## **Practical Aspects of Point-of-Care Ultrasound: From Billing and Coding to Documentation and Image Archiving**



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As point-of-care ultrasound (POCUS) is increasingly implemented into the routine clinical practice of nephrologists, it is important to consider the practical aspects of a POCUS workflow including documentation, image archiving, billing, and coding. Documentation of POCUS studies performed allows for accurate information exchange among all members of the care team and can be effectively implemented using preset documentation worksheets. Image archiving systems provide a mechanism for review, storage, and quality assurance processes that are directly linked to the patient's record. Understanding the coding components required for billing and developing efficient systems to support billing and coding can contribute to ensuring financial support for POCUS programs long term. Each individual component, documentation, image archiving, billing, and coding is necessary to incorporate into a POCUS workflow as documentation, archiving, and coding of studies are required for appropriate billing. Most importantly, incorporating these practical components creates opportunities for communicating clinically relevant findings among care teams and enhances the quality of patient care delivered in health systems.

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Key words: Point-of-care ultrasound, Billing, Coding, Documentation, Archiving

ritical to the development of a robust point-of-care ultrasound (POCUS) program are the practical aspects of documentation, image archiving, billing, and coding. Careful considerations into these components have a number of benefits for patients, providers, and the healthcare system.<sup>1</sup> An established workflow that accounts for how to translate image acquisition to interpretation and clinical decision-making is essential. This workflow must consider image acquisition, interpretation, image archiving, and integration with the patient's medical record. In addition, this workflow includes a process for quality assurance which can be carried out by individuals trained in POCUS. A robust system alleviates the issues associated with phantom scanning, illiterate scans, and blind scans.<sup>2</sup> Phantom scans are ultrasound images that are performed by a provider without documentation or image acquisition (saving of images); illiterate scans are images that are saved without corresponding documentation; and blind scans are documented examinations without image acquisition. Each of these scenarios can be potentially dangerous for patient care as they represent a breakdown in the communication between the individual performing the examination and other providers who may be involved in the patient's care.

There are many benefits to patients and providers when performing bedside POCUS including expedited time to diagnosis, assistance with medical decision making and

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therapeutic intervention, reduction in procedural complications, reduction in length of stay, and decreased patient care costs.<sup>2,3</sup> Without an accompanying robust workflow, these benefits may not be recognized by other members of the care team and may not be communicated throughout the patient's encounter. Additional benefits of a robust workflow includes a quality assurance program that allows for following up patients owing to errors in interpretation, incidental findings, and more generally, offers opportunities for institutional quality improvement, overall supporting the delivery of high quality and safe patient care.<sup>1</sup> Finally, from an institutional perspective, the benefits of an integrated workflow allow for improvements in resource utilization by minimizing costly and invasive procedures and capture services conducted by providers that are a potential source of revenue and reimbursement.

#### DOCUMENTATION

Providing accurate and accessible real-time documentation with interpretation is a critical component of relaying timely information to members of the care teams and assessing therapeutic interventions across the care continuum. Ideally, all members of the care team are able to view documentation and saved images in real time as well. Incomplete and inaccurate documentation creates challenges for clinical care but also limits billing and thus reimbursement.

There are a number of elements that should be included in documentation. For billing purposes, requirements include the indication for the study, a written report, and interpretation.<sup>4</sup> The description of findings and interpretation is ideally completed immediately after the study is performed for clinical and billing efficacy. Creating preset documentation worksheets for common studies will assist clinicians with documentation necessary for clinical care and for billing. The following are items to include when documenting each POCUS study (see Table 1,

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Documentation of POCUS Studies, see Fig 1 Example Documentation). $^{5-7}$ 

## Patient Information Including Name, Date of Birth, Patient ID/Medical Record Number

Depending on the workflow of the department and/or institution, this information can be obtained using a scanning system connected to the ultrasound machine so the patient's barcode can simply be scanned into the system. Another option is to connect the archival system to the electronic health record (EHR) so the patient's information can be manually searched in the worklist.

# Provider Performing the Ultrasound and Provider Interpreting the Ultrasound

Ensure the individual performing and/or interpreting is credentialed appropriately as per departmental/institutional/specialty requirements.<sup>8</sup>

## Date and Time of Ultrasound

This is typically automatically included when the images are saved providing the ultrasound machine date/time is accurate.

## Clinical or Educational Scan

At many institutions, trainees may be engaging in educational activities. While these studies may still undergo quality assurance as part of departmental policies, they are not typically intended for clinical decision-making. Documenting this is important to ensure the studies are not submitted for billing and coding.

## CLINICAL SUMMARY

- Point-of-care ultrasound programs should consider developing and supporting a point-of-care ultrasound workflow that incorporates efficient and effective mechanisms of documentation, image archiving, billing, and coding.
- A point-of-care ultrasound workflow that includes the aforementioned components has many benefits to patients, providers, and health systems including appropriate reimbursement for the time and expertise of the clinician as well as supporting high-quality patient care.

## Acquisition: Including Views Obtained, Description of Findings, Structures Evaluated/Relevant Anatomy, Abnormal Findings

This includes documenting what views were acquired and if any were technically limited or inadequate with an accompanying explanation. Describe what structures were or were not visualized, measurements obtained, normal and/or abnormal findings.

#### Interpretation

The interpretation should clarify whether the study was normal or abnormal, provide an assessment of the findings, and establish how this contributes to medical decision-making.

#### **Comparison to Previous Images (if Applicable)**

Indicate if prior images were obtained and comparison to priors, including whether the interpretation has changed.

## Follow-Up Studies (if Applicable)

Indicate whether a complete ultrasound is indicated after the limited study is performed.

## Image Archival

It is essential to ensure that a system exists for permanently storing/archiving the images that is linked to the patient's medical record. For billing purposes, there is not technically a predetermined type or number of images that must be saved; however, it is helpful to establish institutional or guidelines departmental for the purpose of standardization. For example, obtaining 4 views for a

Limited vs Complete vs Procedural

Most bedside studies will be limited studies as a complete exam includes all anatomical structures in a specific region being evaluated.

For procedural documentation, it's helpful to include at least one image either before or after the procedure to localize the site and real time if possible. The note should also document whether the procedure was ultrasound assisted, used for visualization, and/or ultrasound guided as this would be 2 separate charges. Specifically for vascular access, providers must document the site, vessel patency, and record the needle in the vessel in real time.

#### Indication for the Study

The indication for the examination is important to document as it highlights the medical necessity for the POCUS study, can be linked to an International Classification of Diseases (ICD-10) code and thus can be used for billing/ coding purposes. bedside echo study including parasternal long, short, apical 4, and subxiphoid.

#### Signature

It is important to remember to sign and, if applicable, submit images and interpretation if required for billing.

### **IMAGE ARCHIVING**

Image capture and storage is required for all POCUS studies including procedural studies. Images should be permanently stored and linked to the patient's record. In addition to reimbursement requirements, image storage is beneficial as it allows for other members of the care team to view images and for quality assurance which is a key component of any program. While the number and types of images are not specified, ideally structures are visualized in 2 planes with corresponding labels, demonstrating relevant structures/pathology, relevant measurements, and abnormal findings.<sup>4</sup>

There are a number of options for image archival. Historically, images were printed or stored via a USB drive. We

#### Table 1. Documentation of POCUS Studies

- 1. Patient information including name, date of birth, patient ID/ medical record number
- 2. Provider performing the ultrasound and provider interpreting the ultrasound
- 3. Date and time of ultrasound
- 4. Clinical or educational scan
- 5. Limited vs complete vs procedural
- 6. Indication for the study
- 7. Acquisition including views obtained
- Description of findings, structures evaluated/relevant anatomy, abnormal findings
- 9. Interpretation
- 10. Comparison to previous images (if applicable)
- 11. Follow-up studies (if applicable)
- 12. Signature

Abbreviation: POCUS, point-of-care ultrasound.

have now progressed to digital/web based systems, which are preferred and have the option for integration to the Picture Archiving and Communication System (PACS). Often ultrasound companies and/or machines may have their own dedicated cloud or archival system. There are advantages and disadvantages to all systems and it's important that the system implemented works effectively with existing hospital systems—specifically, dedicated radiology archiving systems. There are multiple additional considerations when choosing a system, which includes how it affects the program's workflow for billing, quality assurance, and education.

#### BILLING

The American Institute of Ultrasound in Medicine position statement concludes that, "any qualified physician who interprets an indicated, appropriately performed, and documented ultrasound examination, should be allowed to bill for imaging services rendered."<sup>9</sup> The US Centers for Medicare and Medicaid Services guidance also supports reimbursement for performance and interpretation of POCUS examinations regardless of the specialty of the physician who is performing the service.<sup>10</sup> Therefore, if a POCUS study is performed and includes an official review process, the department can and should code and bill for POCUS studies.<sup>11</sup> The requirements for billing include a medical indication for the exam, acquisition of images, saving and archiving images, and a report that documents the examination and provides an interpretation with appropriate billing and coding.<sup>2</sup>

Most bedside POCUS studies performed will be limited or focused. A limited examination is defined as an ultrasound examination that has fewer than the required elements that would qualify for a complete examination and therefore does not attempt to visualize and evaluate all major structures within an anatomic region. For example, a complete ultrasound examination of the abdomen is defined as an evaluation of the liver, gallbladder, common bile duct, pancreas, spleen, kidneys, and the abdominal aorta and inferior vena cava. This complete examination would include images of every single organ and must attempt to diagnostically evaluate all of these organs. More realistically, a bedside examination

Patient:	First Name Last Name	
DOB:		
MRN:		

Clinical X Educational

A focused renal ultrasound examination was performed by (provider name) on (date/time) and interpreted by (provider name)

Indication: Flank Pain

Acquisition: view obtained include the right kidney, left kidney, and bladder in the short and long axis.

This study was technically limited for the following reasons: none

Findings:

Right kidney: no hydronephrosis, right renal cyst measuring 3 cm x 2cm Left kidney: mild hydronephrosis Bladder: jets were visualized bilaterally. No bladder abnormalities noted

Interpretation: A right renal cyst was identified, mild hydronephrosis identified on the left

The following follow up studies were obtained: None

Archival System: Images were saved to (archiving system)

Signed by (provider name) on (date/time)

#### Figure 1. Example documentation.

may focus solely on the kidneys or a single quadrant of the abdomen and is considered a limited examination.<sup>4</sup>

POCUS studies can be performed for either diagnostic or therapeutic indications. In the event that a study is used to diagnose a previously unknown pathology and additionally is used for procedural guidance, both examinations can be billed on the same day. However, if ultrasound guidance discovers a previously unknown pathology, a separate diagnostic ultrasound should not be reported.<sup>12</sup> Typically, the documentation of procedural guidance is included in the documentation of the procedure itself and not as a separate report. Of note, POCUS is considered a procedure and therefore if billing for ultrasound, the time spent performing POCUS should not be included in time-based billing for critical care.

In general, when serial POCUS examinatios are performed on the same patient on the same day, only one of these studies should be coded and billed. However, any serial examination can be billed for if there is clinical necessity for that subsequent scan. A modifier should be used if this is the case for a serial examination on the same day. Serial examinations on subsequent days can be billed without a modifier. When separate providers both perform the same examination, they both can bill for the examination using a modifier as long as there is documented medical necessity for the repeat examination. If a provider performs a limited examination and then subsequently determines a complete examination performed by radiology is required, the provider can still bill for the focused examination. In this case, the radiology study would generate a separate charge. In each of these instances, there must be documentation providing the medical necessity for the 2 separate examinations. It is not uncommon that a limited examination can be inconclusive or result in findings with clinical significance for which a complete examination is indicated. It should be noted that typically payers may only reimburse for the examination which answered the clinical question/indication. The caveat is that it would be inappropriate if a provider routinely performs a limited examination before ordering a complete examination. In addition, the same provider cannot perform both a limited and a complete examination. In this case, the limited examination would be considered included in the complete examination. Regardless, appropriate services should be coded based on the Current Procedural Terminology (CPT) codes with appropriate detail in the form of add-on codes or modifiers, and the decisions for reimbursement can be left to the insurer.

While CPT codes do not define the number of images that should be obtained or stored, it does require that the images appropriately reflect the findings and interpretation documented in the report. In general, convention recommends capturing the object of interest in 2 orthogonal planes or classic windows if there is such convention. For procedural guidance, an image of relevant anatomy is sufficient with a report that specifies that the needle was guided and visualized with ultrasound.<sup>4</sup>

All ultrasounds performed have both a professional component and a technical component. The professional

component encompasses the provider performing, interpreting, and documenting the examination. The technical component represents the cost of the equipment, supplies, and additional personnel needed to perform the examination. In general, the provider bills for the professional component and the hospital system or institution would bill for the technical component.<sup>13</sup> The exception would be if the individual also owns the equipment used for the ultrasound examination.

#### CODING

To bill for a POCUS study, appropriate codes should be applied that describe the procedure performed and indication. The CPT Editorial Panel, convened by the American Medical Association, defines a set of codes that allow for uniform description of exams performed.<sup>14</sup> Billing claims are submitted using specific CPT codes, and codes can include a modifier or add-on to better describe what was performed. CPT codes are universal and thus the same for all providers regardless of specialty or practice setting.<sup>4</sup> See Table 2 for common CPT codes. Modifiers and add-on codes help to better define the exam or procedure performed.

To document the indication for a POCUS study, the examination or procedure should be associated with an ICD-10 code. The International Classification of Disease Procedures Coding System is an internationally standardized tool published by the World Health Organization that defines the patient's diagnosis, signs, symptoms, or abnormal diagnostic test and is used by payers to determine the medical necessity for services provided.<sup>7</sup> Payors can publish bulletins known as Local Coverage Determinations which help better define certain ICD-10 codes that will support specific procedures defined by their CPT codes.<sup>15</sup> However, these are often difficult to find and nongovernment organizations are not required to make these bulletins public. In addition, which ICD-10 codes are associated with any particular CPT code can vary between states.<sup>1</sup>

Modifiers are used to better describe what was performed without changing the definition of the code. See Table 3 for common modifiers. Modifiers can distinguish between complete and limited examinations or professional and technical components of an examination. Of note, there are CPT codes in which no corresponding limited procedure exists. If this is the case, the service reduction modifier -52 can be used. When coding, if both the professional and technical components are performed by the provider, no additional modifier is required. However, if only the professional or technical component is performed by the provider, a modifier (-26 for professional component and -TC for technical component) should be used to explain this.

#### **Procedural Codes**

Some CPT codes for procedures include both the POCUS study and procedure and do not require separate coding for the POCUS study. However, if this is not the case,

US Study	CPT Code(s)	Description
eFAST	76705	Ultrasound, abdominal, real time with image documentation;
	93308	limited (eg, single organ, quadrant, follow-up)
	76604	Echocardiography, transthoracic, real-time with image
		documentation (2D), with or without M-Mode recording;
		follow-up or limited
		Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation
Aorta – AAA screening	76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm
Transthoracic echo	93308	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-Mode recording; follow-up or limited
Focused DVT exam	93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study.
Pulmonary	76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation
Bowel	76705	Ultrasound, abdominal, real time with image documentation;
		limited (eg, single organ, quadrant, follow-up)
Renal	76775	Echography, retroperitoneal (eg renal, aorta, nodes); B-scan and/or real time with image documentation; limited
Postvoid residual (bladder)	51798	Measurement of postvoiding residual urine and/or bladder capacity by bladder volume measurement machine
Bladder imaging	76857	Imaging of bladder anatomy, including bladder volume
		measurement using an ultrasound machine
Soft tissue – Neck	76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation
Soft tissue – MSK including axilla	76882	Ultrasound, extremity, nonvascular, B-scan and/or real time with image documentation, limited
Soft tissue – chest wall or upper back	76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation
Soft tissue – abdominal wall or lower back	76705	Echography, abdominal, B-scan and/or real time with image documentation, limited (eq, single organ, guadrant, follow-up)
Soft tissue – pelvic wall	76857	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation, limited, or follow-up

### Table 2. CPT Codes for Focused Examinations

Abbreviation: CPT, Current Procedural Terminology.

and the POCUS study requires a separately coded item, add-on codes 76942 and 76937 can be used. These codes should be assigned along with the procedure code and not assigned alone. They are used when the CPT code itself

does not describe ultrasound guidance. For example, code 32555 is used specifically for ultrasound-guided thoracentesis and therefore does not need an add-on code. However, code 36556 defines nontunneled central venous catheter

#### Table 3. CPT Code Modifiers

Modifier	Description	Explanation
-25	Evaluation and management service	Used for any evaluation and management service provided on the same day as the POCUS
-26	Professional component (PC)	Used for the performance and interpretation of the exam and completing a written report
-TC	Technical component	Used for the equipment, supplies and ancillary personnel associated with an exam
-52	Reduced services	Describes that the typical procedure was not performed as described but at some reduced level of service. This is used for limited ultrasounds where there's not a separate CPT code for a limited exam.
-59	Distinct Procedural Service	Used to report procedures that are distinct but have the same CPT code
-76	Repeat procedure by same provider	Describes a repeat exam by the same provider. All providers in the same specialty or same medical group/employer during the same encounter are viewed as the same provider.
-77	Repeat procedure by different provider	Describes a repeat exam by a different provider

Abbreviations: CPT, Current Procedural Terminology; POCUS, point-of-care ultrasound.

Procedure	CPT Code	Additional Comments
Thoracentesis	32555	Thoracentesis, needle or catheter, aspiration of the pleural space, with image guidance
Thoracentesis with catheter placement	32557	Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance
Paracentesis	49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance
Peritoneal catheter insertion	49418	Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed and radiological supervision and interpretation, percutaneous
Ultrasound-guidance of vascular procedures	+ 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. This is an addon code and requires primary code.
Arterial puncture	+ 76937	This is an addon code and requires primary code 36600
US-guided vascular access placement	+ 76937	<ul> <li>This is an addon code and requires primary code: 36000 (venipuncture or catheter placement), 36410 (venipuncture, &gt; age 3 requiring physician expertise),</li> <li>36555 (nontunneled CVC, age &lt;5), 36556 (nontunneled CVC, age &gt;/ = 5), 36557 (tunneled CVC, age&lt;5), or 36558 (tunneled CVC, age &gt;/ = 5)</li> </ul>
Ultrasound-guided needle placement (nonvascular)	+ 76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation. This is an addon code and requires primary code.
US-guided incision and drainage or aspiration of abscess	+ 76942	This is an addon code and requires primary code: 10160 (simple) or 10061 (complicated)
US-guided suprapubic aspiration of bladder	+ 76942	This is an addon code and requires primary code: 51100
US-guided incision and removal of foreign body	+ 76942	This is an addon code and requires primary code: 10120 (simple) or 10121 (complicated)
US-guided renal biopsy	+ 76942	This is an addon code and requires primary code: 50200

#### Table 4. CPT Codes for Ultrasound-Guided Procedures

Abbreviation: CPT, Current Procedural Terminology.

insertion (including those used for dialysis). If the insertion was performed in a dynamic technique under ultrasound guidance, then the add-on code 76937 should be used. If ultrasound was used to identify the anatomy but not used for real-time needle guidance (as in a static approach), then the add-on code 76937 should not be used.

In addition, some POCUS examinations do not have a single associated CPT code. In the case of an E-FAST performed in a patient who is hypotensive, the examination will be coded for each of the anatomic locations where the examination was performed. This generates 3 distinct codes: cardiac (93308), abdomen (76705), and chest (76604). See Table 4 for procedural codes and Fig 2 for a sample billing scenario.

#### FINANCIAL IMPLICATIONS

To appropriately bill and code for an ultrasound study, images must be archived and documented using required documentation standards. The financial implications of an ultrasound program are important to consider, as implementation of an ultrasound program is costly. One study demonstrated that programs will "break even" around 5 years after implementation which supports the

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need for documentation and billing/coding at initiation or soon after.<sup>3</sup> Prior emergency department based studies indicate that while there is a high utilization of ultrasound, documentation has lagged behind, which is essential for reimbursement and high-quality clinical care.<sup>2</sup> Incorporating and emphasizing documentation early on is critical to the success and sustainability of an ultrasound program so providers are reimbursed for their time and expertise and supported by the hospital system. In addition, completing regular fiscal analyses of programs will assist in evaluation of actual and potential return on investment.

#### BEST PRACTICES FOR WORKFLOW INTEGRATION

As POCUS adoption and implementation continues to expand throughout hospital systems, it has become increasingly important to consider infrastructure that facilitates documenting, archiving, and billing/coding that is incorporated efficiently into the EHR. One study highlighted workflow infrastructure that incorporates an image archiving system, Qpath US work flow solution (Telexy Healthcare, Maple Ridge, British Columbia, Canada), a dedicated ultrasound machine, Zonare Z.One ULTRA ultrasound system (Mindray, Mountain View,

## Case:

54 year old male with a past medical history of diabetes presents to the ED in septic shock. He is diagnosed with an acute kidney injury and pyelonephritis. A private practice nephrologist performs an ultrasound of the bladder and bilateral kidneys to evaluate for potential causes of acute kidney injury. The ultrasound reveals a post-obstructive cause for the patient's acute kidney injury. A foley catheter is placed and the patient's renal function improves. The nephrologist also performs a cardiac and lung exam in the context of shock and hypoxemic respiratory failure due to ARDS. Later the same day, the patient decompensates and is admitted to the ICU with hyperkalemia and worsening renal function. In the ICU, the nephrologist performs a repeat renal ultrasound. The nephrologist also uses ultrasound to identify the right internal jugular vein and places a non-tunneled hemodialysis catheter under ultrasound guidance in preparation for dialysis.

#### **Associated CPT Codes:**

Initial evaluation: Images of bilateral kidneys, bladder, echocardiogram, and thorax obtained Codes:

- 76775-26 kidney ultrasound for AKI (ICD-10 N17.9)
- 93308-26 limited echo for shock state (ICD-10 R57.9)
- 76604-26 limited chest ultrasound for hypoxemic respiratory failure (ICD-10 J96.01)

Note:

- 76857 bladder ultrasound CPT code not used as bladder view is included in the renal ultrasound. If ultrasound of only the bladder is performed, this would be when 76857 is used.
- -26 modifier used to denote professional component (the performance and interpretation of the exam and completing a written report)

Second evaluation: Repeat renal ultrasound performed and a non-tunneled hemodialysis catheter under ultrasound guidance placed.

Codes

- 76775-76 kidney ultrasound for AKI (ICD-10 N17.9)
- 36556 for non-tunneled vascular access placement for age >/=5 years
- + 76937 for ultrasound guided vascular access

Note:

- -76 modifier used to denote repeat procedure by same provider
- Ultrasound guided procedure for central venous access includes both a primary code and an add on code

Figure 2. Sample billing scenario.

CA), and an EHR system, Cerner. The integrated system automates documentation and billing, and images are automatically transferred to the hospitals archiving system picture archiving and communication system and EHR. After implementation of this process, there was a significant increase in billing, specifically a 96% increase in net technical revenue and a 78% increase in professional revenue.<sup>13</sup> Similarly, another study demonstrated improvement in billing and revenue after implementation of a web-based archival system, Qpath, with automatic image transfer and immediate completion of worksheets linked to specific CPT codes.<sup>17</sup> Simply creating a dedicated workflow task force has also demonstrated improvements in documentation compliance and coding and billing.<sup>18</sup>

#### CONCLUSION

There are many benefits of POCUS implementation for patient, providers, and health systems. While the focus of bedside ultrasound has appropriately targeted education and training, equally important is ensuring a process for acquisition, documentation, image archiving, coding, and billing in conjunction with institution-specific systems and requirements. Developing an integrated workflow at the start of program implementation is critical for patient safety and sustainability of POCUS programs.

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