KOSMOS

Critical Care Reimbursement Guide

This guide provides coverage and payment information for diagnostic ultrasound and related ultrasound guided procedures. This information was obtained from third-party sources and is subject to change without notice, as Medicare and other payers may change their reimbursement policies at any time. This document is for educational purposes only. It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for service rendered and to ensure any services provided to patients and submitted for reimbursement are medically necessary EchoNous, Inc. makes no guarantees concerning reimbursement or coverage. If you have questions related to how to bill for these services appropriately, please contact your own reimbursement staff or the patient's insurer, as EchoNous, Inc. cannot provide specific reimbursement guidance.

National Correct Coding Initiative Edits

The National Correct Coding Initiative (NCCI) sets correct coding methodologies for Medicare, as well as many other payers. Under the NCCI, one unit of service is allowed for CPT code 76942 in a single patient encounter regardless of the number of needle placements performed. Per NCCI, "The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations". Providers should review the complete NCCI sourced below should any other coding edits apply.[1]

The following revenue code is used to report the facility portion of ultrasound services in the ICU/CCU setting.

Revenue Code: 402
Descriptor: Other imaging services, ultrasound

Physicians report the professional component of ultrasound services by appending the -26 modifier to the CPT[2] code on the CMS 1500 billing form. The following payment information is based on the 2020 national unadjusted Medicare physician fee schedule and reflects the reimbursement for the physician's service. The actual payment will vary by location.

Please note that when the site of service is the hospital all of the below ultrasound services must have the -26 modifier appended when reporting the professional services.

CPT Code	Descriptor	2020 Medicare Physician Fee Schedule -National Average*Professional Payment
75989	Radiological guidance (ie, fluoroscopy, ultrasound or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation	$59.91
76604	Ultrasound, chest, real time with image documentation	$29.59
76705	Ultrasound, abdominal, real time with image documentation; limited	$29.95

1 National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) Effective January 1, 2017, page IX-19 National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) Effective January 1, 2017, page IX-22.

2 CPT® five-digit codes, nomenclature and other data are Copyright 2020 American Medical Association. All rights reserved. No fee schedule, 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.

76775	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	$29.59
+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	$14.80
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	$32.48
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	$65.32
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	$37.53
93306	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; complete, with spectral Doppler and color flow Doppler.	$75.07
93307	Echocardiography, transthoracic, real time with image documentation (2D) includes M-mode recording when performed; complete, without spectral Doppler or color flow Doppler.	$46.19
93308	Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording when performed; follow-up or limited study	$26.35
+93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete	$18.77
+93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study	$7.58
+93325	Doppler echocardiography color flow velocity mapping	$3.25
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	$22.74

* Source of Information: Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – Final Rule, Addendum B
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

Reimbursement rates shown for payment of services under the Physicians Fee Schedule reflect a 2020 conversion factor of $36.0896

Please refer to the KOSMOS Reimbursement Overview for additional general ultrasound information.

Disclaimer: The information in this handout is intended to assist providers in determining appropriate codes and the other information for reimbursement purposes. It represents the information available to EchoNous, Inc. of the date listed above. Subsequent guidance might alter the information provided. EchoNous disclaims any responsibility to update the information provided.

It is the provider's responsibility to determine and submit appropriate codes, modifiers, and claims for the services rendered. Before filing any claims, providers should verify current requirements and policies with the applicable payer. A provider should not rely on any information provided by EchoNous in submitting any claim for payment, without confirming that information with an authoritative source.

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