Point of Care Ultrasound (PoCUS)

Introduction

Anesthesiologists may employ ultrasound techniques in either anesthetizing locations or intensive care units. This Timely Topic article provides an overview of ultrasound codes most often submitted by anesthesiologists and information on how to support those claims.

Point of care ultrasound (PoCUS) can be defined as the use of ultrasound by a primary treating physician (e.g., an anesthesiologist) either to **guide procedures** or **answer diagnostic questions,** as opposed to a consultant physician who performs a comprehensive, high-level examination (not limited to procedures or diagnostic questions)[1]. PoCUS includes multiple areas of relevance to anesthesiologists, including diagnostic uses (abdominal, thoracic, cardiac, airway, and evaluation of hypotension, respiratory failure, and organ dysfunction), as well as therapeutic/procedural uses (including regional anesthesia and vascular access).

It should be noted that this differs from other types of studies (e.g., Transesophageal echocardiography (TEEs) which may use diagnostic exams to indicate the highest level of examination. As opposed to TEEs, which indicate the highest level of competence and complexity, POCUS diagnostic examinations are focused on specific questions and are considered at a lower level of complexity than comprehensive ultrasound, which is the most complete analysis of a given organ system. According to the Current Procedural Terminology 2023 (CPT), "If less than the required elements for a 'complete' exam are reported (e.g., limited number of organs or limited portion of region evaluated), the 'limited' code for that anatomic region should be used once per patient exam session." A consultative ultrasound is automatically considered comprehensive (even though it might be limited in scope).

Ultrasound Codes Anesthesiologists Use to Describe PoCUS

Numerous codes describe ultrasound services, but many (or even most) will rarely be submitted by anesthesiologists. Anesthesiologists typically use ultrasound to make diagnostic decisions or as guidance for certain procedures. Below (Table 1) is a list of CPT codes that describe ultrasound services most likely to be submitted by anesthesiologists in the peri-operative and intensive care settings. It does not include codes for ultrasound services associated with pain blocks. Anesthesiologists should also be aware that ultrasound services are increasingly being bundled in with the CPT codes that describe procedures requiring the ultrasound. Once there is a bundled code that includes ultrasound, physicians are no longer permitted to submit claims that separate out the procedure and ultrasound codes. Physicians should review these codes each year to avoid denials based on unbundling of services.

Anesthesiologists submitting claims for ultrasound services must determine whether the code should include the 26-modifier (professional component), the TC-modifier (technical component), or neither modifier. The 26-modifier indicates the professional services were provided by the physician but the equipment is owned by another entity (e.g., hospital or outpatient surgery center). If the physician performs the service and owns the equipment, the

claim will include only the code without a modifier. Although likely to occur only rarely, it is possible that one physician practice performs the service while another physician practice owns the equipment.; in such cases, the physician performing the service would attach the 26-modifier to the code while the equipment owning practice would attach the TC-modifier.

This list does not limit anesthesiologists to only these codes, but use of other, more complex codes usually requires in-depth exams and a written report of all findings, including multiple structures within the area of the ultrasound exam. Codes that include the word "complete" in their descriptors typically have guidance that enumerates all the structural items that must be examined and must be included in the report associated with the exam. Codes that include the word "limited" in their descriptors are used to describe ultrasound exams that do not examine and report on all the structures required in a "complete" exam (i.e., are more focused).

Table 1

CPT Code	Code Descriptor	Notes
76506	Echoencephalography, real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated	May be useful in trauma to determine presence of intracranial bleed
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	May be useful to report limited cardiac ultrasound examinations or focused exams of lungs
76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurism	
76800	Ultrasound, spinal canal and contents	
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)	Add on code reported in addition to the code for the primary vascular access procedure

76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation	
76998	Ultrasonic guidance, intraoperative	
76999	Unlisted ultrasound procedure (e.g., diagnostic, interventional)	
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	
93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study	
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography	
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study	

Requirements for documentation

The PoCUS exam may be documented as a separate note or as part of the patient's anesthetic record or daily progress note in addition to the physical exam. The required elements of the note are:

- Indication/medical necessity (not screening). Ideally, the indication pairs well with an appropriate ICD-10 code.
- Operator(s) who performed the exam.
- Type of exam, including full vs limited and initial vs. repeat exam.
- Findings in detail.
- Interpretation of findings, including structures evaluated and relevant anatomy or pathology.

Requirements for Image Archiving

The CPT provides that "all diagnostic ultrasound examinations require permanently recorded images with measurements, when such measurements are clinically indicated." To submit claims for PoCUS examinations, images must be saved and archived in a durable format and able to be reviewed for auditing for at least 5 years after the exam is performed. Local Medicare contractors may have additional requirements beyond these minimums. It is advised that anesthesiologists submitting PoCUS claims should review all local requirements to ensure

compliance. The images and videos should clearly identify relevant anatomy and pertinent normal or abnormal findings to support the corresponding documentation.

Additionally, the images must be stored in a manner that is HIPAA compliant, whether that is in a cloud-based service or stored on a local device drive. The software must have the ability to retrieve the correct exam, potentially years later. Static images are sufficient for billing purposes, though loop video recording may be more useful for patient care.

Credentialing/Privileging

The American Medical Association (AMA) is in support of anesthesiologists performing PoCUS. In its 1999 resolution, the AMA affirmed that ultrasound imaging is within the scope of practice of appropriately trained physicians. Additionally, the resolution states that hospitals should grant privileges to perform ultrasound imaging in accordance with standards developed by each specific specialty.

Anesthesiology departments should adopt credentialing standards for PoCUS that are suitable for their facility and local environment.

References:

1. Bronshteyn, Y.S., J. Blitz, N. Hashmi, S. Krishnan. Logistics of perioperative diagnostic point-of-care ultrasound: nomenclature, scope of practice, training, credentialing/privileging, and billing. *International Anesthesiology Clinics.* 2022;60(3):1–7.

2. Koenig, S.J., B.X Lou, Y. Moskowitz, M. Narasimhan, P.H. Mayo. Ultrasound Billing for Intensivists. *Chest*. 2019;156(4):792–801.

3. Hughes, D., M.M. Corrado, I. Mynatt, M. Prats, N.A. Royall, C. Boulger, C.P. Bahner. Billing I-AIM: a novel framework for ultrasound billing. *Ultrasound J*. 2020;12(1):8.

4. American Medical Association (AMA). Privileging for ultrasound imaging: H-230.9601999.

5. American Medical Association. Current Procedural Terminology 2023, Professional Edition. 2022.