Clinical Policy: Urodynamic Testing

Reference Number: CP.MP.98 [Coding Implications](#Coding_Implications)

Last Review Date: 09/19

Revision Log

**See** [Important Reminder](#Important_Reminder) **at the end of this policy for important regulatory and legal information.**

# 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

1. It is the policy of health plans affiliated with Centene Corporation® that urodynamic testing is **medically necessary** to assist in the diagnosis of urologic dysfunction with **any** of the following indications:
   1. Uncertain diagnosis and inability to develop an appropriate initial treatment plan based on the clinical diagnostic evaluation;
   2. Failure to respond to an adequate therapeutic trial;
   3. Consideration of urologic surgical intervention, particularly if previous surgery failed or if the patient is a high surgical risk;
   4. Presence of other comorbid conditions such as any of the following:
   5. Incontinence associated with recurrent symptomatic urinary tract infection;
   6. Persistent symptoms of difficult bladder emptying;
   7. History of previous anti-incontinence surgery or radical pelvic surgery;
   8. Symptomatic pelvic prolapse;
   9. Abnormal post-void-residual urinalysis;
   10. Diabetes mellitus with secondary urinary incontinence;
   11. Neurological conditions affecting voiding function (neurogenic bladder) such as multiple sclerosis, Parkinson’s disease, and spinal cord lesions or injury;
   12. Complex anorectal malformation.
2. It is the policy of health plans affiliated with Centene Corporation that urodynamic testing in the following cases is considered **not medically necessary**:
   1. More than one cystometrogram (CPT codes 51725 or 51726) or uroflowmetry study (CPT codes 51736 or 51741) per visit.
   2. The use of any urodynamic testing for screening in asymptomatic patients, except for evaluation of neurogenic bladder or urological abnormalitites associated with complex anorectal malformation.

## Background

Lower urinary tract symptoms, 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. 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. 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**

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| **CPT® Codes** | **Description** |
| --- | --- |
| 51725 | Simple cystometrogram (CMG)(eg, spinal manometer) |
| 51726 | Complex cystometrogram (ie, calibrated electronic equipment) |
| 51727 | Complex cystometrogram (ie, calibrated electronic equipment; with urethral pressure profile studies (i.e., urethral closure pressure profile), any technique |
| 51728 | Complex cystometrogram (ie, calibrated electronic equipment; with voiding pressure studies (ie, bladder voiding pressure), any technique |
| 51729 | Complex cystometrogram (ie, calibrated electronic equipment; with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique |
| 51736 | Simple uroflowmetry (UFR)(eg, stop-watch flow rate, mechanical uroflowmeter) |
| 51741 | Complex uroflowmetry (eg, calibrated electronic equipment) |
| +51797 | Voiding pressure studies, intra-abdominal (ie, 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 Medical Necessity**

| **ICD-10-CM Code** | **Description** |
| --- | --- |
| 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 |
| G83.4 | Cauda equina syndrome |
| N30.10-N30.11 | Interstitial cystitis, chronic |
| N30.20-N30.21 | Other chronic cystitis |
| N31.0-N31.9 | Neuromuscular dysfunction of bladder, not elsewhere classified |
| N32.0-N32.89 | Other disorders of bladder |
| N39.0-N39.8 | Other disorders of urinary system |
| N81.0-N81.9 | Female genital prolapse |
| Q05.0-Q05.9 | Spina bifida |
| Q06.0-Q06.9 | Other congenital malformations of spinal cord |
| Q07.00-Q07.9 | Other congenital malformations of nervous system |
| Q42.0-Q42.3 | Congenital absence, atresia and stenosis of large intestine |
| R33.8 | Other retention of urine |
| R33.9 | Retention of urine, unspecified |
| R39.81 | Functional urinary incontinence |
| S34.01XA-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 Code** | **Description** |
| --- | --- |
| N13.8 | Other obstructive and reflux uropathy |
| N40.1 | Benign prostatic hyperplasia with lower urinary tract symptoms |
| N40.3 | Nodular prostate with lower urinary tract symptoms |
| R33.0-R33.9 | Retention of urine |
| R35.0 | Frequency of micturition |

| Reviews, Revisions, and Approvals | Date | Approval Date |
| --- | --- | --- |
| Policy developed | 09/15 | 10/15 |
| Removed ICD-10 codes R34, R39.0 – R39.16 due to no support in literature | 02/16 |  |
| References reviewed and updated  Updated ICD-10 code list | 10/16 | 10/16 |
| References reviewed and updated. Added ICD-10-CM E10.69, E11.69, and S34.0 – S34.9XXS | 09/17 | 10/17 |
| References reviewed and updated. Coding reviewed. | 09/18 | 09/18 |
| References reviewed and updated. Added indication of complex anorectal malformation, along with accompanying diagnosis codes of Q42.0-Q42.3. Noted in investigational statement regarding asymptomatic patients, that evaluation of suspected urological abnormalities is appropriate in the presence of complex anorectal malformation. | 09/19 | 09/19 |

### References

1. Winters JC, Dmochowski RR, Goldman HB, et al. Adult urodynamics: American Urological Association (AUA)/Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SUFU) guideline. Linthicum (MD): American Urological Association (AUA); 2012.
2. Shamliyan T, Wyman J, Kane RL. Nonsurgical treatments for urinary incontinence in adult women: diagnosis and comparative effectiveness. Comparative Effectiveness Review No. 36. Prepared by the University of Minnesota Evidence-based Practice Center under Contract No. HHSA 290-2007-10064-I. AHRQ Publication No. 11(12)-EHC074-EF. Rockville, MD. Agency for Healthcare Research and Quality; April 2012.
3. Holroyd-Leduc JM, Straus SE. Management of urinary incontinence in women: scientific review. JAMA. 2004;291(8):986-995. 
4. Dumoulin C, Cacciari LP, [Hay-Smith J](http://www.ncbi.nlm.nih.gov/pubmed/?term=Hay-Smith%20J%5BAuthor%5D&cauthor=true&cauthor_uid=20091581). Pelvic floor muscle training versus no treatment, or inactive control treatments, for urinary incontinence in women. Cochrane Database Syst Rev. 2018; Issue 10. Art. No.: CD005654. (1):CD005654.
5. Flesh G. Urodynamic evaluation of women with incontinence. In: UpToDate, Brubaker L, Eckler K (Ed), UpToDate, Waltham, MA. Accessed 09/09/19.
6. Anderson CA, Omar MI, Campbell SE, Hunter KF, Cody JD, Glazener CMA. Conservative management for postprostatectomy urinary incontinence. Cochrane Database of Systematic Reviews 2015, Issue 1. Art. No.: CD001843. DOI: 10.1002/14651858.CD001843.pub5. Nepple KG, Cooper CS. Evaluation and diagnosis of bladder dysfunction in children. In: UpToDate, Baskin LS, Kim MS (Ed), UpToDate, Waltham, MA. Accessed 09/09/2019.
7. Art. No.: CD004462. Pang H, Dang X, Yao Z et al. Bilateral spontaneous urinary extravasation shown by computed tomography urography in a patient with benign prostatic hyperplasia [Radiol Case Rep.](http://www.ncbi.nlm.nih.gov/pubmed/26649120) 2015 Sep 15;10(4):53-5. doi: 10.1016/j.radcr.2015.07.001. eCollection 2015.
8. Deng F, Liu X, Li Y, et al. Ureteral obstruction by prostate cancer leads to spontaneous ureteric rupture: a case report. Int J Clin Exp Med. 2015; 8(9): 16842–16844.
9. Sarmah PB, Noah A, Kelly BD, Ryan PG. Asymptomatic ureteral rupture secondary to chronic urinary retention from massive prostatic enlargement. [J Surg Case Rep.](http://www.ncbi.nlm.nih.gov/pubmed/26521159) 2015 Oct 31;2015(11). pii: rjv135. doi: 10.1093/jscr/rjv135.
10. Mori K, Koga S, Noguchi M, et al. Spontaneous peripelvic extravasation of urine due to an inflammatory aneurysm of the abdominal aorta. International Journal of Urology (2004) 11, 419–420
11. Schurch B, Iacovelli V, Averbeck MA, et al**.** Urodynamics in patients with spinal cord injury: A clinical review and best practice paper by a working group of The International Continence Society Urodynamics Committee. Neurourol Urodyn. 2017 Aug 1. doi: 10.1002/nau.23369
12. Clement KD, Lapitan MCM, Omar MI, Glazener CMA. Urodynamic studies for management of urinary incontinence in children and adults. Cochrane Database of Systematic Reviews 2013, Issue 10. Art. No.: CD003195.
13. Lightner DJ, Gomelsky A, Souter L, Vasaveda SP. Diagnosis and Treatment of Overactive Bladder (Non-Neurogenic) in Adults: AUA/SUFU Guideline Amendment 2019. J Urol. 2019 Sep;202(3):558-563.
14. Goossens WJ, de Blaauw I, Wijnen MH, de Gier RP, Kortmann B, Feitz WF. Urological anomalies in anorectal malformations in The Netherlands: effects of screening all patients on long-term outcome. Pediatr Surg Int. 2011 Oct;27(10):1091-7. doi: 10.1007/s00383-011-2959-4.

**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.

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**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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