$3,887.51
0071T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume less than 200 cc of tissue	Carrier priced	Carrier priced	5414	$2,679.56	NA
0072T Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume greater or equal to 200 cc of tissue	Carrier priced	Carrier priced	5414	$2,679.56	NA
0404T Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency	Carrier priced	Carrier priced	5416	$6,933.22	$3,705.10
0421T Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)	Carrier priced	Carrier priced	5376	$8,428.82	$4,152.84
Amniocentesis					
59001 Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)	$181.68	NA	5412	$288.04	$145.93

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Aspiration – Fine Needle					
10005 Fine needle aspiration biopsy, including ultrasound guidance; first lesion	$75.10	$142.23	5071	$635.54	$322.00
+10006 Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)	$51.22	$61.60	NA	Packaged. No extra payment.	Packaged. No extra payment.
Aspiration and/or Injection of Joint					
20600 Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); without ultrasound guidance	$36.34	$54.33	5441	$266.83	$28.38
20604 Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting	$46.72	$84.09	5441	$266.83	$49.83
20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	$37.72	$56.06	5441	$266.83	$29.42
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	$52.60	$91.36	5442	$648.52	$52.95
20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance	$46.03	$66.44	5441	$266.83	$34.95
20611 Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	$60.21	$102.09	5441	$266.83	$59.18

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Biliary Drainage Catheter Placement					
47533 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external	$265.08	$1,250.67	5341	$3,249.35	$1,439.42
47534 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; internal-external	$369.25	$1,362.45	5341	$3,249.35	$1,439.42
Bone Density Measurement					
0508T Pulse-echo ultrasound bone density measurement resulting in indicator of axial bone mineral density, tibia	Carrier priced	Carrier priced	5522	$111.19	$56.34
Bone Marrow Cell Therapy					
0263T Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	Carrier priced	Carrier priced	5243	$4,130.46	$2,092.69
0264T Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	Carrier priced	Carrier priced	5243	$4,130.46	$2,092.69
Breast Biopsy					
19083 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; first lesion, including ultrasound guidance	$157.11	$537.43	5072	$1,436.99	$608.06
+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)	$77.86	$411.47	NA	Packaged. No extra payment.	Packaged. No extra payment.

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Bronchoscopy					
31652 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration(s)/biopsy(ies)), one or two mediastinal and/or hilar lymph node stations or structures	$223.56	$1,366.94	5154	$3,163.58	$1,327.80
31653 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration(s)/biopsy(ies)), 3 or more mediastinal and/or hilar lymph node stations or structures	$247.78	$1,418.85	5154	$3,163.58	$1,327.80
+31654 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure(s))	$67.48	$125.62	NA	Packaged. No extra payment.	Packaged. No extra payment.
Colonoscopy					
44406 Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	$231.52	NA	5312	$1,059.06	$536.57
44407 Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	$278.93	NA	5312	$1,059.06	$536.57
45391 Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	$260.93	NA	5312	$1,059.06	$536.57
45392 Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(ies), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures	$307.30	NA	5312	$1,059.06	$536.57

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Endograft – Femoral Artery					
+34713 Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	$124.93	NA	NA	Packaged. No extra payment.	Packaged. No extra payment.
Endoluminal Imaging – Coronary Artery					
+92978 Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)	$95.86	$95.86	NA	Packaged. No extra payment.	NA
+92979 Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)	$76.48	$76.48	NA	Packaged. No extra payment.	NA
Esophagus					
43231 Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination	$160.57	NA	5302	$1,658.81	$706.21
43232 Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(ies)	$201.75	NA	5302	$1,658.81	$706.21
43237 Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures	$198.29	NA	5302	$1,658.81	$706.21
43238 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/ biopsy(ies), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)	$234.63	NA	5302	$1,658.81	$706.21

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Esophagus (cont.)					
43240 Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter(s)/stent(s), when performed, and endoscopic ultrasound, when performed)	$396.24	NA	5331	$5,140.85	$3,518.52
43242 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(ies) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or asurgically altered stomach where the jejunum is examined distal to the anastomosis)	$266.12	NA	5302	$1,658.81	$706.21
43253 Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (e.g., anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)	$265.78	NA	5302	$1,658.81	$706.21
43259 Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis	$228.05	NA	5302	$1,658.81	$706.21
Implantable Defibrillator					
33274 Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (e.g., fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (e.g., interrogation or programming), when performed	$493.48	NA	5194	$16,402.31	$12,021.98

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Injection of Anesthetic Agent and/or Steroid					
64479 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level	$132.89	$276.85	5443	$840.73	$425.96
+64480 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)	$61.95	$140.50	NA	Packaged. No extra payment.	Packaged. No extra payment.
64483 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	$112.82	$57.47	5443	$840.73	$426.96
+64484 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	$52.26	$116.62	NA	Packaged. No extra payment.	Packaged. No extra payment.
Injection of Biliary Tract					
47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access	$70.25	$456.46	5341	$3,249.35	Packaged. No extra payment.
47532 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (e.g., percutaneous transhepatic cholangiogram)	$211.79	$899.42	5341	$3,249.35	Packaged. No extra payment.
Injection of the Paravertebral Facet Join					
0213T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level	Carrier priced	Carrier priced	5443	$840.73	$425.96
+0214T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)	Carrier priced	Carrier priced	NA	Packaged. No extra payment.	Packaged. No extra payment.

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Injection of the Paravertebral Facet Join (cont.)					
+0215T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)	Carrier priced	Carrier priced	NA	Packaged. No extra payment.	Packaged. No extra payment.
0216T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level	Carrier priced	Carrier priced	5443	$840.73	$425.96
+0217T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)	Carrier priced	Carrier priced	NA	Packaged. No extra payment.	Packaged. No extra payment.
+0218T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)	Carrier priced	Carrier priced	NA	Packaged. No extra payment.	Packaged. No extra payment.
Obstetrics /Gynecology					
59070 Transabdominal amnioinfusion, including ultrasound guidance	$314.22	$409.74	5412	$288.04	$145.93
59072 Fetal umbilical cord occlusion, including ultrasound guidance	$531.21	NA	5412	$288.04	$203.68
59074 Fetal fluid drainage (eg, vesicocentesis, thoracocentesis, paracentesis), including ultrasound guidance	$314.22	$392.78	5412	$288.04	$145.93
59076 Fetal shunt placement, including ultrasound guidance	$531.21	NA	5412	$288.04	$145.93
59897 Unlisted fetal invasive procedure, including ultrasound guidance, when performed	Carrier priced	Carrier priced	5411	$173.99	NA

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Osteogenic Stimulation					
20979 Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)	$32.18	$56.75	5731	$25.23	Packaged. No extra payment.
Physical Therapy Treatment Modality					
97035 Application of a modality to 1 or more areas; ultrasound, each 15 minutes	NA	$14.53	NA	NA	NA
Placement of Localized Markers					
19285 Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance	$85.82	$396.93	5071	$635.54	Packaged. No extra payment.
+19286 Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)	$43.26	$327.72	NA	Packaged. No extra payment.	Packaged. No extra payment.
Renal Procedures					
50389 Removal of nephrostomy tube, requiring fluoroscopic guidance (e.g., with concurrent indwelling ureteral stent)	$53.29	$449.19	5372	$587.56	$297.69
50430 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (e.g., ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	$154.00	$671.71	5372	$587.56	Packaged. No extra payment.
50431 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (e.g., ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	$65.41	$345.37	5372	$587.56	Packaged. No extra payment.
50432 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	$204.52	$969.32	5373	$1,828.65	$816.00

Procedures Using Imaging Guidance and 20202 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Renal Procedures (cont.)					
50433 Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	$253.66	$1,207.76	5374	$3,140.04	$1,428.62
50434 Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	$190.68	$971.40	5373	$1,828.65	$816.00
50435 Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	$100.01	$646.79	5373	$1,828.65	$816.00
50436 Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with post-procedure tube placement, when performed	$150.88	NA	5374	$3,140.04	$1,428.62
50437 Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with post-procedure tube placement, when performed; including new access into the renal collecting system	$249.16	NA	5374	$3,140.04	$1,428.62
+50606 Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	$138.42	$511.83	NA	Packaged. No extra payment.	Packaged. No extra payment.
50693 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	$203.14	$1,064.14	5374	$3,140.04	$1,428.62

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Renal Procedures (cont.)					
50694 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	$265.43	$1,190.45	5374	$3,410.04	$1,428.62
50695 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (e.g., ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	$341.91	$1,430.27	5374	$3,410.04	$1,866.68
+50705 Ureteral embolization or occlusion, including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	$176.15	$1,938.28	NA	Packaged. No extra payment.	Packaged. No extra payment.
Sigmoidoscopy – Flexible					
45341 Sigmoidoscopy, flexible; with endoscopic ultrasound examination	$125.62	NA	5311	$810.48	$410.63
45342 Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(ies)	$171.65	NA	5312	$1,059.06	$537.57
Transcatheter Procedures					
37197 Transcatheter retrieval, percutaneous, of intravascular foreign body (e.g., fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed	$301.77	$1,674.59	5183	$2,923.63	$1,397.78
Shock Wave					
28890 Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	$222.86	$315.26	5112	$1,422.51	$186.18

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Urodynamics					
51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	NA	$10.73	5733	$56.85	Packaged. No extra payment.
Vascular					
37761 Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	$546.43	NA	5183	$2,923.63	$1,397.78
36465 Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (e.g., great saphenous vein, accessory saphenous vein)	$111.74	$1,408.47	5054	$1,749.26	$886.26
36466 Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (e.g., great saphenous vein, accessory saphenous vein), same leg	$155.73	$1,556.93	5054	$1,749.26	$886.26
+37252 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)	$89.63	$1,026.07	NA	Packaged. No extra payment.	Packaged. No extra payment.
+37253 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)	$70.94	$175.45	NA	Packaged. No extra payment.	Packaged. No extra payment.
49185 Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (e.g., ultrasound, fluoroscopy) and radiological supervision and interpretation when performed	$119.39	$1.369.71	5071	$635.54	NA

Procedures Using Imaging Guidance and 2022 Medicare Reimbursement *(cont.)*

CPT®[3] Code / Description	Physician		Facility		
	Medicare Physician Facility Payment[4]	Medicare Physician Non-Facility Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Vascular (cont.)					
46948 Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	$462.68	NA	5313	$2,495.04	$1,174.91
0505T Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion	Carrier priced	Carrier priced	5193	$10,258.49	NA
Vena Cava Filters					
37191 Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	$222.52	$2,199.22	5184	$4,870.25	NA
37192 Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	$349.18	$1,367.64	5183	$2,923.63	NA
37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	$348.83	$1,600.88	5183	$2,923.63	NA
Wound Treatment					
97610 Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	$18.34	$468.91	5051	$183.40	NA

Other Imaging Coding and 2022 Medicare Reimbursement

CPT®[3] Code / Description		Physician	Facility		
		Medicare Physician Payment[4]	APC[5]	Medicare Hospital Outpatient Payment[5]	Medicare ASC Payment[6]
Drainage					
75989 Radiological guidance (i.e., fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (e.g., abscess, specimen collection), with placement of catheter, radiological supervision and interpretation	Professional (-26)*		NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**				
	Global				
MRI					
0398T Magnetic resonance image guided high intensity focused ultrasound (MRgFUS), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed	Non-Facility	Carrier priced	5463	$11,483.38	NA
	Facility	Carrier priced			
Three – Dimensional Manipulation					
76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	Professional (-26)*	$9.69	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$13.84			
	Global	$23.53			
76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	Professional (-26)*	$38.76	NA	Packaged. No extra payment.	Packaged. No extra payment.
	Technical (-TC)**	$35.30			
	Global	$74.06			

Diagnostic Tests – Measurement Codes, used for reporting purposes only. There is no Medicare payment for these CPT codes under the physician, hospital outpatient or ambulatory surgery center fee schedules.

Diagnostic Test
3319F 1 of the following diagnostic imaging studies ordered: chest X-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans (ML)
3320F None of the following diagnostic imaging studies ordered: chest X-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans (ML)
6030F All elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed (CRIT)

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 (Not an all-inclusive list).

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).

59: Distinct Procedural Services
Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier (-59) is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances.

Hospital Inpatient: ICD-10-PCS Procedure Coding
ICD-10-PCS procedure codes are used to report procedures performed in a hospital inpatient setting. The following are examples of possible ICD-10-PCS procedure codes that may be used to report to ultrasound procedures commonly performed (not an all-inclusive list):

BH4CZZZ Ultrasonography of Head and Neck
BW4FZZZ Ultrasonography of Neck
BW40ZZZ Ultrasonography of Abdomen
BW41ZZZ Ultrasonography of Abdomen and Pelvis
BH47ZZZ Ultrasonography of Upper Extremity
BH48ZZZ Ultrasonography of Lower Extremity
B240ZZZ Ultrasonography of Single Coronary Artery
B241ZZZ Ultrasonography of Multiple Coronary Arteries
B244ZZZ Ultrasonography of Right Heart
BY49ZZZ Ultrasonography of First Trimester, Single Fetus
BH40ZZZ Ultrasonography of Right Breast
BH41ZZZ Ultrasonography of Left Breast
BH42ZZZ Ultrasonography of Bilateral Breasts
BU43ZZZ Ultrasonography of Right Ovary
BU44ZZZ Ultrasonography of Left Ovary
BU46ZZZ Ultrasonography of Uterus

ICD-10-CM Diagnosis Coding
Because of the vast array of diagnoses related to the aforementioned procedures, please check with your payer regarding appropriate ICD-10-CM diagnosis code selection.

Documentation Requirements

Ultrasounds performed using either a compact portable ultrasound or a console ultrasound system are reported using the same CPT codes as long as the studies that were performed meet 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 diagnostic ultrasound or ultrasound-guided procedure must be completed and maintained in the patient record.[7] This should include a description of the structures or organs examined and the findings and reason for the ultrasound procedure(s). 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.

Payment Methodologies for Ultrasound Services

Medicare may reimburse for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary. The following describes the various payment methods by site of service.

Physician Office Setting

In the office setting, a physician who owns the ultrasound equipment and performs the service, or a sonographer who performs the service, may report the global code without a -26 modifier.

Hospital Outpatient
When the ultrasound is performed in the hospital outpatient setting, physicians may not submit a global charge to Medicare because the global charge includes both the professional and technical components of the service. If the procedure is performed in the hospital outpatient setting, the hospital may bill for the technical component of the ultrasound service as an outpatient service.

The CPT code filed by the hospital will be assigned to a hospital outpatient system Ambulatory Payment Classification (APC) payment system, and payment will be based on the APC grouping. However, for Medicare, the hospital outpatient facility and the physician must report the same CPT code. If the physician is a hospital employee, the hospital may submit a charge for the global service.

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Payment Methodologies for Ultrasound Services *(cont.)*

Hospital Inpatient Setting

If this service is performed in the inpatient hospital setting, charges would be considered part of the charges submitted for inpatient stay and payment would be made under the Medicare MS-DRG payment system. However, the physician may still submit a bill for his/her professional services regardless.

Note: Medicare may reimburse for ultrasound services when the services are within the scope of the provider's license and are deemed medically necessary.

Coverage

Ultrasound procedures may be a covered benefit if such usage meets all requirements established by the particular payer. However, it is advisable that you verify coverage policies with your local Medicare Administrative Contractor (MAC). 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 private payer plans will reimburse for ultrasound procedures performed by any physician specialist, while other plans will limit ultrasound procedures to specific types of medical specialties. In addition, plans may require providers to submit applications requesting these diagnostic ultrasound and ultrasound-guided 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.

1. Information presented in this document is current as of March 1, 2022. 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. 2022 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.
4. 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 the Federal Register/Vol. 86, No. 221/Friday, November 19, 2021 and subsequent updates based on legislation enacted by CMS. These changes are effective for services provided from 1/1/2022 through 12/31/2022. 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.
5. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. Medicare Ambulatory Payment Classification Correction Notice under the Hospital Outpatient Fee Schedule as published in the Federal Register/Vol. 87, No. 9/Monday, January 10, 2022 and subsequent updates based on legislation enacted by CMS. These changes are effective for services provided from 1/1/2022 through 12/31/2022. 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.
6. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. Ambulatory Surgery Center Fee Schedule Correction Notice, as published in the Federal Register/Vol. 87, No. 9/Thursday, January 13, 2022. 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.
7. 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 post-graduate CME and experience. For further details, contact your Medicare Contractor.

\+ Add-on code

* Professional is the physician payment.
** Technical is the facility payment.

Imagination at work

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