The female urethral dilation codes (53660-53665) involve the insertion of dilators, usually multiple dilators of progressively increasing size, to widen the urethra, and promote complete voiding of the bladder in patients with voiding problems. The physician may use a suppository or perform instillation of other medication to relieve a urethral stricture.

- 53660 — Dilation of female urethra including suppository and/or instillation; initial
- 53661 — ... subsequent
- 53665 — Dilation of female urethra, general or conduction (spinal) anesthesia.

ICD-9-CM Codes

- 595.1 — Chronic interstitial cystitis
- 595.2 — Other chronic cystitis
- 595.3 — Trigonitis
- 598.00 — Urethral stricture due to unspecified infection
- 598.01 — Urethral stricture due to infective diseases classified elsewhere
- 598.1 — Traumatic urethral stricture
- 598.2 — Postoperative urethral stricture
- 598.8 — Other specified causes of urethral stricture
- 625.5 — Pelvic congestion syndrome
- 753.6 — Atresia and stenosis of urethra and bladder neck
- 788.1 — Dysuria
- 788.20 — Retention of urine, unspecified
- 788.21 — Incomplete bladder emptying
- 788.29 — Other specified retention of urine.

Codes 53660 and 53661 are mutually exclusive, and you may not report them together under any circumstances. If a patient has a record of a previous 53660, report 53661 for any subsequent urethral dilation, or 53665 if the physician conducts the dilation under general anesthesia.

Correct Coding Initiative (CCI) edits bundle the catheterization codes (51701-51703) into the urethral dilation codes. It also includes P9612 (Catheterization for collection of specimen, single patient, all places of service) in 53660 and 53661, along with J2001 (Injection, lidocaine HCl for intravenous infusion, 10 mg). In addition, CCI bundles 51700 (Bladder irrigation, simple, lavage and/or instillation) into 53661.

Pubovaginal sling: A physician may report performing a “takedown” of a pubovaginal sling with 57287 (Removal or revision of sling for stress incontinence [eg, fascia or synthetic]). If the sling was originally placed to treat stress incontinence, code 57287 for vaginal release and/or removal of the sling material. If the surgeon approaches suprapublically to cut or loosen the suture, use 10120 (Incision and removal of foreign body, subcutaneous tissues; simple) or 10121 (... complicated). Usually, a physician performs one (57287) or the other (10120 or 10121), but sometimes performs both.

The physician will often perform urethral dilation along with the sling release, and if he does, report 53660. If he performs 57287 during the postoperative period (90 days) of 57288 (Sling operation for stress incontinence [eg, fascia or synthetic], append modifier 78 (Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period) to 57287 and 53660.

Watch out for SNF consolidated billing: Medicare's skilled nursing facility (SNF) consolidated billing program requires physicians who perform services for SNF patients to forward the technical portions of any services, including 53660 and 53661, to the SNF to be billed by the SNF to its Medicare intermediary for payment. Doctors frequently perform urethral dilation on female SNF patients. Medicare carriers will not make payment to physicians and suppliers for technical
components of physician services furnished to beneficiaries in the course of a Medicare Part A covered stay. This policy applies whether the physician performs the services at the SNF or in an office setting; Medicare Part B will reimburse your practice for E/M services provided in the office.

If a patient is an occupant of an SNF bed and you don't know this when you file the claim, you could owe Medicare a refund. CMS has begun issuing refund requests to practices that have submitted claims for the global payment of services to Part B and erroneously received reimbursement for drugs and technical components of services rendered to SNF patients.

Therefore, for SNF patients, bill your Medicare carrier directly for the professional services involved in the dilation with modifier 26 (Professional component) appended. File the claim for the technical aspect of the procedure as though the SNF were an insurance carrier, putting the name of the facility at the top of the CMS form, and your billing information, place of service, etc., below. Append modifier TC (Technical component) to the procedure code. To avoid any payment obstacles, you should draw up a contract that requires the SNF to reimburse you for your technical and other procedural services and drugs.

Warning: An SNF patient's status changes all the time. Make sure you've established the patient's status as a SNF resident the day of the visit, not one day ahead, because it may change daily.

Some private payers deny E/M on same day as urethral dilation: Physicians may perform E/M services at the same visit as minor surgical procedures such as 53660 and 53661. Medicare and some private payers, including Blue Cross, will pay for separately identifiable E/M service along with urethral dilation (53660-53665) with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) appended. Reporting the E/M service with the modifier is appropriate if the medical documentation shows that the E/M was separately identifiable from the surgical procedure. Other private payers, including Aetna and Cigna, frequently deny the E/M claim, however, despite the modifier use and regardless of documentation.

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