healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Urodynamic Studies		
Policy Number:	PO-RE-120v2		
Effective Date:	12/01/2024	**Last Approval Date:**	12/5/2025

I. Policy Description

This policy outlines the reimbursement guidelines for healthcare providers regarding the measurement of post-voiding residual urine by ultrasound when performed in conjunction with urodynamic studies. In accordance with the Centers for Medicare & Medicaid Services (CMS) policy, specific billing codes and coding guidelines apply to ensure accurate and compliant reimbursement for these services.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Medicare HMO and PPO
- Essential Plan (EP)
- Personal Wellness Plan (HARP)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)

Policy Scope

This policy applies to all healthcare providers who perform post-voiding residual urine measurement by ultrasound and urodynamic studies in the context of patient care. Healthcare providers covered under this policy include, but are not limited to physicians, nurse practitioners, and other qualified healthcare professionals.

Reimbursement Guidelines

1. When billing for the ultrasound measurement of post-voiding residual urine (CPT code 76857) on the same day as a urodynamic study (CPT codes 51725-51729, 51736, or 51741), the provider must ensure accurate coding and billing practices.

2. Per CMS policy, CPT code 76857 will be recoded to CPT code 51798 (measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging) when billed alongside a urodynamic study.

3. Healthcare providers should ensure that documentation supports the medical necessity of both the urodynamic study and the post-voiding residual urine measurement by ultrasound to support reimbursement.

4. Proper documentation of the services rendered, including the date of service, CPT codes billed, and clinical indication for the procedures, is essential for accurate reimbursement and audit compliance.

5. Healthcare providers must adhere to CMS guidelines and regulations when billing for post-voiding residual urine measurement by ultrasound with urodynamic studies. Non-compliance with billing regulations may result in denied claims and/or audit findings.

Adjudication and Appeal Process

1. Reimbursement for urodynamic studies will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

Please be advised that all services provided are subject to the member's individual benefit coverage.

II. Applicable Codes

Code	Description	Comment
51725	Simple cystometrogram (CMG) (e.g. spinal manometer)	
51726	Complex cystometrogram (i.e calibrated electronic equipment);	
51727	Complex cystometrogram (i.e. calibrated electronic	

	equipment); with urethral pressure profile studies (i.e. urethral closure pressure profile), any technique	
51728	Complex cystometrogram (i.e. calibrated electronic equipment); with voiding pressure studies (i.e. bladder voiding pressure), any technique	
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	
51736	Simple uroflowmetry (UFR) (e.g. stop-watch flow rate, mechanical uroflowmeter)	
51741	Complex uroflowmetry (e.g. calibrated electronic equipment)	
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (e.g. for follicles)	

III. Definitions

Term	Meaning
NCD	National Coverage Determinations

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

LCD - Urodynamics (L34056) (cms.gov)
Article - Billing and Coding: Urodynamics (A56802) (cms.gov)
LCD - Post-Void Residual Urine and/or Bladder Capacity by Ultrasound (L34085)

VI. Revision History

Revision Date	Summary of Changes
12/5/2025	Added Adjudication and Appeals section.

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.