Coding Companion for Urology/Nephrology

A comprehensive illustrated guide to coding and reimbursement

2013
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50020-50021

50020 Drainage of perirenal or renal abscess; open
50021 percutaneous

Explanation

In 50020, the physician drains an infection (abscess) on the kidney or on the surrounding renal tissue. To access the renal or perirenal abscess, the physician makes a small incision in the skin of the flank, cuts the muscles, fat, and fibrous membranes (fascia) overlaying the kidney, and sometimes removes a portion of the eleventh or twelfth rib. After exploring the abscess cavity, the physician irrigates the site, inserts multiple drain tubes through separate stab wounds, and sutures the drain tube ends to the skin. The physician packs the wound with gauze and sutures the fascia and muscles. The skin and subcutaneous tissue are usually left open to prevent formation of a secondary body wall abscess. In 50021, percutaneous drainage of a perirenal or renal abscess is performed. A small incision in the skin between two ribs proximal to the abscess or in the flank may be created in order to ease placement of drainage instruments through the skin into an abscess located within the kidney or immediately adjacent to it. CAT scan or ultrasound is used to guide placement of a drainage needle or trocar into the abscess. The drainage needle or trocar is advanced through the skin to gain access to the abscess. Fluid is allowed to drain. Once the abscess is drained a catheter may be placed (and later removed) to maintain drainage. Sutures may be placed to secure the drainage catheter in place. The operative site is cleaned and bandaged. For radiological supervision and interpretation, see 75989.

Coding Tips

These codes include placement of drainage catheters. To report drainage of a retroperitoneal abscess, open, see 49060; percutaneous, see 49061.

ICD-9-CM Procedural

55.01 Nephrectomy
55.92 Percutaneous aspiration of kidney (pelvis)
59.09 Other incision of perirenal or periretural tissue

Anesthesia

50020 00862
50021 00860

ICD-9-CM Diagnostic

199.2 Malignant neoplasm associated with transplanted organ — (Code first complication of transplanted organ (996.80-996.89) Use additional code for specific malignancy)
238.77 Post-transplant lymphoproliferative disorder (PTLD) — (Code first complications of transplant (996.80-996.89))

Medicare Edits

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MUE Modifiers

| 50020 | 1 | S1 | N/A | 62* | N/A |
| 50021 | 2 | S1 | N/A | N/A | N/A |

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 (cone 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
74150  Computed tomography, abdomen; without contrast material
74160  with contrast material(s)
74170  without contrast material, followed by contrast material(s) and further sections

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 images 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 the injection of contrast and further sections in one or both body regions.

74174  Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Explanation
Computed tomographic angiography (CTA) of the abdomen and pelvis is performed with contrast material and image postprocessing. CTA is a procedure used for the imaging of vessels. CTA of the abdomen and pelvis may detect aneurysms, thrombosis, and ischemia in the arteries supplying blood to the digestive system, as well as locate gastrointestinal bleeding. Contrast medium is rapidly infused at intervals, usually with an automatic injector, and the patient is scanned with thin section axial or spiral mode x-ray beams. The images obtained are acquired with narrower collimation and reconstructed at shorter intervals than standard CT images. Three-dimensional images are generated and postprocessing reconstruction is done at a workstation on the scanner. Noncontrast images, if performed, are also included in this procedure.

Coding Tips
This code is new for 2012.

74176-74178
74176  Computed tomography, abdomen and pelvis; without contrast material
74177  with contrast material(s)
74178  without contrast material in 1 or both body regions, followed by contrast material(s) and further sections in 1 or both body regions

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 the injection of contrast and further sections in one or both body regions.

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 in to 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
74410  Urography, infusion, drip technique and/or bolus technique;
74415  with 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 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 74420 if done with KUB.
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 $32 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 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.

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. 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 exact same specialty or subspecialty 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 had 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, 99221-99223, 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