



Medical Coverage Policy

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Scrotal Ultrasound

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Related Coverage Resources

- [Infertility Services](#)
- [Male Sexual Dysfunction Treatment: Non-pharmacologic](#)

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Overview

This Coverage Policy (CP) addresses ultrasound (US) of the scrotum (CPT® 76870). This CP does not address penile vessel US or US for biopsy guidance.

Coverage Policy

Scrotal ultrasound is considered medically necessary for an individual with ANY of the following indications:

- acute scrotal pain or testicular torsion
- acute scrotal trauma or injury
- suspected infectious or inflammatory scrotal disease
- scrotal neoplasm or mass
- family history of testicular cancer/ germ cell tumor (GCT)
- scrotal varices (varicocele)
- hydrocele or spermatocele/epididymal cyst
- suspected inguinal hernia (occult)

- nonpalpable testes
- in evaluation of infertility

Scrotal ultrasound is considered not medically necessary for all other indications.

General Background

Ultrasound imaging of the scrotum uses sound waves to produce pictures of the testicles and surrounding tissues. Ultrasound is safe, noninvasive, and does not use ionizing radiation. Standard ultrasound technique is performed with the patient lying supine with the scrotum supported by a towel between the thighs. Additional views may be obtained by changing the patient's position to standing or laying on his side. The scrotum is divided into right and left compartments by the scrotal septum, each containing a testis, epididymis, and spermatic cord. Types of ultrasonography include:

- B (brightness) mode ultrasonography, also known as grey scale, renders a two-dimensional image in which the organs and tissues of interest are depicted as points of variable brightness.
- Doppler US is used to detect moving blood cells or other moving structures and measure their direction and speed of movement.
- Color Doppler US uses a computer to convert the Doppler measurements into an array of colors. This color visualization is combined with a standard ultrasound picture of a blood vessel to show the speed and direction of blood flow through the vessel.
- Power Doppler is used to obtain images that are difficult or impossible to obtain using standard color Doppler and to provide greater detail of blood flow, especially in vessels that are located inside organs. Power Doppler is more sensitive than color Doppler for the detection and demonstration of blood flow, but provides no information about the direction of flow. Color and spectral Doppler both reveal the direction of blood flow.
- Spectral Doppler displays the blood flow measurements graphically, displaying flow velocities recorded over time.

Alternatives to ultrasound may include but are not limited to physical examination, serum or urine lab work, conservative therapy, referral to a specialist and surgical exploration. When evaluating the scrotum, a thorough history and physical is needed. A thorough physical examination should include both standing and supine patient positions.

Literature Review

Pain / Testicular torsion

Acute epididymitis (infection of the tube that carries semen out of the testicles) is the most common cause of scrotal pain in adults. Another common cause is testicular torsion. Any patient presenting with acute scrotal pain and a mass or swelling should be urgently evaluated for testicular torsion because timely diagnosis is key to preserving testicular function. Ultrasonography is helpful to rule out testicular torsion. With the addition of Doppler imaging, the sensitivity and specificity of ultrasonography for testicular torsion range from 86% to 93%. Color Doppler US is highly accurate for diagnosing testicular torsion, with recent studies reporting Doppler sensitivities of 95–100% and specificities of 85–95% for testicular torsion diagnosis. A 2019 systematic review and meta-analysis included eight studies conducted after 2010, pooled sensitivity and specificity were 0.95 and 0.98 respectively. The authors concluded that ultrasound is an effective imaging modality for the diagnosis of testicular torsion in adult patients with acute scrotal pain and should be performed for adult patients with acute scrotal pain (Ota, et al., 2019; Alkhori, et al., 2017; Crawford, et al., 2014).

Trauma or injury

Prompt diagnosis is essential in the triage of patients with scrotal trauma. More than one half of testicular injuries are caused by blunt trauma. Blunt trauma from being struck in the groin during athletic activity is the most common type. The sonographic characteristics of scrotal trauma can be broadly classified into intratesticular (e.g., testicular rupture, hematoma) and extratesticular (e.g., hematocele, traumatic epididymitis, trauma-induced testicular torsion) and intrascrotal and extrascrotal injuries (e.g., to the penis and perineum). Patients with trauma

and scrotal pain should always undergo ultrasonography. High-frequency ultrasound with a linear transducer and gray-scale, color, and spectral Doppler flow technique is the primary noninvasive modality for establishing an accurate diagnosis (Crawford, et al., 2014; Nicola, et al., 2014).

Infectious or Inflammatory scrotal disease

Acute epididymitis is the most common cause of scrotal pain in adults. Epididymitis is most often caused by a bacterial infection, which can include sexually transmitted infections (STIs). If symptoms are localized to the posterior aspect of the testis, a presumptive diagnosis of acute epididymitis can be made. Lower urinary tract symptoms may be present. Orchitis is inflammation of one or both testicles in men, usually caused by an infection. Orchitis can result from the spread of bacteria through the blood from other locations in your body. It also can be a progression of epididymitis. This is called epididymo-orchitis. Epididymo-orchitis is the most common complication of mumps in the adult male, with most patients having fever and parotitis preceding the onset of orchitis. Patients with acute epididymitis should generally improve within 48 to 72 hours after starting appropriate antibiotic therapy. If the symptoms are not better, other causes of scrotal pain should be considered and referral to an urologist for consultation and scrotal ultrasound are advised.

For patients who are febrile, the initial step is to rule out Fournier's gangrene, which is characterized by diffuse scrotal, groin, and lower abdominal pain, tenderness, and swelling and necessitates urgent surgical evaluation. Fournier's gangrene is a necrotizing fasciitis (mixed aerobic/anaerobic infection) of the perineum which often involves the scrotum (Brenner, et al., 2018).

Neoplasm or mass

Approximately 95% of all testicular tumors in adults are derived from the germ cells. They are categorized as seminomatous or nonseminomatous germ cell tumors, and are the most common cancers diagnosed in males 15 to 34 years of age. Urgent referral to an urologist is indicated for patients with intratesticular masses, even though smaller masses are less likely to be cancerous. Gray-scale US is widely used and shows high sensitivity regarding the detection, localization, and sizing of testicular lesions, but it shows low specificity in differentiating benign from malignant intratesticular lesions.

A varicocele is a collection of dilated and tortuous veins in the pampiniform plexus surrounding the spermatic cord in the scrotum. Anatomically, varicoceles are caused by dysfunction of the valves in the spermatic vein, which allows pooling of blood in the pampiniform plexus. This is more likely to occur in the left spermatic vein than in the right because of normal anatomical asymmetry. Varicocele is present in one quarter of men with abnormal semen analyses. However, the precise association between male subfertility and varicocele is unclear. If the varicocele persists in the supine position, has acute onset, or is right-sided (secondary varicocele), then processes that cause inferior vena caval (IVC) obstruction must be ruled out with Doppler ultrasonography.

A hydrocele is a collection of peritoneal fluid between the parietal and visceral layers of the tunica vaginalis. Hydroceles may be communicating or noncommunicating. Hydroceles are common in newborns (whether related to delayed closure of a patent processus vaginalis or fluid trapped at the time of testicular descent is not known). The majority of hydroceles in neonates resolve spontaneously, usually by the first or second birthday. The diagnosis of hydrocele can be made by physical examination and transillumination of the scrotum that demonstrates a cystic fluid collection. Doppler ultrasonography may be necessary to evaluate the testicle and rule out a primary cause or to determine if an abdominoscrotal hydrocele is present.

A spermatocele (epididymal cyst) is a painless, fluid-filled cyst of the head (caput) of the epididymis that may contain nonviable sperm. A spermatocele can be palpated as distinct from the testis and typically transilluminates as a cystic mass. In contrast, testicular tumors are palpated within the testis and do not transilluminate. Ultrasonography may be helpful to confirm the diagnosis of spermatocele. A cyst of the epididymis contains clear fluid. Differing from a spermatocele, these cysts usually no contain sperm and can be diagnosed by transillumination (Mayo Clinic, 2020; Brenner, et al., 2019; Rebik, et al., 2019; Auer, et al., 2017; Macleod, et al., 2015; Mirochnik, et al., 2012; Children's Hospital of Philadelphia, 2012; Lau, et al., 1999).

Inguinal hernia

Groin hernias have a variety of clinical presentations ranging from a finding of a bulge in the groin region on routine physical examination (with or without pain) to emergent, life-threatening presentations due to bowel

strangulation. Approximately 96 percent of groin hernias are inguinal and four percent are femoral. In many cases, it is easier and more reliable to demonstrate a hernia bulge with the patient standing, although some hernias, particularly strangulated hernias, can be appreciated while the patient is supine. Two thirds of groin hernias are located on the right side. Hernias are classified as direct and indirect, depending on their relationship to the inferior course of the inguinal canal:

- Indirect inguinal hernia is caused by a birth defect in the abdominal wall that is congenital (present at birth).
- Direct inguinal hernia usually occurs in adult males. These are most often caused by a weakness in the muscles of the abdominal wall that develops over time, or are due to straining or heavy lifting.

In the majority of cases, a diagnosis of inguinal hernia can be made based upon history and physical examination, without the need for further studies. Scrotal US (CPT® 76870) images the scrotal contents and does not typically include the inguinal canal. If an inguinoscrotal hernia is suspected and the provider is unable to confirm a diagnosis of hernia by physical exam - including standing and with Valsalva maneuver - scrotal ultrasound may be utilized in attempt to locate an occult inguinoscrotal hernia. Operative findings remain the gold standard for confirming a diagnosis of occult hernia (UpToDate/Brooks, 2020; French, et al., 2019; Niebuhr, et al., 2017; Park, et al., 2016; Light, et al., 2011; Bradley, et al., 2003).

In a meta-analysis of 'groin sonography', Robinson, et al. (2013) reported on groin US results of 401 clinically occult hernias:

- Sensitivity 87.3 (79.4–92.4)
- Specificity 85.5 (80.3–89.6) (the values for specificity in particular should be seen as indicative only).
- Positive predictive value 73.6 (65.1–80.6)
- Negative predictive value 93.6 (89.3–96.2)

Robinson stated that “Although sonography is highly accurate in confirming clinically apparent hernias, it is unnecessary in those cases, as there is little additional benefit to patients, and it is an inefficient use of imaging resources. In cases of clinical uncertainty, sonography is able to confirm or refute clinical diagnoses in most patients, and although the overall diagnostic accuracy in this setting is substantially lower than with clinically evident hernias, there is a far greater likelihood of changing clinical diagnoses and reducing unnecessary surgery”.

Nonpalpable testes

Cryptorchidism, or undescended testes, is a common congenital abnormality of male newborns, affecting up to 0.1% to 4.3% of male newborns. US does not add diagnostic accuracy, with sensitivity and specificity to localize nonpalpable testis at 45% and 78%, respectively. At this time, there is no radiological test that can conclude with 100% accuracy that a testis is absent. Diagnostic laparoscopy is the gold standard with high sensitivity and specificity (Kim, et al., 2018; Braga, et al., 2017; Kolon, et al., 2014; Tasian, et al., 2011).

Kim et al. (2018) conducted a systematic review of recent clinical practice guidelines (CPGs) on management of cryptorchidism including all English-based CPGs providing recommendations for the management of cryptorchidism from 2012 to 2017. Five CPGs from Agency for Healthcare Research and Quality (AHRQ), American Urological Association (AUA), British Association of Pediatric Surgeons/British Association of Urologic Surgeons (BAPS/BAUS), Canadian Urological Association (CUA), and European Association of Urology/European Society for Pediatric Urology (EAU/ESPU) were assessed. Using the AGREE II (Appraisal of Guidelines and Research Evaluation) instrument, eligible CPGs were independently appraised by five reviewers. Findings include:

- All guidelines except AHRQ recommend surgical referral by primary care providers, especially if there is no descent of cryptorchidism by six months. The AUA and CUA guidelines further recommend that there should be surgical referral for newly diagnosed cryptorchidism after six months.
- All guidelines recommend against the use of ultrasound and other diagnostic imaging since it does not change management and does not add diagnostic accuracy. However, CUA and EAU/ESPU support limited use of diagnostic imaging for selective cases such as suspicion of disorders of sexual development.

Infertility

Along with a history and physical examination, semen analysis and other laboratory tests, scrotal ultrasound is an accepted diagnostic test to aid in determining the etiology of infertility. Careful physical examination can identify most scrotal pathology, including varicoceles, spermatoceles, absent vasa, epididymal induration, and testicular masses. Scrotal ultrasonography can identify occult varicoceles that are not palpable, but such lesions have no demonstrated clinical significance. Scrotal ultrasonography can be helpful for better defining vague or ambiguous physical examination findings or abnormalities (including apparent masses) and can be performed in men having testes located in the upper scrotum, a small scrotal sac, or other anatomy that hinders physical examination. Testicular ultrasonography also should be considered for men presenting with infertility and risk factors for testicular cancer, such as cryptorchidism or a previous testicular neoplasm (American Society for Reproductive Medicine, 2012).

Testicular microlithiasis

Testicular microlithiasis is the deposition of multiple tiny calcifications throughout one or both testes and is a relatively rare condition that is detected incidentally. Most studies of testicular microlithiasis involve men who had testicular ultrasounds done for some other reason, such as pain or infertility. The microliths do not bring about pain or symptoms and are impalpable. A number of advances in US technology in recent years have further increased US image quality; it is likely that this has resulted in increased detection of testicular microliths (TML). The presence of TML alone in the absence of other risk factors is not an indication for regular scrotal US, further US screening or biopsy. US may be recommended in the follow-up of patients at risk, when risk factors other than microlithiasis are present (e.g., previous germ cell tumor) (Pedersen, et al., 2019; Balawender, et al., 2018; Richenberg, et al., 2015).

Professional Societies/Organizations

American Urological Association (AUA)

The AUA 2019 Clinical Guideline Diagnosis and Treatment of Early Stage Testicular Cancer states:

- A solid mass in the testis identified by physical exam or imaging should be managed as a malignant neoplasm until proven otherwise. (Clinical Principle)
- Scrotal ultrasound with Doppler should be obtained in patients with a unilateral or bilateral scrotal mass suspicious for neoplasm. (Strong Recommendation; Evidence Level: Grade B*)
- Testicular microlithiasis in the absence of solid mass and risk factors for developing a germ cell tumor (GCT) does not confer an increased risk of malignant neoplasm and does not require further evaluation. (Moderate Recommendation; Evidence Level: Grade C)
- Patients with normal serum tumor markers (hCG and AFP) and indeterminate findings on physical exam or testicular ultrasound for testicular neoplasm should undergo repeat imaging in six to eight weeks. (Clinical Principle)
- MRI should not be used in the initial evaluation and diagnosis of a testicular lesion suspicious for neoplasm. (Moderate Recommendation; Evidence Level: Grade C)

The AUA states that risk factors for developing testis cancer include germ cell neoplasia in situ (GCNIS), history of undescended testis (UDT)/ cryptorchidism, family history, and a personal history of testis cancer. Infertility is associated with the presence of GCT, though this association is thought to arise from inherent testicular dysfunction. The AUA notes that men with incidentally detected microlithiasis should not undergo further evaluation or screening. Men with risk factors and testicular microlithiasis should be counseled about the potential increased risk of GCT, perform periodic self-examination, and be followed by a medical professional (Stephenson, et al., 2019).

The AUA Urotrauma Guideline states that for blunt scrotal injuries, clinicians should perform scrotal ultrasonography for most patients having findings suggestive of testicular rupture (evidence strength C; Observational studies that are inconsistent, have small sample sizes or have other problems that potentially confound interpretation of data) (Morey, et al, 2021).

AUA and the American Society for Reproductive Medicine (ASRM) 2021 Guideline on Diagnosis and Treatment of Infertility in Men states that scrotal ultrasound should not be routinely performed in the initial evaluation of the infertile male (Expert Opinion) (Schlegel, et al., 2021).

The AUA Consensus Statement on Urologic Ultrasound Utilization states that the AUA supports the American Institute of Ultrasound in Medicine Practice Guideline for the Performance of an Ultrasound Examination in the Practice of Urology developed in collaboration with the AUA (Reaffirmed October 2018).

The AUA 2014 Evaluation and Treatment of Cryptorchidism states:

- Providers should NOT perform ultrasound (US) or other imaging modalities in the evaluation of boys with cryptorchidism prior to referral, as these studies rarely assist in decision making. (Standard; Evidence Strength: Grade B*)
- Providers should refer infants with a history of cryptorchidism (detected at birth) who do not have spontaneous testicular descent by six months (corrected for gestational age) to an appropriate surgical specialist for timely evaluation. (Standard; Evidence Strength: Grade B)
- Providers should refer boys with the possibility of newly diagnosed (acquired) cryptorchidism after six months (corrected for gestational age) to an appropriate surgical specialist. (Standard; Evidence Strength: Grade B)
- Providers must immediately consult an appropriate specialist for all phenotypic male newborns with bilateral, nonpalpable testes for evaluation of a possible disorder of sex development (DSD). (Standard; Evidence Strength: Grade A) (Kolon, et al., 2014).

*AUA Evidence Strength:

- Grade A: well-conducted and highly generalizable RCTs or exceptionally strong observational studies with consistent findings
- Grade B: RCTs with some weaknesses of procedure or generalizability or moderately strong observational studies with consistent findings
- Grade C: RCTs with serious deficiencies of procedure or generalizability or extremely small sample sizes or observational studies that are inconsistent, have small sample sizes, or have other problems that potentially confound interpretation of data

American Academy of Pediatrics (AAP)

The AAP 2012 Clinical Report on Assessment and Management of Inguinal Hernia in Infants states that the utility of contralateral inguinal exploration in children is an area of active debate. Various diagnostic modalities, such as the physical examination, herniography, or ultrasonographic examination are not particularly sensitive or specific, thus making these efforts unreliable. With the advent of laparoscopic techniques, inspection of the contralateral internal ring has become increasingly popular as the method of choice for evaluating for a patent processus vaginalis (PPV) (Wang, et al., 2012).

American Institute of Ultrasound in Medicine (AIUM)

The American Institute of Ultrasound in Medicine (AIUM) 2021 Practice Parameter for the Performance of Scrotal Ultrasound Examinations states that indications for scrotal ultrasound include but are not limited to the following:

- evaluation of scrotal pain, including but not limited to testicular trauma, ischemia/torsion, postsurgical pain, and infectious or inflammatory scrotal disease
- evaluation of palpable inguinal, intrascrotal, or testicular masses
- evaluation of scrotal asymmetry, swelling, or enlargement
- evaluation of potential intrascrotal hernias
- detection/evaluation of varicoceles
- evaluation of male infertility
- follow-up of prior indeterminate scrotal ultrasound findings
- localization of nonpalpable testes
- evaluation of inguinal testes
- detection of occult primary tumors in patients with metastatic germ cell tumors or unexplained retroperitoneal adenopathy
- follow-up of patients with prior primary testicular neoplasms, leukemia, or lymphoma
- evaluation of abnormalities noted on other imaging studies (including but not limited to computed tomography [CT], magnetic resonance imaging [MRI], and positron emission tomography [PET])

- evaluation of a disorder of sexual development (AIUM, 2021).

The AIUM 2011 Practice Parameter for the Performance of an Ultrasound Examination in the Practice of Urology states indications for a scrotal ultrasound examination include but are not limited to:

- evaluation of scrotal pain, including but not limited to testicular trauma, ischemia/ torsion, and infectious or inflammatory scrotal disease;
- evaluation of palpable inguinal, scrotal, or scrotal masses;
- evaluation of scrotal asymmetry, swelling, or enlargement;
- evaluation of potential scrotal hernias;
- detection/evaluation of varicoceles;
- evaluation of male infertility;
- follow-up of prior indeterminate scrotal ultrasound findings;
- localization of undescended testes;
- detection of occult primary tumors in patients with metastatic germ cell tumors;
- follow-up of patients with prior primary testicular neoplasms, leukemia, or lymphoma;
- evaluation of abnormalities noted on other imaging studies (including but not limited to computed tomography, magnetic resonance imaging, and positron emission tomography); and
- evaluation of intersex conditions (AIUM, 2011).

National Comprehensive Cancer Network® (NCCN®): The NCCN Clinical Practice Guidelines in Oncology Testicular cancer lists ultrasound under Work up for suspicious testicular mass as well as in discussion of pure seminoma and nonseminoma cancers (NCCN, v.2.2021).

The NCCN Clinical Practice Guidelines in Oncology Acute Lymphoblastic Leukemia states that all male patients should be evaluated for testicular involvement of disease, including a scrotal ultrasound as indicated; testicular involvement is especially common in cases of T-cell ALL (NCCN, v.1.2021).

The American Board of Internal Medicine’s (ABIM) Foundation Choosing Wisely® Initiative:

- American Urological Association:
 - Don’t routinely perform ultrasound on boys with cryptorchidism (updated May 26, 2017).
- Society of American Gastrointestinal and Endoscopic Surgeons
 - Avoid the routine use of ultrasound in evaluating clinically apparent inguinal hernia (January 9, 2019).

Use Outside of the US

The Canadian Urological Association-Pediatric Urologists of Canada (CUA-PUC) 2017 guideline for the diagnosis, management, and follow up of cryptorchidism states that “Imaging studies, such as ultrasound, computed tomography scan or magnetic resonance imaging, are unnecessary, expensive, potentially misleading, and not warranted. They can be selectively ordered after specialist evaluation, including patients with suspected disorder of sexual development, and prior to surgical intervention at the discretion of the specialist” (Braga, et al., 2017).

The European Society of Urogenital Radiology (ESUR) 2015 guidelines on testicular microlithiasis imaging state these consensus opinions of the scrotal subcommittee of the ESUR:

- The presence of TML alone in the absence of other risk factors is not an indication for regular scrotal US, further US screening or biopsy.
- US is recommended in the follow-up of patients at risk, where risk factors other than microlithiasis are present. Risk factors include personal/ family history of GCT, maldescent, orchidopexy, testicular atrophy.
- Annual US advised for patients with risk factors up to age 55.
- If TML is found with testicular mass, urgent specialist referral advised (Richenberg, et al., 2015).

The International guidelines for groin hernia management (2018) states that ‘inguinal hernia diagnosis can be confirmed by physical examination alone in the vast majority of patients with appropriate signs and symptoms. Rarely, ultrasound is necessary (HerniaSurge Group, 2018).

European Society of Urogenital Radiology Scrotal and Penile Imaging Working Group (ESUR-SPIWG) guideline on Ultrasound evaluation of varicoceles notes that grey-scale and Doppler US modes are used to assess the parameters required for varicocele classification. There is no universally recognized classification system. In patients with varicoceles, the patient should be examined at rest and during Valsalva in the supine and erect positions; the standing position is often more informative. Bilateral grey-scale, color, and spectral Doppler analysis are recommended (Freeman, et al., 2020).

Medicare Coverage Determinations

	Contractor	Policy Name/Number	Revision Effective Date
NCD	National	NCD for Ultrasound Diagnostic Procedures (220.5) Scrotal US not addressed in this NCD.	5/22/2007
LCD		No Local Coverage Determination found	

Note: Please review the current Medicare Policy for the most up-to-date information.

Coding/Billing Information

- Note:** 1) This list of codes may not be all-inclusive.
2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
76870	Ultrasound, scrotum and contents

ICD-10-CM Diagnosis Codes	Description
C62.10- C62.12	Malignant neoplasm (descended testis, epididymis, spermatic cord)
C63.00- C63.02	Malignant neoplasm of epididymis
C63.10- C63.12	Malignant neoplasm of spermatic cord
C63.2	Malignant neoplasm of scrotum
D29.20	Benign neoplasm of unspecified testis
D29.21	Benign neoplasm of right testis
D29.22	Benign neoplasm of left testis
D29.30	Benign neoplasm of unspecified epididymis
D29.31	Benign neoplasm of right epididymis
D29.32	Benign neoplasm of left epididymis
D29.4	Benign neoplasm of scrotum
D29.8	Benign neoplasm of other specified male genital organs
D29.9	Benign neoplasm of male genital organ, unspecified
D40.10	Neoplasm of uncertain behavior of unspecified testis
D40.11	Neoplasm of uncertain behavior of right testis
D40.12	Neoplasm of uncertain behavior of left testis
I86.1	Scrotal varices
K40.00 - K40.91	Inguinal hernia

ICD-10-CM Diagnosis Codes	Description
N43.0	Encysted hydrocele
N43.1	Infected hydrocele
N43.2	Other hydrocele
N43.3	Hydrocele, unspecified
N43.40	Spermatocele of epididymis, unspecified
N43.41	Spermatocele of epididymis, single
N43.42	Spermatocele of epididymis, multiple
N44.00	Torsion of testis, unspecified
N44.01	Extravaginal torsion of spermatic cord
N44.02	Intravaginal torsion of spermatic cord
N44.03	Torsion of appendix testis
N44.04	Torsion of appendix epididymis
N45.1	Epididymitis
N45.2	Orchitis
N45.3	Epididymo-orchitis
N45.4	Abscess of epididymis or testis
N46.01	Organic azoospermia
N46.021	Azoospermia due to drug therapy
N46.022	Azoospermia due to infection
N46.023	Azoospermia due to obstruction of efferent ducts
N46.024	Azoospermia due to radiation
N46.025	Azoospermia due to systemic disease
N46.029	Azoospermia due to other extratesticular causes
N46.121	Oligospermia due to drug therapy
N46.122	Oligospermia due to infection
N46.123	Oligospermia due to obstruction of efferent ducts
N46.124	Oligospermia due to radiation
N46.125	Oligospermia due to systemic disease
N46.129	Oligospermia due to other extratesticular causes
N46.8	Other male infertility
N46.9	Male infertility, unspecified
N49.2	Inflammatory disorders of scrotum
N49.3	Fournier gangrene
N49.8	Inflammatory disorders of other specified male genital organs
N50.0	Atrophy of testis
N50.1	Vascular disorders of male genital organs
N50.3	Cyst of epididymis
N50.811	Right testicular pain
N50.812	Left testicular pain
N50.819	Testicular pain, unspecified
N50.82	Scrotal pain
P83.5	Congenital hydrocele
Q53.00	Ectopic testis, unspecified
Q53.01	Ectopic testis, unilateral
Q53.02	Ectopic testes, bilateral
Q53.10	Unspecified undescended testicle, unilateral
Q53.111	Unilateral intraabdominal testis
Q53.112	Unilateral inguinal testis
Q53.12	Ectopic perineal testis, unilateral
Q53.13	Unilateral high scrotal testis

ICD-10-CM Diagnosis Codes	Description
Q53.20	Undescended testicle, unspecified, bilateral
Q53.211	Bilateral intraabdominal testes
Q53.212	Bilateral inguinal testes
Q53.22	Ectopic perineal testis, bilateral
Q53.23	Bilateral high scrotal testes
Q53.9	Undescended testicle, unspecified
Q55.22	Retractile testis
Q55.23	Scrotal transposition
S30.22XA	Contusion of scrotum and testes, initial encounter
S30.22XD	Contusion of scrotum and testes, subsequent
S30.22XS	Contusion of scrotum and testes, sequela
S30.94XA	Unspecified superficial injury of scrotum and testes, initial encounter
S30.94XD	Unspecified superficial injury of scrotum and testes, subsequent encounter
S30.94XS	Unspecified superficial injury of scrotum and testes, sequela
S31.30XA	Unspecified open wound of scrotum and testes, initial encounter
S31.30XD	Unspecified open wound of scrotum and testes, subsequent encounter
S31.30XS	Unspecified open wound of scrotum and testes, sequela encounter
S31.31XA	Laceration without foreign body of scrotum and testes, initial encounter
S31.31XD	Laceration without foreign body of scrotum and testes, subsequent encounter
S31.31XS	Laceration without foreign body of scrotum and testes, sequela encounter
S31.32XA	Laceration with foreign body of scrotum and testes, initial encounter
S31.32XD	Laceration with foreign body of scrotum and testes, subsequent encounter
S31.32XS	Laceration with foreign body of scrotum and testes, sequela
S31.33XA	Puncture wound without foreign body of scrotum and testes, initial encounter
S31.33XD	Puncture wound without foreign body of scrotum and testes, subsequent encounter
S31.33XS	Puncture wound without foreign body of scrotum and testes, sequela
S31.34XA	Puncture wound with foreign body of scrotum and testes, initial encounter
S31.34XD	Puncture wound with foreign body of scrotum and testes, subsequent encounter
S31.34XS	Puncture wound with foreign body of scrotum and testes, sequela
S31.35XA	Open bite of scrotum and testes, initial encounter
S31.35XD	Open bite of scrotum and testes, subsequent encounter
S31.35XS	Open bite of scrotum and testes, sequela
S38.02XA	Crushing injury of scrotum and testis, initial encounter
S38.02XD	Crushing injury of scrotum and testis, subsequent encounter
S38.02XS	Crushing injury of scrotum and testis, sequela
Z80.43	Family history of malignant neoplasm of testis
Z80.49	Family history of malignant neoplasm of other genital organs

Considered Not Medically Necessary:

ICD-10-CM Diagnosis Codes	Description
	All other codes

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