Frequently Asked Questions on Ultrasound Coding

Because of the recent Office of Inspector General (OIG) report recommending that the Centers for Medicare & Medicaid Services monitor ultrasound claims for questionable coding practices, the following Q&As, previously published in ACR publications, are provided as a review of appropriate ultrasound coding guidelines. The guidance provided in these answers will be helpful to defend your billing practices should you be audited.

1. Is it appropriate to report the nonobstetrical transvaginal sonogram of the pelvis code (76830) in combination with other abdominal and/or OB/GYN sonogram codes?

The ACR’s Ultrasound Coding User’s Guide states that the pelvic ultrasound using a full bladder as a window to the pelvis and a transvaginal ultrasound using a vaginal probe as a window to the pelvis are separately coded procedures. A common practice is for ultrasound departments to begin with a pelvic ultrasound performed through a full bladder and to supplement the examination with a transvaginal examination when necessary. Use 76856 or 76857, as appropriate, for the pelvic ultrasound procedure. Add 76830 for the transvaginal ultrasound. When the transvaginal examination is used as the only technique, use 76830 to code for the procedure.

This has been a long-standing ACR coding guideline that was first published in an October 1993 Radiology Business Management Association Bulletin coding article. The article titled Transvaginal Sonogram of the Pelvis (76830) stated:

“In order to properly evaluate a patient it is often necessary to perform additional studies during one session. These studies are done in order to acquire additional clinical information not evident from the initial study, or to further investigate an area that appears suspicious or problematic. Performing a transabdominal and a transvaginal pelvic sonogram at one sitting is an example of this type of evaluation.

Transvaginal sonogram is used for both obstetrical and non-obstetrical evaluations. This procedure represents the performance and interpretation of the pelvis structures including the uterus, endometrium, ovaries, and adnexa. A special probe is used transvaginally to aid in such studies as fetal viability, ectopic pregnancies, harvest of ova, and fertility studies.”

If a woman has vaginal bleeding, a transvaginal scan is needed to assess the endometrium at higher resolution than that available with the transabdominal probe. If an adnexal mass is visualized, a transvaginal examination allows for improved characterization of the internal characteristics of the mass.

When coding for both transabdominal and transvaginal studies in a single setting, it is important for the report to clearly state the indication for performing the second examination, for example, for better assessment of the endometrium and/or adnexa.

2. How many times should code 76800 be reported when an ultrasound of the cervical, thoracic, and lumbar spine is performed?

Code 76800 (Ultrasound, spinal canal and contents) includes the entire spinal canal; therefore, report code 76800 only once to describe an ultrasound of the cervical, thoracic and lumbar spine. As noted in the ACR’s Ultrasound Coding User’s Guide 2008, Because of the overlying bone, this examination is generally limited to infants and young children in whom the posterior elements of the spine are not fully ossified, and to adults who have undergone laminectomy. Abnormalities such as tethered spinal cord can be detected with this technique. When ultrasound
of the spinal cord is performed as an intraoperative procedure, use 76998 (Ultrasonic guidance, intraoperative)

3. What is the difference between a “limited” and a “complete” ultrasound? If a large portion of the complete examination is performed, should that not count as complete with limited being left for one or two organs examined?

Complete and limited ultrasound studies are clearly defined in the ultrasound introductory guidelines section of the CPT 2009 code book. Note that the report should contain a description of all elements or the reason that an element could not be visualized (eg, obscured by bowel gas, surgically absent, etc). As stated in the guidelines, if less than the required elements for a ‘complete’ exam are reported (eg, 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.

4. How do you code for ankle/brachial indices with a duplex scan of the lower extremity arterial bilateral blood flow study? Can both studies be coded when performed at the same time? Can color flow velocity mapping also be charged if performed?

When a duplex Doppler of the lower extremities is performed with the addition of ankle/brachial (A/B) indices, it is appropriate to code 93925 (Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study) for the duplex scan and 93922 (Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (eg, ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement) for the A/B indices.

Code 93922 is for a limited noninvasive physiologic arterial study that covers one level only of each leg (eg, ankle brachial indices with ankle waveforms). It is not appropriate to code 93922 in conjunction with 93923 (Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (eg, segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurements, measurements with postural provocative tests, measurements with reactive hyperemia) as 93922 is a limited version of 93923. Code 93923 includes segmental pressures and tracings and is used to report bilateral complex noninvasive physiologic testing procedures.

Duplex scanning (such as 93925) describes an ultrasonic scanning procedure for characterizing the pattern and direction of blood flow in the arteries in a single display of real time images integrating 2-D vascular structure with spectral and color flow Doppler mapping or imaging.

As noted in the CPT 2009 codebook, noninvasive physiologic studies are performed using equipment separate and distinct from the duplex scanner. Codes 93875, 93965, 93922, 93923, and 93924 describe the evaluation of nonimaging physiologic recordings of pressures [such as ankle/brachial indices], Doppler analysis of bidirectional blood flow, plethysmography, and/or oxygen tension measurements appropriate for the anatomic area studied.

5. Is it appropriate for a physician to report the duplex evaluation code 93978 (aorta, inferior vena cava, iliac vasculature) and 93925 (lower extremity arteries or bypass grafts) for the same patient during the same session?

Yes, it is appropriate for a physician to report both a duplex scan of the aorta, IVC, and iliac vasculature (93978) in conjunction with a duplex scan of the lower extremity arteries (93925).
Code 93978 includes duplex evaluation of the aorta, inferior vena cava, iliac vessels, or grafts involving these vessels. The code is the same whether one or more vessels are evaluated. The vessels investigated are studied in their entire intra-abdominal or pelvic course.

Code 93925 includes bilateral duplex scanning of the full length of the common femoral, superficial femoral, and popliteal arteries. The deep femoral and tibio-peroneal arteries may be imaged whenever indicated. The code is also used for evaluation of the complete course of a lower extremity arterial bypass graft including an attempt to image the vessels adjacent to the graft. For iliac arteries, use 93978-93979. Segmental pressure studies are coded separately when performed with proper medical necessity in addition to duplex scans of the lower extremities.

As noted in the Spring 2007 Clinical Examples in Radiology, interpretation and results of duplex Doppler studies should be documented within the report in a manner similar to the following: “Color Doppler flow completely fills the lumen of the aorta with no mural clot or plaques demonstrated. Spectral Doppler analysis demonstrates a normal high resistance flow pattern throughout the abdominal aorta. Peri-aortic soft tissues are within normal limits.”

The ACR believes the noninvasive vascular diagnostic Doppler studies (93875-93990) should only be used when medically necessary, appropriately documented, and when both spectral and color Doppler are performed. If (1) medical necessity can be documented, (2) color and spectral Doppler is documented appropriately within the report, and (3) a study of the entire intra-abdominal or pelvic course of the aorta is performed, it is appropriate to report 93978, Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study.

A duplex Doppler is performed for characterizing the pattern and direction of blood flow in the arteries with the production of real-time images integrating B-mode two dimensional vascular structure with spectral and/or color flow Doppler mapping or imaging. A radiologist may determine the medical necessity of this study. As noted in the Clinical Examples in Radiology (Winter 2006, Vol. 2, Issue 1), the performance of a duplex Doppler evaluation can be performed without an order from the referring physician because it would be exempt under the Ordering of Diagnostic Tests Rule test design.

Vascular studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bidirectional vascular flow or imaging when provided. The use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional vascular flow, is considered to be part of the physical examination of the vascular system and is not separately reported.

Q: If a vascular study (with or without color Doppler) is performed in conjunction with ultrasound of the liver, is it appropriate to report both CPT code 76705 (Abdominal ultrasound, limited) and CPT code 93975 (Duplex scan of arterial inflow and venous outflow of abdominal, pelvic and/or retroperitoneal organs; complete study)?

Yes, if an ultrasound of the liver is performed, and there is a clinical need for further evaluation by duplex scanning, then it is appropriate to code for both 76705 and 93975.

A vascular study (with or without color flow) may be reported in addition to ultrasound studies when it is clinically indicated (medically necessary). The radiology codes for ultrasound (e.g. abdomen, retroperitoneal, etc.) generally represent two-dimensional (gray-scale) imaging. For example, CPT code 76700 includes gray-scale real-time or static images of the entire abdomen...
from the diaphragm to the level of the umbilicus. If the study includes anything less than the all-inclusive code 76700, then the limited code 76705 should be billed.

Sometimes a vascular study is added to the basic gray-scale study when enhancement of suspect areas or more detailed analysis is needed. CPT code 93975 describes evaluation of arterial inflow and venous outflow of abdomen, retroperitoneum, scrotal contents and/or pelvic organs. This code can be used whether single or multiple organs are studied. It is a "complete" procedure in that all major vessels supplying blood flow (inflow and outflow, with or without color flow mapping) to the organ are evaluated. If the study is only a partial evaluation, then the limited code (93976) is billed. Therefore, in cases where it is necessary to perform a vascular study in conjunction with ultrasound of an organ, it would be appropriate to report the vascular study separately.

In order to code an abdominal duplex study, true vascular analysis needs to be performed. Abdominal duplex should not be coded when color is just turned on to determine if a structure is vascular (e.g., distinguishing hepatic artery from the common bile duct). Color Doppler alone, when performed for anatomic structure identification in conjunction with a real-time ultrasound examination, is not reported separately.\(^4\)

Note that since January 1997, Medicare Correct Coding Initiative (CCI) edits have been in place for the vascular study codes (93975/93976) when used in conjunction with the pelvic ultrasound codes (76856/76857). Medicare considers these pairs to be mutually exclusive—that is, they should not be performed by the same physician, for the same patient, on the same date of service. The code pair edits do list a modifier indicator of "1" with the vascular study codes (93975\(^1\),93976\(^1\)); therefore, it would be appropriate to submit these codes together with a modifier attached to the vascular study code (e.g., 93975–59 or 93976–59). For example, a patient comes in with pelvic pain, and the ultrasound of the pelvis demonstrates an enlarged ovary. The differential diagnosis includes torsion of the ovary. A vascular study is requested to establish the arterial inflow and venous drainage of the ovary and determine torsion or infarction. In this scenario, it would be appropriate to code 76856 for the pelvic ultrasound and 93976-59 for the limited vascular study of the ovary.

Q: If a radiologist performs the ultrasound guidance used in conjunction with a percutaneous intra-operative ablation of a renal mass lesion(s) performed by a surgeon, how should this be coded?

When a percutaneous intra-operative ablation is performed by a surgeon, and the ultrasound guidance is performed by a radiologist for the monitoring of the tissue ablation, the radiologist should report 76940 (Ultrasound guidance for, and monitoring of, parenchymal tissue ablation).

The use of ultrasound guidance requires permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized.\(^5\)

\(^1\)CPT Assistant, April 1998:15
\(^2\)ACR Radiology Coding Source, Q&A, July/August 2006.