Priority Health	BILLING POLICY No. 061
BLADDER SCANS	
Date of origin: Dec. 23, 2024	**Review dates: None yet recorded**

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.

CHANGE / REVIEW HISTORY

Date	Revisions made