Coding Companion for Urology/Nephrology

A comprehensive illustrated guide to coding and reimbursement
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49421

Insertion of tunneled intraperitoneal catheter for dialysis, open

Explanation
The physician places a tunneled intraperitoneal catheter for dialysis using an open technique. The physician makes a small abdominal incision, opens the peritoneum (the double-layered sac covering the internal organs and lining the abdominopelvic walls), and inserts the catheter into the cavity. The proximal end of the catheter is tunneled subcutaneously away from the initial incision and brought out through the skin. The incision is closed. A separately reportable subcutaneous extension of the intraperitoneal catheter with a remote chest exit site may also be performed at this time.

Coding Tips
For laparoscopic insertion of a tunneled intraperitoneal catheter, see 49324. To report the insertion of a tunneled intraperitoneal catheter, with subcutaneous port, see 49419; removal, see 49422. Subcutaneous extension of an intraperitoneal catheter with remote chest exit site (49435) is reported with 49421, when performed. For removal of a non-tunneled catheter, report the appropriate E/M code.

ICD-9-CM Diagnostic
250.40 Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled — (Use additional code to identify manifestation: 581.81, 583.81, 585.1-585.9)
250.41 Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled — (Use additional code to identify manifestation: 581.81, 583.81, 585.1-585.9)
250.42 Diabetes with renal manifestations, type II or unspecified type, uncontrolled — (Use additional code to identify manifestation: 581.81, 583.81, 585.1-585.9)
250.43 Diabetes with renal manifestations, type I [juvenile type], uncontrolled — (Use additional code to identify manifestation: 581.81, 583.81, 585.1-585.9)
445.81 Atherosclerosis of kidney — (Use additional code for any associated acute kidney failure or chronic kidney disease: 584, 585)

581.81 Nephrotic syndrome with other specified pathological lesion in kidney in diseases classified elsewhere — (Code first underlying disease: 084.9, 249.4, 250.4, 277.30-277.39, 466.0, 710.0)
581.9 Nephrotic syndrome with unspecified pathological lesion in kidney
584.5 Acute kidney failure with lesion of tubular necrosis
584.6 Acute kidney failure with lesion of renal cortical necrosis
584.7 Acute kidney failure with lesion of medullary (papillary) necrosis
584.8 Acute kidney failure with other specified pathological lesion in kidney
584.9 Acute kidney failure, unspecified
585.4 Chronic kidney disease, Stage IV (severe) — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
585.5 Chronic kidney disease, Stage V — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
585.6 End stage renal disease — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
585.9 Chronic kidney disease, unspecified — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
586 Unspecified renal failure
753.12 Congenital polycystic kidney, unspecified type
993.51 Infected postoperative seroma — (Use additional code to identify organism)
998.59 Other postoperative infection — (Use additional code to identify infection)
V45.11 Renal dialysis status
V56.2 Fitting and adjustment of peritoneal dialysis catheter — (Use additional code to identify the associated condition. Use additional code for any concurrent peritoneal dialysis: V56.8)

HCPCS Equivalent Codes
N/A

Medicare Edits

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* with documentation
**G0416-G0419**

G0416  Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method

Explanation
An alternative technique to the transrectal ultrasound (TRUS) biopsy procedure, the prostate saturation biopsy (PSB) is used to help identify prostate cancer in high-risk patients. The procedure is especially helpful on patients who have high PSA levels and a history of negative biopsies or abnormal biopsies, or abnormal rectal exams. The PSB is usually done under general anesthesia and ultrasonic guidance. The physician is able to identify each specimen/biopsy and create a map of the cancer. Several biopsies are obtained, increasing the chances of detecting cancer. Use these codes to report the pathology services.

**G0420-G0421**

G0420  Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour

G0421  Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour

Explanation
Face-to-face kidney disease education services provide patients with chronic kidney disease the information they need to manage concurrent health issues and to prevent complications. These services also include an explanation of the need to delay dialysis, as well as the treatment options available for renal replacement. These educational services may be done on an individual basis or in a group setting.

**G0442-G0443**

G0442  Annual alcohol misuse screening, 15 minutes

G0443  Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Explanation
Screening and behavioral counseling interventions are used to identify and reduce alcohol misuse. Alcohol misuse includes risky/hazardous and harmful drinking that puts individuals at risk for future problems. Risky or hazardous drinking is defined by the United States Preventive Services Task Force (USPSTF) as "more than seven standard drinks per week or more than three drinks per occasion for women and anyone over the age of 65; more than 14 standard drinks per week or more than four drinks per occasion for men 65 years of age or younger, and alcohol use by pregnant women." Lower limits are recommended for patients taking medication that may interact with alcohol or who are performing activities that require attention, skill, or coordination, such as driving or operating heavy machinery or someone who has a medical condition that may be worsened by alcohol use. Harmful drinking is defined as anyone that is currently experiencing physical, social, or psychological harm from alcohol use but doesn’t meet the criteria for dependence. Alcohol dependence can be defined as at least three of the following: tolerance; withdrawal symptoms; impaired control; preoccupation with acquisition or use; persistent desire or unsuccessful efforts to quit; sustains social, occupational, or recreational disability; used continually despite adverse conditions. The face-to-face counseling code is used to report visits for patients, including pregnant women, who misuse alcohol but don’t meet the criteria for alcohol dependence; who are competent and alert at the time the counseling is provided; and whose counseling is furnished by a primary care health care professional in the primary care setting.

**G0445**

G0445 Semiannual high intensity behavioral counseling to prevent STIs, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior

Explanation
This code is used to report high intensity behavioral counseling to prevent sexually transmitted infections (STI) for sexually active and at risk patients. Risk reduction includes education, behavior modification, and skills training. The United States Preventive Services Task Force (USPSTF) considers patients at high or increased risk who have any of the following conducts: multiple sex partners, using barrier protection inconsistently, having sex under the influence of alcohol or drugs, having sex in exchange for money or drugs, age (24 years of age or younger and sexually active for women for chlamydia and gonorrhea), having an STI within the past year, and IV drug use (hepatitis B only). Men having sex with men (MSM) and engaged in high risk sexual behavior are also considered at risk. The health care provider should also determine risk factors not based on individual behavior, such as a high instance of sexually communicable diseases in the community. Behavioral counseling interventions should include the following Five A’s approach that has been adopted by the (USPSTF): Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior and change goals/methods; Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits; Agree: collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior; Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate; Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment. The appropriate diagnosis code should be reported on the claim to indicate the risk factor.

**74000**

74000  Radiologic examination, abdomen; single anteroposterior view

**74010**

74010  Radiologic examination, abdomen; anteroposterior and additional oblique and cone views

Explanation
Films are taken of the abdominal cavity in one view from front to back. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.

**74020**

74020  Radiologic examination, abdomen; complete, including decubitus and/or erect views
Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $35.5 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under "Instructions for Use of the CPT Codebook" on page xii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase “physician or other qualified health care professional” (QHP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable).” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient’s encounter is classified as it would have been if the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient’s attending