Clinical Policy Title: Transvaginal and transabdominal ultrasound

Clinical Policy Number: 13.01.02

Effective Date: Sept. 1, 2015
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Most Recent Review Date: July 15, 2015
Next Review Date: July, 2016

ABOUT THIS POLICY: Arbor Health Plan has developed clinical policies to assist with making coverage determinations. Arbor Health Plan’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Arbor Health Plan when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Arbor Health Plan’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Arbor Health Plan’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Arbor Health Plan will update its clinical policies as necessary. Arbor Health Plan’s clinical policies are not guarantees of payment.

Coverage Policy

Arbor Health Plan considers the utilization of transvaginal ultrasound (TVUS) and transabdominal ultrasound (TAUS) to be clinically proven and, therefore, medically necessary for the indications specified herein.

The combined use of TAUS and TVUS is clinically proven and medically necessary when either study is insufficient to provide adequate diagnosis.

Limitations:

The combined use of TAUS and TVUS is not clinically proved and therefore not medically necessary in the following circumstances:

You can have this information in other languages and formats at no charge to you. You can also have this interpreted over the phone in any language. Call Member Services at 1-866-935-6760. For TTY, call 1-866-209-6421.

Screening for ovarian cancer with or without serum marker CA-125 in asymptomatic women in the absence of heritable disease
Screening for endometrial cancer in asymptomatic women in the absence of heritable disease
Determination of gender of fetus
Three-dimensional (3-D) or four-dimensional (4-D) ultrasounds

All other uses of TRUS and TAUS are not medically necessary.

Alternative Covered Services:

- Plain radiographs of the abdomen and/or pelvis (with the diagnostic exception of possible or known pregnancy)
- Organ-specific radiographs with contrast (including air insufflation) such as cystography, or hysterosalpingography (with the diagnostic exception of possible or known pregnancy)
- Computed tomography of the abdomen with or without contrast (with the diagnostic exception of possible or known pregnancy)
- Computed tomography of the pelvis with or without contrast (with the diagnostic exception of possible or known pregnancy)
- Magnetic resonance imaging of the abdomen (with the diagnostic exception of possible or known pregnancy)
- Magnetic resonance imaging of the pelvis (with the diagnostic exception of possible or known pregnancy)
- Organ-specific diagnostic procedures such as cystoscopy, hysteroscopy, anoscopy, or sigmoidoscopy.

Background

Use of transvaginal and transabdominal ultrasound – TVUS and TAUS are generally considered to be safe and medically indicated for:

- Confirmation of the presence of an intrauterine pregnancy.
- Evaluation of a suspected ectopic pregnancy.
- Estimation of gestational (menstrual) age.
- Confirmation of fetal cardiac activity.
- Imaging as an adjunct to chorionic villus sampling, embryo transfer, and localization and removal of an intrauterine device (IUD).
- Assessing for certain fetal anomalies, such as anencephaly, in high risk patients.
- Evaluation of pelvic masses and/or uterine abnormalities.
- Measuring the nuchal translucency (NT) when part of a screening program for fetal aneuploidy.
- Evaluation of suspected hydatidiform mole.
- Follow-up evaluation of a fetal anomaly.
- Evaluation of fetal anatomy.
- Evaluation of fetal growth.
• Evaluation of abnormal vaginal bleeding.
• Evaluation of abdominal or pelvic pain.
• Evaluation of cervical insufficiency.
• Evaluation of endometrial thickness.
• Adjunct to cervical cerclage placement.
• Determination of fetal presentation.
• Diagnosis or evaluation of suspected multiple gestation.
• Adjunct to amniocentesis or other procedure.
• Adjunct to follicle puncture for egg retrieval for in vitro fertilization (IVF)
• Adjunct to ovarian cyst puncture and/or aspiration
• Adjunct to embryo transfer in “fresh” IVF cycle, cryopreservation and/or egg donation
• Adjunct to sonohysterography
• Evaluation of cervical length
• Evaluation of significant discrepancy between uterine size and clinical dates.
• Evaluation of pelvic mass.
• Suspected fetal death.
• Suspected uterine abnormality.
• Suspected amniotic fluid abnormalities.
• Suspected placental abruption.
• Adjunct to external cephalic version.
• Evaluation of premature rupture of membranes and/or premature labor.
• Evaluation of abnormal biochemical markers.

**Methods**

**Searches:**

Arbor Health Plan searched PubMed and the databases of:

• Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.

• The Centers for Medicare & Medicaid Services.

Searches were conducted on May 20-21, 2015, using the terms “transvaginal,” “transabdominal” and “ultrasound.”

Included were:

• Systematic reviews, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
• Guidelines based on systematic reviews.

• Randomized Clinical Trials which are clinical trials of a therapeutic agent’s efficacy, in which patients are randomly assigned to different treatment, placebo, or "gold standard" arms of a study.

• Economic analyses, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

Findings

Transvaginal ultrasound is considered to be materially distinct and separate from transabdominal ultrasound of the abdomen. TVUS provides superior imaging of pelvic structures (i.e., uterus, cervix, ovaries and adnexae). Moreover, TVUS requires special instrumentation apart from the abdominal transducer employed for TAUS examination and specialized training and materials to perform. Prudent practice may also require a chaperone for TVUS procedures as performed by either a male or female technician.

There are limitations to TAUS with regard to the deep pelvic organs (i.e., the reproductive organs) that can only be overcome by the transvaginal approach. For example, a calculus of the bladder or implanted mesh to the lower abdomen may create acoustic shadowing that limits adequate visualization of pelvic anatomy from the anterior approach.

Finally, there are instances where TVUS-guided aspiration and/or biopsy of pelvic organs facilitates patient safety by putting the ultrasound probe close to if not directly at the site of a suspicious mass or cyst. For example, a patient presenting with new pelvic pain following radical cystectomy for carcinoma of the bladder in whom there is suspicion of cancer recurrence may be biopsied without risk of transperitoneal insertion of a biopsy needle. The same technical considerations hold true for any pelvic exenterative surgery for carcinoma, including cancer of the uterus, cervix or rectum.

The utilization of TVUS and TAUS in combination may reduce overall investigative cost and surgical delay in the diagnosis of appendicitis (Bondi, 2012). Bertucci (2011) found utilization of TVUS and TAUS in combination facilitated chorionic villus sampling.

Screening for ovarian cancer in asymptomatic women is not recommended by the U.S. Preventive Services Task Force (USPSTF). There is no evidence that a benefit exists from screening for ovarian cancer. (USPSTF, 2012) This recommendation does not apply to women with known genetic mutations (e.g., BRCA mutations) that increase their risk for ovarian cancer.

The Prostate, Lung, Colon and Ovarian (PLCO) study considered data from the first 4 annual screens and found 89 invasive ovarian or peritoneal cancers were diagnosed; 60 were screen-detected (Partridge, 2009). The positive-predictive value (PPV) and cancer yield per 10,000 women screened on the combination of tests were similar across screening rounds (range of 1.0 % to 1.3 % for PPV and 4.7 to 6.2
for yield); however, the biopsy (surgery) rate among screen positives decreased from 34 % at T0 to 15 % to 20 % at T1-T3.

The overall ratio of surgeries to screen-detected cancers was 19.5:1. A total of 72 % of screen-detected cases were late stage (III/IV). The authors concluded that through 4 screening rounds, the ratio of surgeries to screen-detected cancers was high, and most cases were late stage. However, the effect of screening on mortality is as yet unknown.

The Society of Gynecologic Oncologists (2007) recommends that symptomatic women (i.e., bloating, pelvic pain, abdominal pain, dysphagia or early satiety) see a gynecologist if symptoms persist for more than 3 weeks. If there is suspicion of cancer the clinician may choose to perform a TVUS to check the ovaries for signs of malignancy.

Stratifying women into risk groups based on family history slightly enhances the positive predictive values of a combined CA-125 and TVUS-based screening approach (Lacey, 2006).

Whether screening for ovarian cancer with or without serum marker CA-125 and TVUS proves to be efficacious, cost-effective, or clinically useful in screened populations awaits the results of the Prostate, Lung, Colon and Ovarian (PLCO) and other cancer screening studies. PLCO participants are being followed and additional data will be collected through 2015.

**Screening for endometrial cancer.** The National Cancer Institute (NCI, 2004) has stated that there is insufficient evidence to establish whether a decrease in mortality from endometrial cancer occurs with screening asymptomatic women by TVUS. The NCI notes that risks associated with false-positive test results include anxiety and additional diagnostic testing and surgery. In addition, endometrial cancers may be missed by ultrasound.

However, Meyer (2009) stated that about 2 % to 5 % of endometrial cancers may be due to an inherited susceptibility. Lynch syndrome (also known as hereditary non-polyposis colorectal cancer syndrome) accounts for the majority of inherited cases. Current gynecologic cancer screening guidelines for women with Lynch syndrome include annual endometrial sampling and TVUS beginning at age 30 to 35 years. The authors concluded that diagnosing endometrial cancer patients with Lynch syndrome has important clinical implications for the individual and family members, and that screening for endometrial cancer with TVUS in this cohort can decrease the likelihood of developing additional cancers.

### Summary of Clinical Evidence

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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<tbody>
<tr>
<td>ACR Appropriateness Criteria: Abnormal vaginal bleeding (2014)</td>
<td><strong>Transvaginal Ultrasound (p.5) (Level C)</strong>&lt;br&gt;• “TVUS is generally the initial imaging procedure of choice for evaluating abnormal vaginal bleeding due to its ability to depict endometrial pathology, its widespread availability, and its excellent safety profile and cost effectiveness.”</td>
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</table>
Transabdominal Ultrasound (p.6-7) (Level C)
- “TAUS is usually performed in conjunction with TVUS, and the two techniques are complementary.”
- “Transabdominal scanning offers a wider field of view, increased depth of penetration, and an ability to evaluate adjacent organs.”
- “A transabdominal approach is particularly helpful for evaluating a markedly enlarged fibroid uterus, especially if there is extension of subserosal or pedunculated fibroids out of the pelvis.”
- “However, optimum evaluation of the endometrium generally requires TVUS, which allows for higher resolution imaging. If the transvaginal probe cannot be tolerated, as is often the case in a prepubertal or virginal patient, TAUS using the urinary bladder as an acoustic window becomes essential.”

USPSTF (2012)
Ovarian cancer screening in asymptomatic women is not recommended. (Level C)
- This recommendation applies to asymptomatic women.
- Women with known genetic mutations that increase their risk for ovarian cancer (for example, BRCA mutations) are not included in this recommendation.

Bondi (2012)
Prospective study found combination TVUS and TAUS reduced investigational costs and unnecessary surgery. (Level C)
- The sensitivity of the combined approach for accurate diagnosis of appendicitis in 299 women was 97.3 per cent, the specificity 91 per cent, the positive predictive value 91.7 per cent, and the negative predictive value 97 per cent. Suggests that combination TVUS and TAUS obviates need for computerized tomography.

ACR Appropriateness Criteria: Multiple gestations (2011)
Initial Ultrasound Examination (p. 3) (Level C)
- TAUS or TVUS are safe and appropriate for patients with suspected multiple gestation pregnancy, or in patients who have already been diagnosed with twins.
Follow-up Ultrasound Examination and Antepartum Surveillance (p. 6) (Level C)
- The discussion section refers to the superior accuracy of TVUS for measuring cervical length and predicting preterm birth in twin pregnancies.

AIUM Practice Guideline for the Performance of Sonohysterography (2011)
Preliminary endovaginal sonography (p.3) (Level C)
- “Preliminary endovaginal sonography (TVUS) with measurements of the endometrium and evaluation of the uterus, ovaries, and pelvic free fluid should be performed before sonohysterography.”

Bertucci (2011)
Retrospective study found combination TVUS and TAUS facilitated chorionic villous sampling (CVS). (Level C)
In 89 of 90 cases in which TVUS manipulation was carried out access to the trophoblast was improved sufficiently that an adequate TAUS CVS to be performed with a single aspiration.

**Champaneria (2010)**

**Systematic review including 2312 females shows high levels of accuracy of TVUS in non-invasive diagnosis of adenomyosis (Level A)**
- Until recently, the reference standard for a definitive diagnosis was histology of hysterectomy specimens.
- Ultrasound and magnetic resonance imaging (MRI) may allow accurate non-invasive diagnosis.

**ACOG Practice Bulletin No. 101 (2009)**

**Guidelines on Ultrasonography in Pregnancy (Level C)**
- Advises consideration of TVUS or “transperitoneal” US if the cervix appears shortened.
- Does not recommend routine cervical length (CL) assessment in low risk pregnancies because of the lack of evidence supporting this application, other than a demonstrated association between short cervix and preterm delivery.
- Suggests that serial assessment of CL may be useful in certain women at high risk of pre-term birth.

**Partridge (2009)**

**Multicenter randomized controlled trial: Ovarian cancer screening with TVUS and CA-125 in the Prostate Lung Colon Ovarian (PLCO) cancer study (Level B)**
- Data from the first 4 annual screens among 34,261 women concluded that surgical intervention for screen-detected cancers was high, and most cases were late stage. However, the effect of screening on mortality is as yet unknown.

**Meyer (2009)**

**Narrative review: Lynch syndrome (hereditary non-polyposis colorectal cancer syndrome) (Level C)**
- Current gynecologic cancer screening guidelines for women with Lynch syndrome include annual endometrial sampling and TVUS beginning at age 30 to 35 years. The authors concluded that screening and prevention practices can decrease the likelihood of developing additional cancers.

**Hudelist and Keckstein (2009)**

**Systematic review including 1106 women shows high levels of accuracy of TVUS in non-invasive diagnosis of bowel-infiltrating endometriosis (Level A)**
- The prevalence of deeply infiltrating endometriosis (DIE) varied from 24 to 73.3 %. The authors concluded that TVUS with or without the use of prior bowel preparation is an accurate test for non-invasive, pre-surgical detection of DIE of the rectosigmoid.

**AIUM Practice Guideline for Ultrasonography in Reproductive Medicine (2008)**

**Cul-de-sac (p.2) (Level C)**
- “A transvaginal examination may be helpful to distinguish a suspected mass from fluid and feces within the normal rectosigmoid.”

**Ultrasound-Guided Procedures (p. 3) (Level C)**
Follicle Puncture: Ultrasound-assisted (transvaginal or transabdominal) follicle puncture for retrieving eggs for in vitro fertilization (IVF) is appropriate in the following circumstances:

1. The patient has undergone comprehensive sonographic evaluation of the pelvis within 4 to 6 months prior to the start of hormonal stimulation of the ovaries.
2. Real-time continuous guidance is available, and the image demonstrates a safe approach for the needle path.
3. The ovaries can be brought in close proximity to the ultrasound transducer, thus avoiding the puncture of vital structures (e.g., bowel and blood vessels).

Cyst Aspiration: Ultrasound-assisted (transvaginal or transabdominal) ovarian cyst puncture and aspiration is appropriate in patients who have been diagnosed with a persistent ovarian cyst and who meet the following criteria:

1. Failed resolution of the cyst following observation and/or hormonal manipulation.
2. The cyst is unilocular and thin-walled without internal excrescences or septations.
3. Real-time continuous guidance is available, and the image demonstrates a safe approach for the needle path.
4. The cyst can be brought in close proximity to the ultrasound transducer, thus avoiding the puncture of vital structures (e.g., bowel and blood vessels).

Embryo Transfer: Ultrasound-assisted embryo transfer is appropriate in patients undergoing a “fresh” in vitro fertilization (IVF) cycle or following embryo cryopreservation or embryo/egg donation. If an abdominal ultrasound examination is performed, the bladder should be full to facilitate visualization of the endometrium and the transfer catheter.

Ultrasound Examination of the Female Pelvis in the First 10 Weeks (Embryonic Period) of Pregnancy (p.4) (Level C)

Consensus statement to promote early detection of ovarian cancer (Level C)

- Recommends that women who have symptoms -- specifically bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, and urinary frequency and urgency -- are urged to see a gynecologist if symptoms are new and persist for more than 3 weeks.
- If there is a suspicion of cancer, the clinician may choose to perform a TVUS to check the ovaries for signs of cancer.
<table>
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<tr>
<th>Bazot (2007)</th>
<th>Prospective study compared found TVUS superior to transrectal ultrasound (TRUS) for the diagnosis of DIE (Level C)</th>
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<td></td>
<td>• TVUS and TRUS, respectively, had a sensitivity of 87.3 % and 74.7 %, a PPV of 98.6 % and 98.3 %, and an accuracy of 86.4 % and 74 %. The authors concluded that TVUS is more accurate than TRUS for predicting DIE in specific locations</td>
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<th>Lacey (2006)</th>
<th>Systematic review of 28,460 women with a history of breast or ovarian cancer does not prove benefit to screening for ovarian cancer with TVUS and CA-125 serum marker (Level A)</th>
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<td>• Classified women as average (n = 22,687), moderate (n = 2,572), or high (n = 2,163) risk based on family history, or high risk due to a personal history of breast cancer (n = 1,038).</td>
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<td>• The positive predictive values for abnormal screening results were 0.7 % in average-risk, 1.3 % in moderate-risk, and 1.6 % in high-risk groups; 1 ovarian cancer occurred among the breast cancer survivors.</td>
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<td></td>
<td>• The authors concluded that the probabilities of abnormal annual CA-125 and TVUS screens were similar across groups based on family history of breast or ovarian cancer.</td>
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<td>• The authors noted that ongoing studies, including the Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial, will ascertain the efficacy of ovarian cancer screening.</td>
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<td>• PLCO participants are being followed and additional data will be collected through 2015.</td>
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<td>• Until the results of these studies are available, the findings of this analysis demonstrated that stratifying women into risk groups based on family history slightly enhanced the positive predictive values of a combined CA-125 and TVUS-based screening approach.</td>
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<td>• These researchers stated that whether these differences prove to be efficacious, cost-effective, or clinically useful in screened populations awaits the results of the PLCO and other cancer screening studies.</td>
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<tr>
<th>ACOG Committee Opinion No. 48 (2004)</th>
<th>Bulletin on Cervical Insufficiency (Level C)</th>
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<td></td>
<td>• Serial US examinations should be considered in a patient with historical risk factors for cervical insufficiency and should be initiated between 16 and 20 weeks of gestation or later.</td>
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<tr>
<th>NCI (2004)</th>
<th>Statement on screening for endometrial cancer (Level C)</th>
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<tr>
<td></td>
<td>• The National Cancer Institute has stated that there is insufficient evidence to establish whether a decrease in mortality from</td>
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| **Persadie (2002)** | **Narrative review of transvaginal ultrasound (TVUS) promotes its superior detail in imaging pelvic structures (Level C)**  
- Measurement of endometrial thickness with ultrasonography is a modality in common clinical use today.  
- In pre-menopausal women, measurement of endometrial thickness is used to monitor infertility treatment.  
- In post-menopausal women with abnormal uterine bleeding it is useful as an initial investigation for endometrial hyperplasia or cancer. |
| | **ACOG Practice Bulletin No. 27 (2001)**  
**Guidelines on prenatal diagnosis of fetal chromosomal abnormalities (p.1) (Level C)**  
- “This guideline describes the key elements of standard sonographic examinations in the first trimester and second and third trimesters, a more detailed anatomic examination of the fetus may be necessary in some cases, such as when an abnormality is found or suspected on the standard examination or in pregnancies at high risk for fetal anomalies.” |

**Glossary**

**ACOG** — American College of Obstetricians and Gynecologists.

**ACR** — American College of Radiologists.

**AIUM** — American Institute of Ultrasound in Medicine.

**NCI** – National Cancer Institute

**Soc Gyn Onc** – Society of Gynecologic Oncologists

**USPSTF** – U.S. Preventive Services Task Force

**Transabdominal ultrasound (TAUS)**— Transabdominal means ultrasound with the probe outside the body studying structures above the iliac crests (e.g., hepatic ultrasound)

**Transpelvic ultrasound** – Transpelvic means ultrasound of the probe outside the body studying structures below the iliac crests (e.g., ultrasound of uterus and ovaries).

**Transvaginal ultrasound** – Transvaginal means ultrasound with the probe in the vagina with the probe tip usually against the cervix, etc.
**Ultrasound** – The application of ultrasonic waves to therapy or diagnostics, as in deep-heat treatment of a joint or imaging of internal structures.

**References**

**Professional society guidelines/others:**


**Peer-reviewed references:**


Personal Correspondence:

Raymond Tu MD MS FACR
Chairman, Department of Radiology, Vice Chief of Staff, NFPHC/United Medical Center, Clinical Associate Professor, Radiology, The George Washington University, Washington, DC

Clinical Trials:

See summary of clinical evidence section.

Centers for Medicare and Medicaid Services (CMS) National Coverage Determination (NCD)

National Coverage Determination (NCD) for Ultrasound Diagnostic Procedures (220.5)
Effective 5/22/2007

Local Coverage Determinations (LCD)

Search for TVUS or TAUS returned no results.

Commonly Submitted Codes
Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and
bill in accordance with those manuals. Further guidance is available in the ACR "Frequently Asked Questions" appended to this document. (Appendix 1)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>76830</td>
<td>Ultrasound, transvaginal</td>
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<tr>
<td>76856</td>
<td>Ultrasound, pelvic (nonobstetric), real time with image documentation; complete</td>
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<tr>
<td>78657</td>
<td>Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or followup</td>
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<tr>
<th>ICD-9 Code</th>
<th>Description</th>
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<th>ICD-10 Code</th>
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<th>HCPCS Level II</th>
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Appendix 1:

**Frequently Asked Questions on Ultrasound Coding**
Because of the recent Office of Inspector General (OIG) report recommending that the Centers for Medicare & Medicaid Services monitor ultrasound claims for questionable coding practices, the following Q&As, previously published in ACR publications, are provided as a review of appropriate ultrasound coding guidelines. The guidance provided in these answers will be helpful to defend your billing practices should you be audited.

1. Is it appropriate to report the nonobstetrical transvaginal sonogram of the pelvis code (76830) in combination with other abdominal and/or OB/GYN sonogram codes?

The ACR’s Ultrasound Coding User’s Guide states that the pelvic ultrasound using a full bladder as a window to the pelvis and a transvaginal ultrasound using a vaginal probe as a window to the pelvis are separately coded procedures. A common practice is for ultrasound departments to begin with a pelvic ultrasound performed through a full bladder and to supplement the examination with a transvaginal examination when necessary. Use 76856 or 76857, as appropriate, for the pelvic ultrasound procedure. Add 76830 for the transvaginal ultrasound. When the transvaginal examination is used as the only technique, use 76830 to code for the procedure.

This has been a long-standing ACR coding guideline that was first published in an October 1993 Radiology Business Management Association Bulletin coding article. The article titled Transvaginal Sonogram of the Pelvis (76830) stated:

“In order to properly evaluate a patient it is often necessary to perform additional studies during one session. These studies are done in order to acquire additional clinical information not evident from the initial study, or to further investigate an area that appears suspicious or problematic. Performing a transabdominal and a transvaginal pelvic sonogram at one sitting is an example of this type of evaluation.

Transvaginal sonogram is used for both obstetrical and non-obstetrical evaluations. This procedure represents the performance and interpretation of the pelvis structures including the uterus, endometrium, ovaries, and adnexa. A special probe is used transvaginally to aid in such studies as fetal viability, ectopic pregnancies, harvest of ova, and fertility studies.”

If a woman has vaginal bleeding, a transvaginal scan is needed to assess the endometrium at higher resolution than that available with the transabdominal probe. If an adnexal mass is visualized, a transvaginal examination allows for improved characterization of the internal characteristics of the mass.

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.