If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Point-of-Care Ultrasound Examination Policy

Policy Number: CPCP030

Version 1.0

Clinical Payment and Coding Policy Committee Approval Date: June 4, 2021

Effective Date: June 10, 2021

Description

This Clinical Payment and Coding Policy is intended to serve as a reference for facilities and providers (physicians or other qualified health care professionals) when submitting reimbursement for point-of-care ultrasound examination procedures. A point-of-care ultrasound examination may be performed by an appropriately trained qualified provider to use a portable ultrasound device to diagnose and treat a medical problem in real time. These scans are not intended to replace a formal ultrasound scan that is performed in the Radiology Department.

Reimbursement Information:

Ultrasound (sonography) uses high frequency sound waves that allow a provider to view images inside the body. An ultrasound is often used to support other procedures, such as but not limited to, needle placement, real time visualization of vascular needle entry and to evaluate soft tissue for other diagnostic purposes.

The American Medical Association (AMA) outlines a broad range of CPT® codes for anatomical locations. The following list(s) of codes may not be all inclusive. Codes listed within this policy do not imply payment for claims is guaranteed:

Head and Neck	76506, 76510, 76511-76514, 76516, 76519, 76529, 76536
Chest	76604, 76641, 76642
Abdomen and Retroperitoneum	76700, 76705, 76706, 76770, 76775, 76776
Spinal Canal	76800
Pelvis a. Obstetrical b. Non-obstetrical	a. 76801, 76802, 76805, 76810-76821, 76825-76828 b. 76830, 76831, 76856, 76857
Genitalia	76870, 76872, 76873
Extremities	76881, 76882, 76885, 76886

In addition to:

Ultrasonic guidance procedures	76932, 76936, 76937, 76940-76942, 76945, 76946, 76948, 76965
Other procedures	76970, 76975, 76977-76979, 76981-76983, 76998, 76999

Facilities and providers are responsible for submitting appropriate codes and/or modifiers for services rendered during the point-of-care ultrasound examinations. All images should be recorded and documented in the members medical records in addition to the indications for the point-of-care ultrasound examination, results and clinical impression. Documentation may be requested by the plan in order to determine eligible reimbursement. Note, professional providers will not be reimbursed for an ultrasound code when an E/M code(s) is billed for the same date of service.

Appending a Modifier

Ultrasound imaging includes both a technical component (TC) and a professional component (PC). The technical component (the performance of the test) is identified by appending modifier -TC. The professional component (the interpretation of the test and the documented written report) is identified by appending modifier -26. A global procedure/service contains both the TC (-TC) and PC (-26) components and may be billed together if services are rendered and interpreted by the same provider for the same services under a separate facility arrangement. In this scenario, a modifier does not need to be appended.

Limited Ultrasound vs. Complete Ultrasound

A complete ultrasound examination is an evaluation of **all** the major structures of an anatomical location. A limited ultrasound examination is an evaluation of **a certain area for a specific condition**. Limited and Complete ultrasounds are real time and should include permanently recorded images. A point-of-care ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation and a final written report, is not separately reportable.

In situations where there is no available CPT code for a limited ultrasound examination, facilities and providers should report the complete ultrasound study with modifier -52.

Point-of-Care Ultrasound Examinations in the Emergency Department

Emergency Ultrasound (EUS) is a point-of-care evaluation of acute or critical medical conditions. The following is not an all-inclusive list but serves only as a general reference for point-of-care ultrasounds performed in the emergency department. Listing of the items is not a guarantee of payment. Payment depends on the applicable plan documents and facility or provider documentation:

- Adnexal Pathology
- Early Obstetric
- ENT
- Infectious Disease
- Musculoskeletal
- Ocular
- Testicular
- Transcranial Doppler
- Transesophageal Echo
- Trauma
- Vascular

The plan reserves the right to request supporting documentation if claim(s) do not adhere to coding and billing which may result in a denial or reassigned payment rate. Claims may be reviewed on a case by case basis.

References:

Medicare Claims Procesing Manual. Chapter 13-Radiology Services and Other Diagnostic Procedures. March 27, 2019. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf

American College of Emergency Physicians. Appropriate Use of Criteria for Handheld/Pocket Ultrasound Devices. June 2018. https://www.acep.org/globalassets/new-pdfs/policy-statements/appropriate-use-criteria-for-handheld-pocket-ultrasound-devices.pdf

American College of Emergency Physicians. Ultrasound Guidelines: Emergency, Point-of-Care, and Clinical Ultrasound Guidelines in Medicine. June 2016. https://www.acep.org/globalassets/new-pdfs/policy-statements/ultrasound-guidelines---emergency-point-of-care-and-clinical-ultrasound-guidelines-in-medicine.pdf

CPCP023 Modifier Reference Guide

Policy Update History:

Approval Date	Description
05/28/2020	New policy
06/04/2021	Annual Review