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Obstetrical and Non-Obstetrical Pelvic Ultrasound Exams



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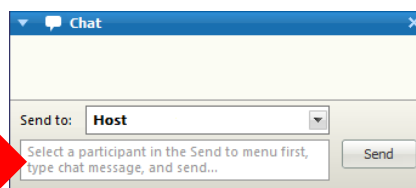
Wendi J. Krumm, RCC

June 2, 2016

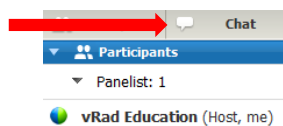
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- Let's talk!** A contact form with fields for First Name, Last Name, Email Address, Healthcare Role (dropdown), State or Province (dropdown), Country (dropdown), Business Phone, and a checkbox for "I'm interested in". A "Submit" button is at the bottom.

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Obstetrical and Non-obstetrical Pelvic Ultrasound Exams



Wendi J. Krumm, RCC






June 2, 2016

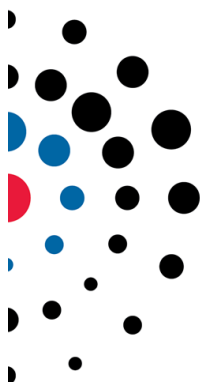
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Our Agenda

Introductions

-  Female and Male Pelvic US Exams (Non-Obstetrical)
-  ICD-10-CM Guidelines for Obstetrical Documentation
-  Female Obstetrical Ultrasound Exams – Early and Late Trimesters
-  Fetal Ultrasound Exams
-  Documentation Tips



Pelvic Ultrasound Required Elements

CPT Codes 76856, 76857, 76830

Non-OB Transabdominal Pelvic Ultrasounds

- 76856** Ultrasound, pelvic (non-obstetric), real time with image documentation; complete
- 76857** Ultrasound, pelvic (non-obstetric), real time with image documentation; limited or follow-up (e.g, for follicles)
- 76830** Ultrasound, transvaginal



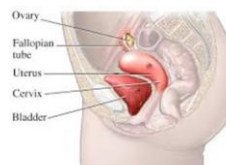
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Required Elements for 76856

Non-OB Female Pelvic US

- Description AND measurements of the uterus and adnexal structures
- Measurement of the endometrium
- Measurement of the bladder (when applicable)
- Any pelvic pathology imaged



Male Pelvic US

- Evaluation and measurement (when applicable) of the urinary bladder
- Evaluation of the prostate and seminal vesicles (to the extent they are visualized transabdominally)
- Any pelvic pathology imaged



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Coding and Documentation Tips: Non-OB Pelvic US

- **The elements most commonly missed on a female pelvic US report:**
 - Bladder
 - Endometrial measurement
- **Complete studies must mention each required element/organ. If not visualized, explain why:**
 - “The seminal vesicles could not be identified as discrete structures due to lack of a sufficient visualization.”
 - “Left ovary surgically removed.”
- **If a limited US exam is ordered and performed, specify this in the dictated title and the technique sections of the report for accurate CPT code assignment**

Section Specific Guideline from the AMA's 2016 Professional Edition CPT®

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, surgically absent).

Transabdominal or Transvaginal or Both?

Specify approach in the title and technique:

- Transabdominal
- Transvaginal
- Both Transabdominal and Transvaginal

Documenting the medical necessity of transvaginal exams:

- Indication for transvaginal approach
 - “Vaginal bleeding required further transvaginal imaging to assess the endometrium at a higher resolution”
 - “Transvaginal exam was performed to further assess an adnexal mass that was visualized on transabdominal exam”
- Findings from each approach

ACR.org July/August 2009 Frequently Asked Questions on Ultrasound Coding

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.



What is Missing From This Dictation?

EXAM: US Pelvis, transvaginal and transabdominal. **EXAM DATE/TIME:** Exam ordered 4/17/2016 5:35 AM

CLINICAL HISTORY: 24 years old, female; Pelvic pain

TECHNIQUE: Real-time transabdominal and transvaginal pelvic ultrasound (complete) with image documentation. Transvaginal imaging was used for better evaluation of the endometrium and adnexa.

COMPARISON: US Pelvic Non OB Complete W/Transvaginal 4/14/2016 5:36:44 PM

FINDINGS:

Endometrium: Endometrial thickness is 8 mm. There is moderate free fluid in the pelvis.

Uterus/cervix: Unremarkable. No myometrial mass.

Right ovary: Unremarkable. No mass. Normal blood flow.

Left ovary: Complex/hemorrhagic cystic lesion in the LEFT ovary/adnexal region measuring 2.7 cm.

Normal blood flow seen within the surrounding tissue.

Free fluid: No free fluid.

Other findings: Transvaginal images were performed for better anatomy visualization.

IMPRESSION:

Moderate free fluid. Complex/hemorrhagic cystic lesion in the LEFT ovary/adnexal region measuring 2.7 cm.

Optimal Dictation for a Complete Non-OB Pelvic Ultrasound Transabdominal and Transvaginal Approaches

EXAM: US Pelvis, transvaginal and transabdominal. **EXAM DATE/TIME:** Exam ordered 8/17/2015 5:35 AM

CLINICAL HISTORY: 24 years old, female; Pelvic pain

TECHNIQUE: Real-time transabdominal and transvaginal pelvic ultrasound (complete) with image documentation. Transvaginal imaging was used for better evaluation of the endometrium and adnexa.

COMPARISON: US Pelvic Non OB Complete W/Transvag 7/14/2015 5:36:44 PM

FINDINGS:

Endometrium: Endometrial thickness is 8 mm. There is moderate free fluid in the pelvis.

Uterus/cervix: Unremarkable. No myometrial mass. - **measurement of the uterus**

Right ovary: Unremarkable. No mass. Normal blood flow. - **measurement of right ovary**

Left ovary: Complex/hemorrhagic cystic lesion in the LEFT ovary/adnexal region measuring 2.7 cm. - **measurement of left ovary**

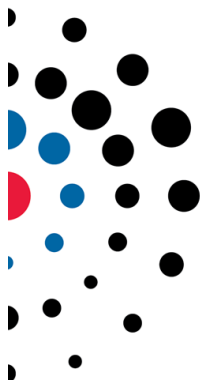
Normal blood flow seen within the surrounding tissue.

Free fluid: No free fluid.

Other findings: Transvaginal images were performed for better anatomy visualization.

IMPRESSION:

Moderate free fluid. Complex/hemorrhagic cystic lesion in the LEFT ovary/adnexal region measuring 2.7 cm.



ICD-10-CM Guidelines for Pregnancy



ICD-10 Guidelines

All OB studies require a code from Chapter 15 (O00 – O99)

Chapter 15 codes have sequencing priority over codes from other chapters but codes from other chapters can be used in addition.

Chapter 15 codes are only for the mother's record (maternal) and never on the newborns record.

Most codes from Chapter 15 have a final character indicating the trimester of pregnancy.

If the provider specifically documents that the pregnancy is an incidental finding, use code **Z33.1 Pregnant state, incidental** as a secondary code.



Trimester Documentation

1st Trimester	less than 14 weeks, 0 days
2nd Trimester	14 weeks, 0 days to less than 28 weeks, 0 days
3rd Trimester	28 weeks, 0 days until delivery

If the LMP is documented, the medical coder can calculate both the gestational week and the trimester.

Due-date calculator:

<http://www.perinatology.com/calculators/Due-Date.htm>

The majority of codes in Chapter 15 need a 7th character extension for the patient's trimester.

The trimester is calculated from first day of the last menstrual period (LMP).



Documenting Weeks of Gestation

In most codes in category Z3A, the last 2 characters correlate to the weeks of gestation:

ICD-10-CM Code	Code Description
Z3A.00	Weeks of gestation of pregnancy not specified
Z3A.01	Less than 8 weeks gestation of pregnancy
Z3A.08	8 weeks gestation of pregnancy
Z3A.09	9 weeks gestation of pregnancy
Z3A.10	10 weeks gestation of pregnancy
Z3A.11	11 weeks gestation of pregnancy
Z3A.12	12 weeks gestation of pregnancy
Continues by Week	
Z3A.42	42 weeks gestation of pregnancy
Z3A.49	Greater than 42 weeks gestation of pregnancy

Weeks of gestation:

A code to identify the specific week of the pregnancy is also often required in ICD-10-CM.

Trimester	Month	Week						
1	0	0	1	2	3	4		
	1	5	6	7	8			
	2	9	10	11	12			
2	3	13	14	15	16	17		
	4	18	19	20	21			
	5	22	23	24	25			
3	6	26	27	28	29	30		
	7	31	32	33	34			
	8	35	36	37	38			
	9	39	40	41	42			

Fetal Complications in Multiple Gestations

Assign a 7th character extension to identify the fetus for which the complication applies:

Ø not applicable or unspecified

- 1 fetus 1
- 2 fetus 2
- 3 fetus 3
- 4 fetus 4
- 5 fetus 5
- 9 other fetus



Assigning unspecified 7th extension:

- For single gestations
- When it is not possible to clinically determine which fetus is affected
- When the documentation in the record is insufficient to determine the fetus affected and it is not possible to obtain clarification.

Spontaneous and Elective Terminations of Pregnancy

Definition and Terminology Changes

- The timeframe for a missed abortion (vs. fetal death) has changed from 22 to 20 weeks.
- In ICD-10-CM, an elective abortion is now described as an elective termination of pregnancy.

ICD-10 –CM documentation:

Code Family		Definition
O02.1	Missed abortion	Early fetal death before completion of 20 wks, with retention of dead fetus
O20	Threatened abortion	Hemorrhage before completion of 20 weeks gestation
O03	Incomplete abortion	Bleeding, os open, retained products of conception (POC)
O03.9	Complete termination	Miscarriage without complications
O04	Complete termination	Miscarriage WITH complications
O07	Failed Attempt	Incomplete elective termination of pregnancy

Document complications, such as:

- Endometritis
- Hemorrhage
- Infection
- Renal failure
- Sepsis

Peripartum and Postpartum Periods

Peripartum and postpartum complication

A postpartum complication is any complication occurring within the *six-week period following delivery*.

Pregnancy-related complications after 6 week period

If the provider documents that a condition is pregnancy related, codes from Chapter 15 may be used after the peripartum or postpartum time periods.



Postpartum

Begins immediately after delivery and continues for six weeks following delivery.

Peripartum

Occurring during the last month of gestation (pregnancy) to five months after delivery, with reference to the mother.



OB Ultrasound Procedures

CPT Codes 76801-76821

CPT® ASSISTANT - October 2001; Volume 11: Issue 10

"Obstetrical Ultrasound Coding

... For female patients with an **established diagnosis of pregnancy**, determined by any method, and with **indications** for the ultrasound procedure that might be pregnancy related, it is appropriate to **report an obstetrical ultrasound code** from the 76805-76815 series.

For a patient with an **established diagnosis of pregnancy** (determined by any means), with signs and **symptoms that could be pregnancy related** and necessitating an ultrasound evaluation of the pelvis, the **obstetrical ultrasound code(s) 76805-76815 should be reported, even if the outcome of the procedure is that the patient is now not pregnant** or has an ultrasonic diagnosis that might be construed as being independent of the pregnancy (e.g., acute appendicitis, torsed ovary, necrotic fibroid).

Pelvic Ultrasound Coding

If a female patient without an established diagnosis of pregnancy presents with gynecological problems necessitating ultrasound evaluation (e.g., dysmenorrhea, oligomenorrhea, menstrual irregularity, pelvic pain, etc.), then it is appropriate to report a **pelvic ultrasound** code 76856 or 76857. The use of **codes 76856 or 76857 is not predicated upon whether or not the outcome of the ultrasound procedure is the diagnosis of pregnancy or a complication related to a pregnancy.**"

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OB US less than (<) 14 weeks, 0 days

- 76801** Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; single or first gestation
- +76802** Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (< 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)



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Required Elements for 76801

Complete studies must mention each of the required elements:

- Number of gestational sacs and fetuses
- Gestational sac/fetal measurements for gestation
- Survey of visible fetal and placental anatomic structures
- Qualitative assessment of amniotic fluid volume/gestational sac shape
- Examination of the maternal uterus and adnexa

NOTE: In early pregnancy, it is not uncommon that the placenta cannot be visualized. Document the reason it could not be visualized:

"The placenta cannot be adequately evaluated due to the early gestational age."

Section Specific Guideline from the AMA's 2016 Professional Edition CPT®

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, surgically absent).

Complete Transabdominal and Transvaginal OB US Exam

EXAM:

US Obstetrical < 14 Weeks Complete, Transabdominal and US Obstetrical, Transvaginal.

CLINICAL HISTORY:

34 years old, female; Signs and symptoms; LMP or gestational age (in weeks): 7 w 5 d; Other: Heavy vaginal bleed; Pregnant; Additional info: Bleeding 8 weeks

TECHNIQUE: Real-time **transabdominal and transvaginal** obstetrical ultrasound (complete) of the maternal pelvis and a < 14 week gestation with image documentation. Transvaginal imaging was used for better evaluation of the fetus and adnexa.

EXAM DATE/TIME: Exam ordered 1/24/2016 3:00 PM

COMPARISON: No relevant prior studies available.

FINDINGS:

No uterine abnormality identified. Uterus measures 9.8 cm sagittal dimension. Normal endometrial thickness of approximately 1 cm. Trace endometrial fluid. **No intrauterine (1) gestational sac** is visualized.

The right ovary has been surgically removed. **(2) Left ovary** normal in size and appearance with color flow measuring 2.4 x 1.2 x 2.9 cm. **(2) No visualized adnexal mass or free pelvic fluid.**

IMPRESSION:

No demonstrable intrauterine pregnancy. Given the reported serum beta HCG and history of previously documented IUP, findings are compatible with spontaneous abortion.

OB US = or > 14 weeks 0 days

- 76805** Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
- +76810** Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)



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Required Elements for 76805

- Determination of number of fetuses and amniotic/chorionic sacs
- Measurements appropriate for gestational age
- Survey of intracranial anatomy
- Survey of abdominal anatomy
- Survey of spinal anatomy
- 4 chamber heart
- Umbilical cord insertion site
- Placenta location
- Amniotic fluid assessment
- Maternal adnexa (when visible)



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76805

EXAM: US Obstetrical > 14 Weeks Complete, Transabdominal.

CLINICAL HISTORY: 18 years old, female; 29 weeks 2 days by previous ultrasound with EDD of 4/3/16. Follow-up growth.

TECHNIQUE: Real-time transabdominal obstetrical ultrasound (complete) of the maternal pelvis and a > 14 week gestation with image documentation.

COMPARISON: 12/15/15

FINDINGS:

Fetus: (1) **Single live intrauterine gestation** is again seen. Heart rate: Heart rate is 138 bpm.

Presentation: The fetus is currently in cephalic. (2) **Placenta:** The placenta is posterior without previa, grade 1.

(3) **Three-vessel cord** and **insertion** are seen. (4) **Amniotic fluid:** AFI is 10.1 cm, the largest pocket is 2.7 cm.

Anatomy: (5) **Four-chamber heart** is seen. The (6) **spinal** and (7) **intracranial structures** all appear normal. The (8) **fetal stomach, kidneys and bladder** are unremarkable. The left renal pelvis measures 5 mm, similar to the prior study and within normal range for gestational age. Fetal gender is male.

(9) **Biometrics:** BPD 7.4 cm, 29 weeks 5 days. HC 26.2 cm, 28 weeks 4 days. AC 25.2 cm, 29 weeks 3 days. FL 5.3 cm, 28 weeks 3 days. Composite gestational age is 29 weeks 0 days, concordant with the prior study. EFW: EFW is 1300 g, 35th percentile.

(10) **MATERNAL:** Uterus: Limited, unremarkable Cervix: The cervix is closed, 2.4 cm. Free fluid: No free fluid.

IMPRESSION:

Cephalic presentation at 29 weeks 2 days by previous study. Today's exam is concordant. EDD is 4/3/16. Fetal survey is normal, as on the prior study.

Detailed Fetal Anatomic US

76811 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation

+76812 Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)



Required Elements of 78611

Required Elements:

- Determination of number of fetuses and amniotic/chorionic sacs
- Measurements appropriate for gestational age
- Survey of intracranial anatomy
- Survey of abdominal anatomy
- Survey of spinal anatomy
- 4 chamber heart
- Umbilical cord insertion site
- Placenta location
- Amniotic fluid assessment
- Maternal adnexa (when visible)

PLUS

Detailed anatomic evaluation of the:

- Fetal brain/ventricles
- Face
- Heart outflow tracts
- Chest anatomy
- Abdominal organ specific anatomy
- Number/length/architecture of limbs
- Umbilical cord
- Placenta
- Other fetal anatomy as clinically indicated

Complete Fetal and Maternal Ultrasound Evaluation Plus Detailed Fetal Anatomic Examination

EXAM: US Obstetrical > 14 Weeks, Transabdominal.

CLINICAL HISTORY: 19 years old, female; Signs and symptoms; LMP or gestational age (in weeks):

EDC 4-8-16; Other: Screening; Pregnant; Prior surgery; Surgery type: C-section

TECHNIQUE: Transabdominal obstetrical ultrasound of the maternal pelvis and a > 14 week gestation with image documentation.

EXAM DATE/TIME: 1/14/2016 9:54 AM

A prior study report dated 10/6/2015 is reviewed, images not submitted.

FINDINGS:

Multiple transverse and longitudinal sonographic images of the pelvis demonstrate a (1) **single live intrauterine pregnancy** in longitudinal lie and cephalic presentation with a fetal heart rate of 160 beats per minute. Appropriate fetal movements were reportedly observed.

(2) **Amniotic fluid** is qualitatively adequate. The posterior (3) **placenta** is clear of the internal cervical os, with anechoic placental lakes noted; no evidence for abruption.

Fetal structural evaluation demonstrates grossly unremarkable (4) **fetal face, nose/lips and profile**, (5) **head**, (6) **lateral ventricles, cerebellum, cisterna magna**, (7) **4-chamber heart and RIGHT ventricular outflow tract**, (8) **stomach, kidneys, bladder**, (9) **3-vessel cord and insertion**, (10) **bilateral upper and lower extremities**, (11) **Spine**, and (12) **chest anatomy**.

(continued on next slide)

Complete Fetal and Maternal Ultrasound Evaluation Plus Detailed Fetal Anatomic Examination

(continued)

(13) Fetal biometry is as follows:

BPD 7.1 cm for EGA of 28 weeks and 3 day(s)

HC 25.8 cm for EGA of 28 weeks and 0 day(s)

AC 23.9 cm for EGA of 28 weeks and 2 day(s) FL 5.3 cm for EGA of 28 weeks and 2 day(s)

HC/AC 1.08

FL/AC 22%

FL/BPD 75%

Overall EGA by current fetal biometry is 28 weeks and 2 day(s), for EDC of 4/5/2016.

EFW is 1,186 +/- 173 grams.

IMPRESSION:

--Single live intrauterine pregnancy with appropriate interval growth by report.

--No demonstrated fetal anomaly.

--Placental lakes noted.

Fetal Nuchal Translucency Ultrasound

76813 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; single or first gestation

+76814 Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)

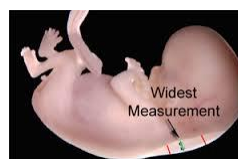


Fetal Nuchal Translucency US

- The fetal nuchal translucency (NT) test is a non-invasive prenatal ultrasound screening in the first trimester of pregnancy.
- Small window of opportunity (11.5 weeks-13 weeks six days of gestation)
- The non-invasive ultrasound test measures the fluid filled nuchal fold thickness. This is an area of tissue at the back of an unborn baby's neck
- Helps to identify higher chances for chromosomal abnormalities such as Trisomy 13, 18, or 21)
- Blood tests are also performed on the mother that measure both free BHCG (beta human chorionic gonadotropin) and PAPP-A (pregnancy associated plasma protein A).

A normal measurement at 11 weeks is up to 2 millimeters (mm).

A normal measurement at 13 weeks, 6 days is up to 2.8 mm.



76813 Dictation

EXAM:

US Obstetrical < 14 Weeks Complete, Transabdominal.

CLINICAL HISTORY:

34 years old, female; LMP at 10/27/15 for current gestational age of 10 weeks 6 days and EDD 8/2/16. Concordant ultrasound on 1/4/16. Evaluate nuchal translucency.

TECHNIQUE:

Real-time transabdominal obstetrical ultrasound (complete) of the maternal pelvis and a < 14 week gestation with image documentation.

COMPARISON:

1/4/16

FINDINGS:

Gestation: Single live intrauterine gestation is again seen. The crown-rump length of 4.8 cm is consistent with 11 weeks 4 days, reasonably concordant with dates and the prior study. Heart rate is 160 bpm. No early fetal complication is suspected. **Nuchal translucency of 0.5 mm is normal.**

Uterus/cervix: The uterus is unremarkable. No myometrial mass.

Ovaries: Unremarkable. No mass.

Free fluid: No free fluid.

IMPRESSION:

Live intrauterine gestation at 10 weeks 6 days by dates with EDD 8/2/16. Today's exam is concordant. No complications are suspected. **Nuchal translucency are 0.5 mm is normal.**

Limited and Follow-up OB Ultrasounds

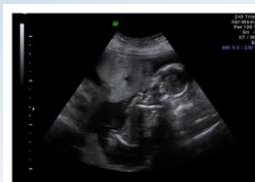
76815 Ultrasound, pregnant uterus, real time with image documentation, limited (eg, fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), 1 or more fetuses

76816 Ultrasound, pregnant uterus, real time with image documentation, follow-up (eg, re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus

NOTE:

Code 76815 includes in its description "one or more fetuses". In multiple pregnancy, code once. Do not code for each fetus.

Code 76816 includes in its description "per fetus" so should be billed for each fetus imaged and evaluated.



Limited and Follow-up OB Ultrasounds

CPT® codes 76815 and 76816 are appropriate when an OB ultrasound study is performed and the report does not document a complete study.

- When a study is performed that lacks any of the required elements of a complete study, 76815 may be assigned.
- Code 76815 would also be used for an intended quick look or selected limited examination of any individual element of any OB study, such as amniotic fluid assessment.
- Code 76816 is appropriate if a study is done to reassess fetal size or to re-evaluate any fetal organ-system abnormality noted on a previous ultrasound study.

OB Ultrasound Transvaginal

76817 Ultrasound, pregnant uterus, real time with image documentation, transvaginal

- Maternal risk factors and/or medical reason should be well documented
- Indication for transvaginal approach, such as
 - Early pregnancies
 - Retroverted uterus
 - Obesity
 - Ectopic pregnancy
- Findings from each approach

Document the medical necessity of performing transvaginal exams



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Biophysical Profile Ultrasound

76818 Fetal biophysical profile; with non-stress testing

76819 Fetal biophysical profile; without non-stress testing

Five Components for Code 76818:

- **Four elements are studied with ultrasound:**
 - 1) Fetal diaphragmatic breathing movements
 - 2) Fetal body movements
 - 3) Fetal tone
 - 4) Quantification of amniotic fluid volume
- **The fifth element - non-stress test**

76818 is often performed by the obstetrician, rather than a radiologist.

76819

The obstetrician performs the non-stress test and reports CPT 59025.

The patient is referred to a radiologist to perform the ultrasound the four variables.



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Biophysical Profile Scoring on the Four Components

A score of "2" or "0" is given for each element with the highest possible score being 8
Reported in the format of "8/8"

TABLE III SCORING CRITERIA FOR THE BIOPHYSICAL PROFILE From Manning FA, Dynamic ultrasound-based fetal assessment: The fetal biophysical score (Clin Obstet Gynecol) ²⁷		
Biophysical Variable	Normal (score = 2)	Abnormal (score = 0)
Fetal breathing movements	1 episode FBM of at least 30 s duration in 30 min	Absent FBM or no episode >30 s in 30 min
Fetal movements	3 discrete body/limb movements in 30 min	2 or fewer body/limb movements in 30 min
Fetal tone	1 episode of active extension with return to flexion of fetal limb(s) or trunk. Opening and closing of the hand considered normal tone.	Either slow extension with return to partial flexion or movement of limb in full extension Absent fetal movement
Amniotic fluid volume	1 pocket of AF that measures at least 2 cm in 2 perpendicular planes	Either no AF pockets or a pocket <2 cm in 2 perpendicular planes
FBM = fetal breathing movement; AF = amniotic fluid.		

FINDINGS:

There is a single live intrauterine pregnancy, with the baby in the cephalic position. The placenta is located anteriorly. Fetal heart rate is detected at 144 beats per minute. Amniotic fluid index is 7.7 cm.

Biophysical profile score is as follows:

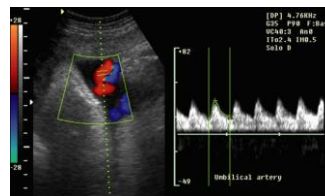
Fetal movement 2/2
Fetal breathing 2/2
Fetal tone 2/2
Amniotic fluid volume 2/2

Total biophysical profile score is 8/8.

Doppler Velocimetry – Umbilical and Middle Cerebral Artery

76820 Doppler velocimetry, fetal; umbilical artery

76821 Doppler velocimetry, fetal; middle cerebral artery

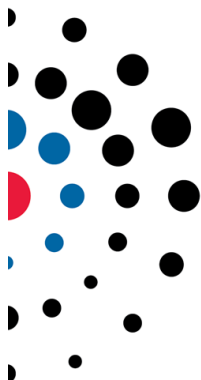


These scans are typically performed later in the pregnancy to assess blood flow.

Helpful in determining fetal anemia and fetal growth restriction caused by placental vascular resistance.

These codes may be assigned in addition to any other OB ultrasound study performed at the same encounter, and are reported per fetus.

76820 will be reported with the ratio of systolic to diastolic flow rates or "S/D ratio."



Documentation Tips



Document to Support Services and Minimize Risks

Accurate and complete documentation of services, dictated by the radiologist, is critical to maximal reimbursement and compliance to CMS regulations.

The radiology report is a legal documentation of what was done.

- **EVERY** portion of a radiology procedure must be clearly documented.
- A coder **CAN NOT** assume that services were included in a procedure if they are not clearly documented.
- Payers perform post-payment audits to assure compliant billing practices.
- The final radiology report must support the billed service.
- Documentation omissions result in lost revenue through non-billable services, suboptimal payments, procedure denials, or reimbursement take-backs.

Tips for Exam Titles

- Exam titles should have all elements for correct code assignment, including:
 - Modality (e.g., MR, ultrasound, CT, X-ray)
 - Anatomical site
 - Laterality
 - Views
 - Whether contrast was used.
- Exams should be succinct—for example: upright, oblique, decubitus views of the abdomen.
- Avoid ambiguous, nonspecific, or unfamiliar terms or abbreviations.
- Avoid phrases without necessary descriptors, such as abdomen complete or abdomen series, or pulmonary embolism study.
- When separate studies are performed and documented in the same report:
 - Document with separate report header and findings
 - Do NOT copy and paste the same report for both studies



Tips for Quality Radiology Reports

- When making recommendations for a follow-up or additional studies, provide the medical necessity for the additional exams.
- Comparison of prior studies, as appropriate.
- Capture clinical documentation for PQRS measures.
- Indication of any limitations in the study, such as poor image quality, poor imaging of specific elements, or poor patient prep.
- A summary of conversations with other health care providers.
- Any known significant patient reaction or complication.



Resources

2016 CPT Manual Professional Edition; published by the AMA

CPT® Assistant; December 2005; Volume 15: Issue 12

CPT® Assistant; March 2003; Volume 13: Issue 3

CPT® Assistant; October 2001; Volume 11: Issue 10; Obstetrical and Pelvic Ultrasound coding

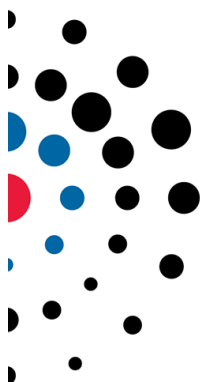
CPT® Assistant; September 2001; Volume 11: Issue 9: Radiology Procedures Part II (CPT 76818, 76819)

ACR Radiology Coding Source; July – August 2009

ACR Radiology Coding Source; March – April 2007

2016 Clinical Modification ICD-10-CM Complete Code Set; AAPC

ICD-10-CM Official Guidelines for Coding and Reporting, FY 2016; CMS, NCHS and DHHS



Thank You

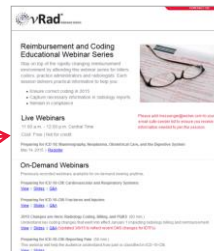
Thank You

Please submit questions using Chat.

Enter question here

Answers, with supporting resources, will be posted on the webinar series webpage:

http://webinars.vrad.com/reimbursement_series



vRad team members with specific scenarios or questions are encouraged to contact Sharon Roeder or Wendi Krumm for further support.

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