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AMERICAN INSTITUTE OF ULTRASOUND IN MEDICINE

Medical Documentation Requirements: Diagnostic Urologic Ultrasound and Ultrasound-Guided Procedures

Over the past several years, physicians have requested guidance from both the AUA and the American Institute of Ultrasound in Medicine (AIUM) on the proper documentation of ultrasound services. The AUA provides information on ultrasound examinations used by urologists and the proper documentation requirements of Current Procedural Terminology® (CPT®) guidelines to report the codes for reimbursement.

The AUA and the AIUM recommend adequate documentation of ultrasound exams to provide high-quality patient care. Taking the extra necessary measures to document diagnostic ultrasound exams and ultrasound-guided procedures will limit unnecessary audits and potentially stressful litigations.

Introduction

Diagnostic ultrasound imaging has been an integral part of urologic medicine for many years. Providing the best care is of utmost importance to the AUA and the AIUM. Quality patient care can be defined in many ways. However, a very important piece is documentation of ultrasound exams.

Diagnostic ultrasound studies and ultrasonic guidance procedures include both a technical component (TC) and a professional component (PC). The technical component is the performance of the test and acquisition of images, while the professional component is the interpretation of the test and creation of a detailed written report. It is necessary to have copies of the ultrasound images in the patient's medical record as proof the procedure was performed. For example, when performing a transrectal ultrasound, include a copy of the image in the chart. The same holds true for ultrasound guided procedures for needle placement. An image showing the needle in the area where the biopsy tissue was taken is needed for proper documentation.

There are several ultrasound services that may be performed by urologists. The CPT® codes include the following:

<i>51798 Measurement of post-voiding residual urine and/or bladder capacity by ultrasound; non-imaging</i>

This ultrasound does not use imaging to obtain a post-voiding residual urine. Regardless of the type of ultrasound machine used or whether an image was obtained, if the intent of the diagnostic procedure is to obtain only a post-voiding residual urine, then CPT® code 51798 is appropriate.

76700 Ultrasound, abdominal, real time with image documentation; complete

A complete ultrasound examination of the abdomen consists of scans of the liver, gallbladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava including any demonstrated abdominal abnormality. If particular elements cannot be visualized, the reason should be documented.

76705 Ultrasound, abdominal, real time with image documentation; limited (ie, single organ, quadrant, follow-up)

This "limited" CPT® code captures a focused examination in the assessment of 1 or more elements listed in the "complete" ultrasound above, such as the kidney(s) only. If you do not visualize all the elements outlined in the "complete" description, the limited CPT® code 76705 should be used.

76770 Ultrasound, retroperitoneal (ie, renal, aorta, nodes), real time with image documentation; complete

A complete ultrasound of the retroperitoneum consists of scans of the kidneys, abdominal aorta, common iliac artery origins and inferior vena cava, including any demonstrated retroperitoneal abnormality. If the clinical history suggests urinary tract pathology, a complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound. Therefore, it is not appropriate to report additional ultrasound codes (such as abdominal or pelvic) for an evaluation of the kidneys and bladder.

76775 Ultrasound, retroperitoneal (ie, renal, aorta, nodes), real time with image documentation; limited

This "limited" CPT® code captures a focused examination in the assessment of 1 or more elements listed in the "complete," such as the ultrasound of the bladder only. If all of the specified elements outlined in the "complete" description are not visualized by ultrasound and documented, then the "limited" CPT® code 76775 should be used. A separate, final written report should be included in the patient's chart as well as any images obtained during the ultrasonic procedure.

76776 Ultrasound, transplanted kidney, real time and duplex Doppler with image documentation

Use this code for the evaluation of a transplanted kidney with duplex Doppler.

76856 Ultrasound, pelvic (nonobstetric), real time with image documentation; complete

Pelvic ultrasound codes are used for both female and male anatomy.

Elements of a complete female pelvic examination include a description and measurement of the uterus and adnexal structures, endometrium, bladder, and of any pelvic pathology (eg, ovarian cysts, uterine leiomyomata, free pelvic fluid).

Elements of a complete male pelvic examination include the evaluation and measurement (when applicable) of the urinary bladder, prostate, and seminal vesicles to the extent they are visualized transabdominally, and any pelvic pathology (eg, bladder tumor, enlarged prostate, free pelvic fluid, pelvic abscess).

76857 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (ie, for follicles)

This "limited" CPT® code covers a focused examination in the assessment of 1 or more elements listed in the "complete" pelvic ultrasound CPT® code 76856. Use this code if an ultrasound of the bladder only is performed but not to obtain a post voiding residual urine only. It also covers the reevaluation of 1 or more pelvic abnormalities previously demonstrated on ultrasound. A separate written report should be dictated and included in the patient's medical chart.

This code should be selected if the urinary bladder alone (not including the kidneys) is imaged (real time). Do not use CPT® code 76770. If post-voiding residual urine is obtained and the imaging of the bladder is obtained but not medically necessary, use CPT® code 51798 instead.

76870 Ultrasound, scrotum and contents

This CPT® code describes the sonographic evaluation of the scrotum and its contents. A separate, written report documenting any scrotal abnormalities must be dictated and included in the patient's medical chart.

76872 Ultrasound, transrectal

It is the standard of care to perform a sonographic evaluation of the prostate for any abnormality prior to a prostate biopsy. These abnormalities will be shown as hypoechoic areas or lesions that need further diagnostic investigation. This sonographic evaluation determines whether the physician should continue with prostate biopsy. A separate report for this diagnostic evaluation is required.

76873 Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)

Prior to brachytherapy treatment, a prostate volume study is performed by taking 5-mm cuts or pictures to plan where the radioactive seeds are to be placed in the prostate. This study aids the radiotherapist in the placement of the seeds into the catheters or needles for placement in the prostate.

A separate report for this diagnostic evaluation is required that documents the size and volume of the prostate for treatment planning prior to the actual brachytherapy treatment. A formal report is signed by the physician and included in the patient's chart.

76940 Ultrasound guidance for, and monitoring of, parenchymal tissue ablation

When percutaneous intraoperative ablation of renal tumors is performed, the ultrasound guidance is performed for the monitoring of the tissue ablation.

76942 Ultrasonic guidance for needle placement (ie, biopsy, aspiration, injection, localization device), imaging supervision, and interpretation

If there are questionable areas found in the 76872 transrectal ultrasound, the physician will normally continue with the sonographically guided biopsy of the prostate. To obtain specimens of the questionable areas, it is important that the physician direct the biopsy needle accurately and this type of sonogram is an essential part of the procedure to ensure the proper placement of the needle.

76965 Ultrasonic guidance for interstitial radioelement application

This ultrasound is used to guide needles into the prostate during brachytherapy treatment to insert the radioactive seeds/needles. Approximately 30-45 seed needles are placed into the coordinates on the template grid and are advanced through the perineum into the prostate until the base ultrasonic image shows the needle tip to be in the proper coordinates.

76998 Ultrasonic guidance, intraoperative

This code describes the use of ultrasonic guidance during an intraoperative procedure.

76999 Unlisted ultrasound procedure (ie, diagnostic, interventional)

Use this code if there are no other CPT® codes to describe the ultrasound procedure performed.

93975 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents, and/or retroperitoneal organs; complete study

93976 Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents, and/or retroperitoneal organs; limited study

93980 Duplex scan of arterial inflow and venous outflow of penile vessels; complete study

93981 Duplex scan of arterial inflow and venous outflow of penile vessels; follow-up or limited study

Doppler evaluation of vascular structures (other than color flow used for anatomical structure identification) is used to monitor the blood flow of urologic organs such as scrotum and penis.

Coding and Billing for Diagnostic Ultrasound and Ultrasound-Guided Procedures

In order to report the appropriate CPT® code(s) for services provided, the services must be documented appropriately including both the images (TC) and the report (PC). This type of documentation must be in the patient's chart. With regard to CPT® descriptors for radiography services, "images" refers to those acquired in either an analog (ie, film) or digital (ie, electronic) manner.

For billing purposes, the technical component should be billed by the entity that owns the machine, while the professional components should be billed by the interpreting provider. Imaging is reported

and reimbursed globally (TC and PC together) if performed and interpreted by the same provider at the same setting. However, the TC and PC can be billed separately if the images are acquired on one day and interpreted on a separate day, or if the interpreting provider does not own the machine (for example, if a provider is using hospital-owned equipment). In the latter case, the performing and interpreting provider must coordinate billing with the hospital, and the interpreting provider will append the CPT® code with the professional component modifier (-26) while the hospital adds the technical component (-TC) modifier.

Limited vs. Complete Ultrasound

Ultrasounds can be classified as complete or limited as indicated in the CPT® code descriptor. To bill for a complete examination, all items and organs listed must be imaged and described, or reason an organ is not imaged or described (ie, organ surgically absent) documented. For example, to bill for CPT® 76856 *Ultrasound pelvic (nonobstetric), or real time with image documentation; complete* evaluation and measurement (when applicable) of the urinary bladder, evaluation of prostate and seminal vesicles (visualized transabdominally), and any pelvic pathology (bladder tumor, enlarged prostate, free pelvic fluid, pelvic abscess) must be performed.

In addition, there are some guidelines in the CPT® manual for codes that are performed at the same time. For example, when an abdominal ultrasound and pelvic ultrasound are performed to evaluate the kidneys and bladder, technically both a 76705 *Ultrasound abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)* and a 76857 *Ultrasound, pelvic (nonobstetric), real time with image documentation, limited or follow-up (ie, for follicles)* are performed to evaluate each of these organs. However, the American Medical Association has determined that CPT® code 76770 *Ultrasound, retroperitoneal (ie, renal, aorta, nodes), real time with image documentation, complete* should be billed if the clinical history suggests urinary tract pathology, and evaluation of both kidneys and bladder.

Ultrasound Documentation Requirements

The American Institute of Ultrasound in Medicine recommends utilizing the *Practice Parameter for Documentation of an Ultrasound Examination* in order to provide high-quality patient care. As explained in this practice parameter, “there should be a permanent record of the ultrasound examination and its interpretation.” Details, regarding making sure that images are stored in a retrievable format, documenting the ultrasound examination in written report with accompanying images, and having this report be available by the next business day are just a few of AIUM’s recommendations found in the above parameter. The minimum documentation required by CPT® is a separate summarized written paragraph documented in the patient's chart with any permanently recorded images (with measurements when clinically indicated) and all anatomic areas imaged must be described.

Many offices and hospitals are now using a picture archiving and communication system (PACS) for short- and long-term storage, retrieval, management, distribution, and presentation of medical images. However, if your practice does not have a PACS, copies of ultrasound images must still be maintained in the electronic health record or in the patients chart. For billing purposes, having the images stored on a

PACS satisfies reporting requirements. Also, making sure that images are stored in the patient's medical chart or PAC system can prevent legal and reimbursement issues in the future. If chart audits are performed by the insurance company and no documentation of the ultrasound (images and report) is in the chart or in the PAC system, money paid on the claim can be requested as well as trigger a larger audit. In addition, a possible litigation could prove detrimental to the physician if request for documentation cannot be provided.

The language describing the written report has recently been revised to reflect the increased use of electronic reporting, as described in the introductory guidelines of the radiology section of the 2016 CPT® manual:

"A written report (eg, handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation."

Imaging Performed on the Same Day as an Encounter

The American Medical Association clarified that if an imaging test is performed on the same day as an Evaluation & Management (E&M) service, that each should be separately documented and billed, as stated in the E&M Services Guidelines Section in the CPT® book:

"The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E&M services. Physician performance of diagnostic test/studies for which specific CPT® codes are available may be reported separately, in addition to the appropriate E&M code. This physician interpretation of the results of diagnostic tests/studies with preparation of a separate, distinctly identifiable signed written report may also be reported separately, using the appropriate CPT® code with the modifier -26, Professional Component, appended."

In addition in the radiology section's guidelines under "supervision and interpretation," the following describes the requirements for documentation:

"Imaging may be required during the performance of certain procedures or certain imaging procedures may require surgical procedures to access the imaged area. Many services include image guidance, which is not separately reportable and is so stated in the descriptor or guidelines. When imaging is not included in a surgical procedure or procedure from the Medicine section, image guidance codes or codes labeled "radiological supervision and interpretation" may be reported for the portion of the service that requires imaging. Both services require image documentation and radiological supervision, interpretation, and report services require a separate interpretation."

Image guidance may be included in the operative report for the procedure for which the guidance was performed. It does not have to have a separate written report but a separate image is required in the chart to show that the guidance (with the needle, etc.) is being used. The AIUM also includes a

description regarding *Reporting of Ultrasound-Guided Procedures* within the *Practice Parameter for Documentation of an Ultrasound Examination*.

Insurance Provider information

Many individual insurers accept the AIUM's *Practice Parameter for Documentation of an Ultrasound Examination* as the standard for reporting an ultrasound exam. However, individual insurers could have their own requirements as to whether the report should be documented on a separate piece of paper in the patient's chart or commented on separately in the office notes or operative notes.

Although, insurer payment policies can vary plan to plan, the following health plans currently require accreditation in Urology for certain ultrasound codes listed above:

- Emblem/HIP
- Horizon BCBSNJ (effective 9/7/17)
- Wellcare, NY (effective 1/1/17)

The AUA has additional **information on practice accreditation** and more is available via the **AIUM**.