Report 51798 when your practice uses simple hand-operated, sonographic equipment that does not provide an image to measure the volume of residual urine. You should also use this code for portable, handheld devices that the physician uses to calculate residual urine.

- 51798 — Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging.

**ICD-9-CM Codes**

- 595.9 — Cystitis, unspecified
- 596.3 — Diverticulum of bladder
- 596.4 — Atony of bladder
- 596.54 — Neurogenic bladder NOS
- 599.0 — Urinary tract infection, site not specified
- 599.70 — Hematuria, unspecified
- 599.71 — Gross hematuria
- 599.72 — Microscopic hematuria
- 600.00 — Hypertrophy (benign) of prostate without urinary obstruction and other lower urinary tract symptoms (LUTS)
- 600.01 — Hypertrophy (benign) of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)
- 600.20 — Benign localized hyperplasia of prostate without urinary obstruction and other lower urinary tract symptoms (LUTS)
- 600.21 — Benign localized hyperplasia of prostate with urinary obstruction and other lower urinary tract symptoms (LUTS)
- 625.6 — Stress incontinence, female
- 788.20 — Retention of urine, unspecified
- 788.21 — Incomplete bladder emptying
- 788.29 — Other specified retention of urine
- 788.30 — Urinary incontinence, unspecified
- 788.31 — Urge incontinence
- 788.32 — Stress incontinence, male
- 788.33 — Mixed incontinence, (male) (female)
- 788.34 — Incontinence without sensory awareness
- 788.35 — Post-void dribbling
- 788.36 — Nocturnal enuresis
- 788.38 — Overflow incontinence

788.39 — Other urinary incontinence
788.41 — Urinary infrequency
788.42 — Polyuria
788.43 — Nocturia
788.5 — Oliguria and anuria
788.61 — Splitting of urinary stream
788.62 — Slowing of urinary stream
788.69 — Other abnormality of urination
788.91 — Functional urinary incontinence
788.99 — Other symptoms involving urinary system.
If the intent of a bladder sonogram is to measure post-void residual urine (PVR), report 51798 regardless of the equipment used, both imaging and nonimaging. Report 76775 (Ultrasound, retroperitoneal [e.g., renal, aorta, nodes], real time with image documentation; limited) and 76857 (Ultrasound, pelvic [nonobstetric], real time with image documentation; limited or follow-up [e.g., for follicles]) when the physician performs a bladder sonogram with imaging to study bladder anatomy, architecture, morphology, wall thickness, bladder diverticula, bladder filing defects, etc., in addition to a post-void residual determination. Most doctors do a bladder sonogram primarily for PVR determination, and you should be billing this with 51798. The handheld devices automatically print out and calculate the residual urine in the bladder, so you don't have to worry about waiting for the test results to come back.

**Count 51798 only once for bladder scanner:** Even if the physician uses the scanner to perform both a pre- and post-void ultrasound, report only one unit of 51798, even though the code specifically describes measurement of post-voiding residual urine and bladder capacity. In the AMA's CPT® Changes 2003: An Insider's View, there is a clinical example of a patient who is scanned immediately after the patient voids. The physician measures residual urine volume and encourages the patient to try again. He then rescans the patient and measures the urine volume again. So some payers might consider the pre-void scan to represent the bladder capacity — and the code contains the wording "bladder capacity and/or post void residual" — so reporting one unit of 51798 is appropriate.

**Assign diagnosis code based on signs and symptoms:** Bladder scans are diagnostic tests. How you assign diagnosis codes for diagnostic tests depends on whether you submit the claim for the ordered test before or after the physician receives or interprets the test results.

If the physician who ordered the test has not received the results, the patient’s diagnosis code should reflect the signs and symptoms he presented with. If the physician ordering the test receives and interprets the test results to determine a definitive diagnosis for the patient before you send the claim to the carrier, that physician should use a diagnosis code to represent the results of the test unless the results are negative. Never use negative or normal test results as the reason for ordering the test. If the test does come back negative, code the signs and symptoms that prompted the physician to order the test.

According to CMS Program Memorandum AB-01-144, Medicare has taken the following stance on assigning diagnosis codes for diagnostic services:

- If the physician has confirmed a diagnosis based on diagnostic test results, the physician interpreting the test should code that diagnosis. You may report the signs and/or symptoms that prompted ordering the test as additional diagnoses if they are not fully explained or are related to the confirmed diagnosis.
- If the diagnostic test did not provide a diagnosis or results were normal, the interpreting physician should code the signs or symptoms that prompted the treating physician to order the study.
- If the results of the diagnostic test are normal or non-diagnostic and the referring physician records a diagnosis preceded by words that indicate uncertainty (for example, probable, suspected, questionable, rule out, or working), then the interpreting physician should not code the referring diagnosis. Rather, the interpreting physician should report the sign(s) or symptom(s) that prompted the study. Diagnoses labeled as “uncertain” are considered by the ICD-9 Coding Guidelines as unconfirmed, and you should not report them.

**Example:** A patient presents with urinary incontinence (788.30), and the physician orders a bladder scan. The results of the bladder scan confirm the presence of a urethral stricture. A urethral stricture (598.9, Urethral stricture, unspecified) is not a covered diagnosis for 51798, which means the doctor should report the signs and symptoms the patient presented with that motivated the physician to order the bladder scan. Have the physician include any additional observations from the bladder scan in his office notes.

But if a patient presents with urinary incontinence, the doctor orders a bladder scan, and the results indicate there is residual urine, you should report the diagnosis code for the incontinence disorder (788.30) as the primary diagnosis code and link it to 51798.

**Multiple studies on same day:** The urodynamics codes (51725-51798) are generally free from Correct Coding Initiative (CCI) bundles, meaning that you should be able to report multiple studies separately when the physician performs them separately during the same surgical session without appending a modifier. Some payers may require modifier 51 (Multiple procedures) appended to each code listed after the first one. Medicare will automatically append modifier 51 to the appropriate codes, so do not append modifier 51 when coding for Medicare carriers.

Payers will usually reduce reimbursement for each procedure listed after the first one, so report the highest-reimbursing
Different studies work together: Medicare covers multiple urodynamics tests, but among private payers you'll find no standard for urodynamic testing. The best advice is to check your payers' specific policies for urodynamic coding and then start a dialogue between your provider and the plan's medical director to get an exception to any edits the plan may have for billing several studies together.

Heads up: Most payers will always want to review your documentation when the physician performs more than three or four procedures on the same date.

Modifiers required during global periods: Payer confusion about the nature of urodynamic testing makes urodynamic coding within the global period difficult. Diagnostic tests such as x-rays, for example, are not part of the global payment for the procedure and are fully payable. Urodynamics testing, including bladder scans, is also diagnostic, and payers should reimburse for it. But because the American Medical Association places urodynamics codes in CPT’s surgery section instead of the medicine section, carriers view them as surgical codes subject to global and surgical guidelines.

Payers typically deny bladder scans if the physician performs them within the postoperative period of a surgery. Both Medicare and some private payers will require modifier 79 (Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period) to receive payment for bladder scans when the physician performs them within the 90-day global period of those surgeries. You must append modifier 79 to each study to receive payment along with a diagnosis, such as bladder atony (596.4) or hypertonicity of the bladder (596.51) that indicates the medical necessity for the urodynamics. These diagnoses should be different and distinct from the diagnosis that necessitated the global surgery.

Depending on the service provided, append modifier 24 (Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period) for unrelated E/M visits in the global period.

Use TOS code "2": Although 51798 seems like it should be a diagnostic radiology procedure that you should report as type of service "4" on your claim form, Medicare sees it differently. CMS assigns 51798 a TOS code of "2," designating it as a surgical procedure. Compare this treatment to 76775, which has a TOS code of "4." CMS deems 51798 a TOS type "2," again, because it is found in CPT’s surgery section instead of among the diagnostic tests. If you report 51798 with a "4" instead of a "2" in the TOS column, your carrier will likely deny your claim.

Scans don’t have professional and technical components: Unlike the other urodynamics codes, Medicare does not split 51798 into professional and technical components. If your doctor reads the scan results after a separate facility performs the actual measurement, you should include the professional interpretation of the study in your documentation and the work that supports your charge. Bill only for your E/M services for the day, which would include the physician reading the sonogram.

Low-level E/M bundled: CCI bundles the lower-level E/M code 99211 (Office or other outpatient visit for the evaluation and management of an established patient …) into 51798. The edit has a modifier indicator of “1,” but that may not help in many cases. For example, a nurse or medical technician performs a handheld Doppler device bladder scan in the doctor's office while the physician is in the office suite. The doctor has had a face- to-face medical encounter during the same visit with the patient that included an evaluation and exam separate and distinct from the bladder scan. You should code the scenario 51798 and 99211-59. However, most payers, including Medicare, will not recognize modifier 59 (Distinct procedural service) when appended to an E/M service.

Use modifier 25 for higher-level E/M and bladder scan: For higher-level E/M services, you may bill for both the E/M and scan if the physician performs both. In the Medicare fee schedule database, 51798 has an “XXX” global period, which means that the global concept does not apply. Therefore, you should treat 51798 as a radiological procedure and

If your carrier denies your claim of 51798 with an E/M service, append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) and appeal.

Check LCDs for POS variations: Check your Medicare carriers for local coverage determinations (LCDs) to determine if
you can bill 51798 when a physician performs the procedure in a setting besides your medical office. Although many carriers may still only pay for 51798 under Part B when done in the office (place of service code 11), some carriers, such as Empire Medicare Services of New York and New Jersey, will reimburse elsewhere. Empire's LCD includes the following POS codes: home (POS code 12), assisted living facility (13), group home (14), nursing facility (32), and custodial care facility (33).

**Sonogram edits:** CCI also bundles 51798 into 76872 (Ultrasound, transrectal), 76873 (… prostate volume study for brachytherapy treatment planning [separate procedure]), and 76942 (Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation). These edits also have a modifier indicator of "1," so you can break the bundles under appropriate clinical circumstances.

**Temporary catheters not bundled with bladder scan:** In the past, a CCI edit bundled 51701 (Insertion of non-indwelling bladder catheter [eg, straight catheterization for residual urine]) and 51702 (Insertion of temporary indwelling bladder catheter; simple [eg, Foley]) into 51798, but that edit is no longer in effect. Physicians frequently will perform an ultrasound for post-void residual, find the patient is not emptying the bladder, and then place a catheter.

- Published on 2019-01-01