

Surgery: Urinary System

This section contains information to assist providers in billing for surgical procedures related to the urinary system.

Extracorporeal Shock Wave Lithotripsy

Medi-Cal covers Extracorporeal Shock Wave Lithotripsy (ESWL) for treating calculi in the renal calyces, the renal pelvis and in the proximal third of the ureter.

Providers must bill ESWL using CPT-4 procedure code 50590 with the appropriate modifier.

ESWL may be inadvisable for patients who:

- Cannot undergo anesthesia
- Do not fit into the patient positioning system (height and weight limitations)
- Have cardiac pacemakers or
 - Aneurysm
 - Life-threatening cardiac problems
 - Renal artery calcification
 - Uncontrolled urinary infection
 - Obstructed ureter
 - Radiolucent stones that cannot be visualized on fluoroscopy
 - Are pregnant

Note: ESWL is not covered to treat calculi in the lower urinary tract, the urinary bladder or the gallbladder.

Providers should use HCPCS code Z7604 when billing for facility use in the outpatient treatment of patients with kidney stones using ESWL. HCPCS code Z7604 covers all institutional services, including room charges, supplies, drugs, X-rays, equipment and staff services.

The physician's component is not included under HCPCS code Z7604. It should be billed using CPT-4 code 50590.

**Urodynamic Studies:
Diagnosis and Billing
Limitations**

Coverage of urodynamic diagnostic studies is limited to three types of urological disorders:

- Neuro-muscular dysfunction of the lower urinary tract
- Neurologic disease affecting the urinary system
- Neurologic dysfunction of the bladder

The claim form must identify, at a minimum, the clinical basis for undertaking the studies. CPT-4 codes list procedures that may be used separately or in many and varied combinations. When multiple procedures are performed in the same investigative session, modifier 51 should be used to identify the second and subsequent procedures.

Modifier AG must not be used when billing for urodynamic procedure codes in the 51725 – 51797 range. These codes are broken down into professional and technical components for billing (split-billed) and must be billed according to the following instructions:

<u>To bill for</u>	<u>Use</u>
<u>Professional services only</u>	<u>Modifier 26 (professional component)</u>
<u>Technical services only</u>	<u>Modifier TC (technical component)</u>
<u>Both professional and technical services</u>	<u>Use one claim line without a modifier or bill the claim on two lines, one with modifier 26 and the other with modifier TC</u>

All procedures covering CPT-4 codes 51725 – 51797 imply that these services are performed by or under the direct supervision of a physician. There are no additional allowances for procedures performed in the physician's office involving the use of equipment, instruments, fluids, medications, technician time and supplies provided by the physician.

Only the urodynamic testing is included under this coverage. The nerve blocks listed may be pudendal, unilateral or bilateral; sacral, unilateral or bilateral, single or multiple; or subarachnoid and epidural of the sacral segments.

Percutaneous Nephrostolithotomy

The CPT-4 codes for percutaneous nephrostolithotomy are as follows:

<u>CPT-4 Code</u>	<u>Description</u>
50080	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm
50081	over 2 cm

CPT-4 codes 50080 and 50081 may be performed at the time of, or subsequent to, code 50392 (introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous). Reimbursement for dilation procedures is included in the reimbursement of codes 50080 and 50081 and should not be billed separately.

Related CPT-4 codes 74420 (retrograde urography), 74425 (antegrade urography), 76000 or 76001 (fluoroscopy), and 76998 (ultrasonic guidance, intraoperative) may be billed in conjunction with codes 50080 and 50081 when appropriate.

Injectable Bulking Agent

HCPCS code L8604 (dextranomer/hyaluronic acid) is allowable for children up to 18 years of age. Two units (2 ml) are allowed per session. No TAR is required. Code L8604 is billed "By Report."

**Endoscopic Injections:
Urinary Incontinence (UI)**

Endoscopic injections for UI are reimbursable for collagen implants for recipients over 18 years of age. Providers should bill this procedure using CPT-4 code 51715 (endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck). Teflon (polytetrafluoroethylene) paste injections are not reimbursable. Assistant surgeon services are not reimbursed for this procedure.

Collagen Bulking Agent

HCPCS code L8603 (collagen implant, urinary tract, 2.5 ml syringe, includes shipping and necessary supplies) is available as a collagen bulking agent. A skin test is required 30 days prior to endoscopic injection. For skin testing, use CPT-4 code 95028 (intracutaneous [intra-dermal] tests with allergenic extracts, delayed type reaction, including reading, specify number of tests). Bill CPT-4 code 51715 and HCPCS code L8603 for use of bulking agent.

Synthetic Bulking Agent

HCPCS code L8606 (synthetic implant, urinary tract, 1 ml syringe, includes shipping and necessary supplies) is available as a synthetic bulking agent and is to be billed with CPT-4 code 51715. A skin test is not required prior to injection.

Note: This supply code can be used for any FDA-approved bulking agents.

Bulking Agents Ineffective

Recipients whose incontinence does not improve after three treatments with bulking agents are not likely to respond to further therapy. Further treatments would not be considered medically necessary.

Authorization
Requirements

Authorization is required for CPT-4 code 51715 and HCPCS codes L8603 and L8606. When requesting authorization, providers must medically justify all of the following information regarding the recipient's medical history and physician qualifications:

- The diagnosis of incontinence (ICD-9-CM codes 599.82, 625.6 and 788.30 – 788.39).
- The incontinence, due to intrinsic sphincter deficiency, must have been present and unimproved for at least 12 months.
- The recipient has undergone complete urodynamic evaluation.
- The recipient does not display contraindications, such as acute conditions involving cystitis, urethritis or other infection.
- The physician has urological training and expertise in cystoscopic procedures.
- The skin test (CPT-4 code 95028) conducted 30 days prior to treatment proved to be negative for collagen implantation

Inflatable Urethral/Bladder Neck Sphincter Billing Restrictions

Claims billed with CPT-4 code 53448 (removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue) are not reimbursable when billed with skin debridement codes 11042 and 11043.

Cystourethroscopy: Ureteral Catheterization

CPT-4 code 52327 (cystourethroscopy [including ureteral catheterization]; with subureteric injection of implant material) is reimbursable to the primary surgeon only. Assistant surgeon and anesthesiology services are not reimbursable.

Urethral Dilation Documentation Requirement

When billing for urethral dilation procedures with CPT-4 codes 53600 – 53621 in conjunction with cystourethroscopy procedure codes 52000 – 52334, 52341 – 52346 and 52351 – 52355 for a male recipient, a report documenting involvement of significant time and effort to perform the urethral dilation must be submitted with the claim.

Transurethral Needle Ablation

Transurethral Needle Ablation (TUNA), for the treatment of Benign Prostatic Hyperplasia (BPH), is reimbursable when billed with CPT-4 code 53852 (transurethral destruction of prostate tissue; by radiofrequency thermotherapy) and modifier AG.

The disposable cartridge, which is required to perform the procedure, is reimbursable when billed with code 53852 and modifier 22. The cartridges will be reimbursed at the lesser of \$1,000 or the invoice price. An invoice for the cartridge must accompany the claim or the claim will be denied.

TAR Requirement

A *Treatment Authorization Request* (TAR) is required when billing code 53852 with modifier AG or modifier 22. When requesting authorization, providers must include both the procedure and the cartridge on the same TAR using separate service lines. The TAR will be approved only when both the procedure and the cartridge are requested at the same time. Providers must document all of the following:

- The trial and failure of medical treatment for the urinary flow obstruction, or contraindication for medical treatment
- The work-up, including:
 - Urinalysis
 - Measurement of prostate specific antigen (PSA)
 - Simple uroflowmetry
 - Transrectal ultrasound
 - Cystoscopy
- A diagnosis of hyperplasia of the prostate (ICD-9-CM codes 600.00 – 600.91).

**Cystourethroscopy:
Transprostatic Implant**

HCPCS codes C9739 (cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants) and C9740 (cystourethroscopy, with insertion of transprostatic implant; 4 or more implants) are for a permanent implant inserted into the male prostate via the urethra to treat symptoms of urinary outflow obstruction secondary to Benign Prostatic Hyperplasia (BPH).

These services are restricted to male recipients 50 years of age and older.

HCPCS codes C9739 and C9740 are restricted to the primary surgeon only and will be priced “By Report.”

**Cystourethroscopy:
Ureteroscopy**

CPT-4 code 52332 (cystourethroscopy, with insertion of indwelling ureteral stent) is not reimbursable with CPT-4 codes 52000, 52353 and 52356 when performed together on the same side.

CPT-4 code 52353 (cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy) is not reimbursable with CPT-4 codes 52332 and 52356 when performed together on the same side.

CPT-4 code 52356 (cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent) is not reimbursable with CPT-4 codes 52332 and 52353 when performed together on the same side.

Providers must document when performed on the opposite side in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on the claim or on an attachment.

Second Assistant Surgeon

Reimbursement for a second assistant surgeon is allowed for CPT-4 codes 51590 and 51595 – 51597.

Providers must document in the *Remarks* field (Box 80)/*Additional Claim Information* (Box 19) of the claim that the services were rendered by more than one assistant surgeon for the same surgery on the same date.