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Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Point of Care Ultrasound (PoCUS)		
Policy Number:	PO-RE-107v1		
Effective Date:	07/01/2024	**Last Approval Date:**	05/20/2024

I. Policy Description

This document describes the policy Healthfirst follows for Point of Care Ultrasound (PoCUS). This policy is executed pursuant to applicable provisions set forth in the contracts for the products indicated above, Articles 44 and 49 of the New York State (NYS) Public Health Law (PBH), as well as applicable Federal and State statutes and regulations.

The information below applies to the following lines of business.

- Child Health Plus
- Small/Individual Group (Commercial Plan)
- Essential Plan
- Medicaid Managed Care
- Medicare PPO
- Integrated Benefits Dual Connection Plan
- Health & Recovery Plan (HARP)
- Medicare Advantage
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)
- Managed Long Term Care Partial Capitation Plan (MLTCP – Senior Health Partners)

Point of Care Ultrasound (PoCUS) has become widely used in acute medical settings as a rapid diagnostic tool. Benefits include its relatively low cost, lack of ionizing radiation, portability, and ease of use. The relatively fast use has made it a potential option in situations where a formal radiological investigation may delay the diagnosis. Data have demonstrated that Point of Care Ultrasound (PoCUS) can improve diagnostic accuracy in numerous common clinical presentations, including acute appendicitis, airway compromise, abdominal aortic aneurysm, traumatic injury assessment.

A point-of-care ultrasound examination may be performed by an appropriately trained qualified provider to use a portable ultrasound device to diagnose and/or 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.

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Policy Scope

A. General

1. Healthfirst will only consider reimbursement for PoCUS when performed by an appropriately trained and qualified provider when used to diagnose and/or treat an acute medical problem in a hospital setting.

2. Hospital systems are responsible for creating and maintaining a credentialing process, including delineation of privileges of clinicians who are appropriately trained and qualified to perform PoCUS.

3. CMS guidelines specify the following five components of documentation: an order, medical necessity, a written report, interpretation, and physician's signature. Medical necessity, sometimes written as the indication(s), is the clinically relevant reason for obtaining the ultrasound.

4. Payment depends on the applicable plan documents and facility or provider documentation. Facilities and Healthcare Providers are responsible for submitting appropriate codes and/or modifiers for services rendered during the point-of-care ultrasound examinations.

5. 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 to determine eligible reimbursement.

6. To be reimbursed for PoCUS, it must be a separate, stand-alone procedure. For example, the clinician evaluating the patient utilizes US at the patient's bedside to answer a focused question or guide an invasive procedure.

7. When PoCUS is used as part of E/M evaluation in the Emergency Department (i.e. not a stand-alone/dedicated procedure), it is considered integral to the exam and cannot be submitted separately for reimbursement. PoCUS in the ED is within the CMS rules for general ED department visits using the CMS chart leveling process. Clinical ultrasound use contributes to the chart leveling process by demonstrating increased complexity and medical decision making by the treating clinician. *Note:* CMS Requirements such as documentation detail and image retention for billing for clinical ultrasound performance and interpretation do not necessarily apply for revenue obtained through E&M, but hospital or departmental policies would still apply.

8. The plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis.

B. Coding

1. CPT Coding: 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:

CPT Code	Ultrasound Study
93308	FAST (focused assessment of sonography in trauma): scan for hemopericardium a and hemoperitoneum, may include lung ultrasound*
76705	For pneumothorax
76604	
76815	Pregnant transabdominal (TA)
76817	Pregnant transvaginal (TV)
76775	Retroperitoneal: aorta, renal
93308	Cardiac
76604	Thoracic (chest only)
76705	Biliary
76857	Bladder
93971	DVT-unilateral
93970	DVT-Bilateral
Soft tissue ultrasound	
76536	Head/neck
76882	Axilla
76604	Chest wall
76641	Breast
76604	Upper back
76705	Lower back
76705	Abdominal wall
76857	Pelvic wall
76882	Extremity
76512	Ocular
76999	Miscellaneous ultrasound
Ultrasound-guided procedure codes	
76937	Ultrasound-guided vascular access placement
32555	Ultrasound-guided thoracentesis
49083	Ultrasound-guided paracentesis
76942	Miscellaneous ultrasound-guided procedure without catheter
76942	Ultrasound-guided abscess drainage
76942	Ultrasound-guided peritonsillar abscess drainage
76942	Ultrasound-guided lumbar puncture
76942	Ultrasound-guided suprapubic aspiration
76942	Ultrasound-guided fb removal

20604	Ultrasound-guided joint aspiration: small joint or bursa-finger, toe
20606	Ultrasound-guided joint aspiration: intermediate joint or bursa-elbow, wrist
20611	Ultrasound-guided joint aspiration: major joint or bursa-shoulder, hip knee

2. 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. The PC will pay only if the services meet the conditions for fee schedule payment and are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as an interpretation of diagnostic procedures and the PC of therapeutic procedures. The interpretation of a diagnostic procedure includes a written report. Hospital bundling rules exclude payment to suppliers of the TC of a radiology service for beneficiaries in a hospital inpatient stay.

3. 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.

II. Applicable Codes

Code	Description	Comment
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting	
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting	
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	
32555	Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance	
49083	Abdominal paracentesis (diagnostic or therapeutic); with	

	imaging guidance	
76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	
76536	Ultrasound, soft tissues of head and neck (e.g., thyroid, parathyroid, parotid), real time with image documentation	
76604	Ultrasound, chest (includes mediastinum), real time with image documentation	
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	
76705	Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)	
76775	Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), real time with image documentation; limited	
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses	
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	
76857	Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up (e.g., for follicles)	
76882	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (e.g., 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	
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	
76999	Unlisted ultrasound procedure (e.g., diagnostic, interventional)	
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	
93970	Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study	
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	

III. Definitions

Term	Meaning
Point of Care Ultrasound (PoCUS)	An advanced diagnostic ultrasonography that is performed and interpreted by the attending physician as a bedside test.[ii]
Diagnostic ultrasound	A non-invasive diagnostic technique used to image inside the body. Ultrasound probes, called transducers, produce sound waves that have frequencies above the threshold of human hearing (above 20KHz), but most transducers in current use operate at much higher frequencies (in the megahertz (MHz) range).

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

Moore C.L., Copel J.A. Point-of-care ultrasonography. *N. Engl. J. Med.* 2011;364:749–757. doi: 10.1056/NEJMra0909487.
The utility of point of care ultrasonography (POCUS) - PMC (nih.gov)
Ultrasound (nih.gov)
Microsoft Word - Ultrasound Guidelines- Emergency, Point-of-care, and Clinical Ultrasound Guidelines in Medicine.docx (acep.org)
Medicare Claims Processing Manual (cms.gov)
Choi W. et al. Role of point-of-care ultrasound in critical care and emergency medicine: update and future perspective. Clin Exp Emerg Med. 2023 Dec; 10(4): 363–381. doi: 10.15441/ceem.23.101
Microsoft Word - Ultrasound Guidelines- Emergency, Point-of-care, and Clinical Ultrasound Guidelines in Medicine.docx (acep.org)

Medicare Claims Processing Manual (cms.gov)
Moore C.L., Copel J.A. Point-of-care ultrasonography. *N. Engl. J. Med.* 2011;364:749–757. doi: 10.1056/NEJMra0909487. The utility of point of care ultrasonography (POCUS) - PMC (nih.gov)
Ultrasound (nih.gov)

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.

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Approval Date/ Signatures:

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