healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Ultrasound Diagnostic Procedures		
Policy Number:	PO-RE-092v1		
Effective Date:	11/1/2020	**Last Approval Date:**	11/20/2023

I. Policy Description

Healthfirst will no longer provide reimbursement for CPT 76856 (Ultrasound, pelvic [non-obstetric], real time with image documentation; complete) or CPT 76857 Ultrasound, pelvic [non-obstetric], real time with image documentation; limited or follow-up) when billed with CPT 76830 (Transvaginal ultrasound) unless extenuating circumstances are present to validate the necessity of both studies. This policy is implemented due to the redundancy of services provided by both procedures, as they evaluate the patient for the same conditions during the same session.

A pelvic ultrasound is defined as a noninvasive diagnostic exam that produces images that are used to assess organs and structures within the female pelvis. A pelvic ultrasound allows quick visualization of the female pelvic organs and structures, including the uterus, cervix, vagina, Fallopian tubes, and ovaries.

A transvaginal ultrasound is defined as a type of pelvic ultrasound used by doctors to examine female reproductive organs. This includes the uterus, Fallopian tubes, ovaries, cervix, and vagina. “Transvaginal” means “through the vagina.” This is an internal examination.

Reimbursement Guidelines

1. Healthfirst will not reimburse CPT 76856 or CPT 76857 when billed with CPT 76830, unless there are extenuating circumstances that validate the necessity of both studies.

2. Extenuating circumstances may include, but are not limited to:
    a. Suspected pathology or medical conditions that require additional evaluation beyond what can be adequately assessed by a single procedure.
    b. Unsuccessful completion of either the pelvic ultrasound or the transvaginal ultrasound due to technical limitations or patient factors.

3. Providers must clearly document the extenuating circumstances in the medical record when submitting a claim for reimbursement of both CPT 76857 and CPT 76830.

Adjudication and Appeal Process

1. Claims submitted for reimbursement of both procedures without sufficient supporting documentation of extenuating circumstances will be denied.
2. Providers must submit claims for reimbursement of pelvic ultrasound (CPT 76857) or transvaginal ultrasound (CPT 76830) separately.
3. Claims submitted for reimbursement of both CPT 76857 and CPT 76830 must include supporting documentation that justifies the medical necessity of both procedures.

In Scope Lines of Business:

Medicare, Medicaid, HARP, Child Health Plus, Essential Plan, Qualified Health Plan, Commercial

II. Applicable Codes

Code	Description	Comment
76856	Ultrasound, pelvic [non-obstetric], real time with image documentation; complete	
76857	Ultrasound, pelvic [non-obstetric], real time with image documentation; limited or follow-up	
76830	Ultrasound, transvaginal	

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

https://hfproviders.org/documents/root/1164-20-Reimbursement-Policy-Updates_Provider-Alert_FINAL.pdf

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.