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Physician Reimbursement for Urodynamics Procedures

Payments for physician services are established by CPT codes according to a fee schedule. Under the Medicare Physician Fee Schedule, CPT codes are assigned Relative Value Units (RVUs) which represent the relative amount of physician work, resources and expertise needed to provide services to patients. Payments differ depending upon where the service is provided (facility or non-facility) to accommodate the expenses associated with procedural equipment, personnel, supplies, etc.

If a physician performs more than one urodynamic procedure on the same patient on the same day, Medicare will pay as follows: The primary procedure (billed first) at 100% of the fee schedule amount; the subsequent procedures (billed using a "51" modifier) will be paid at 50% of the fee schedule amount. CPT 51797 is not subject to the multiple procedure discount.

2018 National Unadjusted Medicare Physician Payment Rates*			
CPT Code	Description	Physician Office Setting (Non-Facility)	Hospital/ASC Setting (Facility)**
51725	Simple cystometrogram (CMG) (eg, spinal manometer)	$193	$79
51726	Complex cystometrogram (i.e., calibrated electronic equipment)	$273	$88
51727	Complex cystometrogram (i.e., calibrated electronic equipment) with urethral pressure profile studies (i.e., urethral closure pressure profile), any technique	$321	$111
51728	Complex cystometrogram (i.e., calibrated electronic equipment); with voiding pressure studies (i.e., bladder voiding pressure), any technique	$328	$108
51729	Complex cystometrogram (i.e., calibrated electronic equipment); with voiding pressure studies (i.e., bladder voiding pressure) and urethral pressure profile studies (i.e., urethral closure pressure profile), any technique	$352	$131
51736	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	$16	$9
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	$16	$9
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	$71	$39
+51797	Voiding pressure studies, intra-abdominal (i.e., rectal, gastric, intraperitoneal) (list separately in addition to code for primary procedure)	$117	$42

- *Code 51729 is a combination of the services described in codes 51727 and 51728.*
- *Code 51797 may be used in conjunction with codes 51728 and 51729, when performed.*

**National physician payment rates were calculated using RVUs and conversion factor published in the CMS CY 2018 Medicare Physician Fee Schedule (MPFS) Database (Addendum B - CY 2018 Final Rule). National unadjusted Medicare rates, rounded to the nearest dollar, are based on these RVUs. Actual payment to a physician will vary based on geographic location. Payment for a given procedure in a given locality is available in the Medicare Physician Fee Schedule Look-up file posted in the Physician Center of the CMS website.*

***Physician services provided in a facility setting are reported with a -26 modifier appended to the CPT code. (See page 3 of this document).*

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Hospital Reimbursement for Urodynamics Procedures

Outpatient procedures are reported by hospitals with CPT codes. The CPT code reported by the hospital is assigned to a Medicare Ambulatory Payment Classification (APC) group, and payment is based on the APC grouping. Some Ambulatory Surgery Center (ASC) procedures are paid under a similar mechanism, but payment rates are lower than APC rates. Nearly all of the outpatient and ASC procedures below are subject to multiple procedure discounting, whereby the highest ranked procedure is paid at 100%, and additional procedures are paid at 50% of the fee schedule amount when the procedures are performed on the same date of service. An exception to this rule is CPT 51784 with a Status Indicator of "S" which would not be subject to the multiple procedure discounting.

2018 National Unadjusted Medicare Hospital Outpatient/ASC Payment Rates*					
CPT Code	Description	APC Group	**Status Indicator	APC Hospital Payment	ASC Payment
51725	Simple cystometrogram (CMG) (eg, spinal manometer)	5371	T	$230	$113
51726	Complex cystometrogram (i.e., calibrated electronic equipment)	5372	T	$566	$295
51727	Complex cystometrogram (i.e., calibrated electronic equipment); with urethral pressure profile studies (i.e., urethral closure pressure profile), any technique	5372	T	$566	$210
51728	Complex cystometrogram (i.e., calibrated electronic equipment); with voiding pressure studies (i.e., bladder voiding pressure), any technique	5372	T	$566	$218
51729	Complex cystometrogram (i.e., calibrated electronic equipment); with voiding pressure studies (i.e., bladder voiding pressure) and urethral pressure profile studies (i.e., urethral closure pressure profile), any technique	5372	T	$566	$220
51736	Simple uroflowmetry (UFR) (eg, stop-watch flow rate, mechanical uroflowmeter)	5734	Q1	$105	packaged
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	5721	Q1	$136	packaged
51784	Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique	5721	S	$136	$32
+51797	Voiding pressure studies, intra-abdominal (i.e., rectal, gastric, intraperitoneal) (list separately in addition to code for primary procedure)	N/A	N	packaged	packaged

** Outpatient Prospective Payment System Addendum B.-Final OPPS Payment by HCPCS Code for CY 2018 and ASC CY 2018 Addendum AA*

*** Status Indicators*

T = Significant Procedure, multiple procedure discount applies

Q1 = STV Packaged Codes, packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S", "T", or "V"

S = Significant procedure, not discounted when multiple

N = Items and services packaged into APC rates

AMA CPT Coding Guidelines

Payment for diagnostic services consists of a technical component and a professional component. These components are identified by the modifiers –TC (technical component) and -26 (professional component) appended to the CPT code. The absence of a modifier represents "global" billing (technical component + professional component). When the physician only interprets the results and/or operates the equipment, the professional component (i.e., modifier -26 appended) is reported.

When multiple procedures are performed in the same investigative session, modifier -51 ("multiple procedures") should be appended.

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Coding Edits

CMS provides guidance on billing via the National Correct Coding Initiative (NCCI) Manual. NCCI contains lists of code pairs that are generally not billable together either because they are considered to be mutually exclusive or because one code is considered to be comprehensive and inclusive of the second code. Code pairs are classified as Column 1 and Column 2. The codes in Column 2 are generally not payable by Medicare when reported with the Column 1 codes. The NCCI edits are updated quarterly. There are multiple edits that impact urodynamics codes.

For example, the 2018 first quarter version of NCCI contains the following code pair edits:

Column I Code	Column II Code	Edit
51726	51725	Report the Column I code only: this is the more extensive procedure
51727	51725	Report the Column I code only: this is the more extensive procedure
51727	51726	Report the Column I code only: HCPCS/CPT procedure code definition
51728	51725	Report the Column I code only: this is the more extensive procedure
51728	51726	Report the Column I code only: HCPCS/CPT procedure code definition
51728	51727	Report the Column I code only: misuse of column two code with column one code
51741	51736	Report the Column I code only: this is the more extensive procedure

This is NOT a complete listing of edits. Please refer to the NCCI manual. The NCCI Manual and edits are available at https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Coding/NationalCorrectCodInitEd/downloads/2018-Jan-Practitioner-PTP-Edits-v24-f3.zip

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ICD-10-CM Diagnosis Codes

For claims to be covered and paid, Medicare and other payers require that procedures performed must be reasonable and necessary. ICD-10 codes are reported to describe conditions, diagnoses, signs, and symptoms associated with a procedure. Each service/procedure billed should be supported by an ICD-10-CM diagnostic code that substantiates the need for those services provided. Common codes that may support medical necessity of urodynamic studies include:

ICD-10-CM Diagnosis Codes*			
F98.0	Enuresis not due to a substance or known physiological condition	N40.___	Enlarged prostate (code additional digits)
N13.___	Obstructive and reflux uropathy (code additional digits)	R33.8	Other retention of urine
N31.___	Neuromuscular dysfunction of bladder (code additional digits)	R35.0	Frequency of micturition
N32.___	Other disorders of bladder (code additional digits)	R35.1	Nocturia
N32.0	Bladder neck obstruction	R39.___	Other and unspecified symptoms and signs involving the genitourinary system (code additional digits)
N32.81	Overactive bladder	R39.11	Hesitancy of micturition
N33.___	Bladder disorders in diseases classified elsewhere (code additional digits)	R39.12	Poor urinary stream
N35.___	Urethral stricture (code additional digits)	R39.14	Feeling of incomplete bladder emptying
N36.___	Disorders of urethra (code additional digits)	R39.15	Urgency of urination
N37	Urethral disorders in disease classified elsewhere	R39.16	Straining to void
N39.4___	Other specified urinary incontinence (code additional digits)		

Source: International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM)
**Refer to ICD-10-CM Manual for a complete list of codes and specific character selection.*

This is not an exhaustive list of all relevant codes. The selection of ICD-10-CM diagnosis codes is based on the patient's medical condition. Physicians must document patient diagnoses and procedures thoroughly and accurately, as it is ultimately the provider's responsibility to determine and submit appropriate codes. Proper coding of clinical procedures and diagnoses are dependent on the information documented in the patient's medical record without consideration of the adequacy of the reimbursement levels assigned by payers to specific codes.