Coding Companion for Urology/Nephrology

A comprehensive illustrated guide to coding and reimbursement
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Kidney

**50576-50580**

**50576**  Renal endoscopy through nephrostomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration and/or incision, with or without biopsy

**50580**  with removal of foreign body or calculus

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**ICD-9-CM Procedural**

55.01  Nephrotomy

55.03  Percutaneous nephrostomy without fragmentation

55.11  Pyelotomy

55.21  Nephroscopy

55.22  Pyeloscopy

55.23  Closed (percutaneous) (needle) biopsy of kidney

55.39  Other local destruction or excision of renal lesion or tissue

**Anesthesia**

00860

**ICD-9-CM Diagnostic**

189.0  Malignant neoplasm of kidney, except pelvis

189.1  Malignant neoplasm of renal pelvis

198.0  Secondary malignant neoplasm of kidney

199.2  Malignant neoplasm associated with transplanted organ — (Code first complication of transplanted organ (996.80-996.89) Use additional code for specific malignancy)

209.24  Malignant carcinoid tumor of the kidney — (Code first any associated multiple endocrine neoplasia syndrome: 258.01-258.03; Use additional code to identify associated endocrine syndrome, as: carcinoid syndrome: 259.2)

209.64  Benign carcinoid tumor of the kidney — (Code first any associated multiple endocrine neoplasia syndrome: 258.01-258.03; Use additional code to identify associated endocrine syndrome, as: carcinoid syndrome: 259.2)

223.0  Benign neoplasm of kidney, except pelvis

223.1  Benign neoplasm of renal pelvis

233.9  Carcinoma in situ of other and unspecified urinary organs

236.91  Neoplasm of uncertain behavior of kidney and ureter

236.92  Neoplasm of kidney and ureter

**Terms To Know**

- **Biopsy**. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.
- **Foreign body**. Any object or substance found in an organ and tissue that does not belong under normal circumstances.
- **Carcinoma in situ of other and unspecified urinary organs**

**Coding Companion for Urology/Nephrology**

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112 — Kidney

**Medicare Edits**

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**Medicare References**: None
74000
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
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
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
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 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 first without contrast and again following the injection of contrast.

74174
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.

74174-74178
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
74190 Pentoneogram (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. Use a separately reportable code for the procedure.

74400
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
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 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.
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 CPT Book. 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 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 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” (QOHC/P) 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/registration (when applicable), and facility privileges (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 any 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 patient was seen by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who earns a patient on behalf of the patient’s attending physician or other qualified health care provider may not bill a new