Clinical Policy: Urodynamic Testing

Reference Number: WNC.CP.174
Last Review Date: 05/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description

Urodynamic testing is an important part of the comprehensive evaluation of voiding dysfunction. The clinician must exercise clinical judgment in the appropriate selection of urodynamic tests following an appropriate evaluation and symptom characterization. The purpose of this policy is to define medical necessity criteria for commonly used urodynamic studies.

Policy/Criteria

I. It is the policy of WellCare of North Carolina® that urodynamic testing is medically necessary to assist in the diagnosis of urologic dysfunction with **any** of the following indications:

A. Uncertain diagnosis and inability to develop an appropriate initial treatment plan based on the clinical diagnostic evaluation;
B. Failure to respond to an adequate therapeutic trial;
C. Consideration of urologic surgical intervention, particularly if previous surgery failed or if the patient is a high surgical risk;
D. Presence of other comorbid conditions such as **any** of the following:
   1. Urinary Incontinence;
   2. Persistent symptoms of difficult bladder emptying;
   3. History of previous anti-incontinence surgery or radical pelvic surgery;
   4. Symptomatic pelvic prolapse;
   5.Prostate nodule, asymmetry or other suspicion of prostate cancer;
   6. Abnormal post-void-residual urinalysis;
   7. Diabetes mellitus with secondary urinary incontinence;
   8. Neurological conditions affecting voiding function (neurogenic bladder) such as multiple sclerosis, Parkinson's disease, and spinal cord lesions or injury;
   9. Complex anorectal malformation.

II. It is the policy of WellCare of North Carolina® that urodynamic testing in the following cases is considered **not medically necessary**:

A. **More than one** cystometrogram (CPT codes 51725 or 51726) or uroflowmetry study (CPT codes 51736 or 51741) per visit.
B. The use of any urodynamic testing for screening in asymptomatic patients, except for evaluation of neurogenic bladder or urological abnormalities associated with complex anorectal malformation.

Background

Lower urinary tract symptoms (LUTS), which include urinary incontinence, are a common and significant source of impaired quality of life and comorbidity in a large number of adults and children. . LUTS is also a general term used to describe symptoms related to overactive bladder such as frequency, urgency and nocturia.[22] Commonly, patients presenting with lower urinary tract symptoms have overlapping symptoms and conditions, making an isolated or homogeneous source of symptoms rare.

Clinicians evaluating these disorders collectively utilize history, physical examination, questionnaires and testing data in the evaluation of symptoms.[3] Cystometrogram, uroflowmetry, urethral pressure profile, and voiding pressure studies, among others, are used to identify abnormal voiding patterns in symptomatic patients with disorders of urinary flow. The urodynamic evaluation measures the relationship between movement and compression of bladder and abdominal pressures during the filling/storage and elimination phase of micturition.[22] Each of the urodynamic studies has benefits and limitations that must be understood for each specific clinical application.

In clinical practice, the role of invasive urodynamic testing is not clearly defined. Urologists generally accept that conservative or empiric, non-invasive treatments may be instituted without urodynamic testing. Conservative treatments for urinary incontinence include pelvic muscle exercises (Kegel exercise), behavioral therapies such as bladder training and/or biofeedback, and pharmacotherapies (e.g., anticholinergic agents, musculotropic relaxants, calcium channel blockers, tricyclic antidepressants, or a combination of anticholinergic, antispasmodic medications and tricyclic antidepressants). Specifically, urge incontinence is more effectively managed with peripherally acting receptor agonists or antagonists, while stress incontinence is better controlled by pelvic muscle exercises, behavioral therapies, or corrective surgery.[4]

Urodynamic studies are indicated only after an initial evaluation is performed that, at minimum, includes an appropriate history, physical exam, and urinalysis with microscopy. Infection, if present, should be treated and effectiveness of treatment observed before further diagnostic (urodynamic) testing or other therapeutic interventions are undertaken.

Many types of urodynamic testing require urethral catheterization and include cystometry, pressure flow studies (PFS), and urethral function testing. Such testing subjects patients to risks of urethral instrumentation including infection, urethral trauma, and pain. Thus, the clinician must weigh whether urodynamic tests offer additional diagnostic benefit beyond symptom assessment, physical examination, and other diagnostic testing. A cystometrogram is used to distinguish bladder outlet obstruction from other voiding dysfunctions.

- In a simple cystometrogram (CPT code 51725), the physician inserts a pressure catheter into the bladder and using a manometer, records the pressure and flow in the lower urinary tract.
- A complex cystometrogram (CPT code 51726) uses a transurethral catheter to fill the bladder with water or gas while simultaneously obtaining rectal pressure and a transducer measures intravesical pressure.
- CPT code 51727 reports a complex cystometrogram performed in conjunction with a measurement of urethral pressure studies.

- CPT code 51728 reports a complex cystometrogram performed in conjunction with a measurement of voiding pressure studies.
- CPT code 51729 reports a complex cystometrogram performed in conjunction with a measurement of voiding pressure studies and urethral pressure studies.
- Voiding pressure studies (CPT code 51797) measure the effort the patient makes while voiding. This measurement includes the pressure required and the subsequent urine flow.

Uroflowmetry and ultrasound post-void residual (PVR) studies may be appropriate noninvasive tests given the clinical scenario and the options for treatment.[3]

- In simple uroflowmetry (CPT code 51736), a stopwatch is used to record the volume of the flow of urine over time.
- Complex uroflowmetry (CPT code 51741) uses electronic equipment to measure and record the volume of urine flow over time.
- Measurement of residual urine and/or bladder emptying capacity (CPT code 51798) is accomplished using ultrasound after voiding.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
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 uroflow meter)
51741	Complex uroflowmetry (e.g., calibrated electronic equipment)
+51797	Voiding pressure studies, intra-abdominal (i.e., rectal, gastric, intraperitoneal (List separately in addition to code for primary procedure)
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
A18.13	Tuberculosis of other urinary organs
C70.1	Malignant neoplasm of spinal meninges
C72.0	Malignant neoplasm of spinal cord
C72.1	Malignant neoplasm of cauda equine
D33.4	Benign neoplasm of spinal cord
E10.69	Type 1 diabetes mellitus with other specified complications
E11.69	Type 2 diabetes mellitus with other specified complication
G20	Parkinson's disease
G35	Multiple sclerosis
G37.3	Acute transverse myelitis in demyelinating disease of central nervous system
G82.21	Paraplegia, complete
G82.22	Paraplegia, incomplete
G83.4	Cauda equina syndrome
N30.10 through N30.11	Interstitial cystitis, chronic
N30.20 through N30.21	Other chronic cystitis
N31.0 through N31.9	Neuromuscular dysfunction of bladder, not elsewhere classified
N32.0 through N32.89	Other disorders of bladder
N39.0 through N39.8	Other disorders of urinary system
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms
N40.3	Nodular prostate with lower urinary tract symptoms
N81.0 through N81.9	Female genital prolapse
Q05.0 through Q05.9	Spina bifida
Q06.0 through Q06.9	Other congenital malformations of spinal cord
Q07.00 through Q07.9	Other congenital malformations of nervous system

Q42.0 through Q42.3	Congenital absence, atresia and stenosis of large intestine
R33.8	Other retention of urine
R33.9	Retention of urine, unspecified
R35.1	Nocturia
R39.11	Hesitancy of micturition
R39.14	Feeling of incomplete bladder emptying
R39.81	Functional urinary incontinence
S14.0XXA through S14.9XXS	Injury of nerves and spinal cord at neck level
S24.0XXA through S24.9XXS	Injury of nerves and spinal cord at thorax level
S34.01XA through S34.9XXS	Injury of lumbar and sacral spinal cord and nerves at abdomen, lower back and pelvis level

In addition to the above ICD-10 codes, the following additional diagnosis codes support medical necessity for CPT code 51798.

ICD-10-CM Codes	Description
N13.8	Other obstructive and reflux uropathy
R33.0 through R33.9	Retention of urine
R35.0	Frequency of micturition

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	03/21	06/21
Reviewed CPT and ICD-10-CM codes. References updated and reformatted for AMA style.	10/21	02/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage. Added criteria I.D.5. for 4.5. Prostate nodule, asymmetry or other suspicion of prostate cancer. Moved N40.3 from ICD-10 Table 2 to ICD-10 Table 1. References reviewed and updated.	05/23	05/23

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North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.