CHAPTER 4
SECTION 14.1

# URINARY SYSTEM

ISSUE DATE: August 26, 1985
AUTHORITY: 32 CFR 199.4(c)(2) and (c)(3)

## I. CPT[1] PROCEDURE CODES

50010 - 53899, 64561, 64581, 64585, 64590, 64595

## II. DESCRIPTION

The urinary system involves those organs concerned in the production and excretion of urine.

## III. POLICY

A. Services and supplies required in the diagnosis and treatment of illness or injury involving the urinary system are covered.

B. Benefits may be considered for the implantation of similar FDA approved devices. The Sacral Nerve Root Stimulation (SNS) has received FDA approval. Services and supplies related to the implantation of the SNS may be covered for individuals with urge incontinence, nonobstructive urinary retention, or symptoms of urgency-frequency syndrome that is not due to a neurologic condition, who have failed previous conservative treatments, and who have had a successful peripheral nerve evaluation test.

C. The use of a bedwetting alarm for the treatment of primary nocturnal enuresis may be considered for cost sharing when prescribed by a physician and after physical or organic causes for nocturnal enuresis have been ruled out.

D. Collagen implantation of the uretha and/or bladder neck may be covered for patients not amenable to other forms of urinary incontinence treatment.

E. Cryoablation for renal cell carcinoma (CPT[1] procedure codes 50250 and 50593) may be considered for coverage under the Rare Disease policy (Chapter 1, Section 3.1) on a case-by-case basis. Effective June 1, 2006.

F. Under the provisions for the treatment of rare diseases, coverage of laparoscopic radiofrequency ablation (CPT[1] procedure code 50542) and percutaneous radiofrequency

[1] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

ablation (CPT[2] procedure code 50592) may be considered on a case-by-case basis for the treatment of Renal Cell Carcinoma (RCC) and genetic syndromes associated with RCC including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma for patients who are not appropriate candidates for surgical intervention.

## IV. EXCLUSIONS

A. Peri-urethral Teflon injection is unproven.

B. Silastic gel implant.

C. Acrylic prosthesis (Berry prosthesis).

D. Bladder stimulators, direct or indirect, such as spinal cord, rectal and vaginal electrical stimulators, or bladder wall stimulators. Payment for any related service or supply, including inpatient hospitalization primarily for surgical implementation of a bladder stimulator.

E. Transurethral balloon dilation of the prostate (CPT[2] procedure code 52510) is unproven.

F. Cryoablation for the treatment of renal angiomyolipoma is unproven.

## V. EFFECTIVE DATE

A. Transurethral Needle Ablation (TUNA) of the prostate is proven (CPT[2] procedure code 53852). Effective June 1, 2004.

B. March 28, 2007, for laparoscopic radiofrequency ablation or percutaneous radiofrequency ablation for the treatment of RCC and genetic syndromes associated with RCC, including von Hippel-Lindau syndrome, hereditary papillary cell carcinoma, or hereditary clear-cell carcinoma.

- END -