



BILLING POLICY No. 208

UROLOGY BILLING

Date of origin: 09/26

Review dates:

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards. Urology billing encompasses the coding, claim submission, and reimbursement processes for diagnostic, therapeutic, and surgical services involving the urinary tract and male reproductive system.

DEFINITIONS

Urologists diagnose and treat a broad range of conditions affecting the urinary system and male reproductive organs. Common urological conditions include kidney stones, benign prostatic hyperplasia (BPH), prostate cancer, bladder cancer, urinary tract infections, overactive bladder, urinary retention, male infertility, erectile dysfunction, and hematuria.

Cystourethroscopy is an outpatient procedure that allows visual examination of the bladder and urethra.,

MEDICAL POLICY

- N/A

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD [in our Provider Manual](#).

POLICY SPECIFIC INFORMATION

Coding specifics

Urology CPT codes fall into several groups: endoscopic procedures, urodynamic testing, prostate procedures, stone management, and minor surgical services. Below is a sample table of common CPT® procedure codes with their descriptions, grouped by category for clarity:

Procedure Category	CPT Code	Description
Cystoscopy	52000	Diagnostic Cystourethroscopy
Cystoscopy with biopsy	52204	Cystourethroscopy with biopsy
Cystoscopy with fulguration	52224	Cystourethroscopy with fulguration of lesion
Cystoscopy with stent	52332	Cystourethroscopy with insertion of indwelling ureteral stent
Urethra and Bladder transurethral surgical procedure	52284	Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug deliver by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed
Urodynamics	51741	Complex uroflowmetry

Urodynamics	51726/ 51728	Cystometrography, simple or complex
Urodynamics	51772	Urethral pressure profile study
Prostate surgery	52601	Transurethral resection of prostate
BPH treatment	52441/52442	Cystourethroscopy with permanent implant (Urolift)
BPH treatment	53854	Transurethral water vapor thermotherapy (Rezum)
Kidney stone	50590	Extracorporeal shock wave lithotripsy
Kidney stone	52356	Ureteroscopy with lithotripsy and stent
Vasectomy	55250	Vasectomy, unilateral or bilateral
Circumcision	54150	Circumcision using clamps or device

*For a claim line with a procedure code for cystourethroscopy that does not meet patient gender requirements and does not contain a diagnosis within the excluded diagnosis list, the claim line will deny.

Modifiers

The list of Modifiers in urology billing included in the table below represents whether a service was reduced, distinct, repeated, or split between professional and technical components. Incorrect modifier use is one of the leading causes of denied or underpaid urology claims.

Modifier	Description
51	Multiple procedures
59	Distinct procedural service
26	Professional component
TC	Technical component
25	Significant, separate E/M service
24	Unrelated E/M during postoperative period
79	Unrelated procedure during postoperative period
76	Repeat procedure, same physician
LT/RT	Procedures on paired structures such as kidneys or testes

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information [in our Provider Manual](#).

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Reimbursement specifics

Submit references for fee schedules or specific reimbursements. Usually present in older versions of the policy.

Resources

- [CMS](#)
- [Medtronic Urology surgery](#)
- [Transcure urology billing](#)

Related policies

Related denial language

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency which are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
09/28/2026	New policy was created.