CorroHealth

Ultrasound Documentation Requirements: Complete vs. Limited

June 2023

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Introduction

Many facilities bill diagnostic ultrasound services from the referring physician's order as an automated process, without any review by a coding professional. This practice is discouraged because when charging for complete diagnostic ultrasounds, the CPT® Manual outlines very specific documentation requirements for these examinations.

The radiology report serves as the documentation for both the professional and technical portions of the examination. The documentation within the medical record must support the exam that was performed - both for the professional fee (the radiologist's interpretation) and the technical fee (the technologist's work of performing the exam). It is

the reading radiologist's responsibility to ensure the components of each diagnostic ultrasound exam performed are documented appropriately in the radiology report.

The CPT® guidelines for diagnostic ultrasound state that all diagnostic ultrasound studies require the following:

- Permanently recorded images with measurements (when such measurements are clinically indicated)
- A final, written report to be issued for inclusion in the patient's medical record

Per CPT®, "**Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable.**"

Complete vs. Limited Ultrasound

CPT® instructions pertaining to coding a complete vs. a limited ultrasound are as follows:

> "For those anatomic regions that have 'complete' and 'limited' ultrasound codes, note the elements that comprise a 'complete' exam. The report should contain a description of these elements or the reason that an element could not be visualized (eg, obscured by bowel gas, sugically absent).
>
> 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. A 'limited' exam of an anatomic region should not be reported for the same exam session as a 'complete' exam of that same region."

Breast Ultrasound – 76641 and 76642

Complete diagnostic ultrasound of the unilateral breast requires evaluation and documentation of the following:

- All four quadrants of the breast
- Retroareolar region
- Axilla, if performed

If a focused assessment of one or more, but not all, of these elements are evaluated and documented, the limited code 76642 should be reported.

Abdominal Ultrasound – 76700 and 76705

Complete diagnostic ultrasound of the abdomen requires real-time evaluation and documentation of the following:

- Liver
- Gallbladder
- Common bile duct
- Pancreas
- Spleen
- Kidneys
- Upper abdominal aorta
- Inferior vena cava

If less than the required elements for a complete exam are performed and documented, code 76705 should be reported.

Retroperitoneal Ultrasound – 76770 and 76775

Complete diagnostic ultrasound of the retroperitoneum requires real-time evaluation and documentation of the following:

- Kidneys
- Abdominal aorta
- Common iliac artery origins
- Inferior vena cava

OR

If clinical history suggests urinary tract pathology, complete evaluation of the kidneys *and* urinary bladder also comprises a complete retroperitoneal ultrasound.

If less than the required elements for a complete exam as described above are documented, the exam should be reported using limited code 76775.

Obstetrical Ultrasound – First Trimester – 76801 and 76802

Complete first trimester (<14 weeks 0 days gestation) OB ultrasound evaluation requires real-time evaluation and documentation of the following:

- Determination of number of gestational sacs and fetuses
- Gestational sac/fetal measurements appropriate for gestational age
- Survey of fetal visible fetal and placental anatomic structure
- Qualitative assessment of amniotic fluid volume and gestational sac shape
- Examination of the maternal uterus and adnexa

If less than the required elements for a complete exam are performed and documented, code 76815 should be reported.

Obstetrical Ultrasound – After First Trimester – 76805 and 76810

Complete OB ultrasound evaluation *after* the first trimester (> or = 14 weeks 0 days gestation) requires real-time evaluation and documentation of the following:

- Determination of number of fetuses and amniotic/chorionic sacs
- Measurements appropriate for fetal age
- Survey of intracranial, spinal, and abdominal anatomy
- 4-chambered heart
- Umbilical cord insertion site
- Placenta location
- Amniotic fluid assessment
- Examination of the maternal adnexa

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If less than the required elements for a complete exam are performed and documented, code 76815 should be reported.

Obstetrical Ultrasound – Detailed Fetal Anatomic Eval – 76811 and 76812

Complete OB ultrasound with detailed fetal anatomic evaluation requires real-time evaluation and documentation of the following:

- All the elements required for code 76805/76810, plus:
- Fetal brain/ventricles
- Face
- Heart/outflow tracts and chest anatomy
- Abdominal organ specific anatomy
- Number, length, and architecture of limbs
- Detailed evaluation of umbilical cord and placenta
- Other fetal anatomy as clinically indicated

The imaging report should document the results of the evaluation of each element described above or the reason for non-visualization.

If less than the required elements for a complete exam are performed and documented, code 76815 should be reported.

Obstetrical Ultrasound – Transvaginal – 76817

Code 76817 describes obstetrical ultrasound evaluation via a transvaginal approach. Per CPT® *Assistant*, November 2011, this code includes evaluation of:

- Embryo(s) and gestational sac(s)
- Maternal uterus, adnexa, and/or cervix

76817 may be reported in addition to a follow-up transabdominal approach OB US (76816) when necessary to adequately view the structures.

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Female Pelvic Ultrasound – 76856 and 76857

Complete non-obstetric ultrasound of the female pelvic anatomy requires real-time evaluation and documentation of the following:

- Description and measurements of the uterus and adnexal structures (i.e., fallopian tubes and ovaries)
- Measurement of the endometrium
- Measurement of the bladder (when applicable)
- Description of any pelvic pathology (e.g., ovarian cysts, uterine leiomyomata, free pelvic fluid)

If less than the required elements for a complete exam are performed and documented, code 76857 should be reported.

Female Pelvic Ultrasound – Transvaginal – 76830

According to the American College of Radiology (ACR) *Ultrasound Coding User's Guide*, a complete non-OB transvaginal ultrasound includes evaluation of:

- Uterus
- Endometrium
- Ovaries
- Adnexa (e.g., ovaries, fallopian tubes, and uterine ligaments)

Clinical Examples in Radiology (Winter 2016) indicates that while the adnexa must be evaluated and documented, the fallopian tubes do not need to specifically be mentioned. If evaluation of the uterus is not performed or documented, modifier 52 should be applied to code 76830 to indicate reduced services.

It is appropriate to report 76856 or 76857 with 76830 when both are performed together. However, the practice of performing and reporting both studies for every patient is discouraged. Per *Clinical Examples in Radiology* (Spring 2020), when transabdominal and transvaginal pelvic ultrasound are performed together, the transvaginal ultrasound is considered a specialized, problem-focused exam and should be performed only when medically necessary.

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Male Pelvic Ultrasound – 76856 and 76857

Complete ultrasound of the male pelvic anatomy requires real-time evaluation and documentation of the following:

- Evaluation and measurement (when applicable) of the urinary bladder
- Prostate and seminal vesicles (to the extent visualized transabdominally)
- Any pelvic pathology (e.g., bladder tumor, enlarged prostate, free pelvic fluid, pelvic abscess)

If less than the required elements for a complete exam are performed and documented, code 76857 should be reported.

Extremity Ultrasound – 76881 and 76882

Complete ultrasound of a specific joint within an extremity requires real-time evaluation and documentation of the following:

- Joint space (e.g., effusion)
- Peri-articular soft tissue structures surrounding the joint (muscles, tendons, other soft-tissue structures)
- Any identifiable abnormality

The imaging report should document the results of the evaluation of each element described above or the reason for non-visualization.

If less than the required elements for a complete exam are performed and documented, code 76882 should be reported.

Ultrasound Guidance

Accurate and complete documentation is essential when reporting ultrasound guidance. The documentation should clearly indicate the type of procedure, the specific anatomical location of the images, the specific anatomic structures visualized, and a documented description of the localization process. This information is critical to ensure that the service is accurately reported.

The CPT® Manual states the following:

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> "Ultrasound guidance procedures also require 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. Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable."

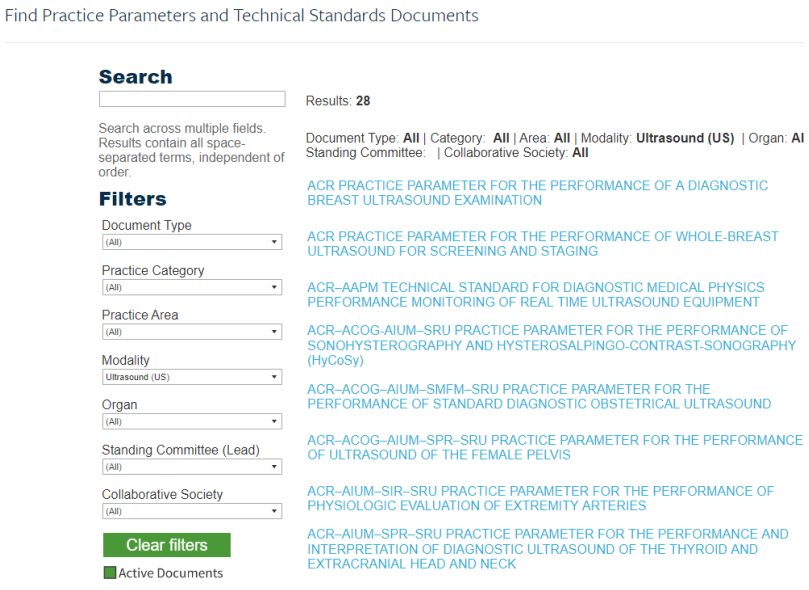
For additional information regarding accurate documentation and reporting of ultrasound guidance, please see the below PARA Paper located in the PARA Data Editor:

Ultrasound Guidance in the Hospital Setting

Additional Resources

The American College of Radiology (ACR) offers specific parameters for the performance and interpretation of various types of imaging exams, including ultrasound:

https://www.acr.org/Clinical-Resources/Practice-Parameters-and-Technical-Standards



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Test Your Knowledge

Below is an example of a radiology report for a complete abdominal ultrasound. Does this documentation meet the criteria for reporting a complete exam of the abdomen?

EXAM: Ultrasound abdomen, complete.

HISTORY: 38-year-old male admitted from the emergency room, decreased mental status and right upper lobe pneumonia. The patient has diffuse abdominal pain. There is a history of AIDS.

TECHNIQUE: An ultrasound examination of the abdomen was performed.

FINDINGS: The liver has normal echogenicity. The liver is normal sized. The gallbladder has a normal appearance without gallstones or sludge. There is no gallbladder wall thickening or pericholecystic fluid. The common bile duct has a normal caliber at 4.6 mm. The pancreas is mostly obscured by gas. A small portion of the head of pancreas is visualized which has a normal appearance. The aorta has a normal caliber. The aorta is smooth walled. The right kidney measures 10.8 cm in length and the left kidney 10.5 cm. No masses, cysts, calculi, or hydronephrosis is seen. There is normal renal cortical echogenicity. The spleen is somewhat prominent with a maximum diameter of 11.2 cm. There is no ascites. The urinary bladder is distended with urine and shows normal wall thickness without masses. The prostate is normal sized with normal echogenicity.

IMPRESSION:
1. Spleen size at the upper limits of normal.

Answer: No, this report does not meet the documentation criteria for reporting a complete abdominal ultrasound. There is no documentation of evaluation of the inferior vena cava (IVC), which is a component of a complete abdominal US. If the IVC was evaluated, the radiologist should include this documentation in the report to support a complete study. In this instance, an amended or corrected report could be issued to support charging a complete study.

Conclusion

Code selection for diagnostic ultrasound is based on a variety of very specific documentation requirements. Clear documentation is extremely important to ensure proper coding and reimbursement. Code descriptions and documentation should be reviewed carefully, and when unclear, the provider should be queried.