PRIME POCUS LEARNING NETWORK

POCUS Billing and Coding

A CPT coding reference for point-of-care ultrasound in family medicine: by code, by application and by tier.

Read this first. This is an educational reference, not billing, coding or legal advice. Always work with your professional billers and coders, and with the relevant compliance office at your institution, before billing any of these codes. Coverage, bundling edits and payment vary by payer and locality.

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NAVIGATE

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SECTION 1

Coding basics

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How a scan is billed, and each modifier with a POCUS example.

SECTION	ITEM	WHAT IT MEANS AND WHEN TO USE IT
Read this first	**Disclaimer**	This is an educational reference, not billing, coding or legal advice. Always work with your professional billers and coders, and with the relevant compliance office at your institution, before billing any of these codes. Coverage, bundling edits and payment vary by payer and locality.
How a scan is billed	**Global (no modifier)**	The whole service: the technical component (machine, supplies, staff) plus the professional component (interpretation and report). Use it when your practice owns the ultrasound machine and you interpret the scan in a non-facility office. Example: 76705 with no modifier in a freestanding clinic.
	26 - Professional component	Interpretation and report only. Use it when someone else owns the machine and bills the technical part: hospital-based clinics, the emergency department, inpatient units. All of the work RVU sits here. Example: 93308-26 for a limited echo on the wards.
	TC - Technical component	Equipment, supplies and staff only, with no physician interpretation. Billed by whoever owns the machine when a different entity bills the interpretation. Clinicians doing POCUS rarely bill TC themselves; in hospital settings the facility captures it on its own claim.
	Codes with no 26/TC split	Procedure codes (20604, 20606, 20611, 49083, 32555, 36556, 62270 and similar) have no technical component and take neither modifier: they pay one fee at the office or the facility rate. 51798 (bladder scanner) is technical only, with no physician work.
Side and site modifiers	**RT - Right side / LT - Left side**	Identify the side on codes that describe one side of the body: 76882, 76881, 76642, 76512, 93971 and the joint injection codes. Example: 76882-RT for a right knee effusion.
	50 - Bilateral procedure	The same unilateral service done on both sides at one session. Payers differ: some want one line with 50, others two lines with RT and LT. Example: bilateral knee injections, 20611-50. Do not use on codes that already cover both sides: 76604 (one unit for both lungs) and 93971 (a limited study of both legs is still one unit).

SECTION	ITEM	WHAT IT MEANS AND WHEN TO USE IT
Same-day and repeat services	**25 - Separately identifiable E/M**	Goes on the office visit code, not the ultrasound code, when a visit and a procedure with a global period happen the same day. Example: 99214-25 with 20611. Usually not needed when the only other service is a diagnostic ultrasound, though some payers ask for it.
	59 - Distinct procedural service (or XE, XS, XP, XU)	Says that two services which normally bundle were truly separate: a different site, session or structure. Examples: 76816-59 for each additional fetus; a diagnostic 76882 of the left knee on the day of a guided right shoulder injection. Medicare prefers the more specific X modifiers (XS separate structure, XE separate encounter). Use sparingly and only with documentation that supports it.
	76 - Repeat by the same clinician	The same scan repeated later the same day by the same clinician for a new clinical reason. Example: a second limited echo, 93308-76, after a change in status. Each scan needs its own images and report.
	77 - Repeat by another clinician	The same scan repeated the same day by a different clinician. Example: a second limited abdominal scan by the admitting team after one in the emergency department.
Other modifiers	**52 - Reduced services**	Where a limited code exists, use it instead of 52: a partial abdominal exam is 76705, not 76700-52. Where no limited code exists, 52 is the way to show a focused exam: a transvaginal scan for IUD location only can be reported as 76830-52, and a focused transvaginal scan in pregnancy as 76817-52 (per ACEP and the CPT ultrasound guidelines). Payers handle 52 differently, some reduce payment or review the claim, and some coding sources consider it unnecessary on these codes, so follow your coders.

SECTION 2

By code

Each code opens with what it is used for and closes with general notes on the code.

Contents ↑

76882 Limited extremity ultrasound

Diagnostic - limited | 2026 work RVU: 0.67

Musculoskeletal	**Joint effusion (knee, shoulder, hip)**	Always this code whichever joint is scanned: suprapatellar recess of the knee (Tier 1), glenohumeral joint or subacromial bursa of the shoulder (Tier 5), elbow, ankle, hip. Report RT/LT. If you go on to aspirate or inject under ultrasound, report the guided-injection code (20611, 20606 or 20604) rather than adding a guidance code.
	Baker's cyst	Focal posterior knee exam. Report RT/LT.
	Ganglion cyst	Focal exam of the wrist or hand. Report RT/LT.
	Carpal tunnel syndrome	Focal median-nerve exam at the wrist with cross-sectional area. Report RT/LT. Not the comprehensive nerve code 76883.
	Achilles tear	Focal tendon exam. Report RT/LT.
	Fracture	Focal bony exam of an extremity. Report RT/LT. Rib fracture is 76604.
	Hematoma	Use when the hematoma is on an extremity (report RT/LT). Document size.
Soft Tissue	**Abscess, cellulitis and edema**	Use when the finding is on an extremity (report RT/LT). Document cobblestoning versus a drainable collection, with size and depth.
	Lipoma and epidermal inclusion cyst	Use when the lesion is on an extremity (report RT/LT). Document size, depth and internal characteristics.
	Foreign body	Use when the foreign body is on an extremity (report RT/LT). Document depth and relation to nearby structures.
Procedural	**Soft-tissue procedures (abscess drainage, foreign body removal, mass removal)**	The procedure codes (10060/10061, 10160, 10120/10121, excision codes) contain no ultrasound. The scan that finds, measures or characterizes the target is billable as a diagnostic study, using the soft-tissue code for the body region (76882 on an extremity), when an image is saved and findings are reported. Not together with 76942 for the same scan.

General notes on code 76882. The workhorse MSK and extremity soft-tissue code: a focused look at one joint or one structure (tendon, muscle, nerve, soft tissue, mass). Extremity sites only; other body regions use their own site codes. Report per extremity with RT/LT. Companion complete code 76881 (complete joint) requires the joint space plus all peri-articular structures (tendons, muscles, nerves, other soft tissue) to be imaged and reported, which a focused POCUS question rarely does. 76883 (comprehensive nerve, entire course in one extremity) is not the code for a focal median-nerve look.

76705 Limited abdominal ultrasound

Diagnostic - limited | 2026 work RVU: 0.58

Abdominal and Hepatobiliary	**Free fluid in abdomen**	Focused scan for free fluid. One unit even if several quadrants are scanned.
	Gallbladder (cholelithiasis, cholecystitis, sludge)	One limited right upper quadrant exam answers all three questions. Document stones or sludge, wall thickness, pericholecystic fluid and sonographic Murphy sign.
Musculoskeletal	**Hematoma**	Use when the hematoma is on the abdominal wall or lower back. Document size.

Soft Tissue	**Abscess, cellulitis and edema**	Use when the finding is on the abdominal wall or lower back. Document cobblestoning versus a drainable collection, with size and depth.
	Lipoma and epidermal inclusion cyst	Use when the lesion is on the abdominal wall or lower back. Document size, depth and internal characteristics.
	Foreign body	Use when the foreign body is on the abdominal wall or lower back. Document depth and relation to nearby structures.

General notes on code 76705. Limited = a single organ, a single quadrant or a focused question (free fluid, gallbladder, bowel). Also the code for abdominal-wall and lower-back soft tissue. One unit per session even when several quadrants or organs are scanned. Companion complete code 76700 requires liver, gallbladder, common bile duct, pancreas, spleen, kidneys, upper abdominal aorta and IVC to be imaged and reported (or the reason one was not seen), so it is rarely appropriate for POCUS.

76775 Limited retroperitoneal ultrasound

Diagnostic - limited | 2026 work RVU: 0.57

Renal, Bladder, and Genitourinary	**Kidney (hydronephrosis, nephrolithiasis, simple renal cyst)**	One or both kidneys for a focused question. Document hydronephrosis grade, any visualized stone, and cyst characteristics (simple vs complex).
Vascular	**Abdominal aortic aneurysm - diagnostic**	Diagnostic code: a symptomatic patient, or surveillance of a known aneurysm. Screening an asymptomatic eligible patient is the separately covered preventive code 76706. Never both for the same scan.
	IVC diameter and collapsibility	When the IVC is imaged on its own. Some practices instead use limited echo (93308) when the IVC is assessed as part of a focused cardiac exam, where it is included rather than billed in addition. Confirm locally that a standalone IVC exam is billable.

General notes on code 76775. Limited retroperitoneal = kidney(s), aorta or IVC for a focused question. Kidneys and aorta at the same session are still one unit. Companion complete code 76770 requires kidneys, abdominal aorta, common iliac artery origins and IVC (or, for a urinary tract indication, a complete evaluation of kidneys and bladder), which is uncommon for POCUS. For the aorta this is the diagnostic code (symptoms, or surveillance of a known aneurysm); one-time screening of an asymptomatic eligible patient is the covered preventive code 76706. Never both for the same scan.

76857 Limited pelvic ultrasound

Diagnostic - limited | 2026 work RVU: 0.49

Renal, Bladder, and Genitourinary	**Bladder (volume, Foley catheter or other foreign body)**	Imaging of the bladder with a saved image and a documented interpretation: volume in three dimensions, catheter balloon position. The technical-only code 51798 is the one to use when no image is retained, typically a nurse measuring volume with a bladder scanner. Never both for the same assessment.
Obstetric and Gynecologic	**Uterus and IUD (IUD identification, uterine position)**	Transabdominal look in a non-pregnant patient. IUD location only when medically indicated (pain, missing strings, difficult insertion), not routinely after insertion.
Musculoskeletal	**Hematoma**	Use when the hematoma is on the pelvic wall, buttock or perineum. Document size.
Soft Tissue	**Abscess, cellulitis and edema**	Use when the finding is on the pelvic wall, buttock or perineum. Document cobblestoning versus a drainable collection, with size and depth.
	Lipoma and epidermal inclusion cyst	Use when the lesion is on the pelvic wall, buttock or perineum. Document size, depth and internal characteristics.
	Foreign body	Use when the foreign body is on the pelvic wall, buttock or perineum. Document depth and relation to nearby structures.

General notes on code 76857. Limited or follow-up pelvic exam: bladder, transabdominal look at the uterus or an IUD, and pelvic-wall soft tissue. Companion complete code 76856 requires the full pelvis (female: uterus, endometrium, adnexa and bladder; male: bladder, prostate and seminal vesicles), so it is less used for POCUS. A technical-only alternative, 51798, is the code when no image is retained, for example a nurse measuring volume with a bladder scanner; never report both for the same bladder assessment. Not for pregnant patients (use the OB codes).

76815 Limited OB ultrasound

Diagnostic - limited | 2026 work RVU: 0.63

Obstetric and Gynecologic	**Limited obstetric exam (fetal presentation, intrauterine pregnancy, fetal heart rate, pregnancy dating by crown-rump length, placental location, multiple gestation, amniotic fluid)**	One code and one unit for any combination of these focused questions, regardless of the number of fetuses. Document what was assessed: presenting part; gestational sac with yolk sac or fetal pole within the uterus; heart rate with an M-mode or clip; crown-rump length; placental location; fetal number; qualitative fluid.

General notes on code 76815. The main POCUS OB code. Advantage: no comprehensive-exam requirement. It answers a focused question (fetal heartbeat, presentation, placental location, qualitative amniotic fluid, fetal number, intrauterine location) in any trimester, with one saved image set and a short report. Reported once per exam no matter how many fetuses. Trade-off: lower RVUs than the complete codes. Companion complete codes 76801 (under 14 weeks) and 76805 (14 weeks and over) require a full fetal and maternal survey and are rarely met by a focused scan.

93308 Limited echocardiogram

Diagnostic - limited | 2026 work RVU: 0.52

Cardiac	**Focused cardiac exam (pericardial effusion, HFrEF, right ventricular strain, left ventricular hypertrophy, dilated cardiomyopathy, cardiac tamponade)**	One code and one unit for any combination of these questions. Save clips and document what was assessed: effusion size and chamber collapse, qualitative left ventricular systolic function, right ventricular size relative to the left ventricle and septal position, wall thickness, chamber size.
Vascular	**IVC diameter and collapsibility**	Some practices use limited echo for the IVC: when it is assessed as part of a focused cardiac exam it is included in 93308, not billed in addition. Imaged on its own, the usual code is 76775.

General notes on code 93308. Follow-up or limited TTE: the code for focused cardiac ultrasound (effusion, global left ventricular function, right ventricular size, wall thickness). IVC assessed during the echo is part of this code. Companion complete codes 93306 (with spectral and color Doppler) and 93307 (without Doppler) require all chambers, valves, pericardium and proximal aorta with measurements, and many payers expect an accredited echo lab, so they are not POCUS codes. Doppler add-ons (+93321, +93325) are not typically reported for focused cardiac ultrasound.

93971 Limited venous duplex (DVT)

Diagnostic - limited | 2026 work RVU: 0.44

Vascular	**Lower extremity proximal DVT**	Requires Doppler (spectral and color) in addition to compression, documented by segment.

General notes on code 93971. A duplex code: it requires B-mode compression plus Doppler (spectral and color) documented by venous segment. A compression-only two-region exam does not meet the descriptor, so build Doppler into the DVT template before billing. A limited study of both legs is still one unit of 93971: do not add modifier 50 or bill it twice (the Medicare fee schedule does not allow a bilateral adjustment on this code). Companion complete code 93970 is a complete bilateral duplex study of the full venous system of both legs with spectral and color Doppler, typically done in a vascular lab, so it is rarely appropriate for POCUS.

76642 Limited breast ultrasound

Diagnostic - limited | 2026 work RVU: 0.66

Musculoskeletal	**Hematoma**	Use when the hematoma is in the breast, or the axilla when scanned with the breast (report RT/LT). Document size.
Soft Tissue	**Abscess, cellulitis and edema**	Use when the finding is in the breast, or the axilla when scanned with the breast (report RT/LT). Document cobblestoning versus a drainable collection, with size and depth.
	Lipoma and epidermal inclusion cyst	Use when the lesion is in the breast, or the axilla when scanned with the breast (report RT/LT). Document size, depth and internal characteristics.
	Foreign body	Use when the foreign body is in the breast, or the axilla when scanned with the breast (report RT/LT). Document depth and relation to nearby structures.

General notes on code 76642. Focused breast exam (abscess, cyst, focal mass); includes the axilla when scanned with the breast. Unilateral: report RT/LT, and follow payer rules (modifier 50 or two lines) if both sides are scanned. Companion complete code 76641 requires all four quadrants and the retroareolar region.

76830 Transvaginal ultrasound, non-OB (complete only)

Diagnostic - single code (no limited version) | 2026 work RVU: 0.67

Obstetric and Gynecologic	**Uterus and IUD (IUD identification, uterine position)**	When the scan is transvaginal, including a position check after a difficult IUD insertion when indicated. No limited version; the probe needs high-level disinfection. Consider modifier 52 for a focused scan, since no limited code exists.

General notes on code 76830. There is no limited transvaginal code: any transvaginal scan in a non-pregnant patient, however focused, is 76830. Because no limited code exists, a focused scan that does not cover the full exam (for example IUD location only) can be reported with modifier 52 (reduced services), as ACEP and the CPT ultrasound guidelines describe; payers handle 52 differently and some coding sources consider it unnecessary, so follow your coders. Requires high-level disinfection of the probe between patients plus a single-use probe cover. Be aware that high-level disinfection requirements may add significant expense and logistic challenge to incorporation of transvaginal ultrasound into practice (see the AIUM high-level disinfection guideline). May be reported with 76857 when transabdominal and transvaginal exams are each medically necessary and separately documented; check payer edits.

76817 Transvaginal OB ultrasound (complete only)

Diagnostic - single code (no limited version) | 2026 work RVU: 0.73

Obstetric and Gynecologic	**Transvaginal obstetric exam (intrauterine pregnancy, fetal heart rate, pregnancy dating by crown-rump length)**	The same focused questions when the scan is transvaginal, typically in early pregnancy. No limited version; the probe needs high-level disinfection. Consider modifier 52 for a focused scan, since no limited code exists.

General notes on code 76817. There is no limited transvaginal OB code: any transvaginal scan in pregnancy is 76817. Because no limited code exists, a focused scan that does not cover the full exam (for example confirming an intrauterine pregnancy or fetal heartbeat only) can be reported with modifier 52 (reduced services), as ACEP and the CPT ultrasound guidelines describe; payers handle 52 differently and some coding sources consider it unnecessary, so follow your coders. Requires high-level disinfection of the probe between patients plus a single-use probe cover. Be aware that high-level disinfection requirements may add significant expense and logistic challenge to incorporation of transvaginal ultrasound into practice (see the AIUM high-level disinfection guideline). May be performed alone or in addition to a transabdominal exam; check payer edits before pairing with 76815.

76604 Chest or lung ultrasound (single code)

Diagnostic - single code (no limited version) | 2026 work RVU: 0.58

Pulmonary	**Lung and pleura (pulmonary edema, pleural effusion, pneumonia, pneumothorax)**	One unit per session for any combination, even when both sides are scanned. Document findings by zone: B-lines, effusion, consolidation, lung sliding or lung point. Not billed for the localization scan when you go on to thoracentesis (32555).
Musculoskeletal	**Rib fracture**	Focal look at a rib. Extremity fractures are 76882.
	Hematoma	Use when the hematoma is on the chest wall or upper back. Document size.
Soft Tissue	**Abscess, cellulitis and edema**	Use when the finding is on the chest wall or upper back. Document cobblestoning versus a drainable collection, with size and depth.
	Lipoma and epidermal inclusion cyst	Use when the lesion is on the chest wall or upper back. Document size, depth and internal characteristics.
	Foreign body	Use when the foreign body is on the chest wall or upper back. Document depth and relation to nearby structures.

General notes on code 76604. One code for any chest ultrasound: there is no limited/complete pair. Covers lung and pleura as well as soft tissue of the chest wall and upper back, and ribs. One unit per session even when both sides are scanned. Not reported for the localization scan that is part of a thoracentesis (32555).

76536 Head and neck ultrasound (single code)

Diagnostic - single code (no limited version) | 2026 work RVU: 0.55

Ocular and Other HEENT	**Thyroid or neck mass evaluation**	Thyroid, lymph nodes, parotid or neck soft tissue. Not one of the tiered applications.
Musculoskeletal	**Hematoma**	Use when the hematoma is on the head or neck. Document size.
Soft Tissue	**Abscess, cellulitis and edema**	Use when the finding is on the head or neck. Document cobblestoning versus a drainable collection, with size and depth.
	Lipoma and epidermal inclusion cyst	Use when the lesion is on the head or neck. Document size, depth and internal characteristics.
	Foreign body	Use when the foreign body is on the head or neck. Document depth and relation to nearby structures.

General notes on code 76536. One code for any head or neck soft-tissue exam (thyroid, parotid, lymph nodes, neck soft tissue): there is no limited/complete pair. The soft-tissue site code for the head and neck only.

76870 Scrotal ultrasound (single code)

Diagnostic - single code (no limited version) | 2026 work RVU: 0.62

Renal, Bladder, and Genitourinary	**Scrotal evaluation**	Hydrocele, varicocele, mass. Torsion needs Doppler; ask coders about 93976. Not one of the tiered applications.
Musculoskeletal	**Hematoma**	Use when the hematoma is in the scrotum. Document size.
Soft Tissue	**Abscess, cellulitis and edema**	Use when the finding is in the scrotum. Document cobblestoning versus a drainable collection, with size and depth.
	Lipoma and epidermal inclusion cyst	Use when the lesion is in the scrotum. Document size, depth and internal characteristics.
	Foreign body	Use when the foreign body is in the scrotum. Document depth and relation to nearby structures.

General notes on code 76870. One code for scrotum and contents; also the site code for scrotal soft-tissue findings. Torsion evaluation depends on Doppler flow; a limited duplex code (93976) may apply when Doppler is documented, so confirm with your coders.

76512 Ocular ultrasound (B-scan) (single code)

Diagnostic - single code (no limited version) | 2026 work RVU: 0.55

Ocular and Other HEENT	**Retinal detachment**	B-scan of one eye. Report RT/LT.

General notes on code 76512. Diagnostic B-scan of one eye. Unilateral: report RT/LT, or follow payer rules when both eyes are scanned.

76706 AAA screening ultrasound

Diagnostic - screening | 2026 work RVU: 0.54

Vascular	**Abdominal aortic aneurysm - screening**	Covered preventive code: one-time screening of an asymptomatic eligible patient (Medicare: with a referral; family history of AAA, or men 65 to 75 who have smoked at least 100 cigarettes; no deductible or coinsurance). A symptomatic patient or follow-up of a known aneurysm is the diagnostic code 76775.

General notes on code 76706. The covered preventive code: screening only, in an asymptomatic eligible patient. Medicare covers it once per lifetime with a referral for patients with a family history of AAA or men aged 65 to 75 who have smoked at least 100 cigarettes; deductible and coinsurance are waived. A symptomatic patient or follow-up of a known aneurysm is the diagnostic code (76775).

51798 Bladder scanner volume (non-imaging)

Diagnostic - measurement only | 2026 work RVU: 0.00

Renal, Bladder, and Genitourinary	**Bladder volume**	Technical only: no physician work in this code. Use it when no image is retained, typically a nurse measuring volume with a bladder scanner. If you image the bladder, save the image and interpret it, use 76857.

General notes on code 51798. Technical component only: the code carries no physician work and no professional component. It is the code to use when no image is retained, typically a nurse using a bladder scanner. For an automated post-void residual or bladder capacity measurement with no diagnostic image and no physician interpretation. If you image the bladder, save an image and write an interpretation, use 76857 instead. Never both for the same assessment.

76816 OB ultrasound, follow-up

Diagnostic - follow-up | 2026 work RVU: 0.83

Obstetric and Gynecologic	**Follow-up of amniotic fluid or fetal growth**	Re-evaluation after a prior study; per fetus. A first focused fluid check is 76815.

General notes on code 76816. Re-evaluation of fetal growth, amniotic fluid volume or a previously identified abnormality, transabdominal. Reported per fetus (modifier 59 for each additional fetus). Not for a first focused look; that is 76815.

76819 Biophysical profile (no NST)

Diagnostic - OB | 2026 work RVU: 0.75

Obstetric and Gynecologic	**Biophysical profile**	Without a non-stress test; per fetus. With NST use 76818. Not one of the tiered applications.

General notes on code 76819. Biophysical profile scored by ultrasound alone, per fetus. With a non-stress test use 76818.

76881 Complete joint ultrasound

Complete study (reference) | 2026 work RVU: 0.88

General notes on code 76881. Requires the joint space and all peri-articular soft-tissue structures (tendons, muscles, nerves, other soft tissue) plus any abnormality, each imaged and described. Most POCUS joint scans answer one question and are 76882.

76801 Complete OB ultrasound, under 14 wk

Complete study (reference) | 2026 work RVU: 0.97

Obstetric and Gynecologic	**Pregnancy dating by crown-rump length**	Only if every element of the complete first-trimester exam is performed and documented. Focused dating is 76815 or 76817.

General notes on code 76801. Requires number of gestational sacs and fetuses, gestational sac and fetal measurements, survey of visible fetal and placental anatomy, qualitative amniotic fluid or sac shape, and maternal uterus and adnexa. A focused crown-rump length for dating is 76815 (transabdominal) or 76817 (transvaginal). Each additional gestation is +76802.

76805 Complete OB ultrasound, 14 wk and over

Complete study (reference) | 2026 work RVU: 0.97

General notes on code 76805. The fetal anatomic survey: fetal number, biometry, intracranial, spinal and abdominal anatomy, four-chamber heart, cord insertion, placental location, amniotic fluid and maternal adnexa when visible. Not a POCUS code. Each additional gestation is +76810.

20611 Major joint injection with US

Procedure - ultrasound included | 2026 work RVU: 1.07

Procedural	**Major joint aspiration or injection (knee, shoulder, hip)**	Knee joint injection or aspiration is the tiered application (Tier 3); shoulder, hip and the subacromial or trochanteric bursa use the same code. Guidance and permanent recording are built in: do not add 76942. A diagnostic 76882 at the same visit must be a distinct, separately documented study.

General notes on code 20611. Knee, shoulder, hip, subacromial or trochanteric bursa. Ultrasound guidance and the permanent recording are built into the code: do not add 76942. Save an image and document the guidance in the procedure note. Without ultrasound the code is 20610. Bill the drug separately. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

20606 Intermediate joint injection with US

Procedure - ultrasound included | 2026 work RVU: 0.98

Procedural	**Intermediate joint aspiration or injection (wrist, elbow, ankle, AC joint)**	Guidance and permanent recording are built in: do not add 76942.

General notes on code 20606. Wrist, elbow, ankle, AC joint, olecranon bursa. Guidance and permanent recording included: do not add 76942. Without ultrasound the code is 20605. Carpal tunnel injection is not this code (see 20526). Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

20604 Small joint injection with US

Procedure - ultrasound included | 2026 work RVU: 0.87

Procedural	**Small joint aspiration or injection (fingers, toes, thumb CMC)**	Guidance and permanent recording are built in: do not add 76942.

General notes on code 20604. Fingers, toes, thumb CMC. Guidance and permanent recording included: do not add 76942. Without ultrasound the code is 20600. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

49083 Paracentesis with imaging guidance

Procedure - ultrasound included | 2026 work RVU: 1.95

Procedural	**Paracentesis**	Imaging guidance is built in: do not add 76942 or 76705 for the localization scan.

General notes on code 49083. Diagnostic or therapeutic paracentesis with imaging guidance included: do not add 76942 or a diagnostic code for the localization scan. Without imaging the code is 49082. Save an image of the pocket. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

32555 Thoracentesis with imaging guidance

Procedure - ultrasound included | 2026 work RVU: 2.21

Procedural	**Thoracentesis**	Imaging guidance is built in: do not add 76942 or 76604 for the localization scan. Not one of the tiered applications.

General notes on code 32555. Needle or catheter aspiration of the pleural space with imaging guidance included: do not add 76942 or 76604 for the localization scan. Without imaging the code is 32554. If a catheter is left in place for drainage the code is 32557. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

32557 Pleural catheter with imaging guidance

Procedure - ultrasound included | 2026 work RVU: 3.04

Procedural	**Thoracentesis**	When a drainage catheter is left in place.

General notes on code 32557. Percutaneous pleural drainage with an indwelling catheter left in place; imaging guidance included. Without imaging the code is 32556. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

10030 Catheter drainage of fluid collection

Procedure - ultrasound included | 2026 work RVU: 2.68

Procedural	**Soft-tissue procedures (abscess drainage, foreign body removal, mass removal)**	Abscess or other collection only when a drainage catheter is left in place; guidance included.

General notes on code 10030. Only when a drainage catheter is left in place (abscess, hematoma, seroma, cyst); imaging guidance included. Rare in primary care: needle aspiration and incision and drainage are not this code. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

76937 US guidance, vascular access (add-on)

Guidance code - reported with a procedure code | 2026 work RVU: 0.29

Procedural	**Vascular access (central venous catheter, arterial line, difficult peripheral IV)**	Add-on to the access code: 36556 or 36555 central line, 36620 arterial line, 36410 difficult peripheral access. All four documentation elements are required. Routine peripheral IV starts are bundled by Medicare, so guidance for them often goes unpaid.

General notes on code 76937. Add-on code: reported in addition to the access procedure (central line 36556 or 36555, arterial line 36620, difficult peripheral access). Requires four things in the note: evaluation of potential access sites, documented patency of the selected vessel, real-time visualization of needle entry, and a permanently recorded image. A quick pre-scan with a landmark stick does not qualify.

76942 US guidance, needle placement

Guidance code - reported with a procedure code | 2026 work RVU: 0.65

Procedural	**Soft-tissue procedures (abscess drainage, foreign body removal, mass removal)**	Add to the procedure code when the needle or instrument is guided in real time with a saved image. Not together with a diagnostic site code for the same scan.
	Carpal tunnel or tendon sheath injection	Add to 20526 or 20550/20551 when the needle is guided in real time with a saved image.
	Lumbar puncture	Only with real-time needle guidance (62270 + 76942). Landmark marking before the procedure is generally not billable.

General notes on code 76942. Reported alongside a procedure code that has no imaging guidance built in (tendon sheath or carpal tunnel injection, cyst or abscess aspiration, lumbar puncture). Requires real-time guidance of the needle with a saved image and a line in the procedure note. One unit per session. Never with codes that already include guidance (20604, 20606, 20611, 49083, 32555, 32557, 10030), and not with a diagnostic ultrasound code for the same scan at the same session.

36556 Central venous catheter, age 5 and over

Procedure - add an ultrasound guidance code | 2026 work RVU: 1.71

Procedural	**Vascular access (central venous catheter, arterial line, difficult peripheral IV)**	Central line, age 5 and over (36555 under 5). Add +76937 for the guidance.

General notes on code 36556. The line code itself does not include imaging. Report ultrasound guidance with add-on +76937 when all four documentation elements are met. Under age 5 the code is 36555. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

36620 Arterial line

Procedure - add an ultrasound guidance code | 2026 work RVU: 0.98

Procedural	**Vascular access (central venous catheter, arterial line, difficult peripheral IV)**	Arterial line. Add +76937 for the guidance.

General notes on code 36620. Arterial line. Report ultrasound guidance with add-on +76937 when the documentation elements are met. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

36410 Venipuncture needing clinician skill

Procedure - add an ultrasound guidance code | 2026 work RVU: 0.18

Procedural	**Vascular access (central venous catheter, arterial line, difficult peripheral IV)**	Difficult peripheral access requiring clinician skill, per the ACEP guide. Add +76937 for the guidance; confirm payment locally.

General notes on code 36410. The ACEP coding guide pairs ultrasound-guided peripheral IV access with 36410 + 76937 when the clinician's skill is required. Routine IV starts (36000) are bundled by Medicare and not separately paid, so guidance for a routine peripheral IV often goes unpaid. Confirm locally. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

10060 Abscess incision and drainage

Procedure - no ultrasound in the code | 2026 work RVU: 1.19

Procedural	**Soft-tissue procedures (abscess drainage, foreign body removal, mass removal)**	Abscess incision and drainage; 10061 if complicated or multiple.

General notes on code 10060. The I&D codes contain no ultrasound. Two ways ultrasound is captured: (1) a diagnostic soft-tissue scan by body site (for example 76882) when it is a distinct evaluation, such as deciding whether there is a drainable collection, with a saved image and report; or (2) 76942 when the needle or blade is guided in real time. Not both for the same scan. Needle aspiration is 10160. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

10160 Puncture aspiration

Procedure - no ultrasound in the code | 2026 work RVU: 1.22

Procedural	**Soft-tissue procedures (abscess drainage, foreign body removal, mass removal)**	Needle aspiration of an abscess, hematoma or cyst instead of incision.

General notes on code 10160. No ultrasound in the code. Add 76942 when the needle is guided in real time with a saved image, or bill a separate diagnostic site code when the scan was a distinct diagnostic evaluation. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

10120 Foreign body removal

Procedure - no ultrasound in the code | 2026 work RVU: 1.19

Procedural	**Soft-tissue procedures (abscess drainage, foreign body removal, mass removal)**	Foreign body removal, simple; 10121 if complicated.

General notes on code 10120. No foreign-body removal code includes ultrasound. The localization scan is billable as a diagnostic study by body site (for example 76882) when an image is saved and findings are reported; 76942 applies when the instrument is guided in real time. Not both for the same scan. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

62270 Lumbar puncture

Procedure - no ultrasound in the code | 2026 work RVU: 1.19

Procedural	**Lumbar puncture**	Diagnostic lumbar puncture (62272 therapeutic). Add 76942 only for real-time needle guidance.

General notes on code 62270. 62328 and 62329 are for fluoroscopic or CT guidance only, not ultrasound. Ultrasound-guided lumbar puncture is 62270 + 76942 when the needle is guided in real time. Most bedside use is pre-procedure landmark marking, which is not real-time needle guidance and is generally not separately billable; confirm with your coders. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

58300 IUD insertion

Procedure - no ultrasound in the code | 2026 work RVU: 0.98

Procedural	**IUD placement**	IUD insertion. Confirm position afterwards with 76857 or 76830 only when indicated.

General notes on code 58300. Ultrasound is not part of the code and is not routine. To confirm position afterwards when medically indicated (pain, missing strings, difficult insertion), report 76857 (transabdominal) or 76830 (transvaginal). A routine post-insertion check is not billable. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

20526 Carpal tunnel injection

Procedure - no ultrasound in the code | 2026 work RVU: 0.92

Procedural	**Carpal tunnel or tendon sheath injection**	Carpal tunnel injection. Add 76942 for real-time guidance.

General notes on code 20526. Therapeutic injection of the carpal tunnel. Guidance is not included: add 76942 when the needle is guided in real time. Not 20606. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

20550 Tendon sheath injection

Procedure - no ultrasound in the code | 2026 work RVU: 0.73

Procedural	**Carpal tunnel or tendon sheath injection**	Tendon sheath or ligament injection (20551 tendon origin/insertion). Add 76942 for real-time guidance.

General notes on code 20550. Guidance is not included: add 76942 when the needle is guided in real time with a saved image. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

Varies Mass or cyst excision

Procedure - no ultrasound in the code | 2026 work RVU: varies by code

Procedural	**Soft-tissue procedures (abscess drainage, foreign body removal, mass removal)**	Soft-tissue mass or cyst removal; excision code chosen by site and size.

General notes on excision codes. Excision codes (benign lesion excision 11400-11446, or the site-specific soft-tissue tumor excision codes) contain no ultrasound. A preprocedural scan that characterizes or locates the lesion is billable as a diagnostic study by body site when an image is saved and findings are reported. Global procedure code with no technical component: it pays a single fee at the office or the facility rate, and the ultrasound machine is not paid separately.

SECTION 3

By application

Contents ↑

Grouped by organ system. Each row is a code that can be used for that application, and when.

Abdominal and Hepatobiliary

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Free fluid in abdomen	**76705**	Limited abdominal ultrasound	Focused scan for free fluid. One unit even if several quadrants are scanned.
Gallbladder (cholelithiasis, cholecystitis, sludge)	**76705**	Limited abdominal ultrasound	One limited right upper quadrant exam answers all three questions. Document stones or sludge, wall thickness, pericholecystic fluid and sonographic Murphy sign.

Cardiac

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Left ventricular hypertrophy	**93308**	Limited transthoracic echocardiogram	Focused echo; document wall thickness measurement.
Left ventricular systolic function (HFrEF, dilated cardiomyopathy, ejection fraction)	**93308**	Limited transthoracic echocardiogram	Focused echo with qualitative left ventricular systolic function (visual estimate of ejection fraction) and chamber size.
Pericardial effusion and cardiac tamponade	**93308**	Limited transthoracic echocardiogram	Focused echo for effusion. Describe its size and any chamber collapse, and save clips.
Right ventricular strain	**93308**	Limited transthoracic echocardiogram	Focused echo; document right ventricular size relative to the left ventricle and septal position.

Musculoskeletal

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Achilles tear	**76882**	Limited extremity ultrasound (joint or focal structure)	Focal tendon exam. Report RT/LT.
Baker's cyst	**76882**	Limited extremity ultrasound (joint or focal structure)	Focal posterior knee exam. Report RT/LT.
Carpal tunnel	**76882**	Limited extremity ultrasound (joint or focal structure)	Focal median-nerve exam at the wrist with cross-sectional area. Report RT/LT.
	20526	Carpal tunnel injection	Carpal tunnel injection; add 76942 when the needle is guided in real time.

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Fracture	**76882**	Limited extremity ultrasound (joint or focal structure)	Focal bony exam of an extremity. Report RT/LT.
	76604	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Rib fracture.
Ganglion cyst	**76882**	Limited extremity ultrasound (joint or focal structure)	Focal exam of the wrist or hand. Report RT/LT.
Hematoma	**76882**	Limited extremity ultrasound (joint or focal structure)	Finding is on an extremity (arm, leg, hand, foot). Report RT/LT.
	76536	Head and neck soft-tissue ultrasound (one code; no limited or complete version)	Finding is on the head or neck.
	76604	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Finding is on the chest wall or upper back.
	76705	Limited abdominal ultrasound	Finding is on the abdominal wall or lower back.
	76857	Limited pelvic ultrasound (non-obstetric, transabdominal)	Finding is on the pelvic wall, buttock or perineum.
	76642	Limited breast ultrasound, unilateral	Finding is in the breast (axilla when scanned with the breast). Report RT/LT.
	76870	Scrotal ultrasound (one code; no limited or complete version)	Finding is in the scrotum.
Joint effusion (knee, shoulder, hip)	**76882**	Limited extremity ultrasound (joint or focal structure)	Focused look for fluid in one joint: suprapatellar recess of the knee, glenohumeral joint or subacromial bursa of the shoulder, anterior recess of the hip. Report RT/LT.
	20611	Major joint or bursa aspiration/injection with ultrasound guidance	If you aspirate or inject under ultrasound, report 20611 instead of adding a guidance code.

Obstetric and Gynecologic

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Amniotic fluid, heart rate, presentation, placenta	**76815**	Limited obstetric ultrasound (transabdominal)	One limited transabdominal exam answers any of these: qualitative amniotic fluid, heart rate (save an M-mode or clip), presenting part, placental location. One unit per exam regardless of the number of fetuses.
	76817	Transvaginal obstetric ultrasound (complete; no limited code)	When the scan is transvaginal, for example an early heart rate. No limited version; probe needs high-level disinfection. Consider modifier 52 for a focused scan, since no limited code exists.
	76816	Obstetric ultrasound, follow-up, per fetus	Re-evaluation of fluid or growth after a prior study; per fetus.
Biophysical profile	**76819**	Fetal biophysical profile without non-stress test	Biophysical profile without a non-stress test; per fetus. With NST use 76818.
Fetal growth follow-up	**76816**	Obstetric ultrasound, follow-up, per fetus	Follow-up biometry and fluid after a prior study; per fetus.
IUD identification	**76857**	Limited pelvic ultrasound (non-obstetric, transabdominal)	Transabdominal location check when medically indicated (pain, missing strings).
	76830	Transvaginal ultrasound, non-obstetric (complete; no limited code)	When the scan is transvaginal. No limited version; probe needs high-level disinfection. Consider modifier 52 for a focused scan, since no limited code exists.
Intrauterine pregnancy and fetal number	**76815**	Limited obstetric ultrasound (transabdominal)	Transabdominal: document a gestational sac with yolk sac or fetal pole within the uterus, and the number of fetuses. One unit regardless of the number of fetuses.
	76817	Transvaginal obstetric ultrasound (complete; no limited code)	When the scan is transvaginal. No limited version; probe needs high-level disinfection. Consider modifier 52 for a focused scan, since no limited code exists.
Pregnancy dating (crown-rump length)	**76815**	Limited obstetric ultrasound (transabdominal)	Focused transabdominal crown-rump length.
	76817	Transvaginal obstetric ultrasound (complete; no limited code)	When the scan is transvaginal. Consider modifier 52 for a focused scan, since no limited code exists.
	76801	Complete obstetric ultrasound, under 14 weeks	Only if every element of the complete first-trimester exam is performed and documented.
Uterine position	**76857**	Limited pelvic ultrasound (non-obstetric, transabdominal)	Transabdominal look in a non-pregnant patient.
	76830	Transvaginal ultrasound, non-obstetric (complete; no limited code)	When the scan is transvaginal. Consider modifier 52 for a focused scan, since no limited code exists.

Ocular and Other HEENT

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Retinal detachment	**76512**	Ophthalmic ultrasound, B-scan (one code; no limited or complete version)	B-scan of one eye. Report RT/LT.
Thyroid or neck mass evaluation	**76536**	Head and neck soft-tissue ultrasound (one code; no limited or complete version)	Thyroid, lymph nodes, parotid or neck soft tissue. One code; no limited version.

Procedural

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Abscess drainage	**10060**	Incision and drainage of abscess, simple or single (10061 complicated or multiple)	**Primary procedure code, no imaging included:** Incision and drainage; 10061 if complicated or multiple. No ultrasound in the code.
	10160	Puncture aspiration of abscess, hematoma, bulla or cyst	**Primary procedure code, no imaging included:** Needle aspiration instead of incision. No ultrasound in the code.
	10030	Image-guided catheter drainage of a soft-tissue fluid collection	**Procedure code, imaging included:** Only if a drainage catheter is left in place; guidance included.
	76942	Ultrasound guidance for needle placement	**Add-on imaging guidance code:** Add when the needle or blade is guided in real time with a saved image.
	76882	Limited extremity ultrasound (joint or focal structure)	**Separate diagnostic imaging code:** Diagnostic soft-tissue code for the body site (76882 on an extremity), when the scan is a distinct evaluation (is there a drainable collection?) with image and report. Not together with 76942 for the same scan.
Arterial line	**36620**	Arterial catheterization, percutaneous	**Primary procedure code, no imaging included:** Arterial catheter placement.
	76937	Ultrasound guidance for vascular access (add-on)	**Add-on imaging guidance code:** Add-on for the ultrasound guidance when the documentation elements are met.
Central venous catheter	**36556**	Central venous catheter, non-tunneled, age 5 and over	**Primary procedure code, no imaging included:** Line placement, age 5 and over (36555 under 5). Imaging is not in the line code.
	76937	Ultrasound guidance for vascular access (add-on)	**Add-on imaging guidance code:** Add-on for the ultrasound guidance when all four documentation elements are met.

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Foreign body removal	**10120**	Foreign body removal, subcutaneous, simple (10121 complicated)	**Primary procedure code, no imaging included:** Simple subcutaneous removal; 10121 if complicated. No ultrasound in the code.
	76942	Ultrasound guidance for needle placement	**Add-on imaging guidance code:** When the instrument is guided in real time with a saved image. Not together with the diagnostic code for the same scan.
	76882	Limited extremity ultrasound (joint or focal structure)	**Separate diagnostic imaging code:** Diagnostic soft-tissue code for the body site (76882 on an extremity) for the localization scan, with image and report.
IUD placement	**58300**	IUD insertion (58301 removal)	**Primary procedure code, no imaging included:** IUD insertion. Ultrasound is not included and not routine.
	76857	Limited pelvic ultrasound (non-obstetric, transabdominal)	**Separate diagnostic imaging code:** To confirm position after a difficult insertion (transabdominal), when indicated.
	76830	Transvaginal ultrasound, non-obstetric (complete; no limited code)	**Separate diagnostic imaging code:** To confirm position transvaginally, when indicated. Consider modifier 52 for a focused scan, since no limited code exists.
Knee injection & aspiration	**20611**	Major joint or bursa aspiration/injection with ultrasound guidance	**Procedure code, imaging included:** Ultrasound guidance and permanent recording are built in; do not add 76942. Without ultrasound use 20610.
Lumbar puncture	**62270**	Lumbar puncture, diagnostic (62272 therapeutic)	**Primary procedure code, no imaging included:** Diagnostic lumbar puncture (62272 therapeutic). No ultrasound in the code; 62328 is fluoroscopy or CT only.
	76942	Ultrasound guidance for needle placement	**Add-on imaging guidance code:** Only when the needle is guided in real time. Landmark marking before the procedure is generally not billable.
Paracentesis	**49083**	Abdominal paracentesis with imaging guidance	**Procedure code, imaging included:** Imaging guidance is built in; do not add 76942 or 76705 for the localization scan. Without imaging use 49082.
Peripheral IV (difficult access)	**36410**	Venipuncture requiring physician or APP skill, age 3 and over	**Primary procedure code, no imaging included:** Venipuncture requiring clinician skill, per the ACEP guide. Routine IV starts are bundled by Medicare.
	76937	Ultrasound guidance for vascular access (add-on)	**Add-on imaging guidance code:** Add-on for the ultrasound guidance when the documentation elements are met.
Small or intermediate joint injection	**20604**	Small joint or bursa aspiration/injection with ultrasound guidance	**Procedure code, imaging included:** Small joint or bursa (fingers, toes, thumb CMC); guidance included.
	20606	Intermediate joint or bursa aspiration/injection with ultrasound guidance	**Procedure code, imaging included:** Intermediate joint or bursa (wrist, elbow, ankle, AC joint); guidance included.

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Soft-tissue mass removal	**Varies**	Soft-tissue mass or cyst excision (code by site and size)	**Primary procedure code, no imaging included:** Excision code chosen by site and size. No ultrasound in the code.
	76882	Limited extremity ultrasound (joint or focal structure)	**Separate diagnostic imaging code:** Diagnostic soft-tissue code for the body site (76882 on an extremity) for the preprocedural scan, with image and report.
Tendon sheath injection	**20550**	Tendon sheath or ligament injection (20551 tendon origin/insertion)	**Primary procedure code, no imaging included:** Tendon sheath or ligament injection (20551 for tendon origin/insertion). Guidance not included.
	76942	Ultrasound guidance for needle placement	**Add-on imaging guidance code:** Add when the needle is guided in real time with a saved image.
Thoracentesis	**32555**	Thoracentesis with imaging guidance	**Procedure code, imaging included:** Imaging guidance is built in; do not add 76942 or 76604 for the localization scan. Without imaging use 32554.
	32557	Pleural drainage with indwelling catheter, with imaging guidance	**Procedure code, imaging included:** When a drainage catheter is left in place.

Pulmonary

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Pleural effusion	**76604**	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Diagnostic scan for effusion. Not billed for the localization scan when you go on to thoracentesis (32555).
Pneumonia	**76604**	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Document findings by lung zone. One unit per session.
Pneumothorax	**76604**	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Document lung sliding or lung point with a saved clip.
Pulmonary edema	**76604**	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Lung ultrasound for B-lines. One unit per session even when both sides are scanned.

Renal, Bladder, and Genitourinary

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Bladder foreign body (Foley)	**76857**	Limited pelvic ultrasound (non-obstetric, transabdominal)	Imaging of the bladder and catheter balloon with a saved image.

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Bladder volume	**76857**	Limited pelvic ultrasound (non-obstetric, transabdominal)	When you image the bladder, save an image and document an interpretation.
	51798	Bladder volume by non-imaging ultrasound (bladder scanner)	Technical-only code: use it when no image is retained, typically a nurse measuring volume with a bladder scanner, with no physician interpretation.
Hydronephrosis	**76775**	Limited retroperitoneal ultrasound	One or both kidneys for a focused question; document the grade.
Nephrolithiasis	**76775**	Limited retroperitoneal ultrasound	Document hydronephrosis grade and any visualized stone.
Scrotal evaluation	**76870**	Scrotal ultrasound (one code; no limited or complete version)	Hydrocele, varicocele, mass. Torsion needs Doppler; ask coders about 93976.
Simple renal cyst	**76775**	Limited retroperitoneal ultrasound	Document cyst characteristics (simple vs complex).

Soft Tissue

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Abscess, cellulitis and edema	**76882**	Limited extremity ultrasound (joint or focal structure)	Finding is on an extremity (arm, leg, hand, foot). Report RT/LT.
	76536	Head and neck soft-tissue ultrasound (one code; no limited or complete version)	Finding is on the head or neck.
	76604	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Finding is on the chest wall or upper back.
	76705	Limited abdominal ultrasound	Finding is on the abdominal wall or lower back.
	76857	Limited pelvic ultrasound (non-obstetric, transabdominal)	Finding is on the pelvic wall, buttock or perineum.
	76642	Limited breast ultrasound, unilateral	Finding is in the breast (axilla when scanned with the breast). Report RT/LT.
	76870	Scrotal ultrasound (one code; no limited or complete version)	Finding is in the scrotum.

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Foreign body	**76882**	Limited extremity ultrasound (joint or focal structure)	Finding is on an extremity (arm, leg, hand, foot). Report RT/LT.
	76536	Head and neck soft-tissue ultrasound (one code; no limited or complete version)	Finding is on the head or neck.
	76604	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Finding is on the chest wall or upper back.
	76705	Limited abdominal ultrasound	Finding is on the abdominal wall or lower back.
	76857	Limited pelvic ultrasound (non-obstetric, transabdominal)	Finding is on the pelvic wall, buttock or perineum.
	76642	Limited breast ultrasound, unilateral	Finding is in the breast (axilla when scanned with the breast). Report RT/LT.
	76870	Scrotal ultrasound (one code; no limited or complete version)	Finding is in the scrotum.
Lipoma and epidermal inclusion cyst	**76882**	Limited extremity ultrasound (joint or focal structure)	Finding is on an extremity (arm, leg, hand, foot). Report RT/LT.
	76536	Head and neck soft-tissue ultrasound (one code; no limited or complete version)	Finding is on the head or neck.
	76604	Chest ultrasound, lung and chest wall (one code; no limited or complete version)	Finding is on the chest wall or upper back.
	76705	Limited abdominal ultrasound	Finding is on the abdominal wall or lower back.
	76857	Limited pelvic ultrasound (non-obstetric, transabdominal)	Finding is on the pelvic wall, buttock or perineum.
	76642	Limited breast ultrasound, unilateral	Finding is in the breast (axilla when scanned with the breast). Report RT/LT.
	76870	Scrotal ultrasound (one code; no limited or complete version)	Finding is in the scrotum.

Vascular

APPLICATION	CODE	CODE NAME	WHEN AND HOW TO USE IT
Abdominal aortic aneurysm	**76775**	Limited retroperitoneal ultrasound	Diagnostic code: a symptomatic patient, or surveillance of a known aneurysm.
	76706	AAA screening ultrasound	Covered preventive code: one-time screening of an asymptomatic eligible patient (Medicare: with a referral; family history of AAA, or men 65 to 75 who have smoked at least 100 cigarettes; no deductible or coinsurance).
IVC diameter and collapsibility	**76775**	Limited retroperitoneal ultrasound	When the IVC is imaged on its own. Confirm locally that a standalone IVC exam is billable.
	93308	Limited transthoracic echocardiogram	Some practices use limited echo instead: when the IVC is assessed as part of a focused cardiac exam it is included in 93308, not billed in addition.
Proximal lower-extremity DVT	**93971**	Limited or unilateral venous duplex (DVT)	Requires Doppler (spectral and color) in addition to compression, documented by segment.

SECTION 4

By tier

Contents ↑

The 52 tiered applications (STFM POCUS Education Task Force), then common applications outside the tiers.

Tier 1 6 applications

APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Knee effusion Musculoskeletal	**76882**	20611	**76882:** Focused look at the suprapatellar recess for fluid. Report RT/LT. **20611:** If you aspirate or inject under ultrasound, report 20611 instead of adding a guidance code.
Fetal presentation Obstetric and Gynecologic	**76815**		Limited OB code; no comprehensive exam required.
Bladder volume Renal, Bladder, and Genitourinary	**76857**	51798	**76857:** When you image the bladder, save an image and document an interpretation. **51798:** Technical-only code: use it when no image is retained, typically a nurse measuring volume with a bladder scanner, with no physician interpretation.
Abscess Soft Tissue	**76882**	76536, 76604, 76705, 76857, 76642, 76870	**76882:** Finding is on an extremity (arm, leg, hand, foot). Report RT/LT. **76536:** Finding is on the head or neck. **76604:** Finding is on the chest wall or upper back. **76705:** Finding is on the abdominal wall or lower back. **76857:** Finding is on the pelvic wall, buttock or perineum. **76642:** Finding is in the breast (axilla when scanned with the breast). Report RT/LT. **76870:** Finding is in the scrotum.
Abscess drainage Procedural	**10060**	10160, 10030, 76942, 76882	**10060:** Primary procedure code, no imaging included: Incision and drainage; 10061 if complicated or multiple. No ultrasound in the code. **10160:** Primary procedure code, no imaging included: Needle aspiration instead of incision. No ultrasound in the code. **10030:** Procedure code, imaging included: Only if a drainage catheter is left in place; guidance included. **76942:** Add-on imaging guidance code: Add when the needle or blade is guided in real time with a saved image. **76882:** Separate diagnostic imaging code: Diagnostic soft-tissue code for the body site (76882 on an extremity), when the scan is a distinct evaluation (is there a drainable collection?) with image and report. Not together with 76942 for the same scan.
Cellulitis / edema Soft Tissue	**76882**	76536, 76604, 76705, 76857, 76642, 76870	**76882:** Finding is on an extremity (arm, leg, hand, foot). Report RT/LT. **76536:** Finding is on the head or neck. **76604:** Finding is on the chest wall or upper back. **76705:** Finding is on the abdominal wall or lower back. **76857:** Finding is on the pelvic wall, buttock or perineum. **76642:** Finding is in the breast (axilla when scanned with the breast). Report RT/LT. **76870:** Finding is in the scrotum.

Tier 2 11 applications

APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Free fluid in abdomen Abdominal and Hepatobiliary	**76705**		Limited abdominal code.
Intrauterine pregnancy Obstetric and Gynecologic	**76815**	76817	**76815:** Transabdominal confirmation: document gestational sac with yolk sac or fetal pole within the uterus. **76817:** When the scan is transvaginal. No limited version; probe needs high-level disinfection. Consider modifier 52 for a focused scan, since no limited code exists.
Fetal heart rate Obstetric and Gynecologic	**76815**	76817	**76815:** Transabdominal: document the rate and save an M-mode or clip. **76817:** When the scan is transvaginal. Consider modifier 52 for a focused scan, since no limited code exists.
Pulmonary edema Pulmonary	**76604**		Chest code, once per session.
Pleural effusion Pulmonary	**76604**		Chest code, once per session.
Hydronephrosis Renal, Bladder, and Genitourinary	**76775**		Limited retroperitoneal code.
Foreign body Soft Tissue	**76882**	76536, 76604, 76705, 76857, 76642, 76870	**76882:** Finding is on an extremity (arm, leg, hand, foot). Report RT/LT. **76536:** Finding is on the head or neck. **76604:** Finding is on the chest wall or upper back. **76705:** Finding is on the abdominal wall or lower back. **76857:** Finding is on the pelvic wall, buttock or perineum. **76642:** Finding is in the breast (axilla when scanned with the breast). Report RT/LT. **76870:** Finding is in the scrotum.
Foreign body removal Procedural	**10120**	76942, 76882	**10120:** Primary procedure code, no imaging included: Simple subcutaneous removal; 10121 if complicated. No ultrasound in the code. **76942:** Add-on imaging guidance code: When the instrument is guided in real time with a saved image. Not together with the diagnostic code for the same scan. **76882:** Separate diagnostic imaging code: Diagnostic soft-tissue code for the body site (76882 on an extremity) for the localization scan, with image and report.
IVC diameter Vascular	**76775**	93308	**76775:** When the IVC is imaged on its own. Confirm locally that a standalone IVC exam is billable. **93308:** Some practices use limited echo instead: when the IVC is assessed as part of a focused cardiac exam it is included in 93308, not billed in addition.
IVC collapsibility Vascular	**76775**	93308	**76775:** When the IVC is imaged on its own. Confirm locally that a standalone IVC exam is billable. **93308:** Some practices use limited echo instead: when the IVC is assessed as part of a focused cardiac exam it is included in 93308, not billed in addition.

APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Abdominal aortic aneurysm Vascular	**76775**	76706	**76775:** Diagnostic code: a symptomatic patient, or surveillance of a known aneurysm. **76706:** Covered preventive code: one-time screening of an asymptomatic eligible patient (Medicare: with a referral; family history of AAA, or men 65 to 75 who have smoked at least 100 cigarettes; no deductible or coinsurance).

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APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Cholelithiasis Abdominal and Hepatobiliary	**76705**		Limited abdominal code.
Pericardial effusion Cardiac	**93308**		Limited echo code.
HFrEF Cardiac	**93308**		Limited echo code.
Knee injection & aspiration Procedural	**20611**		Guidance included; no technical component.
Baker's cyst Musculoskeletal	**76882**		Limited extremity code.
Ganglion cyst Musculoskeletal	**76882**		Limited extremity code.
IUD identification Obstetric and Gynecologic	**76857**	76830	**76857:** Transabdominal location check when medically indicated (pain, missing strings). **76830:** When the scan is transvaginal. No limited version; probe needs high-level disinfection. Consider modifier 52 for a focused scan, since no limited code exists.
Pregnancy dating (crown-rump length) Obstetric and Gynecologic	**76815**	76817, 76801	**76815:** Focused transabdominal crown-rump length. **76817:** When the scan is transvaginal. Consider modifier 52 for a focused scan, since no limited code exists. **76801:** Only if every element of the complete first-trimester exam is performed and documented.
Pneumonia Pulmonary	**76604**		Chest code, once per session.
Pneumothorax Pulmonary	**76604**		Chest code, once per session.
Bladder foreign body (Foley) Renal, Bladder, and Genitourinary	**76857**		Limited pelvic code.

APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Epidermal inclusion cyst Soft Tissue	**76882**	76536, 76604, 76705, 76857, 76642, 76870	**76882:** Finding is on an extremity (arm, leg, hand, foot). Report RT/LT. **76536:** Finding is on the head or neck. **76604:** Finding is on the chest wall or upper back. **76705:** Finding is on the abdominal wall or lower back. **76857:** Finding is on the pelvic wall, buttock or perineum. **76642:** Finding is in the breast (axilla when scanned with the breast). Report RT/LT. **76870:** Finding is in the scrotum.
Lipoma Soft Tissue	**76882**	76536, 76604, 76705, 76857, 76642, 76870	**76882:** Finding is on an extremity (arm, leg, hand, foot). Report RT/LT. **76536:** Finding is on the head or neck. **76604:** Finding is on the chest wall or upper back. **76705:** Finding is on the abdominal wall or lower back. **76857:** Finding is on the pelvic wall, buttock or perineum. **76642:** Finding is in the breast (axilla when scanned with the breast). Report RT/LT. **76870:** Finding is in the scrotum.
Proximal lower-extremity DVT Vascular	**93971**		Duplex code: compression alone does not meet it.

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APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Cholecystitis Abdominal and Hepatobiliary	**76705**		Limited abdominal code.
Gallbladder sludge Abdominal and Hepatobiliary	**76705**		Limited abdominal code.
Carpal tunnel Musculoskeletal	**76882**	20526	**76882:** Focal median-nerve exam at the wrist with cross-sectional area. Report RT/LT. **20526:** Carpal tunnel injection; add 76942 when the needle is guided in real time.
Achilles tear Musculoskeletal	**76882**		Limited extremity code.
Fracture Musculoskeletal	**76882**	76604	**76882:** Focal bony exam of an extremity. Report RT/LT. **76604:** Rib fracture.
Uterine position Obstetric and Gynecologic	**76857**	76830	**76857:** Transabdominal look in a non-pregnant patient. **76830:** When the scan is transvaginal. Consider modifier 52 for a focused scan, since no limited code exists.
Placental location Obstetric and Gynecologic	**76815**		Limited OB code.

APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
IUD placement Procedural	**58300**	76857, 76830	**58300:** Primary procedure code, no imaging included: IUD insertion. Ultrasound is not included and not routine. **76857:** Separate diagnostic imaging code: To confirm position after a difficult insertion (transabdominal), when indicated. **76830:** Separate diagnostic imaging code: To confirm position transvaginally, when indicated. Consider modifier 52 for a focused scan, since no limited code exists.
Multiple gestation Obstetric and Gynecologic	**76815**		Limited OB code, once per exam.
Amniotic fluid Obstetric and Gynecologic	**76815**	76816	**76815:** Qualitative fluid assessment on a focused exam. **76816:** Re-evaluation of fluid or growth after a prior study; per fetus.
Simple renal cyst Renal, Bladder, and Genitourinary	**76775**		Limited retroperitoneal code.
Soft-tissue mass removal Procedural	**Varies**	76882	**Varies:** Primary procedure code, no imaging included: Excision code chosen by site and size. No ultrasound in the code. **76882:** Separate diagnostic imaging code: Diagnostic soft-tissue code for the body site (76882 on an extremity) for the preprocedural scan, with image and report.
Hematoma Musculoskeletal	**76882**	76536, 76604, 76705, 76857, 76642, 76870	**76882:** Finding is on an extremity (arm, leg, hand, foot). Report RT/LT. **76536:** Finding is on the head or neck. **76604:** Finding is on the chest wall or upper back. **76705:** Finding is on the abdominal wall or lower back. **76857:** Finding is on the pelvic wall, buttock or perineum. **76642:** Finding is in the breast (axilla when scanned with the breast). Report RT/LT. **76870:** Finding is in the scrotum.

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APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Paracentesis Procedural	**49083**		Guidance included; no technical component.
Right ventricular strain Cardiac	**93308**		Limited echo code.
Left ventricular hypertrophy Cardiac	**93308**		Limited echo code.
Dilated cardiomyopathy Cardiac	**93308**		Limited echo code.
Cardiac tamponade Cardiac	**93308**		Limited echo code.

APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Shoulder effusion Musculoskeletal	**76882**	20611	**76882:** Focal joint or bursa exam. Report RT/LT. **20611:** If you aspirate or inject under ultrasound, report 20611 instead of adding a guidance code.
Retinal detachment Ocular and Other HEENT	**76512**		Unilateral B-scan code.
Nephrolithiasis Renal, Bladder, and Genitourinary	**76775**		Limited retroperitoneal code.

Not tiered 11 applications

APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Thoracentesis Procedural	**32555**	32557	**32555:** Procedure code, imaging included: Imaging guidance is built in; do not add 76942 or 76604 for the localization scan. Without imaging use 32554. **32557:** Procedure code, imaging included: When a drainage catheter is left in place.
Central venous catheter Procedural	**36556**	76937	**36556:** Primary procedure code, no imaging included: Line placement, age 5 and over (36555 under 5). Imaging is not in the line code. **76937:** Add-on imaging guidance code: Add-on for the ultrasound guidance when all four documentation elements are met.
Arterial line Procedural	**36620**	76937	**36620:** Primary procedure code, no imaging included: Arterial catheter placement. **76937:** Add-on imaging guidance code: Add-on for the ultrasound guidance when the documentation elements are met.
Peripheral IV (difficult access) Procedural	**36410**	76937	**36410:** Primary procedure code, no imaging included: Venipuncture requiring clinician skill, per the ACEP guide. Routine IV starts are bundled by Medicare. **76937:** Add-on imaging guidance code: Add-on for the ultrasound guidance when the documentation elements are met.
Lumbar puncture Procedural	**62270**	76942	**62270:** Primary procedure code, no imaging included: Diagnostic lumbar puncture (62272 therapeutic). No ultrasound in the code; 62328 is fluoroscopy or CT only. **76942:** Add-on imaging guidance code: Only when the needle is guided in real time. Landmark marking before the procedure is generally not billable.
Small or intermediate joint injection Procedural	**20604**	20606	**20604:** Procedure code, imaging included: Small joint or bursa (fingers, toes, thumb CMC); guidance included. **20606:** Procedure code, imaging included: Intermediate joint or bursa (wrist, elbow, ankle, AC joint); guidance included.
Tendon sheath injection Procedural	**20550**	76942	**20550:** Primary procedure code, no imaging included: Tendon sheath or ligament injection (20551 for tendon origin/insertion). Guidance not included. **76942:** Add-on imaging guidance code: Add when the needle is guided in real time with a saved image.

APPLICATION	PRIMARY CODE	OTHER CODES	PRACTICAL NOTES
Thyroid or neck mass evaluation Ocular and Other HEENT	**76536**		Head and neck code.
Scrotal evaluation Renal, Bladder, and Genitourinary	**76870**		Scrotal code.
Biophysical profile Obstetric and Gynecologic	**76819**		76819; with NST 76818.
Fetal growth follow-up Obstetric and Gynecologic	**76816**		Follow-up OB code.

SECTION 5

Notes and sources

Rules that cut across codes, definitions, sources and the disclaimer.

Contents ↑

What this is	PRIME POCUS billing and coding reference for family medicine. Three views of the same content: By Code (applications that share one code and one body part are grouped on one row), By Application and By Tier (the 52 tiered applications, plus common applications outside the tiers). Categories follow the Delphi organ systems. Regional anesthesia is not included.
What is a tier	The STFM POCUS Education Task Force identified 52 POCUS applications for family medicine residency training and grouped them into five implementation tiers. The ranking used weighted criteria: impact on patient management (weighted highest), ease of learning, ease of teaching, applicability across family medicine, and prevalence in continuity care. Programs start with Tier 1 and build upward. Source: Paulus R, on behalf of the STFM POCUS Education Task Force. Multiorganizational Recommendations for Point-of-Care Ultrasound in Family Medicine Residency Education. Fam Med. 2026. https://doi.org/10.22454/FamMed.2026.426882
Four things every billed scan needs	Medical necessity documented; a permanently stored image; a written interpretation/report that is separately identifiable in the record; and the name of the interpreting clinician. A look that is not saved and reported is part of the E/M visit.
Limited vs complete	Where a body region has both, the complete code requires every listed element to be imaged and reported. If one is missing, report the limited code. POCUS answers a focused question, so limited codes are the norm.
Codes with no limited version	Transvaginal ultrasound (76830, 76817), chest (76604), head and neck (76536), scrotum (76870) and ophthalmic B-scan (76512) each have a single code.
Transvaginal scanning	Requires high-level disinfection of the probe between patients plus a single-use probe cover. Be aware that high-level disinfection requirements may add significant expense and logistic challenge to incorporation of transvaginal ultrasound into practice (see the AIUM high-level disinfection guideline).
Soft tissue is billed by region	Extremity 76882, head/neck 76536, chest wall or upper back 76604, abdominal wall or lower back 76705, pelvic wall/perineum 76857, breast 76642, scrotum 76870. There is no universal soft-tissue code.
Professional and technical components	Diagnostic ultrasound codes split into professional (-26) and technical (TC) components. Bill globally when your practice owns the machine in a non-facility office; bill -26 in hospital-based settings where the facility bills the technical part.
Procedures with ultrasound built in	20604 (small joint injection), 20606 (intermediate joint injection), 20611 (major joint injection), 49083 (paracentesis), 32555 (thoracentesis), 32557 (pleural drainage with a catheter left in place) and 10030 (catheter drainage of a soft-tissue fluid collection) include imaging guidance. No separate guidance or diagnostic code for the same scan. These procedure codes have no technical component.
Procedures that take a guidance code	Vascular access codes 36556 and 36555 (central venous catheter) and 36620 (arterial line) take add-on 76937 (ultrasound guidance for vascular access). Procedures with no built-in guidance, 20526 (carpal tunnel injection), 20550 (tendon sheath injection), 10160 (puncture aspiration) and 62270 (lumbar puncture), take 76942 (ultrasound guidance for needle placement) when the needle is guided in real time.
Procedures with no ultrasound in the code	Abscess drainage, foreign body removal, mass excision, lumbar puncture and IUD insertion. Ultrasound is captured, if at all, by a separate diagnostic scan (image + report) or a guidance code; see each row.

Types of RVU	Every code has three RVU parts: work (the clinician's time, skill and judgment), practice expense (staff, supplies and equipment; higher in the office than in a facility) and malpractice. Medicare payment = total RVUs x the conversion factor. The work RVU (wRVU) is the part used for productivity and compensation; it is the same in any setting, and for imaging codes all of it sits in the professional (-26) component, while the technical component has none. Codes with a work RVU of 0, such as 51798, are technical only.
Work RVU column	2026 work RVUs from the CMS Physician Fee Schedule relative value file RVU26A (January 2026 release, updated 29 Dec 2025). 58300 is not covered by Medicare; its RVU is listed for reference. Payment detail lives in the PRIME POCUS Revenue Estimator.
Code set and date	CPT 2026 codes, compiled 11 Nov 2026. CPT 2027 takes effect 1 Jan 2027; published summaries of the 2027 radiology changes reviewed so far do not list changes to these codes, but recheck against the 2027 code book.
Sources	ACEP Emergency Ultrasound Coding Guide 2025; PRIME POCUS CPT Code List (fact-checked 14 Oct 2026) and its cited sources (ACOG LARC Quick Coding Guide, CMS AAA screening guidance, CMS RVU26A); PRIME POCUS Revenue Estimator; CPT descriptors and ultrasound guidelines.
Official CPT code descriptors	Code names in this resource are plain-language summaries written by PRIME, not official CPT descriptors. For the official descriptors and guidelines, use the current AMA CPT code book or the AMA CPT resources. CPT is copyrighted by the American Medical Association; see the AMA CPT licensing overview.
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