

Payment Policy: Non-obstetrical Pelvic and Transvaginal Ultrasounds

Reference Number: CC.PP.061

Product Types: ALL

Last Review Date:

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

Pelvic (transabdominal) ultrasound and trans-vaginal ultrasound may be performed during the same non-obstetrical patient encounter when medically necessary. When both procedures are reported for the same patient on the same day, the health plan will reimburse the primary procedure (transvaginal ultrasound) at 100% of the fee schedule allowed amount and apply a multiple procedure payment reduction to the second procedure (pelvic ultrasound) of 50%.

Application

Professional and Outpatient Facility Claims.

Policy Description

The health plan supports the Centers for Medicare and Medicaid (CMS) guidelines that multiple procedure payment reductions apply when multiple services are furnished by the same physician or physicians within the same group practice, to the same patient on the same day and during the same session.

It is the policy of the Plan that when a provider acquires multiple non-obstetrical ultrasound images in a single session, most of the clinical labor activities are neither performed nor furnished twice. Provider reimbursement for a procedure code includes reimbursement for clinical labor costs associated with that service. The following clinical labor activities are some examples of activities that are not duplicated for subsequent procedures:

- Greeting the patient
- Gowning the patient
- Preparing and cleaning the room
- Positioning and escorting the patient
- Providing education and obtaining consent
- Retrieving prior examinations
- Different probes in this case

Furthermore, the majority of supplies are not duplicated for subsequent procedures. Equipment time and indirect costs are allocated based on clinical labor time; therefore, these conditions should be reduced. A multiple procedure payment will adjust provider reimbursement to offset duplication of clinical labor activities that were only rendered once.

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Reimbursement

CPT code 76856 represents a non-obstetrical pelvic ultrasound, real time with image documentation; complete. CPT code 76830 represents a non-obstetrical transvaginal ultrasound.

During the course of an office visit, if a provider performs a pelvic ultrasound and determines that the image is unclear and that a transvaginal ultrasound is necessary, only the transvaginal ultrasound will be reimbursed at 100% of the allowed amount. The pelvic ultrasound will be reimbursed at 50% of the allowed amount.

Documentation Requirements

NA

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2017, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
76830	Ultrasound, transvaginal
76856	Ultrasound, pelvic (nonobstetric), real time with image documentation; complete

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	NA

Definitions

Transvaginal Ultrasound: A transvaginal ultrasound is 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.

Pelvic Ultrasound: A pelvic ultrasound is 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. The transducer is pressed firmly against the skin and swept

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back and forth over the lower abdomen and images are obtained of the uterus, ovaries, and surrounding pelvic structures. This is an external examination.

Non-Obstetrical: Not related to the pregnancy, child birth nor postpartum period.

Related Documents or Resources

NA

References

Revision History	
05/30/18	Initial Policy Draft

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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