Billing Guide - Prostate Biopsy

KOELIS
Advancing Prostate Care

MRI-Ultrasound fusion guided biopsy combines a magnetic resonance imaging (MRI) scan with an ultrasound (US) image to precisely target the area of the prostate that needs to be biopsied. Images from a previously performed MRI are fused with ultrasound images obtained in real time using the TRINITY™ 3D Prostate Suite system to guide a prostate biopsy.

There is currently not a specific CPT code to report the MRI-US fusion biopsy procedure. As a result, codes typically used for a standard transrectal ultrasound (TRUS) guided biopsy (see below) are often used for MRI-US, when permitted by Medicare or commercial insurers.

There is currently no CPT code which describes the fusion of a MRI with ultrasound images. Also, urologist should not bill for 3D rendering of the images if this has been performed by the radiologist.

CPT Code	Description	APC	2023 Medicare National Average Payment Rate[1]			
			Hospital Outpatient	ASC	Physician	
					Facility	Non-Facility
Ultrasound and Biopsy[2]						
76872	Ultrasound, transrectal	5522	$106.88	$55.65[3]	$32.19	$204.34
55700	Biopsy, prostate; needle or punch, single or multiple, any approach	5373	$1,854.88	$848.03	$129.11	$244.33
55706	Biopsies, prostate, needle, transperineal, sterotatic template guided saturation sampling, including imaging guidance	5374	$3,205.12	$1,496.56	$376.83	--
76942	Ultrasonic guidance for needle placement (e.g, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Packaged service	No separate payment	No separate payment	$30.50	$58.96
MRI[4,5]						
72195	Magnetic resonance (e.g, proton) imaging, pelvis; without contrast material(s)	5523	$233.52	$121.59	$70.15	$242.97
72196	Magnetic resonance (e.g., proton) imaging, pelvis; with contrast material(s)	5572	$368.43	$191.83	$83.36	$285.33
72197	Magnetic resonance (e.g., proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences	5572	$368.43	$191.83	$105.05	$358.19
3D Rendering[6]						
76376	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image post-processing on an independent workstation	Packaged service	No separate payment	No separate payment	$9.49	$24.40
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image post-processing on an independent workstation	Packaged service	No separate payment	No separate payment	$37.95	$76.92

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Billing Guide - Other Procedures

The versatile TRINITY™ system can also be used for other non-prostate biopsy procedures where ultrasound is required. The compact all-in-one TRINITY system has the size and mobility to easily integrate into smaller settings with a variety of ultrasound probes to meet your needs.

CPT Code	Description	APC	2023 Medicare National Average Payment Rate[1]			
			Hospital Outpatient	ASC	Physician	
					Facility	Non-Facility
Procedures						
55873	Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring).	5376	$8,557.73	$6,449.58	$764.50	$5.859.10
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed (SpaceOAR). Includes ultrasound guidance (76942)	5375	$4,702.18	$3,563.78	$163.68	$2,9849.88
55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple. Can bill ultrasound guidance separately (76942) unless performed with SpaceOAR procedure.	5613	$1,340.67	$902.94	$101.66	$153.17
50200	Renal biopsy; percutaneous, by trocar or needle. Can bill ultrasound guidance (76942) separately.	5072	$1,499.55	$637.11	$125.72	$527.29
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	5373	$1,854.88	$848.03	$202.65	$929.87
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	5374	$3,205.12	$1,496.56	$251.44	$1,158.60
50435	Other Renal Introduction (Injection/Change/Removal) Procedures	5373	$1,825.65	$848.03	$98.95	$616.41
54200	Injection procedure for Peyronie's disease. Can bill ultrasound guidance (76870) separately.	5371	$271.77	$73.06	$87.09	$243.99
51102	Aspiration of bladder; by needle with insertion of suprapubic catheter. Can bill ultrasound guidance (76857) separately.	5373	$1,854.88	$848.03	$143.00	$243.99
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous. (Do not report in conjunction with 76940, 77002, 77013, 77022)	5362	$9,087.30	$7,707.66	Carrier priced	Carrier priced
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open. (Do not report in conjunction with 76940, 77002, 77013, 77022)	5362	$9,087.30	$5,501.48	Carrier priced	Carrier priced
Potential Associated Ultrasound Codes						
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection and localization device), imaging supervision and interpretation. (Cannot be billed in conjunction with 55874) .	Packaged service	NA	NA	$30.50	$58.96
76857	Ultrasound, pelvic [non-obstetric], real time with image documentation; limited or follow-up	5522	$106.88	$24.80	$23.72	$49.48
76870	Ultrasound, scrotum and contents	5522	$106.88	NA	$30.84	$103.02
76872	Ultrasound, transrectal	5522	$106.88	$55.65	$32.19	$204.34
76770	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation;complete	5522	$106.88	$55.65	$35.24	$110.81
76775	Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited. (For kidney stone diagnosis or follow up from any one of the following procedures: 52310, 52352, 52353, 52356, 50080, 50081,50591)	5522	$106.88	NA	$27.79	$59.98

[1] Outpatient APC and ASC payments based on CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS 1772-FC) (Federal Register, November 23, 2022). Physician payment rates based on Medicare and Medicaid Programs: CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1770-F) (Federal Register, November 18, 2022).

[2] CPT 76872 and CPT 76942 cannot be billed together due to a Medicare National Correct Coding Initiative (NCCI) bundling edit in place.

[3] Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list.

[4] CPT 77021; Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation, is used for an "in-bore" (in the MRI machine) needle placement. Therefore it is not proper to use this code as part of an MRI-TRUS fusion prostate biopsy procedure. Urologists should not bill CPT 77021, even if there is MRI equipment in the urology practice, unless they are personally performing in-bore needle placement.

[5] CPT 76498; Unlisted Magnetic Resonance procedure (e.g., diagnostic, interventional) is a potential code for the additional work of fusing the MRI and an ultrasound, but is potentially not reimbursable. It is recommend that providers verify insurance coverage policies prior to billing this code.

[6] The urologist should not bill for 3D rendering (CPT 76376 or CPT 76377) if this has been performed by the radiologist.

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