Priority Health	BILLING POLICY No. 056
PELVIC AND TRANSVAGINAL ULTRASOUND	
Date of origin: Nov. 12, 2024	**Review dates: 2/2025, 2/2026,9/2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation for pelvic and transvaginal, ensuring claims are processed according to contractual agreements and industry standards for pelvic and transvaginal ultrasound.

DEFINITION

A pelvic and transvaginal ultrasound is a diagnostic imaging procedure that uses high-frequency sound waves to produce detailed images of the female pelvic organs, including the uterus, ovaries, cervix, and surrounding structures.

POLICY SPECIFIC INFORMATION

When pelvic and transvaginal ultrasounds are performed concurrently, the pelvic ultrasound service would be considered inclusive to transvaginal ultrasound. Pelvic ultrasounds are clinically integral to the transvaginal examination and don't warrant separate reimbursement. A transvaginal ultrasound (TV-US) provides superior detail in images of pelvic structures.

Coding specifics

CPT Code	Description
76856	**Ultrasound exam pelvic, complete**
76857	**Ultrasound exam pelvic, limited**
76830	**Ultrasound, transvaginal**
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
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal

76856 is a complete evaluation and must minimally include:

1. Female: description and measurements of the uterus and adnexal structures, measurement of the endometrium and bladder, and a description of any pelvic pathology.
2. Male: evaluation and measurement of the bladder, evaluation of the prostate and seminal vesicles and any pelvic pathology.

76857 is a limited study and typically focuses on one or more elements listed under **76856** and/or the reevaluation of one or more pelvic abnormalities.

76830 assess the reproductive organs, that is, the uterus, fallopian tubes, ovaries, cervix and vagina in a female patient.

76801 will be denied when billed with **76817** OR **76830.**

76856 will be denied when billed with **76817** OR **76830**.

76857 will be denied when billed with **76817** OR **76830.**

Modifiers

- **26**: Professional component
- **TC**: Technical component
- 59: Modifier used to indicate a distinct procedural service
- **76**: Repeat procedure or service, on the same day, by the same physician or other qualified healthcare professional
- **77**: Repeat procedure by another physician or other qualified healthcare professional in a separate encounter on the same day.

Unbundling of the procedures is allowed if the procedures are done at separate times on the same date of service (e.g., morning and evening, different providers) with a valid reason. If done on the same day, documentation will be required to prove why a second, separate exam was done. Medical records will need to be submitted with an appeal.

Documentation requirements

76856 & 76857

- The medical record must contain clear documentation of medical necessity for performing pelvic ultrasonography (e.g., history, physical findings, and/or laboratory/imaging studies).
- A permanent record of the sonographic examination and its interpretation must be in the patient's record and made available to Medicare upon request.

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- Reason for performing the transvaginal ultrasound
- Date and time of the procedure
- Specific reproductive organs assessed during the procedure
- Findings or abnormalities observed during the ultrasound
- Signature of the healthcare provider performing the procedure

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section
Feb. 18, 2026	Reviewed- No updates
Sept. 2026	Added Policy overview, definition and added CPT codes to coding specific sections. Also, Modifier 59 has been added to the modifier section.