

Title: Payment Policy: Transabdominal, Transvaginal Ultrasounds	Division: Medical Management Department: Utilization Management
Approval Date:	LOB: Medicaid, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, QHP, Essential, HARP, Medicare
Effective Date:	Policy Number:
Review Date:	Cross Reference Number:
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1. POLICY DESCRIPTION:

MetroPlusHealth supports Centers for Medicare and Medicaid Services, (CMS) guidelines that diagnostic imaging furnished on the same day, by the same physician/same physician group and/or other healthcare provider for the same patient encounter are applied multiple procedure payment reductions when appropriate.

When a non-obstetrical transabdominal/pelvic ultrasound is completed with a transvaginal ultrasound during a single patient encounter by the same physician/same physician group and/or other healthcare provider, most clinical labor activities and supplies are not furnished multiple times.

Common Procedure codes (CPT codes) include reimbursement for clinical labor and equipment costs for each billed service therefore full payment of secondary diagnostic imaging procedures would contain duplicative payments. To remove duplicate payment of components already paid by the primary procedure, MetroPlusHealth will apply a multiple procedure payment reduction to the secondary procedure to account for clinical labor/ equipment costs that were only furnished once.

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claims Department, Providers Contracting.

3. DEFINITIONS:

Same physician/same physician group and/or other healthcare provider: All physicians and other health care professionals billing under the same Federal Tax Identification number.

Same patient encounter: Services furnished on the same day by the same physician/same physician group and/or other healthcare provider to a unique patient.

4. POLICY:

When medically necessary, a non-obstetrical transabdominal/pelvic ultrasound may be performed during the same patient encounter as a transvaginal ultrasound.

When both procedures are billed for the same patient, on the same day, the primary procedure (transvaginal ultrasound) will be reimbursed at 100% of the fee schedule and a multiple procedure payment reduction will be applied to the secondary procedure.

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50% of fee schedule for the secondary procedure (transabdominal ultrasound)

This policy is related to correct coding and not medical necessity.

5. LIMITATIONS/ EXCLUSIONS:

Place of Service

The policy will be effective for professional claims submitted in the office setting. In this setting, even if a modifier is applied, the multiple procedure payment reduction will still be in effect.

6. APPLICABLE PROCEDURE CODES:

CPT	Description
76856	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE
76830	ULTRASOUND, TRANSVAGINAL

7. REFERENCES:

- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.
- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services.

REVISION LOG:

REVISIONS	DATE
Creation date	



Policy and Procedure

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Approved:	Date:	Approved:	Date:
Glendon Henry, MD Senior Medical Director		Sanjiv Shah, MD Chief Medical Officer	

Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that



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MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.