Ultrasound Billing CPT Codes Summary and Notes

- CPT codes for ultrasound examinations are considered to be “complete” studies unless specified as “limited” studies in their code definitions.
- A limited study would address only a single quadrant, a single diagnostic problem or might be a follow-up examination.
- One should be aware that the use of modifiers may draw attention to the claim by the payer and may prompt requests for additional information.
- **“-26” Professional Component**
  - The professional component, indicated by the –26 modifier, is typically reported by the physician for professional services and includes interpretation of diagnostic tests/studies with preparation of a separate distinctly identifiable signed written report.
  - Unmodified codes are utilized by physician offices, clinics or free standing emergency facilities not operated by a hospital, that provide professional services as well as own and maintain the equipment. Hospital-based Emergency Physicians would report ultrasound CPT codes with the professional component modifier e.g. 76815-26 (Echography, pregnant uterus; limited; professional component).
- **“-52” Reduced Services**
  - The typical procedure was not performed as described, but rather at some reduced level of service.
- **“-59” Distinct Procedural Service**
  - This modifier is used to report procedures that are distinct but have the same CPT code.
  - Example would be foreign bodies in each upper extremity
- **“-79” Repeat Procedure by Same Physician**
  - The -76 modifier would be appropriate if the repeat exam was performed by the same exact Emergency Physician or if the patient had been signed out to another Emergency Physician and this second Emergency Physician repeated the study.
- **“-77” Repeat Procedure by Another Physician**

- This modifier defines a repeat procedure by another physician during the same patient encounter.
- As always the medical necessity for repeating these procedures should be documented in the chart in addition to applying the modifier.

- Need to be aware of accepted ICD-9 codes that would support the medical necessity of corresponding ultrasound CPT codes
- A first-pass edit rejection may be reimbursed after appeal when the service provider can demonstrate the medical necessity of the ultrasound procedure.
- Trauma Ultrasound:
  - There is no CPT code that specifically describes the emergency ultrasound trauma examination as this is not a single ultrasound procedure
  - Currently, there are three CPT codes which reflect separately identifiable elements of the FAST exam as described by the AIUM/ ACEP documents: 1) cardiac 93308-26, 2) abdomen 76705-26, and 3) chest 76604-26.
  - These CPT codes must be used judiciously and must be supported by ICD- 9 codes, which provide evidence of medical necessity for each ultrasound examination.
- OB/Gyn scans:
  - If the physician is utilizing ultrasound to evaluate the pregnancy or a suspected complication of pregnancy, then the obstetric pelvic codes would be utilized (e.g. limited pelvic ultrasound in a woman known to be pregnant (76815-26) or complete transvaginal pelvic ultrasound in a woman known to be pregnant (76817-26 with or without -52 modifier for reduced level of service).
  - If pregnancy is documented to be absent prior to the ultrasound examination and ultrasound was utilized to evaluate pelvic pain, amenorrhea, vaginal bleeding or non-gynecologic pelvic pathology, then the non-obstetric pelvic codes would be utilized (e.g. limited transabdominal pelvic ultrasound in a woman known to be not pregnant (76857-26) or complete transvaginal ultrasound in a woman known to be not pregnant (76830-26 with or without -52 reduced service modifier). This would hold true even if the result of the subsequent ultrasound examination was an intrauterine or ectopic pregnancy.
  - Transvaginal examination in pregnant and non-pregnant women may be utilized to gain a higher resolution view of pelvic anatomy and is appropriately coded with either 76817-26 (pregnant) or 76830-26 (non-pregnant).
  - The planned sequencing for every transabdominal ultrasound to be followed by a transvaginal ultrasound would be inappropriate.

- If complete evaluation of the pelvic anatomy is not performed, the -52 modifier should be used. This should always be the case in my opinion.

- AAA and urinary tract/post-void:
  - Symptoms concerning for AAA or an emergency ultrasound of a patient with suspected hydronephrosis would be coded for by 76775-26, a limited retroperitoneal ultrasound.
  - If sectional views of the kidney were imaged in this same patient, the limited retroperitoneal code (76775-26) would still apply and would not be separately billable.
  - A specific code exists for measurement of post-void residual volume by ultrasound (51798-26: measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging)
  - 76857 should be utilized when an actual image of the bladder is obtained and evaluated for abnormalities. For example, in addition to reporting on post-residual volume, one would be expected to comment on the presence of bladder diverticula when present.
- Cardiac:
  - Transthoracic evaluation of the heart to evaluate for pericardial effusion, cardiac function in arrhythmia or etiology of hypotension would be coded by 93308-26, a limited transthoracic echocardiogram.
- Biliary:
  - Evaluation of the gallbladder for gallstones would be coded by 76705-26, a limited abdominal ultrasound.
- DVT:
  - Two-point compression ultrasound of the lower extremity to evaluate for DVT would be coded by a limited duplex scan of the extremity veins (93971-26).
- Soft Tissue/MSK:
  - The most common use for soft tissue ultrasound is to distinguish between cellulitis and abscess.
  - No specific code exists for soft tissue ultrasound
  - The reduced service modifier (-52) is not required for any of the soft tissue codes

- Coding for MSK applications is not well developed. The only existing codes are extremity ultrasound, non-vascular, B-scan and/or real time with image documentation (76882-26), complete infant ultrasound hip, and limited infant ultrasound hip (76886-26).
- Emergency ultrasounds to evaluate for foreign bodies, abscess, tendon laceration as well as other focused area of an extremity would be appropriately coded for with 76882. (76882- codes for a non-vascular extremity limited: includes report on specific anatomic structure such as a soft tissue mass, specific tendon.)
- Ultrasound for miscellaneous musculoskeletal indications including fracture evaluation, tendon rupture, or muscle tear would all be coded by 76882-26.

• <u>Ocular:</u>

- Ocular ultrasound is used to detect posterior chamber and orbital pathology as well as evaluation of the optic nerve sheath diameter. All of these studies would be appropriately coded by 76512-26, ophthalmic ultrasound, diagnostic, B-scan (with or without superimposed non-quantitative A-scan). **Ocular foreign body has a separate code (76529-26).**

• Ultrasound Guidance Procedures:

- 3 main categories:
    1. Ultrasound-guidance for needle placement (76942-26)
    2. Ultrasound-guidance for vascular access (76937-26)
    3. Ultrasound-guidance for pericardiocentesis (76930-26)
- **Ultrasound-guidance for needle placement (76942-26)** continues to apply to virtually all localization and needle placement procedures performed by Emergency Physicians other than vascular access and pericardiocentesis (including paracentesis, thoracentesis, suprapubic aspiration, lumbar puncture, foreign body removal, etc).
    - Requires permanently recorded images
    - Does *not* required a real-time image of the needle in the target
- For **vascular access (76937-26)**, we interpret the CPT requirements for recorded images as requiring an image of the target vessel, but not necessarily an image of the needle in the vessel as it is entering. We recommend permanent recording of the selected vessel

or of the needle entering the vessel when this is feasible and safe, while using a procedure note to document the procedure was performed with concurrent real-time visualization.

- Diagnostic and procedural ultrasounds may be billed on the same day during the same encounter as long as each one is not subsumed in the other. For example, if a focused cardiac ultrasound was performed to diagnose the tamponade, then a diagnostic code and a procedural code would be appropriate.

- Regarding Payer Policy and coverage:
  - **ICD-9**, the International Classification of Diseases, 9th Revision, is a cataloging tool developed by the World Health Organization for the international comparison of morbidity and mortality data. ICD-9 codes may be driven by diagnosis, symptoms, signs, abnormal diagnostic tests, by external causes of injury (E codes) or factors influencing health status (V codes). ICD-9 codes are often used by payers to determine why you performed a procedure as opposed to CPT codes that explain what procedure(s) were performed. Carriers often look first at these ICD-9 codes as an indicator of medical necessity by developing, as a first-pass edit, lists of ICD-9 codes that support certain CPT codes.
  - **Medical necessity** or medically necessary services are described as those that are felt by payers to be safe, effective and consistent with the symptoms or diagnosis of the illness or injury being treated.
    - Screening examinations are generally not covered services by Medicare, and are not an ED service
  - **Payment Edits** are policy-driven computer programs or manual reviews that check information available on payment claim forms in an effort to identify the coding of services with a higher probability of being incorrect or medically unnecessary.
    - Documentation of medical necessity for the study in the medical record will be essential in any effort to overcome a first-pass edit denial.
    - Examples of these:
      1. *Procedure to diagnosis* (“diagnosis” or “payment” edits). The CPT code is compared to a list of previously approved ICD-9 codes. If previously approved as compatible, then the study is paid.
      2. *Procedure to procedure*. Edit to assure one procedure or diagnostic code doesn’t already cover another code.
      3. *Frequency to time*. Multiple studies of the same type on the same day may be rejected unless there is a good explanation as to why it needed to be repeated.

4. *Site of service*. A global U/S service (without the professional modifier) would be rejected.

- Ultrasound Documentation and Image Storage
  - There are three specific requirements for reporting procedures in the Emergency Department:
    1. A written report
    2. Test indication
    3. Interpretation
  - The U/S report should identify who performed the procedure
  - CPT requires that all diagnostic and procedure guidance ultrasounds have permanently recorded images in order to meet coding criteria.
  - CPT does not indicate image documentation specifications, e.g. how many images, what views, what medium is utilized for storage or where images are stored. Image retention is subject to facility policy and may differ from department to department.
- Technical Charges:
  - CPT codes for technical charges should be identical to the physician charges except that there is a technical component (-TC) modifier instead of a professional component (-26) modifier. An ultrasound image and report must be in the patient's medical record in order for a technical charge to be billed. Medicare Outpatient Prospective Payment System considers the technical component of ultrasound-guided procedures to be a packaged service which is paid for through reimbursement for the procedure being performed. Of note, Medicare reimbursement for technical charges is often more robust than the professional charges.
- Multiple Procedure Payment Reduction (MPPR) 2012
  - Medicare will initiate a 25% reduction in Pro Fees for multiple imaging within an Imaging Family on the same day by same provider. The imaging family relative to emergency ultrasound is listed below. Medicare will scan for the presence of these codes and adjust reimbursement accordingly. A distinct procedural service (-59 modifier) may be applied judiciously when a distinct exam is performed for disparate clinical reasons: ex. chest ultrasound for abscess and abdominal ultrasound for gallstones.

CORE EMERGENCY ULTRASOUND CODES

ULTRASOUND STUDY	CPT CODE	CPT DESCRIPTION	NOTES
FAST: Scan for hemopericardium and hemoperitoneum, may include lung U/S for pneumothorax	93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	
	76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	
	76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation	
Pregnant Transabdominal (TA)	76815	Ultrasound, pregnant uterus, real time with image documentation, limted (eg fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	
Pregnant Transvaginal (TV)	76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	No limited code exists
Non-pregnant Transvaginal (TV)	76830	Ultrasound, transvaginal	No limited code exists
AAA	76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited	
Cardiac	93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	

ULTRASOUND STUDY	CPT CODE	CPT DESCRIPTION	NOTES
Biliary	76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	
Urinary Tract	76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited	
Post-void residual (imaging)	76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up	
Post-void residual (non-imaging)	51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, nonimaging	For instruments that don't produce images (e.g. The Bladderscan)
Focused DVT study	93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study.	
Thoracic	76604	Ultrasound, chest (includes mediastinum), real time with image documentation	To evaluate for pneumothorax
Ocular	76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	
Ocular foreign body	76529	Ophthalmic ultrasonic foreign body localization	
Soft Tissue: **Neck**	76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation	
Soft Tissue: **Axilla**	76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	

ULTRASOUND STUDY	CPT CODE	CPT DESCRIPTION	NOTES
Soft Tissue: **Chest Wall**	76604	Ultrasound, chest (includes mediastinum), real time with image documentation	
Soft Tissue: **Breast**	76645	Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation	
Soft Tissue: **Upper Back**	76604	Ultrasound, chest (includes mediastinum), real time with image documentation	
Soft Tissue: **Lower Back**	76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	
Soft Tissue: **Abdominal Wall**	76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	
Soft Tissue: **Pelvic Wall**	76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Male or Female
Soft Tissue: **Lower Extremity**	76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	
Musculoskeletal (Extremity, non-vascular)	76882	Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific	
Infant hip, static	76886	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)	
U/S-guided thoracentesis	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Additional CPT code: **32421**

ULTRASOUND STUDY	CPT CODE	CPT DESCRIPTION	NOTES
U/S-guided suprapubic aspiration	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Additional CPT code: **51100**
U/S-guided paracentesis	49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance	Additional CPT code: **49080**
U/S-guided abscess drainage	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Additional CPT code: **10160** or **10161**
U/S-guided peritonsillar abscess drainage	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Additional CPT code: **42700**
U/S-guided foreign body removal	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Additional CPT code: **10120** or **10121**
U/S-guided lumbar puncture	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Additional CPT code: **62270**
U/S-guided joint aspiration	76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Additional CPT code: **20600**, **20605**, or **20610**
U/S-guided pericardiocentesis	76930	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Additional CPT code: **33010**

ULTRASOUND STUDY	CPT CODE	CPT DESCRIPTION	NOTES
U/S-guided vascular access placement	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)	Additional CPT code: **36400, 36410, 36555, 36556, 36568, 36569**

Separately Billable CPT Codes for U/S-Guided Procedures

CPT CODE	CPT DESCRIPTION
10120	INCISION AND REMOVAL FOREIGN BODY SIMPLE
10121	INCISION AND REMOVAL FOREIGN BODY COMPLICATED
10160	INCISION AND DRAINAGE OF ABSCESS SIMPLE
10061	INCISION AND DRAINAGE OF ABSCESS COMPLICATED
20600	ARTHROCENTSIS SMALL JOINT
20605	ARTHOCENTESIS MEDIUM JOINT
20610	ARTHROCENTSIS LARGE JOINT
32421	THORACENTESIS, PUNCTURE OF PLEURAL CAVITY FOR ASPIRATION, INITIAL OR SUBSEQUENT
33010	PERICARDIOCENTESIS, INITIAL
36400	VENIPUNCTURE REQUIRING PHYSICIAN SKILL AGE < 3 YO

36410	VENIPUNCTURE REQUIRING PHYSICIAN SKILL AGE >3 YO
36555	INSERTION OF NON-TUNNELED CENTRAL VENOUS CATHETER AGE < 5 YO
36556	INSERTION OF A NON-TUNNELED CENTRAL VENOUS CATHETER AGE > 5 YO
36557	INSERTION OF A PERIPHERALLY INSERTED NON-TUNNELED CENTRAL VENOUS CATHETER AGE <5 YO
36558	INSERTION OF A PERIPHERALLY INSERTED NON-TUNNELED CENTRAL VENOUS CATHETER AGE > 5YO
49080	ABDOMINAL PARACENTESIS
51100	ASPIRATION OF BLADDER BY NEEDLE