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CHAPTER VII
SURGERY: URINARY, MALE GENITAL, FEMALE GENITAL, MATERNITY CARE AND DELIVERY SYSTEMS
CPT CODES 50000 -59999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES

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Chapter VII
Surgery: Urinary, Male Genital, Female Genital, Maternity Care and Delivery Systems
CPT Codes 50000 - 59999

A. Introduction

The general policies previously promulgated regarding CPT 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. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a Global period of 000, 010, 090, XXX, YYY, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure.

Since NCCI edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier -57. Other E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. NCCI does not contain edits based on this rule because Medicare Carriers have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier -25. NCCI does contain some edits based on these principles, but the Medicare Carriers have separate edits. Neither the NCCI nor Carriers have all possible edits based on these principles.

Procedures with a global surgery indicator of "XXX" are not covered by these rules. Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code. Other "XXX" procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same day of service which may be reported by appending modifier –25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. Appending modifier –25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding.

C. Urinary System

1. Many procedures involving the female and male urinary system include the placement of a urethral catheter for postoperative 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 codes 51701, 51702, and 51703) are not separately reported when done at the time of or just prior to a surgical procedure.

2. Cystourethroscopy with biopsy (CPT code 52204) includes all biopsies during the procedure and should be reported with one unit of service.

3. Many lesions of the genitourinary tract which require biopsy, excision or destruction involve the mucocutaneous border and several CPT 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 code that most accurately describes the service rendered is reported. When a biopsy is followed by an excision or destruction during the same session, only the more extensive service is reported. Additionally, separate CPT codes for integumentary and genitourinary procedures are not to be reported unless the biopsy, excision, destruction, etc., service involves completely separate lesions in the genitourinary tract and skin. In these cases, modifier -59 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 a separate specimen for pathological evaluation.

4. Policies regarding injections and infusions (e.g., HCPCS/CPT codes 36000, 36410, 90760-90775, C8950-C8952) 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 reported.

5. Unless otherwise defined by *CPT Manual* instructions, the repair and closure of surgical procedures are included in the CPT code for the more extensive procedure and are not to be separately reported. In many genitourinary services, hernia repair is included in the *CPT Manual* descriptor for the service; accordingly, a hernia repair is not separately reported. If the hernia repair performed is at a different site, this can be separately reported with modifier -59 indicating that this service occurred at a different site (i.e., via a different incision).

6. In general, multiple methods of performing a procedure (e.g., prostatectomy) cannot be performed at the same patient encounter. (See general policy on mutually exclusive services.) Therefore, only one method of accomplishing a given procedure may be reported. If an initial approach is unsuccessful and is

followed by an alternative approach, only the successful or last unsuccessful approach may be reported.

7. When an endoscopic procedure is performed as an integral part of an open procedure, only the open procedure is reported. If the endoscopy is confirmatory or is performed to assess the surgical field ("scout endoscopy"), the endoscopy does not represent a diagnostic or surgical endoscopy. The endoscopy represents exploration of the surgical field, and should not be separately reported under the diagnostic or surgical endoscopy codes. When an endoscopic procedure is attempted unsuccessfully and converted to an open procedure, only the open procedure is reported (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 Manual* narrative includes endoscopy, then the diagnostic endoscopy is not separately coded. If the narrative does not include endoscopy and a separate endoscopy is necessary as a diagnostic procedure, this can be reported separately. Modifier -58 may be used to indicate that the diagnostic endoscopy and the subsequent therapeutic service are staged or planned procedures. The medical record must describe the intent and findings of the diagnostic endoscopy in these cases.

8. When multiple endoscopic procedures are performed at the same session, the more comprehensive code accurately describing the service performed is reported; if several procedures are performed at the same endoscopic session, modifier -51 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 coding would be CPT codes 50557 and 50561-51, not CPT codes 50551, 50555, 50557, and 50561.) This policy applies to endoscopic procedures in general and specifically to endoscopic procedures of the genitourinary system.

9. 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 code 51700) is not to be reported. This code is to be used for irrigation with therapeutic agents or for irrigation as an independent therapeutic service.

10. When electromyography (EMG) is performed as part of a biofeedback session, neither CPT code 51784 nor 51785 is to be

reported unless a significant, separately identifiable diagnostic EMG service is provided. If either CPT code 51784 or CPT 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 for diagnostic purposes.

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

12. When urethral catheterization or urethral dilation (e.g., CPT codes 51701-51703) is necessary to accomplish a more extensive procedure, the urethral catheterization/dilation is not to be separately reported.

13. Multiple ureteral anastomosis procedures are defined by CPT codes 50740-50810, and 50860. In general, they represent mutually exclusive procedures and are not to be reported 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 code to describe the service performed on the respective ureter.

14. CPT code 50860 (ureterostomy, transplantation of ureter to skin) is mutually exclusive of CPT codes 50800-50830 (e.g., ureterostomy, ureterocolon conduit, urinary undiversion) unless performed at different locations in which case an anatomic modifier should be used.

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

16. CPT code 78730 (Urinary bladder, residual study) is a nuclear medicine procedure requiring use of a radiopharmaceutical. This CPT code should not be utilized to report measurement of residual urine in the urinary bladder determined by other methods.

17. CPT code 52332 (Cystourethroscopy, with insertion of indwelling ureteral stent) should not be reported to describe insertion and removal of a temporary ureteral stent during diagnostic or therapeutic cystourethroscopy (CPT codes 52320-52355). The insertion and removal of a temporary ureteral stent during these procedures is not separately reportable and should not be reported with CPT codes 52005 or 52007. Similarly, the insertion and removal of a temporary ureteral catheter (CPT codes 52005, 52007) during cystourethroscopic procedures coded as CPT codes 52320-52355 is not separately reportable.

18. Prostatectomy procedures (CPT codes 55801-55845) include cystoplasty or cystourethroplasty as a standard of surgical practice. CPT code 51800 (cystoplasty or cystourethroplasty…) should not be reported separately with prostatectomy procedures.

19. CPT code 50650 (ureterectomy, with bladder cuff (separate procedure)) should not be reported with other procedures on the ipsilateral ureter. Since CPT code 50650 includes the “separate procedure” designation, CMS does not allow additional payment for the procedure when it is performed with other procedures in an anatomically related area.

D. Male Genital System

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

2. Urethral catheterization (e.g., CPT codes 51701, 51702, and 51703), when medically necessary to successfully accomplish a procedure, should not be separately reported.

3. The puncture aspiration of a hydrocele (e.g., CPT code 55000) is included in services involving the tunica vaginalis and proximate anatomy (scrotum, vas deferens) 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 reported together (see mutually exclusive policy). While a number of these groups of codes exist in CPT, a specific example includes the series of codes describing prostate procedures (CPT codes 55801-55845). In addition, all prostatectomy procedures (e.g., CPT codes 52601-52648 and 55801-55845) are also mutually exclusive of one another.

E. Female Genital System

1. When a pelvic examination is performed in conjunction with a gynecologic procedure, either as a necessary part of the procedure or as a confirmatory examination, the pelvic examination is not separately reported. A diagnostic pelvic examination may be performed for the purposes of deciding to perform a procedure; however, this examination is included in the evaluation and management service at the time the decision to perform the procedure is made.

2. All surgical laparoscopic, hysteroscopic or peritoneoscopic procedures include diagnostic procedures. Therefore, CPT code 49320 is included in 38120, 38570-38572, 43280, 43651-43653, 44180-44227, 44970, 47560-47570, 49321-49323, 49650-49651, 54690-54692, 55550, 58545-58554, 58660-58673, 60650; and 58555 is included in 58558-58563.

3. Lysis of adhesions (CPT code 58660) is not to be reported separately when done in conjunction with other surgical laparoscopic procedures.

4. Pelvic exam under anesthesia indicated by CPT 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 or cervix (CPT codes 57400 or 57800), when done in conjunction with vaginal approach procedures, is not to be reported separately unless the CPT code descriptor states "without cervical dilation."

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

7. Colposcopy (CPT codes 56820, 57420, 57452) should not be reported separately when performed as a “scout” procedure to confirm the lesion or to assess the surgical field prior to a surgical procedure. A diagnostic colposcopy resulting in the decision to perform a non-colposcopic procedure may be reported with modifier -58. Diagnostic colposcopies (56820, 57420, 57452) are not separately reported with other colposcopic procedures.

F. Maternity Care and Delivery

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

- CPT codes 59050 and 59051(fetal monitoring during labor), 59300 (episiotomy) and 59414 (delivery of placenta) are included in CPT codes 59400 (routine obstetric care, vaginal delivery), 59409 (vaginal delivery only), 59410 (vaginal delivery and postpartum care), 59510 (routine obstetric care, cesarean delivery), 59514 (cesarean delivery only), 59515 (cesarean delivery and postpartum care), 59610 (routine obstetric care, vaginal delivery, after previous cesarean delivery), 59612 (vaginal delivery only after previous cesarean delivery), 59614 (vaginal delivery and postpartum care after previous cesarean delivery), 59618 (routine obstetric care, cesarean delivery, after previous cesarean delivery), 59620 (cesarean delivery only after previous cesarean delivery), and 59622 (cesarean delivery and postpartum care after previous cesarean delivery). They are not to be separately reported.

- The total obstetrical packages (e.g., CPT 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.

G. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips, topical skin adhesive, or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service.

3. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical service when provided by the physician performing the service. The physician should not report CPT codes 00100-01999. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), or drug administration (CPT codes 90760-90775) should not be reported when these services are related to the delivery of an anesthetic agent.

Medicare may allow separate payment for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing the medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

Drug administration services (CPT codes 90760-90775) are not separately reportable by the physician performing an operative procedure for drug administration during the operative procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT

codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report HCPCS/CPT codes C8950-C8952, 90772 or 90773 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. HCPCS/CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (HCPCS/CPT codes 90760-90775, C8950-C8952) may be reported with an NCCI-associated modifier.

4. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (eg, needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

5. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.