

Diagnostic Spinal Ultrasonography (for Kentucky Only)

Policy Number: CS113KY.05
Effective Date: December 1, 2024

[Instructions for Use](#)

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Related Policies

None

Application

This Medical Policy only applies to the state of Kentucky.

Coverage Rationale

Spinal ultrasonography is considered proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Imaging:

- Imaging, Spine, Cervical
- Imaging, Spine, Lumbar
- Imaging, Spine, Thoracic

[Click here to view the InterQual® criteria.](#)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
76800	Ultrasound, spinal canal and contents

CPT® is a registered trademark of the American Medical Association

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

The use of musculoskeletal ultrasound to diagnose low back pain is a procedure and as such, is not regulated by the FDA. However, the devices used to perform this procedure are regulated by the FDA and many ultrasound devices and probes have received FDA approval for marketing. Additional information, under product code IYO (subsequent product codes IXT and IYN), is available at: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm>. (Accessed May 6, 2024)

Policy History/Revision Information

Date	Summary of Changes
12/01/2024	Supporting Information <ul style="list-style-type: none">Removed <i>Description of Services</i> sectionArchived previous policy version CS113KY.04

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare uses InterQual® for the primary medical/surgical criteria, and the American Society of Addiction Medicine (ASAM) for substance use, in administering health benefits. If InterQual® does not have applicable criteria, UnitedHealthcare may also use UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and/or Utilization Review Guidelines that have been approved by the Kentucky Department for Medicaid Services. The UnitedHealthcare Medical Policies, Coverage Determination Guidelines, and Utilization Review Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.