Priority Health	BILLING POLICY No. 061
BLADDER SCANS	
Date of origin: Dec. 23, 2024	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

A bladder scan is a procedure that uses ultrasound technology to measure the amount of urine in the bladder. The provider performs an ultrasound on your stomach to get images of your bladder with sound waves. The provider can use these images to calculate the amount of urine left in your bladder.

POLICY SPECIFIC INFORMATION

Coding specifics

CPT code 51798 (Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging) shouldn't be performed more than once per day.

This is a technical component only code.

When ultrasound measurement for post-void residual is the only service clinically indicated and/or rendered, it's inappropriate to report a pelvic ultrasound code (76856 or 76857) instead of, or in addition to, this service. Likewise, if a pelvic ultrasound code is appropriately billed, it's inappropriate to bill separately for the PVR measurement since payment for this has already been included in the payment of the pelvic study.

The use of both ultrasound and catheterization during the same session to determine PVR isn't medically necessary and only the comprehensive service will be reimbursed.

For facility services in the inpatient and outpatient setting, bladder scans are considered inclusive of general inpatient charges and should not be separately payable. Bladder scans may be performed routinely to monitor bladder volumes as a component of bladder bundles utilized for prevention in urinary care. Reference our Inpatient and outpatient unbundling billing policy for additional detail

Place of service

POS 11 – Office

Documentation requirements

- The assessment of the patient by the ordering provider as it relates to the complaint of the patient for that visit
- Relevant medical history
- Results of pertinent tests/procedures
- Signed and dated office visit record/operative report (Note that all services ordered or rendered to Medicare beneficiaries must be signed.)

The patient's medical record must contain documentation that fully supports the medical necessity for services. This documentation includes, but isn't limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

The patient's clinical record should indicate the plan of treatment and any changes/alterations in medications prescribed for the treatment of the patient's condition. There must be an attending/treating physician's order for each test documented in the patient's medical/clinical record.

The medical record should include the results of the test including documentation that the measurement was done immediately post-void, along with the date of the test, and identification of the person performing the test.

DISCLAIMER

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

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

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

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

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

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

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section