Ultrasound Guidance in the Hospital Setting

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Introduction

Ultrasound imaging guidance is an integral component of many procedures in the hospital setting. Ultrasound guidance provides real-time visualization of anatomical structures and can aid in the accurate placement of devices, reduce complications, and improve patient outcomes. However, it is essential that the coding and reporting of ultrasound comply with Medicare guidelines to avoid potential errors and financial penalties.

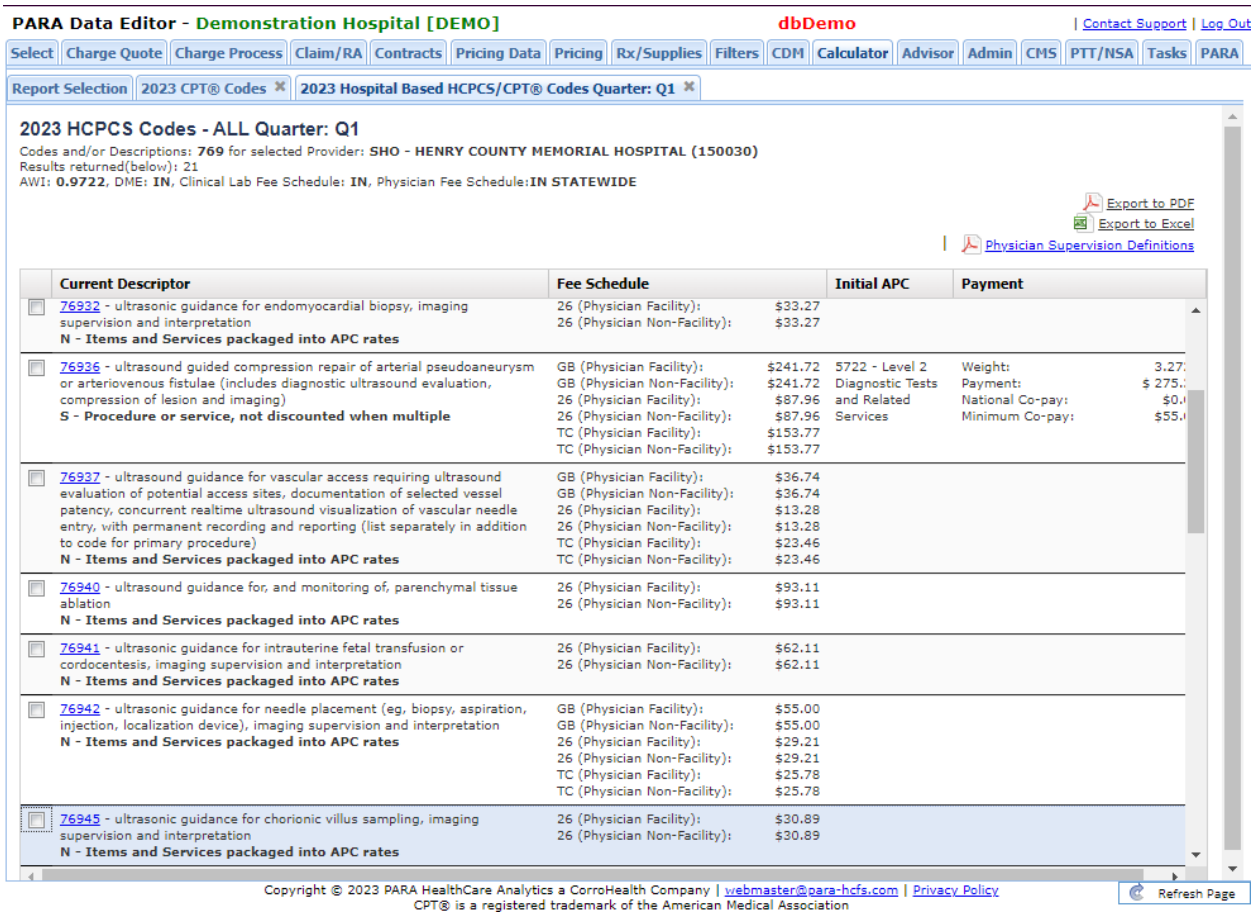
Medicare, the largest payer of healthcare services in the United States, has specific guidelines that govern coding and reporting of imaging guidance. The use of ultrasound in conjunction with surgical and interventional procedures requires careful attention to ensure compliance with Medicare's rules and regulations. Accurate coding of ultrasound guidance according to official guidelines is essential for ensuring appropriate reimbursement, compliance, and quality of care.

Documentation for Ultrasound Guidance

Accurate and complete documentation is essential when reporting ultrasound guidance. The documentation should clearly indicate the type of procedure, the specific anatomical location of the images, the specific anatomic structures visualized, and a documented description of the localization process. This information is critical to ensure that the service is accurately reported.

All imaging guidance codes are unconditionally packaged under Medicare's hospital outpatient (OPPS) reimbursement methodology, so no separate OPPS payment will be received for these codes. Nearly all imaging guidance codes have a Medically Unlikely Edit (MUE) limit of 1 unit per date of service (adjudication indicator 3).

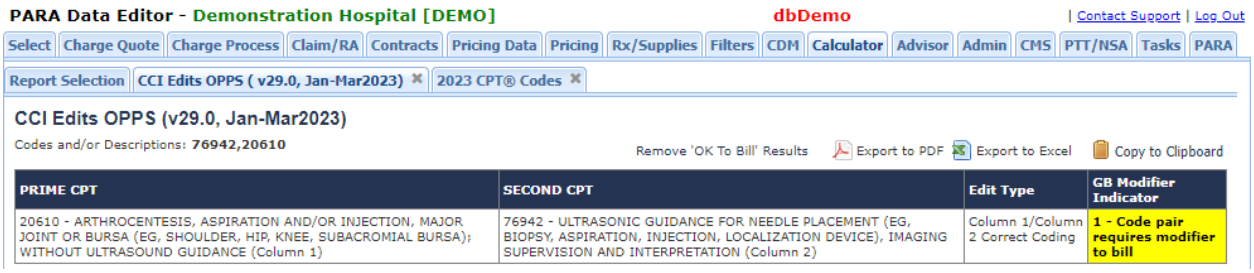
There are a variety of specific CPT® codes which represent ultrasound guidance when performed in conjunction with certain procedures, including, but not limited to, 76942 (needle placement, e.g., biopsies), +76937 (vascular access), 76940 (tissue ablation), and 76946 (amniocentesis):

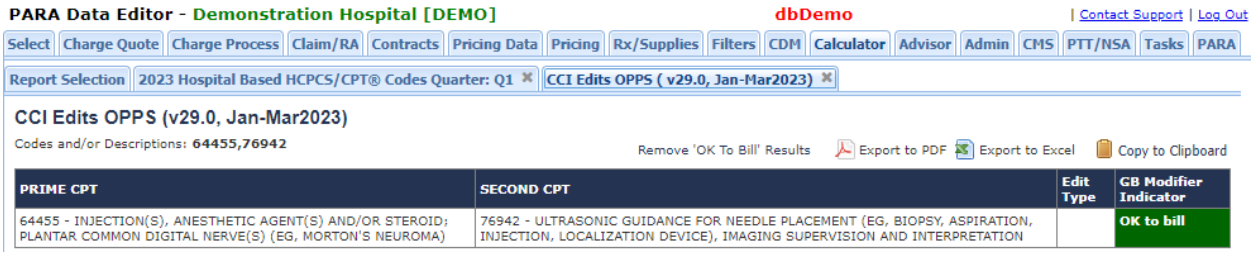


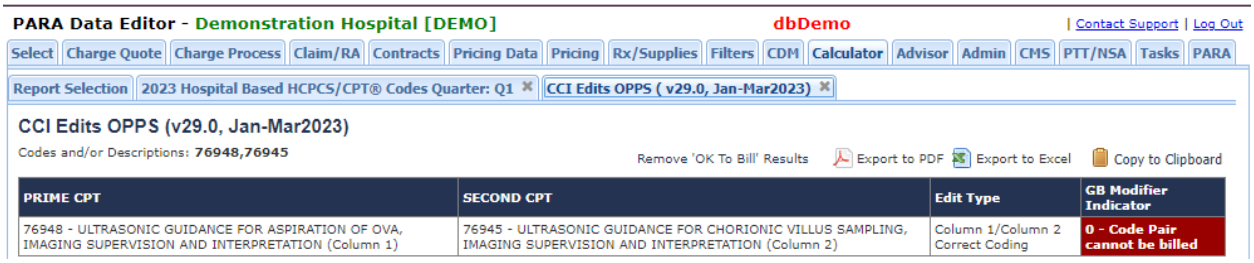
The documentation requirements may differ for each specific guidance code, so it is important to ensure the requirements for the code being submitted are met. Report the corresponding ultrasound guidance code for the type of service being provided when applicable.

All ultrasound guidance codes require a permanent image of the anatomic site evaluated to be stored in the patient's medical record. While best practice is to document the acquisition of the permanent image within the radiology report, it is not necessary to do so as long as the image is stored in the record or PACS and can be accessed in the event of an audit.

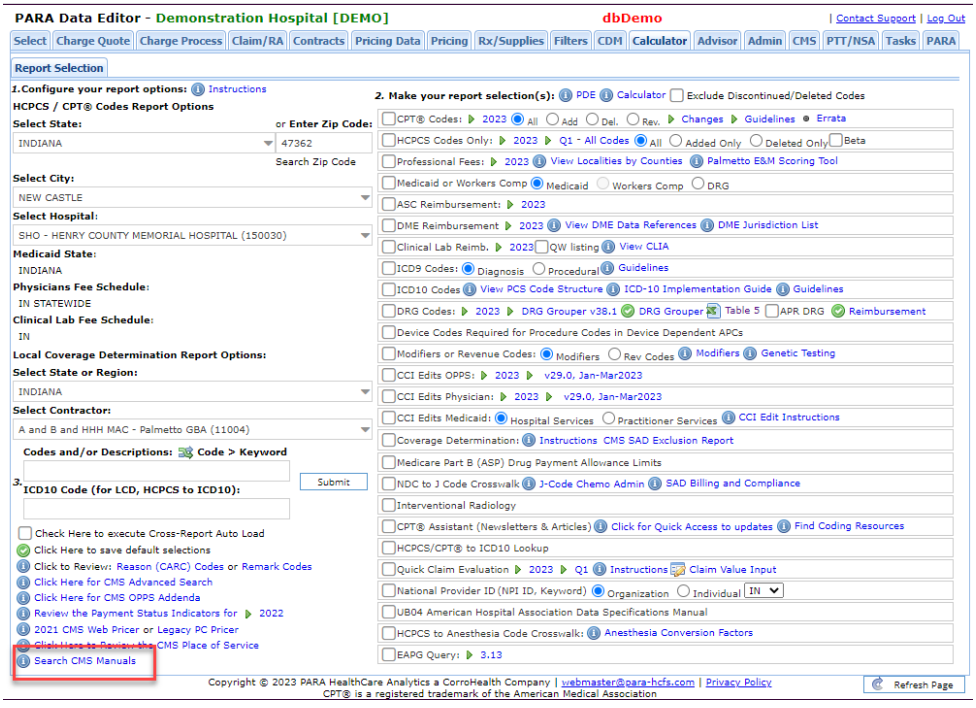
It is important to note that ultrasound guidance is inclusive to many surgical and interventional procedures, as discussed below. Some code pairs will have specific NCCI PTP edits (as shown below), and some may not. However, the National Correct Coding Initiative (NCCI) Policy Manual prohibits ultrasound from being reported in conjunction with certain procedures. PARA Data Editor users can review PTP NCCI edits on the Calculator tab:

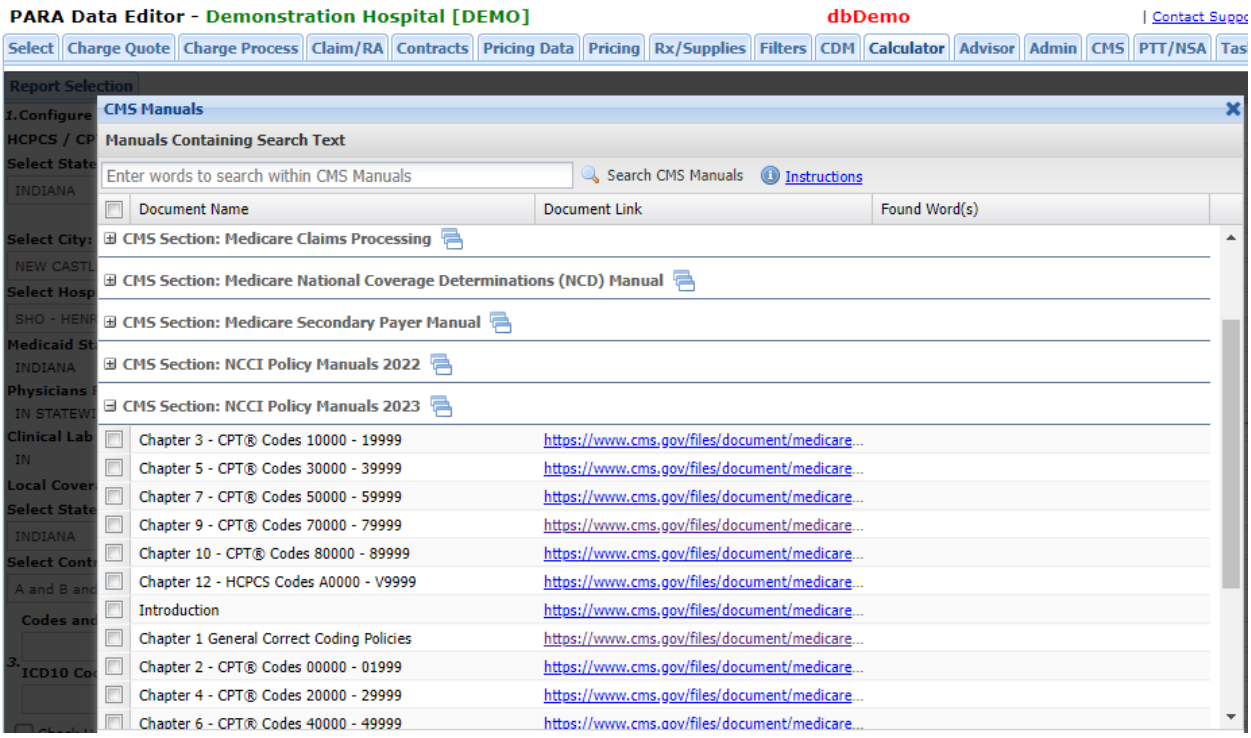






The current year NCCI Manuals are also located on the Calculator tab of the PARA Data Editor:





Arthrocentesis

Codes 20610-20611 describe arthrocentesis for aspiration and/or injection of the joints or bursae with or without ultrasound guidance. Because specific codes exist to describe this procedure when performed under ultrasound guidance, the US guidance should not be reported separately.

Central Venous Access

Ultrasound guidance for vascular access, including (but not limited to) central venous access device procedures, is reported with add-on code +76937. This code is reported in addition to the primary code for the intervention or central venous access device procedure performed, when applicable. Under Medicare (42 CFR 410.32(b)(3)(iii)), this service requires personal physician supervision:

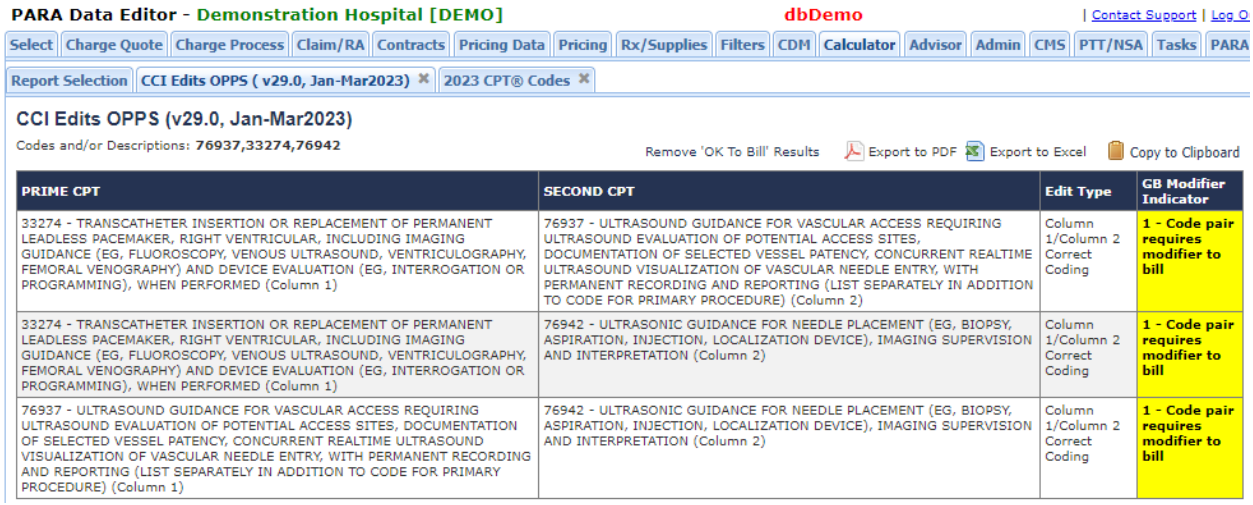
> (iii) *Personal supervision* means a physician must be in attendance in the room during the performance of the procedure.

Many central venous access device procedure codes already include all necessary imaging guidance to complete the procedure, so it is important to review the specific code description to determine if +76937 should be reported separately when documentation requirements are met.

The description for code +76937 states this code requires documentation of evaluation of potential access sites, selected vessel patency, and concurrent real-time ultrasound visualization of needle entry. *Clinical Examples in Radiology* (Summer 2014) indicates that describing the vessel as "patent, narrowed,

aneurysmal, or even thrombosed" supports the documentation of selected vessel patency. Like all other US guidance codes, this code requires acquisition and storage of a film or digital permanent image documenting the guidance procedure. This code should not be reported when a hand-held ultrasound device is used but the above documentation requirements are not met (e.g., no documentation of vessel patency, no permanent image).

Some payers may only reimburse add-on code +76937 when reported with certain primary codes. However, as stated, it is appropriate to report this code for US-guided vascular access (not just for central venous access procedures) when applicable and when documentation requirements are met. There is an extensive list of codes in the CPT® manual with which code +76937 should not be reported; it is important to consult this list as well as PTP NCCI edits (as seen in the Calculator tab of the PARA Data Editor below) when reporting this code.


PARA Data Editor - Demonstration Hospital [DEMO] dbDemo | Contact Support | Log O

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx/Supplies | Filters | CDM | Calculator | Advisor | Admin | CMS | PTT/NSA | Tasks | PARA

Report Selection | CCI Edits OPPS (v29.0, Jan-Mar2023) | 2023 CPT® Codes

CCI Edits OPPS (v29.0, Jan-Mar2023)

Codes and/or Descriptions: 76937,33274,76942

Remove 'OK To Bill' Results | Export to PDF | Export to Excel | Copy to Clipboard

PRIME CPT	SECOND CPT	Edit Type	GB Modifier Indicator
33274 - TRANSCATHETER INSERTION OR REPLACEMENT OF PERMANENT LEADLESS PACEMAKER, RIGHT VENTRICULAR, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, VENTRICULOGRAPHY, FEMORAL VENOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN PERFORMED (Column 1)	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) (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
33274 - TRANSCATHETER INSERTION OR REPLACEMENT OF PERMANENT LEADLESS PACEMAKER, RIGHT VENTRICULAR, INCLUDING IMAGING GUIDANCE (EG, FLUOROSCOPY, VENOUS ULTRASOUND, VENTRICULOGRAPHY, FEMORAL VENOGRAPHY) AND DEVICE EVALUATION (EG, INTERROGATION OR PROGRAMMING), WHEN PERFORMED (Column 1)	76942 - ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), IMAGING SUPERVISION AND INTERPRETATION (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
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) (Column 1)	76942 - ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), IMAGING SUPERVISION AND INTERPRETATION (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill

Spinal Procedures

Category III codes 0213T – 0218T represent diagnostic or therapeutic injections of the paravertebral facet joints under ultrasound guidance. These codes include the necessary imaging guidance, so an ultrasound guidance code (e.g., 76942) should not be reported separately.

Additionally, many other codes for spinal injections or interventions in CPT® include imaging guidance within their descriptions; US guidance should not be reported separately in addition to these codes.

Cardiovascular Procedures

Codes 33510-33523 for coronary artery bypass grafting often require performance of epi-aortic ultrasound. This can be reported with code 76998 & appending modifier 59 or XS. Code 76998 is not to be reported for ultrasound guidance used to procure the vascular graft.

Ultrasound guidance (+76937, 76942, 76998, 93318, or other ultrasound codes) is not separately reportable with codes for several pacemaker/implantable defibrillator procedures (33202-33275) and intracardiac electrophysiology (EP) procedures (93600-93662).

Additionally, transcatheter aortic valve or mitral valve replacement procedures also include ultrasound guidance when performed.

Image-Guided Biopsy, Aspiration, and Drainage

Code 75989 represents imaging guidance (either fluoroscopy, ultrasound, or CT) performed in conjunction with a percutaneous drainage procedure where the catheter is left in place at the end of the procedure. Many percutaneous drainage procedures (e.g., 49405 – 49407) include imaging guidance. This code should not be reported with any code in which the imaging guidance is inherent or included based on the code description. It should also not be reported in addition to any other imaging guidance codes (e.g., 77012, 76942). Code 75989 has an MUE limit of 2 units per date of service.

Codes for fine needle aspiration (FNA) (10021, 10004 – 10012) are separated into two groups: those which include imaging guidance and those which do not. Ultrasound guidance (76942) should not be reported separately when it is used; instead, coders should select the appropriate procedure code which includes the imaging guidance necessary to complete the procedure.

Most anatomy-specific percutaneous needle core biopsy codes (e.g., 19083, 20220, 47000, 49180) do not include imaging guidance. Therefore, ultrasound guidance may be reported separately when applicable using code 76942. The exception to this rule is code 32408 (lung or mediastinum biopsy), which includes imaging guidance and therefore does not support separately reporting any other guidance code.

Codes for thoracentesis and paracentesis exist which include imaging guidance (32555, 49083), so 76942 should not be reported separately in conjunction with these procedures.

Codes for cyst aspiration (e.g., 10160, 19000, 50390, 60300) do not include imaging guidance; therefore, US guidance may be reported separately using code 76942 when performed.

Codes Inclusive of Radiologic/Imaging Guidance

According to the NCCI Policy Manual, "If the code descriptor for a HCPCS/CPT® code, CPT® Manual instruction for a code, or CMS instruction for a code indicates that the procedure includes radiologic guidance, a provider/supplier shall not separately report a HCPCS/CPT code for radiologic guidance including, but not limited to, fluoroscopy, ultrasound, computed tomography, or magnetic resonance imaging codes. If the physician performs an additional procedure on the same date of service for which a radiologic guidance or imaging code may be separately reported, the radiologic guidance or imaging code

appropriate for that additional procedure may be reported separately with an NCCI PTP-associated modifier if appropriate."

Three-dimensional (3D) rendering of an imaging modality (e.g., CPT codes 76376, 76377) shall not be reported for mapping the sites of multiple biopsies or other needle placements under radiologic guidance. For example, a provider performing multiple prostate biopsies under ultrasound guidance (e.g., CPT code 76942) shall not report CPT codes 76376 or 76377 for developing a map of the locations of the biopsies

Diagnostic and Interventional Radiologic Procedures

When a diagnostic ultrasound of a specific anatomic region and US guidance for a needle placement procedure on the *same* region are performed on the same date of service, only either the diagnostic US or the ultrasound guidance may be reported, but not both. Codes for other types of ultrasounds (e.g., 76998) should not be reported separately with an ultrasound guidance procedure. The NCCI Manual specifically states:

> Providers/suppliers shall not avoid edits based on this principle by requiring patients to have the procedures performed on different dates of service if historically the evaluation of the anatomic region and guidance for needle biopsy procedures were performed on the same date of service. Physicians shall not inconvenience beneficiaries nor increase risks to beneficiaries by performing services on different dates of service to avoid MUE or NCCI PTP edits.

Diagnostic ultrasound and ultrasound guidance (76942) may be reported separately on the same date if the 2 procedures are performed on different anatomic regions; a modifier -59 or -XS is required to bypass the NCCI edit.

Radiological supervision and interpretation codes include all imaging necessary to complete the service. Therefore, codes for ultrasound or ultrasound guidance (e.g., 76942, 76998) should not be reported separately.

Chapter 9 of the NCCI Policy Manual states, "Providers/suppliers shall not report radiologic supervision and interpretation codes, radiologic guidance codes, or other radiology codes where the radiologic procedure is integral to another procedure being performed at the same patient encounter. PTP edits that bundle these radiologic codes into the relevant procedure codes have modifier indicators of '1' allowing use of NCCI PTP-associated modifiers to bypass them. An NCCI PTP-associated modifier may be used to bypass such an edit if and only if the radiologic procedure is performed for a purpose unrelated to the procedure to which it is integral.

Conclusion

Ultrasound imaging guidance is a vital component of many procedures in the hospital setting. However, it is critical to ensure that the coding and billing for these procedures comply with Medicare guidelines to

avoid potential errors and financial penalties. Understanding the nuances of correct and compliant coding for ultrasound imaging guidance can help ensure that healthcare providers are properly reimbursed for their services and can continue to provide quality care to their patients.