CAUTION: Read the ICD-9 Policy Holding Library page about policy in this document.

Radiology: Diagnostic Ultrasound

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-4 codes 76536 (ultrasound, soft tissues of head and neck) and 76999 (unlisted ultrasound procedure) are not reimbursable when billed with a diagnosis of acute sinusitis (ICD-9-CM codes 461.0 – 461.9) or chronic sinusitis (ICD-9-CM codes 473.0 – 473.9).

Ultrasound of the Breast

Ultrasound of the breast (CPT-4 code 76645) is a Medi-Cal benefit for the diagnostic evaluation of the breast. CPT-4 code 76645 covers reimbursement for either a unilateral or bilateral ultrasound, including B-scan and/or real time with image documentation.

Ultrasound of Infant Hips

CPT-4 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-4 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-9-CM diagnosis codes:

630 – 633.99	V23.9
640.00 – 663.93	V28.0 – V28.6
V22.0 – V23.7	V28.81 – V28.99
V23.81 – V23.89	V61.5 – V61.7

Ultrasound: Spinal Canal

CPT-4 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-9-CM codes, and must be documented in the *Diagnosis or Nature of Illness or Injury* field (Box 21)/*Principal Diagnosis Code* field (Box 67):

324.1	741.93
685.1	751.2
741.9	756.13

Failure to document the appropriate ICD-9-CM 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.

Ultrasound: Head and Neck

CPT-4 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 payable only when billed in conjunction with one of the following ICD-9-CM diagnosis codes:

364.22 *	371.20
364.77 *	371.23
365.00 – 365.9 *	371.57
371.03	371.58

* CPT-4 code 76514 is payable only once-in-a-lifetime when billed with the glaucoma-related diagnosis codes indicated in the above table.

Corneal pachymetry is included as part of the preoperative and postoperative evaluation of corneal transplant surgeries (CPT-4 codes 65710, 65730, 65750, 65755 and 65756) and is not separately payable. If claims history indicates previous payment of corneal pachymetry within the 60 days prior to surgery, this reimbursement amount will be deducted from the payable 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 payable 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: Extremities

CPT-4 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.

Codes Not Split-Billable

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

CPT-4 Code	Description
76998	Ultrasonic guidance, intraoperative