Chapter VII
Urinary, Male Genital
Laparoscopy, Female Genital,
Maternity
CPT-4 50000 - 59999

A. Introduction

The general policies previously promulgated regarding CPT-4 defined services apply to the urinary tract. Because of the contiguous nature of the urinary tract, and the accessibility of the urinary tract to endoscopic intervention, several specific issues require emphasis.

B. Urinary System

1. Many procedures involving the female and male urinary system include the placement of a urethral catheter for post-operative drainage. Because this is integral to the service and represents the standard of medical practice, placement of a urinary catheter is not separately coded. In addition, catheterizations (e.g. CPT-4 codes 53670 and 53675) are not separately billed when done at the time of or just prior to a surgical procedure.

2. Many lesions of the genitourinary tract which require biopsy, excision or destruction involve the mucocutaneous border and several CPT-4 codes may generally describe the nature of the biopsy obtained. For a biopsy of a lesion or group of similar lesions, one unit of service for the CPT-4 code that most accurately describes the service rendered is billed. As noted in the general policies, in Chapter I, when a biopsy is followed by an excision or destruction during the same session, only the most extensive service is billed. Additionally, separate codes (e.g., integumentary and genitourinary excision codes) are not to be billed unless the biopsy, excision, destruction, etc., service involves completely separate lesions, in these cases the "DS" modifier will indicate that separate lesions were removed. The medical record should reflect accurately the precise location of the lesions removed, particularly if it is medically necessary to submit each lesion as separate specimens for pathologic evaluation.

3. Policies regarding injections and infusions (e.g., HCPCS/CPT-4 codes 36000, 36410, G0001, 90780 and 90781) as part of more extensive procedures have previously been defined and apply to the genitourinary family of codes. When irrigation procedures or drainage procedures are necessary and are integral to successfully accomplish a genitourinary (or any other) procedure, only the more extensive service is billed.

4. Unless otherwise defined by CPT-4 manual instructions, the repair and closure of surgical procedures are included in the CPT-4 code for the more extensive procedure and are not to be separately billed. In many genitourinary services, hernia repair is included in the CPT-4 manual narrative for the service; accordingly, a hernia repair is not separately billed. If the hernia repair is at a different site, and is performed, this can be separately billed with the "DS" modifier indicating that this service occurred at a different site (i.e., via a different incision).

5. In general, multiple methods of accomplishing a procedure (e.g., prostatectomy) are not performed at the same session (see general policy on mutually exclusive services); therefore, only one method of accomplishing a given procedure can be billed. In the event that an initial approach is unsuccessful, and an alternative approach is undertaken, the approach which successfully accomplishes the procedure becomes the medically necessary service and is billed.

6. When an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is billed. When an endoscopic procedure is attempted unsuccessfully and converted to an open procedure, only the open procedure is billed (see general policy on sequential procedures). If the endoscopy is performed for diagnostic purposes and a subsequent therapeutic service can be performed at the same session, the procedure is coded at the highest level of specificity; if the CPT-4 manual narrative includes endoscopy, then the endoscopy is not separately coded. If the narrative does not include endoscopy and a separate endoscopy was necessary for diagnosis, this can be billed separately using the "DS" modifier (diagnostic service). The medical record must an entry describing the findings of the diagnostic endoscopy in these cases. If the endoscopy is only confirmatory ("scout endoscopy"), the endoscopy does not represent a diagnostic or surgical endoscopy, but represents exploration of

the surgical field, and should not be separately billed under the diagnostic or surgical endoscopy codes.

7. In general, when multiple endoscopic procedures are performed at the same session, the most comprehensive code accurately describing the service performed is billed; if several procedures are performed at the same endoscopic session, the "51" modifier is attached. (For example, if a renal endoscopy is performed through an established nephrostomy, a biopsy is performed, a lesion is fulgurated and a foreign body (calculus) is removed, the appropriate CPT-4 coding would be CPT-4 codes 50557 and 50561-51, not CPT-4 codes 50551, 50555, 50557, and 50561.) This policy applies to endoscopic procedures in general and specifically to endoscopic procedures of the genitourinary system.

8. When bladder irrigation is performed as part of a more comprehensive procedure, or in order to accomplish access or visualization of the urinary system, the bladder irrigation (CPT-4 code 51700) is not to be billed. This code is to be used for irrigation with therapeutic agents or for irrigation as an independent therapeutic service.

9. When electromyography is performed as part of a biofeedback session, CPT-4 code 51785 is not to be billed unless a significant separately identifiable diagnostic EMG service is provided. If the CPT-4 code 51785 is to be used for a diagnostic electromyogram, a separate report must be available in the medical record to indicate this service was performed.

10. When endoscopic visualization of the urinary system involves several regions (e.g., nephrostomy, renal pelvis, calyx, and ureter) the appropriate CPT-4 code is defined by the approach (e.g. nephrostomy, pyelostomy, ureterostomy, etc.) as indicated in the CPT-4 descriptor. When multiple endoscopic approaches are simultaneously necessary to accomplish a medically necessary service (e.g., renal endoscopy through a nephrostomy and cytourethroscopy performed at the same session) they may be separately coded with the multiple procedure modifier "51". When multiple endoscopic approaches are necessary to accomplish a procedure, the successful endoscopic approach should be billed.

11. When urethral catheterization or urethral dilation (e.g., CPT-4 codes 53600-53675) is necessary to accomplish a more extensive

procedure, the urethral catheterization/dilation is not to be separately billed.

12. When a urinalysis by dip stick (e.g., CPT-4 codes 81000-81003) is performed in conjunction with a urinary system procedure, the dip stick urinalysis is included in the major procedure as part of the procedure. Medically necessary urinalysis, with microscopy, is separately billed as this represents a significant, separately identifiable, service.

13. Multiple ureteral anastomosis procedures are defined by CPT-4 codes 50740-50810, and 50860. In general, they represent mutually exclusive procedures and are not to be billed together. If one anastomosis is performed on one ureter, and a different anastomosis is performed on a contralateral ureter, the appropriate modifier (e.g., "LT", "RT") is used with the appropriate CPT-4 code to describe the service performed on the respective ureter.

14. CPT-4 code 50860 (ureterostomy) is mutually exclusive of CPT-4 codes 50800-50830 (e.g., ureterostomy, ureterocolon conduit, urinary undiversion).

15. The CPT-4 codes 53502-53515 describe urethral repair codes for urethral wounds or injuries (urethrorrhaphy). When a urethroplasty is performed, codes for urethrorrhaphy should not be billed in addition as "suture to repair wound or injury" is included in the urethroplasty service.

C. Male Genital

1. Transurethral drainage of a prostatic abscess (e.g., CPT-4 code 52700) is included in male transurethral prostatic procedures and is not billed separately.

2. Urethral catheterization (e.g., CPT-4 codes 53670 and 53675), when medically necessary to successfully accomplish a procedure, should not be separately billed.

3. The puncture aspiration of a hydrocele (e.g. CPT-4 code 55000) is included in services involving the tunica vaginalis and proximate anatomy (scrotum, vas deferens, spermatic cord, seminal vesicles) and in inguinal hernia repairs.

4. A number of codes describe surgical procedures of a progressively more comprehensive nature or with different approaches to accomplish similar services. In general, these groups of codes are not to be billed together (see mutually exclusive policy). While a number of these groups of codes exist in CPT-4, a specific example includes the series of codes describing prostate procedures (CPT-4 codes 55700-55865). In addition, all prostatectomy procedures (e.g., CPT-4 codes 52601-52650 and 55801-55845) are also mutually exclusive of one another.

D. Female Genital

1. When a pelvic examination is performed for diagnostic purposes it may be separately billed, even if a therapeutic service is provided at the same session. If, however, the pelvic examination is of a confirmatory nature prior to a surgical service (e.g.. to confirm the nature of the lesion(s) requiring surgical repair or to establish the anatomy during a surgical service) it is not to be billed separately. When billed with a surgical service, the "DS" modifier should be attached indicating that this is a diagnostic service (procedure). The medical record should reflect that a significant, separately identifiable service was performed.

2. All surgical laparoscopic, hysteroscopic or peritoneoscopic procedures include diagnostic procedures. Therefore, CPT-4 code 56300 is included in 56301-56342, 56350 is included in 56351-56361, and 56362 is included in 56363.

3. Lysis of adhesions (CPT-4 code 56304) is not to be reported separately when done in conjunction with other surgical laparoscopic procedures.

4. Pelvic exam under anesthesia indicated by CPT-4 code 57410, is included in all major and most minor gynecological procedures and is not to be reported separately. This procedure represents routine evaluation of the surgical field.

5. Dilation of vagina and cervix (CPT-4 codes 57400 or 57800), when done in conjunction with vaginal approach procedures, is not to be reported separately unless the CPT-4 code manual description states "without cervical dilation."

6. Administration of anesthesia, when necessary, is included in every surgical procedure code, when performed by the surgeon.

E. Maternity Care and Delivery

1. The majority of procedures in this section (CPT-4 codes 59000-59899) include only what is described by the code in the CPT-4 definition. Additional procedures performed on the same day would be reported separately. The few exceptions to this rule include:

- CPT-4 codes 59050 (fetal monitoring during labor), 59300 (episiotomy) and 59414 (delivery of placenta) are included in CPT-4 codes 59400 (routine obstetric care), 59409 (vaginal delivery only), 59410 (vaginal delivery and postpartum care), 59510 (routine obstetric care), 59514 (cesarean delivery), 59515 (cesarean delivery and postpartum care). They are not separately billed.

- The total obstetrical packages (e.g., CPT-4 codes 59400 and 59510) include antepartum care, the delivery, and postpartum care. They do not include among other services, ultrasound, amniocentesis, special screening tests for genetic conditions, visits for unrelated conditions (incidental to pregnancy) or additional and frequent visits due to high risk conditions.