Reimbursement Information for Urology Ultrasound Procedures[1]

2020

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This overview addresses coding, coverage, and payment for urology ultrasound procedures performed by Primary Care Physicians.[2] This advisory focus is 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 2020 national unadjusted Medicare Physician Fee Schedule (MPFS), 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.

2020 Medicare Reimbursement for Point of Care Ultrasound Procedures

CPT Code®[3]/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					
50430 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	$160.96	$583.57	5372	$556.53	Bundled. No extra payment.
50431 Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	$67.85	$265.62	5522	$ 556.53	Bundled. No extra payment.
50432 Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	$215.09	$913.07	5522	$1,771.55	$789.71
50433 Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	$267.06	$1,181.21	5522	$3,018.54	$1,376.97
50434 Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	$200.66	$940.49	5523	$1,771.55	$1,058.01

2020 Medicare Reimbursement for Point of Care Ultrasound Procedures (cont.)

CPT Code®[3]/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.)*					
50435 Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	$103.94	$578.52	5373	$1,771.55	$789.71
50436 Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with post procedure tube placement, when performed	$156.99	NA	5373	$1,771.55	$789.71
50437 Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, 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	$263.09	NA	5374	$3,018.54	$1,376.97
50605 Ureterotomy for insertion of indwelling stent, all types	$1,041.91	NA	NA	Inpatient only	NA
+50606 Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	$159.16	$642.39	NA	Packaged. No extra payment.	Bundled. No extra payment.
50684 Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter	$52.33	$120.54	NA	Packaged. No extra payment.	Bundled. No extra payment.
50693 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	$213.65	$1,070.78	5374	$3,018.54	$1,376.97
50694 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	$280.78	$1,189.15	5374	$3,018.54	$1,376.97
50695 Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	$359.81	$1,440.70	5374	$3,018.54	$1,376.97

2020 Medicare Reimbursement for Point of Care Ultrasound Procedures (cont.)

CPT Code®[3]/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.)*					
+50705 Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	$184.42	$1,950.64	NA	Packaged. No extra payment.	Bundled. No extra payment.
+50706 Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	$191.27	$972.98	NA	Packaged. No extra payment.	Bundled. No extra payment.
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	$8,067.93	$3,995.65

Other Procedures

CPT Code®[3]/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]
Abdominal Ultrasound					
76700 Ultrasound, abdominal, real time with image documentation; complete	Professional (-26)*	$41.86	5522	$112.08	$56.63
	Technical (-TC)**	$83.37			
	Global	$125.23			
76705 Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	Professional (-26)*	$29.95	5522	$112.08	$56.63
	Technical (-TC)**	$62.80			
	Global	$92.72			
76770 Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete	Professional (-26)*	$37.53	5522	$112.08	Bundled. No extra payment.
	Technical (-TC)*	$77.59			
	Global	$115.13			
76775 Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited	Professional (-26)*	$29.59	5522	$112.08	$56.63
	Technical (-TC)**	$30.32			
	Global	$59.91			
76776 Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation	Professional (-26)*	$39.34	5522	$112.08	$56.63
	Technical (-TC)**	$119.82			
	Global	$159.16			

Other Procedures (cont.)

CPT Code®[3]/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]
Abdominal Ultrasound *(cont.)*					
76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	Professional (-26)*	$35.01	5522	$112.08	$56.63
	Technical (-TC)**	$76.51			
	Global	$111.52			
76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	Professional (-26)*	$25.26	5522	$112.08	$23.82
	Technical (-TC)**	$24.18			
	Global	$49.44			
Imaging Guidance Ultrasound					
76940 Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	Professional (-26)*	$105.74	NA	Packaged. No extra payment.	Bundled. No extra payment.
	Technical (-TC)**	Carrier Priced			
	Global	Carrier Priced			
76942 Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Professional (-26)*	$32.48	NA	Packaged. No extra payment.	Bundled. No extra payment.
	Technical (-TC)**	$25.98			
	Global	$58.47			
76970 Ultrasound study follow-up (specify)	Professional (-26)*	$19.85	5522	$112.08	Bundled. No extra payment.
	Technical (-TC)*	$70.74			
	Global	$90.58			
Unlisted procedures					
51999 Unlisted laparoscopy procedure, bladder	NA	Carrier Priced	5361	$4,833.71	NA
76999 Unlisted ultrasound procedure (eg, diagnostic, interventional)	NA	Carrier Priced	5521	$79.81	Bundled. No extra payment.

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)
3302F 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 Service

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 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 urology ultrasound procedures commonly performed (not an all-inclusive list):

BD47ZZZ	Ultrasonography of Gastrointestinal Tract
BD49ZZZ	Ultrasonography of Duodenum
BG40ZZZ	Ultrasonography of Right Adrenal Gland
BG41ZZZ	Ultrasonography of Left Adrenal Gland
BG42ZZZ	Ultrasonography of Bilateral Adrenal Glands
BT41ZZZ	Ultrasonography of Right Kidney
BT42ZZZ	Ultrasonography of Left Kidney
BT43ZZZ	Ultrasonography of Bilateral Kidneys
BT45ZZZ	Ultrasonography of Urethra
BT46ZZZ	Ultrasonography of Right Ureter
BT47ZZZ	Ultrasonography of Left Ureter
BT48ZZZ	Ultrasonography of Bilateral Ureters
BW40ZZZ	Ultrasonography of Abdomen

ICD-10-CM Diagnosis Coding

Because of the vast array of diagnoses related to the afore-mentioned 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 is 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.

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.

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.

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.

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References

1. Information presented in this document is current as of March 2020. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.
2. The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.
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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 Federal Register/Vol. 84, No. 221/Wednesday, November 15, 2019. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
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 a Medicare Ambulatory Payment Classification under the hospital outpatient prospective payment system, as published in the Federal Register/Vol. 84, No. 218/Monday, November 12, 2019. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
6. Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. Ambulatory Surgery Center prospective payment system, as published in the Federal Register/Vol. 84, No. 218/Monday, November 12, 2019. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.
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.

† OPPS capped payment amount: Section 5102(b) of the Deficit Reduction Act of 2005 requires a payment cap on the technical component (TC) of certain diagnostic imaging procedures and the TC portions of the global diagnostic imaging services. This cap is based on the Outpatient Prospective Payment System (OPPS) payment. To implement this provision, the physician fee schedule amount is compared to the OPPS payment amount and the lower amount is used in the formula to calculate payment.

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