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Third-trimester ultrasound scans

Q When a patient is scanned during the third trimester for indications such as advanced maternal age, pregnancy-induced hypertension, a large-for-gestational-age fetus, oligohydramnios, or shortened cervix, which code should I use: 76811, 76815, or 76816?

A Your choice of code will depend on what was documented previously and which elements of the scan are being documented at the present time. (I am assuming there was an initial scan, usually reported using codes 76801-76810).

Use code 76811 (ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation) only when all of its elements are performed. If you are scanning for 1 or more of the conditions you have listed but not performing all the elements included in 76811, your coding choice is either 76815 (ultrasound, pregnant uterus, real time with image documentation, limited) or 76816 (ultrasound, pregnant uterus, real time with image documentation, follow-up ..., transabdominal approach, per fetus).

It all boils down to what was known before this scan was ordered. If 1 or more of the conditions you listed were discovered at the time of a previous scan and now require ongoing monitoring, use code 76816. If 1 or more of the conditions mentioned are only now in evidence, use code 76815.

Scanning for breech, low amniotic fluid

Q If we do an ultrasound to rule out breech presentation and also to evaluate low amniotic fluid, should we code both a limited ultrasound and a follow-up ultrasound modified by -51 (multiple procedure) or -59 (distinct procedure)?

A If you are reevaluating a previously documented problem (the low amniotic fluid) and then discover or evaluate the possibility of a new one (the breech), you should be reporting only 1 code—the one with the highest relative value.

If you are billing for the complete service (technical and professional component), report code 76815 (2.39 relative value units [RVUs] as opposed to 2.35 RVUs for 76816). If you are billing for the professional service only, report 76816-26 (1.20 RVUs compared to .91 RVUs for 76815-26).

'Once per exam' means once per encounter

Q Can you clarify what CPT means by "once per exam, not per element"? This note comes after the limited ultrasound code.

A The code for a limited ultrasound, 76815, is meant to describe a "quick" focused look at 1 or more of the examples listed in parentheses (fetal heart beat, placental location, fetal position, qualitative amniotic fluid volume, etc) in the nomenclature for this ultrasound code.

"Once per exam, not per element" means that 76815 is reported only 1 time for that encounter, regardless of how many of the listed examples you document and regardless of the number of fetuses present. ■

Ms. Witt, former program manager in the Department of Coding and Nomenclature at the American College of Obstetricians and Gynecologists, is an independent coding and documentation consultant. *Reimbursement Adviser reflects the most commonly accepted interpretations of CPT-4 and ICD-9CM coding. When in doubt on a coding or billing matter, check with your individual payer.*