Although other types of guidance — CT, MR, and more — are located in the “Radiologic Guidance” section of the “Radiology” chapter, you’ll find ultrasonic guidance in the Diagnostic Ultrasound section.

**Pick 76930 for First Pericardiocentesis**

Physicians typically perform pericardiocentesis under ultrasonic guidance, which you should report with 76930 (Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation).

The physician who performs the pericardiocentesis, aspirating fluid from the sac surrounding the heart, the pericardium, would report the appropriate procedure code, such as 33010 (Pericardiocentesis; initial).

**Verify Documentation for +76937**

If the radiologist uses ultrasound guidance when accessing a vessel for a catheter placement but doesn't record the images, watch your step.

You should not report +76937 (Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting [List separately in addition to code for primary procedure]) because the descriptor tells you this code requires permanent recording.

Prior to 2004, when CPT® added +76937, you could assign 76942 (Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation) when a provider used ultrasound guidance for vascular access.

But now that you have a specific code for this service, you should not report 76942. Use only +76937 for ultrasound guidance for vascular access. If your documentation doesn't meet +76937 criteria, you shouldn't assign an ultrasound code.

**Pair 76940 With Proper Ablation Code**

Code 76940 (Ultrasound guidance for, and monitoring of, parenchymal tissue ablation) is specific to parenchymal tissue ablation (the parenchyma includes the elements of the organ key to functioning, as opposed to the capsule or connective tissue). Notes with the code state that the appropriate ablation procedure codes are:

- 32998 — Ablation therapy for reduction or eradication of 1 or more pulmonary tumor[s]..
- 47370-47382 — liver tumor ablation
- 50592-50593 — renal tumor ablation

The guidance code includes guidance for getting the radiofrequency needle electrode to the tumor(s), monitoring electrode repositioning within the lesion, confirming satisfactory outcome, and comparison to pre-ablation images.

**Don't miss:** If the radiologist uses CT or MR guidance, look to these codes instead:

- 77013 — Computed tomography guidance for, and monitoring of, parenchymal tissue ablation.
- 77022 — Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation.

**Case Study:**

**Get a Grip on When 76942 Isn't Separately Reportable**
Technique: Real-time ultrasonic evaluation of the abdomen was performed. An appropriate site was selected for paracentesis ... 5-gauge Yueh catheter advanced into collection. A total of 6-ml straw-colored fluid obtained. The needle was removed.

Answer: For the abdominal paracentesis with image guidance, you would report 49083 (Abdominal paracentesis [diagnostic or therapeutic]; with image guidance).

According to a parenthetical note with 49083, you should not separately report imaging guidance (76942, 77002, 77012, 77021).

Key Concepts:

Guidance Denials? Check MUEs

If you're receiving denials for multiple guidance codes per encounter, one possibility is that you're running up against medically unlikely edits (MUEs) from Medicare. If you check the list of practitioner MUEs, you'll find that many guidance codes have a limitation of one unit.

For example, 76942 (Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation) is listed with an MUE of “1.” That means if you report more than one unit of 76942 for a single beneficiary on a single service date, you'll get a denial.

CMS states that you should rarely exceed the limits, but when the radiologist performs and documents a medically necessary number of services that exceed MUEs, check your payer’s reporting preference. HCPCS offers modifier GD (Units of service exceeds medically unlikely edit value and represents reasonable and necessary services). But payers may prefer that you report the guidance codes on separate lines and choose modifier 59 (Distinct procedural service), modifier 76 (Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional), or other modifiers to indicate the separate nature of the services. You also may need to supply documentation showing medical necessity for the additional units.

According to CMS, "Since each line of a claim is adjudicated separately against the MUE value for the code on that line, the appropriate use of Current Procedural Terminology (CPT®) modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value." The FAQ indicated several options, including modifiers 76, 77 (Repeat Procedure by Another Physician or Other Qualified Health Care Professional), and anatomic modifiers. CMS stated you should use modifier 59 only if not other modifier described the service.

OB Exams: Report US and Us Guidance Separately

Scenario: An obstetrician ordered a routine ultrasound for a first-time mother at 15 weeks gestation. After finding an anomaly, the radiologist called the obstetrician, who performed an amniocentesis with ultrasonic guidance by the radiologist. How should you code for the ultrasound and guidance the radiologist provided?

Answer: You should report 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) for the ultrasound. The guidance merits 76946 (Ultrasonic guidance for amniocentesis, imaging supervision and interpretation).

Depending on your payer, you may also need to append modifier 59 (Distinct procedural service) or 51 (Multiple procedures) to 76946 to indicate that the ultrasound and guidance were two different procedures.

Don't forget: If you report ultrasonic guidance and a fetal ultrasound on the same date, your physician should include separate reports in the medical record documenting the individual procedures. Your physician should also document the specific findings that led to the recommended amniocentesis.

Understand HDR Division of Labor

There are several services performed in connection with prostate high-dose rate (HDR) therapy or prostate seed implants, and the documentation determines which physician can bill for the procedures:
**Guidance:** Code 76965 (*Ultrasonic guidance for interstitial radioelement application*) is used for the ultrasonic guidance prostate seed implants. Some payers will accept 77387 (*Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed*) for HDR catheter placement; other payers accept 76942 (*Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation*) for catheter placement guidance. If the physician performs only the ultrasonic guidance, he would report the 769xx code. But you may see other services, as well:

**HDR:** The physician responsible for the brachytherapy should report a code from the 77785-77787 series (*Remote afterloading high dose rate radionuclide brachytherapy ...*) for the actual HDR, depending on the number of source positions required for treatment.

**Catheters:** The physician who placed the catheters should report 55875 (*Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy*).

**Note** — only one physician can report this code.

- Published on 2015-01-01