Reimbursement Information for Diagnostic Ultrasound Procedures Performed by Primary Care Physicians[1]

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This overview addresses coding, coverage, and payment for ultrasound procedures performed by Primary Care Physicians.[2] This advisory focuses on Medicare program policies. Non-Medicare payers may have different rules and 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 Payment Rates

The following provides 2018 national unadjusted Medicare Physician Fee Schedule (MPFS), the Hospital Outpatient Ambulatory Payment Category (APC) and the Ambulatory Surgery Center (ASC) payment rates for the CPT codes identified in this guide. Payment will vary in geographic locality.

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

2018 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician's office setting

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Primary Care					
10022 Fine needle aspiration; with imaging guidance	Facility	$67.68	5071	$572.85	$73.08
	Non-Facility	$144.00			
76536 Ultrasound, soft tissues of head and neck, real time with image documentation	Professional	$28.80	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$90.72			
	Global	$119.52			
76705 Ultrasound, abdominal, real time with image documentation; limited	Professional	$30.24	5522	$114.46	$61.87
	Technical	$63.72			
	Global	$93.96			
76770 Ultrasound, retroperitoneal, real time with image documentation; complete	Professional	$37.80	5522	$114.46	$61.87
	Technical	$78.48			
	Global	$116.28			
76775 Ultrasound, retroperitoneal, real time with image documentation; limited	Professional	$29.52	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$29.88			
	Global	$59.40			
76815 Ultrasound, pregnant uterus, real time with image documentation, limited, 1 or more fetuses	Professional	$33.48	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$53.28			
	Global	$86.76			
76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal	Professional	$38.88	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$60.84			
	Global	$99.72			
76818 Fetal biophysical profile; with non-stress testing	Professional	$55.80	5522	$114.46	$61.87
	Technical	$70.92			
	Global	$126.72			
76881 Ultrasound, extremity, nonvascular, real-time with image documentation; complete	Professional	$32.40	5522	$114.46	$61.87
	Technical	$71.64			
	Global	$104.04			
76882 Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	Professional	$25.20	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$33.84			
	Global	$59.04			

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

2018 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician's office setting *(cont.)*

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Primary Care (cont.)					
76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Professional	$33.12	N/A	Packaged service/ item; no separate payment made	Packaged service/item; no separate payment made
	Technical	$28.08			
	Global	$61.20			
93306 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	Professional	$74.88	5524	$468.69	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$138.96			
	Global	$213.84			
93307 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	Professional	$46.08	5524	$468.69	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$99.36			
	Global	$145.44			
93308 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	Professional	$26.28	5523	$232.31	Not on ASC list of approved procedures
	Technical	$81.72			
	Global	$108.00			
93321 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); follow-up or limited study (List separately in addition to codes for echocardiographic imaging)	Professional	$7.56	N/A	Packaged service/ item; no separate payment made	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$20.52			
	Global	$28.08			
93325 Doppler echocardiography color flow velocity mapping (List separately in addition to codes for echocardiography)	Professional	$3.24	N/A	Packaged service/ item; no separate payment made	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$23.04			
	Global	$26.28			
93880 Duplex scan of extracranial arteries; complete bilateral study	Professional	$41.04	5523	$232.31	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$168.12			
	Global	$209.16			
93882 Duplex scan of extracranial arteries; unilateral or limited study	Professional	$25.92	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$108.00			
	Global	$133.92			
93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study	Professional	$63.36	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$65.88			
	Global	$129.24			

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

2018 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician's office setting *(cont.)*

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Cardiology					
93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report	Facility	$72.72	N/A	Not recognized by OPPS	Nonsurgical procedure not Medicare allowable in an ASC
	Non-Facility	$72.72			
93320 Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete	Professional	$18.72	N/A	Packaged service/ item; no separate payment made	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$36.72			
	Global	$55.44			
93350 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report	Professional	$72.72	5524	$486.69	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$139.32			
	Global	$212.04			
Dialysis Access					
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)	Professional	$14.76	N/A	Packaged service/ item; no separate payment made	Packaged service/item; no separate payment made
	Technical	$17.28			
	Global	$32.04			
93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	Professional	$35.28	5523	$232.31	Not on ASC list of approved procedures
	Technical	$166.68			
	Global	$201.96			
93971 Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	Professional	$23.04	5522	$114.46	Not on ASC list of approved procedures
	Technical	$100.80			
	Global	$123.84			
93990 Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	Professional	$25.20	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$114.48 DRA Capped			
	Global	$139.68 DRA Capped			
G0365 Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)	Professional	$12.60	5522	$114.46	$61.87
	Technical	$114.48 DRA Capped			
	Global	$127.08 DRA Capped			

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

2018 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician's office setting *(cont.)*

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Musculoskeletal					
20611 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	Facility	$63.36	5441	$244.70	$47.88
	Non-Facility	$92.88			
Nephrology					
76776 Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation	Professional	$38.88	5522	$114.46	$61.87
	Technical	$122.04			
	Global	$160.92			
93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	Professional	$59.40	5523	$232.31	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$231.48			
	Global	$290.88			
93976 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	Professional	$40.68	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$114.48 DRA Capped			
	Global	$155.16 DRA Capped			
G0365 Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)	Professional	$12.60	5522	$114.46	$61.87
	Technical	$114.48 DRA Capped			
	Global	$127.08 DRA Capped			
OB/GYN					
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	$51.12	5522	$114.46	$61.87
	Technical	$75.60			
	Global	$126.72			
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	$43.56	N/A	Packaged service/ item; no separate payment made	Packaged service/item; no separate payment made
	Technical	$23.04			
	Global	$66.60			
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	$51.84	5522	$114.46	$61.87
	Technical	$94.32			
	Global	$146.16			

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

2018 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician's office setting *(cont.)*

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
OB/GYN (cont.)					
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	$51.48	N/A	Packaged service/ item; no separate payment made	Packaged service/item; no separate payment made
	Technical	$44.28			
	Global	$95.76			
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	$100.44	5522	$114.46	$61.87
	Technical	$87.48			
	Global	$187.92			
76813 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation	Professional	$62.28	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$63.00			
	Global	$125.28			
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	$52.92	N/A	Packaged service/ item; no separate payment made	Packaged service/item; no separate payment made
	Technical	$30.24			
	Global	$83.16			
76815 Ultrasound, pregnant uterus, real time with image documentation, limited, 1 or more fetuses	Professional	$33.48	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$53.28			
	Global	$86.76			
76816 Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, 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	$45.00	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$73.80			
	Global	$118.80			
76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal	Professional	$38.88	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$60.84			
	Global	$99.72			
76818 Fetal biophysical profile; with non-stress testing	Professional	$55.80	5522	$114.46	$61.87
	Technical	$70.92			
	Global	$126.72			
76819 Fetal biophysical profile; without non-stress testing	Professional	$40.32	5522	$114.46	$51.48
	Technical	$51.84			
	Global	$92.16			

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

2018 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician's office setting *(cont.)*

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
OB/GYN (cont.)					
76830 Ultrasound, transvaginal	Professional	$35.64	5522	$114.46	$61.87
	Technical	$89.64			
	Global	$125.28			
76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	Professional	$35.28	5522	$114.46	$61.87
	Technical	$77.76			
	Global	$113.04			
76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Professional	$25.56	5522	$114.46	$23.76
	Technical	$24.12			
	Global	$49.68			
76946 Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	Professional	$20.16	N/A	Packaged service/ item; no separate payment made	Packaged service/item; no separate payment made
	Technical	$13.32			
	Global	$33.48			
76948 Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation	Professional	$35.64	N/A	Packaged service/ item; no separate payment made	Packaged service/item; no separate payment made
	Technical	$37.44			
	Global	$73.08			
Breast					
76641 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Professional	$37.44	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$72.72			
	Global	$110.16			
76642 Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Professional	$34.92	5521	$62.12	Packaged service/item; no separate payment made
	Technical	$55.44			
	Global	$90.36			
19083 Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance	Facility	$164.16	5072	$1348.03	$542.96
	Non-Facility	$687.23			
Phlebology					
76970 Ultrasound study follow-up (specify)	Professional	$19.44	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$74.88			
	Global	$94.32			
93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	Professional	$35.28	5523	$232.31	Not on ASC list of approved procedures
	Technical	$166.68			
	Global	$201.96			
93971 Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	Professional	$23.04	5522	$114.46	Not on ASC list of approved procedures
	Technical	$100.80			
	Global	$123.84			

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

2018 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician's office setting *(cont.)*

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Podiatry					
93926 Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study	Professional	$24.84	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$114.48 DRA Capped			
	Global	$139.32 DRA Capped			
Urology					
51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	Facility	$16.20	5733	$55.96	Packaged service/item; no separate payment made
	Non-Facility	$16.20			
76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	Professional	$35.28	5522	$114.46	$61.87
	Technical	$77.76			
	Global	$113.04			
76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Professional	$25.56	5522	$114.46	$23.76
	Technical	$24.12			
	Global	$49.68			
76870 Ultrasound, scrotum and contents	Professional	$32.76	5522	$114.46	Packaged service/item; no separate payment made
	Technical	$36.72			
	Global	$69.48			
76872 Ultrasound, transrectal	Professional	$34.56	5522	$114.46	$61.87
	Technical	$64.44			
	Global	$99.00			
76873 Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)	Professional	$79.92	5522	$114.46	$61.87
	Technical	$97.56			
	Global	$177.48			
Vascular/Vascular Access					
93925 Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	Professional	$40.68	5523	$232.31	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$227.52			
	Global	$268.20			
93926 Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study	Professional	$24.84	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$114.48 DRA Capped			
	Global	$139.32 DRA Capped			
93930 Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study	Professional	$41.04	5523	$232.31	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	173.88			
	Global	$214.92			

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

2018 Medicare reimbursement for procedures related to diagnostic ultrasound procedures performed in the General Practitioners and Family Practice physician's office setting *(cont.)*

CPT/HCPCS Code	Physician		Facility		
	Reimbursement Component	Medicare Physician Fee Schedule Amount[4]	APC	Hospital Outpatient Payment[5]	Ambulatory Surgery Center[6]
Vascular/Vascular Access (cont.)					
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)	Professional	$14.76	N/A	Packaged service/ item; no separate payment made	Packaged service/item; no separate payment made
	Technical	$17.28			
	Global	$32.04			
93931 Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study	Professional	$25.20	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$108.36			
	Global	$133.56			
93970 Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	Professional	$35.28	5523	$232.31	Not on ASC list of approved procedures
	Technical	$166.68			
	Global	$201.96			
93971 Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	Professional	$23.04	5522	$114.46	Not on ASC list of approved procedures
	Technical	$100.80			
	Global	$123.84			
93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study	Professional	$59.40	5523	$232.31	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$231.48			
	Global	$290.88			
93976 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study	Professional	$40.68	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$114.48			
	Global	$155.16			
93978 Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study	Professional	$40.68	5523	$232.31	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$156.60			
	Global	$197.28			
93979 Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study	Professional	$25.56	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$99.00			
	Global	$124.56			
93981 Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study	Professional	$22.32	5522	$114.46	Nonsurgical procedure not Medicare allowable in an ASC
	Technical	$56.52			
	Global	$78.84			
G0365 Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)	Professional	$12.60	5522	$114.46	$61.87
	Technical	$114.48 DRA Capped			
	Global	$127.08 DRA Capped			

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 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
BW4GZZZ	Ultrasonography of Pelvic Region

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

Ultrasound 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 hardcopy, 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.

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.

Site of Service *(cont.)*

Hospital Inpatient Setting

Although this service would not typically be performed in the inpatient hospital setting, if it is performed in this setting, charges for the ultrasound services occurring in the hospital inpatient setting would be considered part of the charges submitted for the 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. 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.

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 JUNE 1, 2018, AND 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 June 1, 2018. 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. Current Procedural Terminology (CPT) is copyright 2017 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 on 11/15/17 in the (Federal Register / Vol. 82, No. 219 / Wednesday, November 15, 2017 and subsequent updates. These changes are effective for services provided from 1/1/2018 through 12/31/2018. CMS may make adjustments to any or all of the data inputs from time to time. All CPT codes are copyright AMA. 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. 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. 82, No. 217 / Monday, November 13, 2017 and subsequent updates based on legislation enacted by CMS. These changes are effective for services provided from 1/1/2018 through 12/31/2018. 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. Ibid.
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.

Imagination at work

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