Butterfly™
The New Image of Health

2021 Clinical Reimbursement Resource Guide

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Butterfly iQ+ Reimbursement Pathway

Ultrasound usage should be driven by clinical management not by monetary reimbursement.

Step 1. Reimbursement Pathway

Determine which path of reimbursement to use by defining the circumstances and site of service for the Ultrasound procedure. Ultrasound examinations performed using the Butterfly iQ/iQ+ may be reported using the same CPT® codes applicable to traditional ultrasound systems provided that all applicable requirements are met. These requirements include without limitation: documentation in the patient record, appropriate level of completeness, medical necessity (determined by the payer) and accurate CPT code selection.

- If these requirements are not met, and/or a follow-up ultrasound exam is ordered to determine the diagnosis, the ultrasound exam is considered part of the patient's initial Evaluation and Management (E/M) examination and may be billed accordingly.

Step 2. Personnel Qualifications

Ensure all personnel qualification and documentation criteria are met, per the payer guidelines, the American Medical Association and your local Medicare contractor:

- **Personnel Qualification.**[1]
  These criteria tend to be distinct to Medicare, local payer/s as well as individual institutions and should be strictly followed. In general, guidelines require that the examinations be performed within the scope of the physician's state license. Note that some insurers require physicians to submit applications requesting ultrasound be added to their list of services performed at that institution.

- **Documentation.**[2]
  The ultrasound procedure/s should be recorded in the permanent patient medical record, including the reason for the exam, and findings. Images should be appropriately labeled and appropriately identified. If possible, a copy of the image should be included in the medical record. Per CPT guidelines, a written report signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation.[3]

- **Note — Bundled service:**
  Many procedures involve ultrasound imaging and consequently the imaging is included in the CPT code description. Be sure to review the CPT code to determine if the imaging is included or if it may be eligible for separate coding and billing.

- **Site of Service:**
  Consider the optimal site of service for the ultrasound procedure. Note that some services are not covered in the ASC (Ambulatory Surgery Center) setting or are reimbursed at a substantially lower rate.

1. Medicare National Coverage Determinations Manual, Ch. 1, Part 4, § 220.5,Ultrasound Diagnostic Procedures (Effective May 22, 2007) (Rev. 173, Issued: 09-04-14, Effective: Upon Implementation: of ICD-10, Implementation: Upon Implementation of ICD-10)
2. CPT® is copyright 2020 by the American Medical Association. All rights reserved.
3. CPT® 2021 Professional Edition, American Medical Association, page 513.

Butterfly iQ+ Reimbursement Pathway

Step 3. Preauthorization

If the procedure for which Butterfly will be used is planned and scheduled, preauthorization should be considered. Payers will typically require information on the patient's diagnosis or symptoms and the CPT procedure code for the intended and appropriate ultrasound procedure. Billing occurs according to payer requirements using appropriate and accurate Current Procedural Terminology (CPT) and ICD-10-CM Coding. Some payers allow electronic claims filing, while other payers require manual claims filing.

Step 4. Track the claim

Track billing and claims submission and appeal any coverage or payment determination you disagree with.

Disclaimer

The information provided herein is gathered from third-party sources* and is subject to change. It is intended to serve as a general reference guide and should not be considered reimbursement or legal advice. For all coding, coverage and reimbursement matters or questions, please consult your third-party payers, certified coders, reimbursement specialists and/or legal counsel. Please note, the use of any particular code(s) will not guarantee coverage or payment at any specific level. Coverage for these procedures may vary by payer.

2021 Medicare National Average Payment Rates

Specialty: Anesthesiology

Note: General anesthesiology coding is not included herein; anesthesiologists should refer to codes 00100-01999 and medical record documentation to determine appropriate billing.

CPT Code	Description	Physician[4]	ASC[5]	Hospital — Medicare Natl OPPS	
				APC[6]	Payment
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	F: $39.78 NF: $57.22	$27.81 / P3	5441/T	$261.17
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	F: $38.73 NF:$55.48	$29.31 / P3	5441/T	$261.17
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	F:$43.62 NF: $64.51	$34.20 / P3	5441/T	$261.17
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	F: $61.41 NF: $101.19	$57.57 / P3	5441/T	$261.17
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	F: $54.78 NF: $76.42	$36.29 / P3	5441/T	$261.17
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus	F: $64.20 NF: $116.89	$415.61 / A2	5443/T	$822.46
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve	F: $61.76 NF: $144.46	$415.61 / A2	5443/T	$822.43
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	F: $58.62 NF: $91.42	$48.15 / P3	5442/T	$634.59
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	F: $60.37 NF: $102.59	$320.67 / A2	5442/T	$634.59
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)	F: $25.47 NF: $34.54	$415.61 / A2	5443/T	$822.56
64425	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	F: $56.53 NF: $117.94	$79.21 / P3	5442/T	$634.59

CPT Code	Description	Physician[4]	ASC[5]	Hospital — Medicare Natl OPPS	
				APC[6]	Payment
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve	F: $54.78 NF: $131.90	$93.51 / P3	5442/T	$634.59
64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)	F: $60.02 NF: $60.02	$415.61 / G2	5443/T	$822.46
64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve	F: $53.74 NF: $92.12	$50.59 / P3	5442/T	$634.59
64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)	F: $61.76 NF: 61.76	$415.61 / G2	5443/T	$822.46
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	F: $43.27 NF: $79.91	$50.59 / P3	5442/T	$634.59
76937	Ultrasonic 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)	GL: $39.08 TC: $25.12 26: $13.96	Packaged into payment for the primary service	N	Packaged into payment for the primary service
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow up or limited study	GL: $102.93 TC: $77.46 26: $25.47	Not payable in this site of service	5523/S	$230.13

4. **NF** = Non facility (physician services provided in a non-facility setting such as physician office); **F** = Facility (physician serviced provided in a facility setting, such as hospital outpatient or ASC setting) **GL** = Global; refers to the entire procedure and is the technical and professional component combined; **TC** = Technical Component; generally associated with the provider who owns or is responsible for provision of the equipment, supplies, etc. **26** = Professional Component; includes all of the provider's work in providing the service, including interpretation and reporting of the procedure, cost of malpractice insurance, and other expenses that are part of (or incident to) maintaining a provider's practice.
5. ASC (Ambulatory Surgery Center) Key: **P3** = Payment based on physician fee schedule practice expense RVUs; **A2** = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)
6. APC (Ambulatory Payment Category) Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed

2021 Medicare National Average Payment Rates

Specialty: Cardiology

CPT Code	Description	Physician[7]	ASC[8]	Hospital — Medicare Natl OPPS	
				APC[9]	Payment
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	GL: $68.39 TC: $39.78 26: $28.61	Packaged into payment for the primary service	5522/Q1(S)	$109.97
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	GL: $166.79 TC: $129.80 26: $36.99	Packaged into payment for the primary service	5524/S	$482.89
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow up or limited	GL: $102.93 TC: $77.46 26:$25.47	Packaged into payment for the primary service	5523/S	$230.13

7. **NF** = Non facility (physician services provided in a non-facility setting such as physician office); **F** = Facility (physician serviced provided in a facility setting, such as hospital outpatient or ASC setting) **GL** = Global; refers to the entire procedure and is the technical and professional component combined; **TC** = Technical Component; generally associated with the provider who owns or is responsible for provision of the equipment, supplies, etc. **26** = Professional Component; includes all of the provider's work in providing the service, including interpretation and reporting of the procedure, cost of malpractice insurance, and other expenses that are part of (or incident to) maintaining a provider's practice.
8. ASC Key: **P3** = Payment based on physician fee schedule practice expense RVUs; **A2** = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)
9. APC Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed

2021 Medicare National Average Payment Rates

Specialty: Critical Care

CPT Code	Description	Physician[10]	ASC[11]	Hospital — Medicare Natl OPPS	
				APC[12]	Payment
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	F: $39.78 NF: $57.22	$27.81 / P3	5441/T	$261.17
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	F: $61.41 NF: $101.19	$57.57 / P3	5441/T	$261.17
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	F: $54.78 NF: $76.42	$36.29 / P3	5441/T	$261.17
64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve	F:$53.72 NF: $92.12	$50.59 / P3	5442/T	$634.59
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	F: $43.27 NF: $79.91	$50.59 / P3	5442/T	$634.59
75989	Radiological guidance (ie, fluoroscopy, ultrasound or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation	GL: $121.43 TC: $64.53 26: $56.88	Packaged into payment for the primary service	N	Packed into payment for the primary service
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	GL: $119.33 TC: $91.07 26: $28.26	Packaged into payment for the primary service	5522/Q1(S	$108.97
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	GL: $68.39 TC: $39.78 26: $28.61	Packaged into payment for the primary service	5522/Q1(S)	$108.97
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	GL: $93.16 TC: $63.85 26: $29.31	Packaged into payment for the primary service	5522/Q3(S)	$108.97
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited	GL: $60.02 TC: $31.05 26: $284.96	Packaged into payment for the primary service	5522/Q1	$108.97

CPT Code	Description	Physician[10]	ASC[11]	Hospital — Medicare Natl OPPS	
				APC[12]	Payment
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	GL: $86.19 TC: $53.74 26: $32.45	Packaged into payment for the primary procedure	5522/Q1(S)	$108.97
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)	GL: $39.08 TC: $25.12 26: $13.96	Packaged into payment for the primary procedure	N	Packaged into payment for the primary service
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	GL: $166.79 TC: $129.80 26: $36.99	Packaged into payment for the primary procedure	5524/S	$482.89
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	GL: $102.93 TC: $77.46 26: $25.47	Packaged into payment for the primary procedure	5523/S	$230.13
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	GL: $125.95 TC: $103.98 26: $21.98	Packed into payment for the primary service	5522/S	$108.97

10. **NF** = Non facility (physician services provided in a non-facility setting such as physician office); **F** = Facility (physician serviced provided in a facility setting, such as hospital outpatient or ASC setting) **GL** = Global; refers to the entire procedure and is the technical and professional component combined; **TC** = Technical Component; generally associated with the provider who owns or is responsible for provision of the equipment, supplies, etc. **26** = Professional Component; includes all of the provider's work in providing the service, including interpretation and reporting of the procedure, cost of malpractice insurance, and other expenses that are part of (or incident to) maintaining a provider's practice.
11. ASC Key: **P3** = Payment based on physician fee schedule practice expense RVUs; **A2** = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)
12. APC Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed

2021 Medicare National Average Payment Rates

Specialty: Emergency Medicine

CPT Code	Description	Physician[13]	ASC[14]	Hospital — Medicare Natl OPPS	
				APC[15]	Payment
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	F: $39.78 NF: $57.22	$27.81 / P3	5441/T	$262.17
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	F: $38.73 NF:$55.48	$29.31 / P3	5441/T	$261.17
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	F:$43.62 NF: $64.51	$34.20 / P3	5441/T	$26.17
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	F: $61.41 NF: $101.19	$57.57 / P3	5441/T	$261.17
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	F: $43.27 NF: $79.91	$50.59 / P3	5442/T	$634.59
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	GL: $68.39 TC: $39.78 26: $28.61	Packaged into payment for the primary service	5522/Q1(S)	$108.97
76705	Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)	GL: $93.16 TC: $63.85 26: $29.31	Packaged into payment for the primary service	5522/Q3(S)	$108.97
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited	GL: $60.02 TC: $31.05 26: $284.96	Packaged into payment for the primary service	5522/Q1	$108.97
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	GL: $86.19 TC: $53.74 26: $32.45	Packaged into payment for the primary procedure	5522/Q1(S)	$108.97

CPT Code	Description	Physician[13]	ASC[14]	Hospital — Medicare Natl OPPS	
				APC[15]	Payment
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation	GL: $67.79 TC: $36.64 26: $31.05	Packaged into payment for the primary service	5522/S	$109.97
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation	GL: $57.57 TC: $33.85 26: $23.73	Packaged into payment for the primary service	5522/Q1(S)	$108.97
76937	Ultrasonic 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)	GL: $39.08 TC: $25.12 26: $13.96	Packaged into payment for the primary service	N	Packaged into payment for the primary service
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow up or limited study	GL: $102.93 TC: $77.46 26: $25.47	Not payable in this site of service	5523/S	$230.13

13. **NF** = Non facility (physician services provided in a non-facility setting such as physician office); **F** = Facility (physician serviced provided in a facility setting, such as hospital outpatient or ASC setting) **GL** = Global; refers to the entire procedure and is the technical and professional component combined; **TC** = Technical Component; generally associated with the provider who owns or is responsible for provision of the equipment, supplies, etc. **26** = Professional Component; includes all of the provider's work in providing the service, including interpretation and reporting of the procedure, cost of malpractice insurance, and other expenses that are part of (or incident to) maintaining a provider's practice.
14. ASC Key: **P3** = Payment based on physician fee schedule practice expense RVUs; **A2** = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)
15. APC Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed

2021 Medicare National Average Payment Rates

Specialty: Musculoskeletal

CPT Code	Description	Physician[16]	ASC[17]	Hospital — Medicare Natl OPPS	
				APC[18]	Payment
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation	GL: $67.79 TC: $36.64 26: $31.05	Packaged into payment for the primary service	5522/S	$108.97
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation	GL: $57.57 TC: $33.85 26: $23.73	Packaged into payment for the primary service	5522/Q1(S)	$108.97

16. **NF** = Non facility (physician services provided in a non-facility setting such as physician office); **F** = Facility (physician serviced provided in a facility setting, such as hospital outpatient or ASC setting) **GL** = Global; refers to the entire procedure and is the technical and professional component combined; **TC** = Technical Component; generally associated with the provider who owns or is responsible for provision of the equipment, supplies, etc. **26** = Professional Component; includes all of the provider's work in providing the service, including interpretation and reporting of the procedure, cost of malpractice insurance, and other expenses that are part of (or incident to) maintaining a provider's practice.
17. ASC Key: **P3** = Payment based on physician fee schedule practice expense RVUs; A2 = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)
18. APC Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed

2021 Medicare National Average Payment Rates

Specialty: Ultrasound Guided Procedures that can be billed with CPT 76942

CPT Code	Description	Physician[19]	ASC[20]	Hospital — Medicare Natl OPPS	
				APC[21]	Payment
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	F: $58.27 NF: $82.70	$44.31 / P3	5441/T	$261.17
20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	F: $66.65 NF: $88.63	$44.87 / P3	5441/T	$261.17
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	F: $39.78 NF: $57.23	$27.81 / P3	5441/T	$261.17
20551	Injection(s); single tendon origin/insertion	F: $40.13 NF: $58.62	$29.31 / P3	5441/T	$261.17
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s	F: $38.73 NF: $55.48	$29.31 / P3	5441/T	$261.17
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	F: $43.62 NF: $63.51	$34.20 / P3	5441/T	$261.17
20612	Aspiration and/or injection of ganglion cyst(s) any location	F: $40.22 NF: $64.90	$36.99 / P3	5441/T	$261.17

19. **NF** = Non facility (physician services provided in a non-facility setting such as physician office); **F** = Facility (physician serviced provided in a facility setting, such as hospital outpatient or ASC setting) **GL** = Global; refers to the entire procedure and is the technical and professional component combined; **TC** = Technical Component; generally associated with the provider who owns or is responsible for provision of the equipment, supplies, etc. **26** = Professional Component; includes all of the provider's work in providing the service, including interpretation and reporting of the procedure, cost of malpractice insurance, and other expenses that are part of (or incident to) maintaining a provider's practice.
20. ASC Key: **P3** = Payment based on physician fee schedule practice expense RVUs; A2 = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)
21. APC Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed

2021 Medicare National Average Payment Rates

Specialty: Ultrasound Guided Procedures that cannot be billed with CPT 76942

(In other words, Do **NOT** report CPT Code 76942 in addition to the below services)

CPT Code	Description	Physician[22]	ASC[23]	Hospital — Medicare Natl OPPS	
				APC[24]	Payment
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	F: $73.62 NF: $139.22	$314.30 / G2	5057/T	$621.97
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)	F: $51.29 NF: $61.76	Packaged into payment for the primary service	N	Packaged into payment for the primary service
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	F:$47.11 NF: $82.70	$48.15 / P3	5441/T	$261.17
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	F: $54.08 NF: $90.72	$51.29 / P3	5442/T	$634.59
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	F: $61.41 NF: $109.19	$57.57 / P3	5441/T	$261.17

22. **NF** = Non facility (physician services provided in a non-facility setting such as physician office); **F** = Facility (physician serviced provided in a facility setting, such as hospital outpatient or ASC setting) **GL** = Global; refers to the entire procedure and is the technical and professional component combined; **TC** = Technical Component; generally associated with the provider who owns or is responsible for provision of the equipment, supplies, etc. **26** = Professional Component; includes all of the provider's work in providing the service, including interpretation and reporting of the procedure, cost of malpractice insurance, and other expenses that are part of (or incident to) maintaining a provider's practice.

23. ASC Key: **P3** = Payment based on physician fee schedule practice expense RVUs; **A2** = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)

24. APC Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed

2021 Medicare National Average Payment Rates

Specialty: Primary Care

CPT Code	Description	Physician[25]	ASC[26]	Hospital — Medicare Natl OPPS	
				APC[27]	Payment
10005	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	F: $73.62 NF: $139.22	$314.30 / G2	5057/T	$621.97
10006	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)	F: $51.29 NF: $61.76	Packaged into payment for the primary service	N	Packaged into payment for the primary service
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	F:$47.11 NF: $82.70	$48.15 / P3	5441/T	$261.17
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	F: $54.08 NF: $90.72	$51.29 / P3	5442/T	$634.59
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	F: $61.41 NF: $109.19	$57.57 / P3	5441/T	$261.17
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	$10.47 (for all sites of service)	Packaged into payment for the primary service	5733/S	$55.66
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	GL: $119.33 TC: $91.07 26: $28.26	Packaged into payment for the primary service	5522/Q1(S)	$108.97
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	GL: $68.39 TC: $39.78 26: $28.61	Packaged into payment for the primary service	5522/Q1(S)	$108.97

CPT Code	Description	Physician[25]	ASC[26]	Hospital — Medicare Natl OPPS	
				APC[27]	Payment
76705	Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)	GL: $93.16 TC: $63.85 26: $29.31	Packaged into payment for the primary service	5522/Q3(S)	$108.97
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)	GL: $112.36 TC: $84.79 26: $27.57	Packaged into payment for the primary service	5522/S	$108.97
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited	GL: $60.02 TC: $31.05 26: $284.96	Packaged into payment for the primary service	5522/Q1	$108.97
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	GL: $86.19 TC: $53.74 26: $32.45	Packaged into payment for the primary procedure	5522/Q1(S)	$108.97
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	GL: $48.85 TC: $24.77 26: $24.08	Packaged into payment for the primary service	5522/Q3(S)	$108.97
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft tissue structures) real-time with image documentation	GL: $67.79 TC: $36.64 26: $31.05	Packaged into payment for the primary service	5522/S	$108.97
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft tissue structure[s], or soft tissue mass[es]), real-time with image documentation	GL: $57.57 TC: $33.85 26: $23.73	Packaged into payment for the primary service	5522/Q1(S)	$108.97
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	GL: $102.93 TC: $77.46 26: $25.47	Packaged into payment for the primary service	5523/S	$230.13
93882	Duplex scan of extracranial arteries; unilateral or limited study	GL: $134.94 TC: $108.17 26: $24.77	Packaged into payment for the primary service	5522/S	$108.97

25. **NF** = Non facility (physician services provided in a non-facility setting such as physician office); **F** = Facility (physician serviced provided in a facility setting, such as hospital outpatient or ASC setting) **GL** = Global; refers to the entire procedure and is the technical and professional component combined; **TC** = Technical Component; generally associated with the provider who owns or is responsible for provision of the equipment, supplies, etc. **26** = Professional Component; includes all of the provider's work in providing the service, including interpretation and reporting of the procedure, cost of malpractice insurance, and other expenses that are part of (or incident to) maintaining a provider's practice.
26. ASC Key: **P3** = Payment based on physician fee schedule practice expense RVUs; **A2** = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)
27. APC Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed

2021 Medicare National Average Payment Rates

Specialty: Obstetrics/Gynecology

CPT Code	Description	Physician[28]	ASC[29]	Hospital — Medicare Natl OPPS	
				APC[30]	Payment
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	G: $124.22 TC: $75.37 26: $48.84	Not Payable in ASC	5522 / S	$108.97
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)	G: $63.85 TC: $22.68 26: $41.17	Not Payable in ASC	N	Packaged
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	G: $143.06 TC: $94.21 26: $48.85	Not Payable in ASC	5522 / S	$108.97
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)	$93.16 TC: $44.66 26: $48.50	Not Payable in ASC	N	Packaged
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation	G: $179.70 TC: $86.19	Not Payable in ASC	5523 / S	$230.13
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)	G: $203.08 TC: $115.50 26: $87.58	Not Payable in ASC	N	Packaged
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	G: $86.19 TC: $53.74 26: $32.45	Not Payable in ASC	5522 / Q1(S)	$108.97

CPT Code	Description	Physician[28]	ASC[29]	Hospital — Medicare Natl OPPS	
				APC[30]	Payment
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	G:$116.19 TC: $73.97 26: $42.22	Not Payable in ASC	5522 / Q1(S)	$108.97
76818	Fetal biophysical profile; with non-stress testing	G: $119.33 TC: $67.34 26: $51.99	Not Payable in ASC	5522 / S	$108.97
76819	Fetal biophysical profile; without non-stress testing	G: $88.28 TC: $49.90 26: $38.38	Not Payable in ASC	5522 / S	$108.97
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete	G: $112.36 TC: $78.16 26: $34.20	Not Payable in ASC	5522 / Q3(S)	$108.97
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	G: $48.85 TC: $24.77 26: $24.08	Not Payable in ASC	5522 / O3(S)	$108.97
76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation	G: $33.15 TC: $14.31 26: $18.84	Not Payable in ASC	N	Packaged

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29. ASC Key: **P3** = Payment based on physician fee schedule practice expense RVUs; **A2** = Payment based on OPPS payment rates; **G2** = Payment based on OPPS payment (non- office based surgical procedure)
30. APC Key: **N** = Packaged into APC rate, not separately paid; **S** = Significant procedure, not discounted when multiple; **T** = Procedure, discounted 50% when another procedure with a T status is billed