Butterfly™
The New Image of Health

MSK Reimbursement Guide 2021

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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 followed in strict accordance. 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 mindful of the fact that some services are not covered in the ASC (Ambulatory Surgery Center) setting or are reimbursed at a substantially lower rate. Medicare's calculation of ASC services is complex, involving historical billing data from physician office settings versus hospital outpatient settings.

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

Consider preauthorizing the procedure with the patient's payer. 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. Note: Generally, Medicare does not preauthorize services.

Step 4. Track the claim

Track billing and appeal any denied and/or underpaid claims.

The following guide provides coding and payment information for diagnostic ultrasound and related ultrasound-guided procedures. Payment rates are calculated based on current Medicare fee schedules. Private payers and Medicaid agents may pay more or less than Medicare. 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. Butterfly Network disclaims any responsibility to update the information provided.

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: Musculoskeletal

CPT Code	Description	Physician[4]	ASC[5]	Hospital — Medicare Natl OPPS	
				APC[6]	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
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	GL: $58.97 TC: $27.57 26: $31.40	Packaged into payment for the primary service	N	Packaged into payment for the primary service

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: Ultrasound Guided Procedures that can be billed with CPT 76942

CPT Code	Description	Physician[7]	ASC[8]	Hospital — Medicare Natl OPPS	
				APC[9]	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

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: 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[10]	ASC[11]	Hospital — Medicare Natl OPPS	
				APC[12]	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

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