Radiology: Diagnostic Ultrasound

Page updated: January 2024

This section describes policies and guidelines for billing diagnostic ultrasound procedures.

Ultrasound of the Sinuses

Ultrasound of the sinuses is not a Medi-Cal benefit. Claims for CPT® codes 76536 (ultrasound, soft tissues of head and neck, real time with image documentation) and 76999 (unlisted ultrasound procedure) are not reimbursable when billed with a diagnosis of acute sinusitis (ICD-10-CM codes J01.00 thru J01.91) or chronic sinusitis (ICD-10-CM codes J32.0 thru J32.9).

Ultrasound of the Breast

CPT codes 76641 (ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete) and 76642 (…limited) are reimbursable for the diagnostic evaluation of the breast. These codes are split-billable and must be billed with modifier TC when billing only for the technical component; modifier 26 when billing only for the professional component; or when billing for both the professional and technical service components, a component modifier is not required. The anatomical modifier, RT or LT, must also be billed with any of the three scenarios above.

Note: When this service is performed on both breasts, on the same date of service, providers should bill the code on two separate claim lines, (once with modifier RT and once with modifier LT) and one unit of service for each line. This will designate a bilateral procedure was performed. If only billing either 26 or TC, each line should also include the appropriate component modifier on the first modifier position of the claim line followed by the anatomical modifier.

‹‹CPT code 0857T (opto-acoustic imaging, breast, unilateral, including axilla when performed, real-time with image documentation, augmentative analysis and report [List separately in addition to code for primary procedure]) is reimbursable for ages 18 years and older. Documentation is required indicating that beneficiary has a malignant breast tumor and modifiers RT and LT must be applied.››

Ultrasound of Infant Hips

CPT codes 76885 (ultrasound of infant hips, real time with imaging documentation; dynamic [requiring physician manipulation]) and 76886 (…limited, static [not requiring physician manipulation]) may be reimbursed for either:

- One professional component (modifier 26) plus one technical component (modifier TC) for the same date of service, any provider; or
- Both the professional and technical components (no modifier) for the same date of service, same provider.

Reimbursement is limited to twice per year to any provider for the same recipient, unless attached documentation supports medical necessity for additional study.

Ultrasound: Pelvic, Non-Obstetric

Claims for CPT codes 76830 (ultrasound, transvaginal), 76856 (ultrasound, pelvic [nonobstetric], real time with image documentation; complete) and 76857 (…limited or follow-up [eg, for follicles]) are not reimbursable when billed in conjunction with the following ICD-10-CM diagnosis codes:

F53.0 – F53.1	Z34.00 – Z34.93
O00.00 – O9A.53	Z36.0 – Z36.9
Z33.1	Z64.0
Z33.2	Z64.1

Ultrasound: Spinal Canal

CPT code 76800 (ultrasound, spinal canal and contents) is reimbursable for recipients 5 years of age or younger, for up to two procedures per calendar year for the same recipient, any provider. Code 76800 is reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes, and must be documented in the *Diagnosis or Nature of Illness or Injury* field (Box 21)/*Principal Diagnosis Code* field (Box 67):

G06.1	Q05.5 – Q05.9	Q76.49
L05.91	Q07.00	Q82.6
L05.92	Q42.0 – Q42.9	

Failure to document the appropriate ICD-10-CM diagnosis code will result in claim denial.

Reimbursement for additional procedures (more than two per calendar year) will require a *Treatment Authorization Request* (TAR) with medical justification.

‹‹CPT code 0815T (ultrasound-based radiofrequency echographic multi-spectrometry [REMS], bone-density study and fracture-risk assessment, 1 or more sites, hips, pelvis, or spine) is reimbursable.››

Ultrasound: Head and Neck

CPT code 76514 (ophthalmic ultrasound, diagnostic; B-scan and quantitative A-scan performed during the same patient encounter; corneal pachymetry, unilateral or bilateral [determination of corneal thickness]) is reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes:

H17.10 – H17.13	H40.001 – H40.10X4 *
H18.10 – H18.13	H40.1110 – H40.1194 *
H18.20	H40.1210 – H40.9 *
‹‹H18.511 thru H18.599››	H42
H21.551 – H21.559 *	Q15.0

Corneal pachymetry is included as part of the preoperative and postoperative evaluation of corneal transplant surgeries (CPT codes 65710, 65730, 65750, 65755 and 65756) and is not separately reimbursable. If claims history indicates previous reimbursement of corneal pachymetry within the 60 days prior to surgery, this reimbursement amount will be deducted from the reimbursable amount of the corneal transplant surgery procedure. If billed on the same date of service up to 90 days after surgery, the claim will be denied.

Corneal pachymetry is not reimbursable when performed as part of the preoperative or postoperative evaluation of a patient undergoing a non-Medi-Cal covered ophthalmologic refractive surgery, such as elective LASIK (laser-assisted in situ keratomileusis).

Ultrasound: Abdominal

CPT code 76706 (ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm) is split-billable with an approved TAR and must be billed with modifier TC when billing only for the technical component, and modifier 26 when billing only for the professional component. When billing for both the professional and technical service components, a modifier is neither required nor allowed. Reimbursement is limited to four per year to any provider for the same recipient. A TAR may be submitted to override the frequency limit. The code may also be billed in conjunction with modifiers U7 and 99.

Note: Modifier 99 must not be billed in conjunction with modifier 26 or modifier TC. The claim will be denied.

Ultrasound: Extremities

CPT codes 76881 (ultrasound, extremity, nonvascular, real-time with image documentation; complete) and 76882 (ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific) are reimbursable to portable imaging providers and podiatrists with an approved TAR.

Ultrasound: Other

The following radiology procedure codes may be billed for ultrasound services:

‹‹**Table of CPT Codes for Other Ultrasound Services**››

CPT Code	Description
‹‹0898T	Noninvasive prostate cancer estimation map, derived from augmentative analysis of image-guided fusion biopsy and pathology, including visualization of margin volume and location, with margin determination and physician interpretation and report››
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion
76979	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection
76981	Ultrasound, elastography parenchyma
76982	Ultrasound, elastography; first target lesion
76983	Ultrasound, elastography; each additional target lesion
76984	Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic
76987	Intraoperative epicardial cardiac ultrasound (i.e., echocardiography) for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report
76988	Intraoperative epicardial cardiac ultrasound (i.e., echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only
76989	Intraoperative epicardial cardiac ultrasound (i.e., echocardiography) for congenital heart disease, diagnostic; interpretation and report only

The codes may also be billed in conjunction with modifiers U7 and 99.

CPT codes 76978, 76979, 76981 and 76982 are split-billable and should be billed with modifier TC when billing only for the technical component, and modifier 26 when billing only for the professional component. Modifier 99 must not be billed in conjunction with modifier 26 or modifier TC. The claim will be denied.

CPT code 76982 has a frequency limitation of two per year for any provider. CPT code 76983 has a frequency limitation of eight per year for any provider. A TAR may be used to override either of these frequency limitations.

‹‹HCPCS code 0898T is approved for recipients 18 years of age and older. ICD-10-CM diagnosis code C61 is required.››

Codes Not Split-Billable

The following radiology procedure code is not split-billable and must not be billed with modifier 26, or TC.

‹‹**Table of CPT Codes Not Split-Billable**››

CPT Code	Description
76998	76998

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	CPT code 76514 is reimbursable only once in a lifetime when billed with the glaucoma-related diagnosis codes indicated in the above table.