Coding Companion for Urology/Nephrology

A comprehensive illustrated guide to coding and reimbursement
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**Explanation**

The physician creates an opening through the kidney to the exterior of the body by making an incision in the skin of the flank, cuts the muscles, fat, and fibrous membranes (fascia) overlying the kidney, and sometimes removes a portion of the eleventh or twelfth rib. Using an incision to open the renal pelvis (pyelotomy), the physician passes a curved clamp into the renal pelvis, a middle or lower minor calyx, and the cortex of the kidney. The physician inserts a catheter tip through the same path as the clamp, and passes the tube through a stab incision in the skin of the flank. After suturing the incisions, the physician inserts a drain tube, bringing it out through a separate stab incision, and performs a layered closure.

**ICD-9-CM Procedural**

55.01 Nephropathy
55.02 Nephropathy

**Coding Tips**

For guide wire introduction, with dilation, to establish nephrostomy tract, percutaneous, see 50395. Cystourethroscopy with ureteral guide wire insertion for percutaneous nephrostomy, retrograde, is reported with 52334. For pyelotomy with drainage (pyelostomy), see 50125. Introduction of intracatheter or catheter into renal pelvis for drainage/injection, percutaneous, see 50392. For change of nephrostomy or pyelostomy tube, see 50398. For renal endoscopy through the nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, see 50531-50562.

**ICD-9-CM Diagnostic**

588.81 Secondary hyperparathyroidism (of renal origin)
588.89 Other specified disorders resulting from impaired renal function
590.10 Acute pyelonephritis without lesion of renal medullary necrosis — (Use additional code to identify organism, such as E. coli, 041.4)
590.11 Acute pyelonephritis with lesion of renal medullary necrosis — (Use additional code to identify organism, such as E. coli, 041.4)
590.2 Renal and perinephric abscess — (Use additional code to identify organism, such as E. coli, 041.4)
590.3 Pyeloureteritis cystica — (Use additional code to identify organism, such as E. coli, 041.4)
590.80 Unspecified pyelonephritis — (Use additional code to identify organism, such as E. coli, 041.4)
592.0 Calculus of kidney
593.2 Acquired cyst of kidney
593.4 Other ureteric obstruction
593.70 Vesicoureteral reflux, unspecified or without reflux nephropathy
593.89 Other specified disorder of kidney and ureter
599.70 Hematuria, unspecified
599.71 Gross hematuria
599.72 Microscopic hematuria
753.11 Congenital single renal cyst
753.13 Congenital polycystic kidney, autosomal dominant
753.14 Congenital polycystic kidney, autosomal recessive
753.15 Congenital renal dysplasia
753.16 Congenital medullary cystic kidney
753.17 Congenital medullary sponge kidney
753.19 Other specified congenital cystic kidney disease
753.20 Unspecified obstructive defect of renal pelvis and ureter
753.21 Congenital obstruction of ureteropelvic junction
753.22 Congenital obstruction of ureterovesical junction
753.23 Congenital ureterocele
753.29 Other obstructive defect of renal pelvis and ureter
866.01 Kidney hematoma without rupture of capsule or mention of open wound into cavity
958.5 Traumatic anuria

**Terms To Know**

**calcium.** Abnormal, stone-like concretion of calcium, cholesterol, mineral salts, or other substances that forms in any part of the body.

**catheter.** Flexible tube inserted into an area of the body for introducing or withdrawing fluid.

**congenital.** Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

**hematoma.** Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.

**nephrostomy.** Placement of a stent, tube, or catheter that forms a passage from the exterior of the body into the renal pelvis or calyx, often for drainage of urine or an abscess, for exploration, or calculus extraction.

**pyelonephritis.** Infection of the renal pelvis and ureters that may be acute or chronic, often occurring as a result of a urinary tract infection, particularly in instances of vesicoureteric reflux, the backflow of urine from the bladder into the kidney pelvis or ureters.

**ureterocele.** Saccular formation of the lower part of the ureter, protruding into the bladder.

**CCI Version 16.3**

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**Medicare References:** None
**74000**
Radiologic examination, abdomen; single anteroposterior view

**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.

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

**Explanation**
Films are taken of the abdominal cavity from front to back, with an oblique view and a focused (coned down or spot) view. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.

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

**Explanation**
Films are taken of the abdominal cavity from front to back, back to front, or front to back with the patient lying on the side and/or standing. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.

**74022**
Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest

**Explanation**
Films are taken of the abdominal cavity with the patient lying flat, standing, and/or lying on the side. This procedure includes an upright chest x-ray. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.

**74150-74170**
Computed tomography, abdomen; without contrast material

**Explanation**
Computed tomography directs multiple thin beams of x-rays at the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered as well as a contrast medium for image enhancement. These codes report an exam of the abdomen. Report 74150 if no contrast is used. Report 74160 if performed with contrast and 74170 if performed first without contrast and again following the injection of contrast.

**74176-74178**
Computed tomography, abdomen and pelvis; without contrast material

**Explanation**
Computed tomography directs multiple thin beams of x-rays at the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered, as well as a contrast medium for image enhancement. These codes report an exam of the abdomen and pelvis. Report 74176 if no contrast is used; 74177 if performed with contrast; and 74178 if performed first without contrast in one or both body regions, followed by contrast material(s) and further sections in one or both body regions.

**Coding Tips**
These codes are new for 2011.

**74190**
Peritoneogram (eg, after injection of air or contrast), radiological supervision and interpretation

**Explanation**
A radiographic exam is done on the peritoneal cavity to define the pattern of air in the cavity after injection of air or contrast. The physician inserts a needle or catheter into the peritoneal cavity and injects air or contrast as a diagnostic procedure. X-rays are then taken. The needle or catheter is removed. This code reports the radiological supervision and interpretation for a peritoneogram. Use a separately reportable code for the procedure.

**74400**
Urography (pyelography), intravenous, with or without KUB, with or without tomography

**Explanation**
Radiographic imaging of the kidneys and ureters is done before and after the administration of an intravenous contrast material to identify abnormalities of the kidneys and urinary tract. Abdominal films are first obtained and then the contrast medium is injected into a vein. Radiographs are again obtained while the contrast material is being excreted. This is also known as intravenous pyelography or IVP. This procedure may be done with or without KUB, a general abdominal x-ray, or with or without tomography. X-rays taken onto film moving opposite the beams to yield a single plane shadowless image.

**74410-74415**
Urography, infusion, drip technique and/or bolus technique; with or without nephrotomography

**Explanation**
Radiographic imaging of the kidneys and ureters is done immediately following an infused intravenous drip or a rapid bolus injection of contrast agent. A front to back film of the abdomen is taken after contrast administration. Report 74415 if done with nephrotomography, x-rays taken onto film moving opposite the beams to yield a single plane shadowless image. This can be used to check the patency of a nephrostomy tube.

**74420**
Urography, retrograde, with or without KUB

**Explanation**
Radiographic imaging of the kidneys and ureters is done following retrograde (against the normal flow) administration of a radiopaque contrast material, usually barium sulfate. A catheter is passed into the bladder and on through a ureter into the kidney. The contrast material in injected through the catheter or tube. Films are taken to show the flow of contrast as it moves through the urethra and into the upper urinary tract. This may be performed with KUB, a general x-ray of the abdomen.

**74425**
Urography, antegrade (pyelogram, nephrogram, loopogram), radiological supervision and interpretation

**Explanation**
A radiographic exam of the urinary tract is performed with injection or instillation of a contrast medium. This test is done to follow the normal flow of urine through the tract (antegrade) and may
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 $29 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 understood.

### 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’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 within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient’s encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient’s attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99233, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician...