Optum

Coding Companion

Urology/ Nephrology

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

Contents

Getting Started with Coding Companion

Coding Companion for Urology/Nephrology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to urology/nephrology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

50590 Lithotripsy, extracorporeal shock wave

could be found in the index under the following main terms:

Calculus
Destruction
Kidney
Extracorporeal Shock Wave Lithotripsy, 50590

or **Destruction**
Calculus
Kidney, 50590

or **ESWL**, 50590

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv 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). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

36415-36416

36415 Collection of venous blood by venipuncture
36416 Collection of capillary blood specimen (eg, finger, heel, ear stick)

Capillary blood is collected.
The specimen is typically collected by finger stick

Explanation

A needle is inserted into the skin over a vein to puncture the blood vessel and withdraw blood for venous collection in 36415. In 36416, a prick is made into the finger, heel, or ear and capillary blood that pools at the puncture site is collected in a pipette. In either case, the blood is used for diagnostic study and no catheter is placed.

Coding Tips

These procedures do not include laboratory analysis. If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For venipuncture, younger than 3 years of age, femoral or jugular vein, see 36400; scalp or other vein, see 36405–36406. For venipuncture, age 3 years or older, for non-routine diagnostic or therapeutic purposes, necessitating the skill of a physician or other qualified healthcare professional, see 36410. Do not append modifier 63 to 36415 as the description or nature of the procedure includes infants up to 4 kg. Medicare and some payers may require HCPCS Level II code G0471 to report this service when provided in an FQHC.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Associated HCPCS Codes

G0471 Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA)

AMA: **36415** 2022,Jan; 2019,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
36415	0.0	0.0	0.0	0.0
36416	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
36415	0.0	0.0	0.0	0.0
36416	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
36415	N/A	X	2(3)	N/A	N/A	N/A	N/A	None
36416	N/A	B	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

blood vessel. Tubular channel consisting of arteries, veins, and capillaries that transports blood throughout the body.

capillary. Tiny, minute blood vessel that connects the arterioles (smallest arteries) and the venules (smallest veins) and acts as a semipermeable membrane between the blood and the tissue fluid.

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

diagnostic. Examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.

pipette. Small, narrow glass or plastic tube with both ends open used for measuring or transferring liquids.

specimen. Tissue cells or sample of fluid taken for analysis, pathologic examination, and diagnosis.

venipuncture. Piercing a vein through the skin by a needle and syringe or sharp-ended cannula or catheter to draw blood, start an intravenous infusion, instill medication, or inject another substance such as radiopaque dye.

venous. Relating to the veins.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2023.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2022.

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

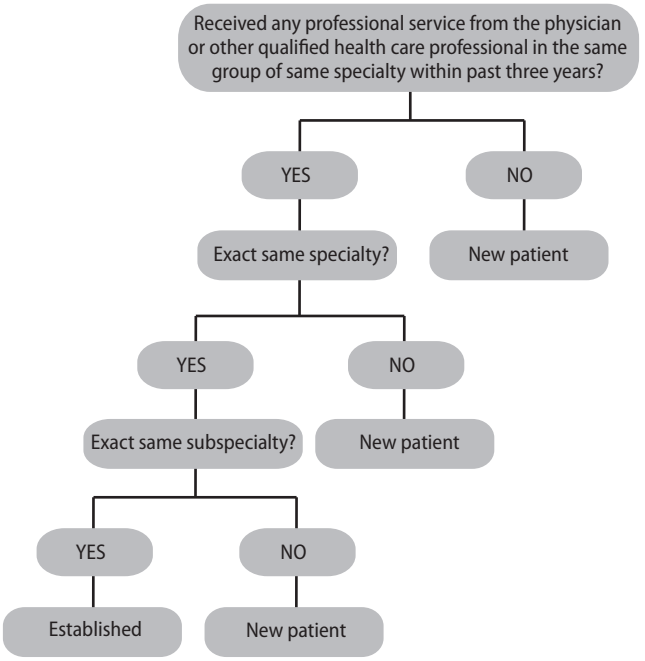
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◀

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶◀ = Contains new or revised text

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

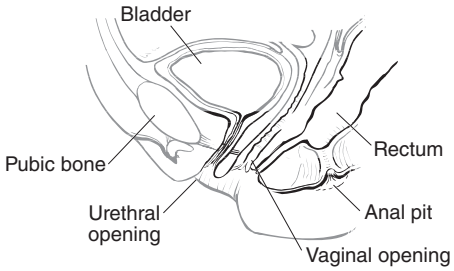
Terms To Know

new patient. Patient who is receiving face-to-face care from a physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider-based clinic or emergency department, within the past three years.

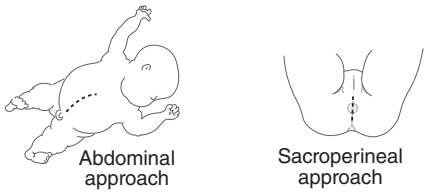
46744-46746

46744 Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, sacroperineal approach

46746 Repair of cloacal anomaly by anorectovaginoplasty and urethroplasty, combined abdominal and sacroperineal approach;



Persistent cloaca: common urinary, fecal, and reproductive passage



During early stages of fetal development, the rectal, urinary, and reproductive tracts drain through a common passage–the cloaca. In some anomalies, the cloaca persists or is abnormal

Explanation

The physician repairs a cloacal anomaly. The patient is placed in a lithotomy position. The physician makes a small incision in the perineum. The bladder, urethra, and vagina are dissected free of each other. A new rectum is formed by interposing muscle posterior to the rectum. The incision is closed with sutures. Report 46746 when a combined abdominal and sacroperineal approach is used.

Coding Tips

Coding surgical repair of cloacal anomaly is dependent on the approach (sacroperineal or combined abdominal/sacroperineal) and the need for intestinal grafting or pedicle flaps. Do not append modifier 63 to 46744 as the description or nature of the procedure includes infants up to 4 kg.

ICD-10-CM Diagnostic Codes

K63.89	Other specified diseases of intestine
N36.5	Urethral false passage
N36.8	Other specified disorders of urethra
Q43.3	Congenital malformations of intestinal fixation
Q43.6	Congenital fistula of rectum and anus
Q43.7	Persistent cloaca
Q43.8	Other specified congenital malformations of intestine
Q52.4	Other congenital malformations of vagina ♀
Q52.8	Other specified congenital malformations of female genitalia ♀
Q64.79	Other congenital malformations of bladder and urethra
Q64.8	Other specified congenital malformations of urinary system

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
46744	58.94	31.64	14.89	105.47
46746	65.44	34.21	16.53	116.18
Facility RVU	**Work**	**PE**	**MP**	**Total**
46744	58.94	31.64	14.89	105.47
46746	65.44	34.21	16.53	116.18

	FUD	Status	MUE	Modifiers				IOM Reference
46744	90	A	1(2)	51	N/A	62*	80	None
46746	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

anomaly. Irregularity in the structure or position of an organ or tissue.

approach. Method or anatomical location used to gain access to a body organ or specific area for procedures.

cloacal anomaly. Congenital anomaly resulting from the failure of one common urinary, anal, and reproductive vaginal passage of the early embryonic stage to develop into the properly divided rectal and urogenital sections.

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

dissection. Separating by cutting tissue or body structures apart.

lithotomy position. Common position patients may be placed in for some surgical procedures and examinations involving the pelvis and/or lower abdomen. The patient is placed supine (on their back), hips and knees flexed, thighs apart, with feet supported in raised stirrups.

perineal. Pertaining to the pelvic floor area between the thighs; the diamond-shaped area bordered by the pubic symphysis in front, the ischial tuberosities on the sides, and the coccyx in back.

posterior. Located in the back part or caudal end of the body.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

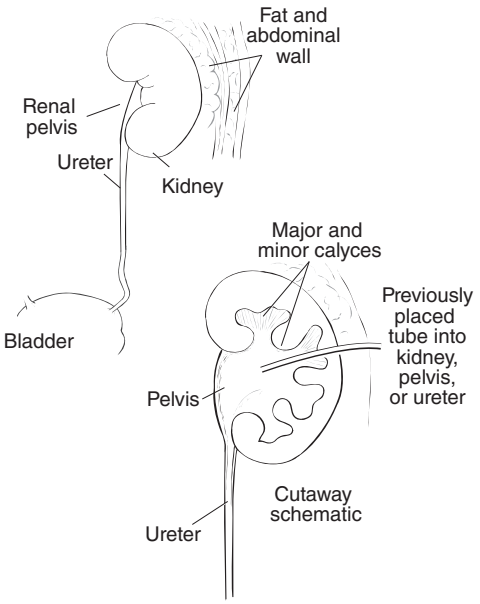
interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

50391

50391 Instillation(s) of therapeutic agent into renal pelvis and/or ureter through established nephrostomy, pyelostomy or ureterostomy tube (eg, anticarcinogenic or antifungal agent)



A therapeutic agent is instilled through an established opening into the kidney, renal pelvis, and/or ureter via established nephrostomy, pyelostomy, or ureterostomy tube

Explanation

The physician instills a therapeutic agent, such as an anticarcinogenic or an antifungal, through the tube of an established opening between the skin and kidney (nephrostomy), renal pelvis (pyelostomy), or ureter (ureterostomy). This type of intracavitary topical therapy is reliably done through a tube left in place following a previous surgery. After inserting a guidewire, an endoscope or flexible delivery catheter is passed through the tube into the kidney, renal pelvis, or ureter. To better view renal and ureteric structures, the physician may flush (irrigate) or introduce by drops (instillate) a saline solution. The physician introduces the therapeutic agent to the target area. After examination, the physician removes the instruments and reinserts the nephrostomy, pyelostomy, or ureterostomy tube or allows the surgical passageway to seal on its own.

Coding Tips

For renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation or instillation, see 50551.

ICD-10-CM Diagnostic Codes

B37.89	Other sites of candidiasis
B48.8	Other specified mycoses
C64.1	Malignant neoplasm of right kidney, except renal pelvis ☑
C64.2	Malignant neoplasm of left kidney, except renal pelvis ☑
C65.1	Malignant neoplasm of right renal pelvis ☑
C65.2	Malignant neoplasm of left renal pelvis ☑
C66.1	Malignant neoplasm of right ureter ☑
C66.2	Malignant neoplasm of left ureter ☑
C67.6	Malignant neoplasm of ureteric orifice
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis ☑
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis ☑
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C7A.093	Malignant carcinoid tumor of the kidney
C80.2	Malignant neoplasm associated with transplanted organ
D09.0	Carcinoma in situ of bladder
D09.19	Carcinoma in situ of other urinary organs
D41.01	Neoplasm of uncertain behavior of right kidney ☑
D41.02	Neoplasm of uncertain behavior of left kidney ☑
D41.11	Neoplasm of uncertain behavior of right renal pelvis ☑
D41.12	Neoplasm of uncertain behavior of left renal pelvis ☑
D41.21	Neoplasm of uncertain behavior of right ureter ☑
D41.22	Neoplasm of uncertain behavior of left ureter ☑
D41.4	Neoplasm of uncertain behavior of bladder
D49.511	Neoplasm of unspecified behavior of right kidney ☑
D49.512	Neoplasm of unspecified behavior of left kidney ☑
D49.59	Neoplasm of unspecified behavior of other genitourinary organ
N10	Acute pyelonephritis
N11.0	Nonobstructive reflux-associated chronic pyelonephritis
N11.1	Chronic obstructive pyelonephritis
N11.8	Other chronic tubulo-interstitial nephritis
N12	Tubulo-interstitial nephritis, not specified as acute or chronic
N13.6	Pyonephrosis

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
50391	1.96	1.5	0.23	3.69
Facility RVU	**Work**	**PE**	**MP**	**Total**
50391	1.96	0.66	0.23	2.85

	FUD	Status	MUE	Modifiers				IOM Reference
50391	0	A	1(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

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

instillation. Administering a liquid slowly over time, drop by drop.

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.

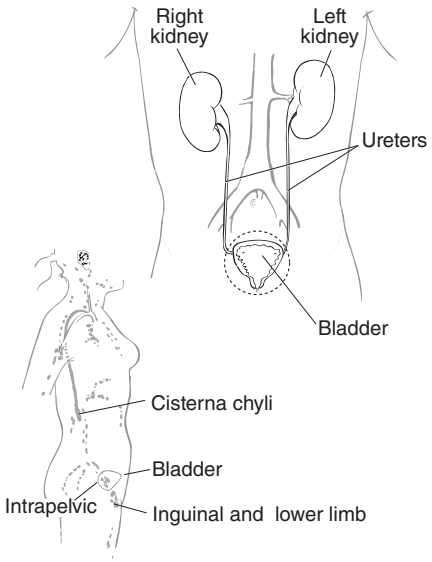
pyelostomy. Surgical creation of an opening through the abdominal wall into the renal pelvis.

ureterostomy. Placement of a stent, tube, or catheter into the ureter, forming a passageway from the exterior of the body to the ureter.

N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

51570-51575

51570 Cystectomy, complete; (separate procedure)
51575 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes



Explanation

The physician removes the bladder (cystectomy). To access the bladder, the physician makes an incision in the skin of the lower abdomen and cuts the corresponding muscles, fat, and fibrous membranes (fascia). Report 51570 if the physician dissects and ties (ligates) the hypogastric and vesical vessels, and severs the bladder from the urethra, rectum, surrounding peritoneum, vas deferens, and prostate (if applicable). After removing the bladder and controlling bleeding, the physician inserts drain tubes and performs a layered closure. If the physician bilaterally removes the pelvic lymph nodes, report 51575.

Coding Tips

Note that 51570, a separate procedure by definition, is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. For removal of the bladder with urinary diversion, see 51580–51585. For complete removal of the bladder in combination with a continent diversion, see 51596. If the bladder removal is part of pelvic exenteration, see 51597.

ICD-10-CM Diagnostic Codes

C67.0 Malignant neoplasm of trigone of bladder
C67.1 Malignant neoplasm of dome of bladder
C67.2 Malignant neoplasm of lateral wall of bladder
C67.3 Malignant neoplasm of anterior wall of bladder
C67.4 Malignant neoplasm of posterior wall of bladder
C67.5 Malignant neoplasm of bladder neck
C67.6 Malignant neoplasm of ureteric orifice
C67.8 Malignant neoplasm of overlapping sites of bladder
C77.5 Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C79.11 Secondary malignant neoplasm of bladder
D09.0 Carcinoma in situ of bladder
D30.3 Benign neoplasm of bladder
D41.4 Neoplasm of uncertain behavior of bladder
D49.4 Neoplasm of unspecified behavior of bladder
D49.511 Neoplasm of unspecified behavior of right kidney ☑
D49.512 Neoplasm of unspecified behavior of left kidney ☑
D49.59 Neoplasm of unspecified behavior of other genitourinary organ
N30.10 Interstitial cystitis (chronic) without hematuria
N30.11 Interstitial cystitis (chronic) with hematuria

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
51570	27.46	12.11	3.34	42.91
51575	34.18	14.73	4.2	53.11
Facility RVU	**Work**	**PE**	**MP**	**Total**
51570	27.46	12.11	3.34	42.91
51575	34.18	14.73	4.2	53.11

	FUD	Status	MUE	Modifiers				IOM Reference
51570	90	A	1(2)	51	N/A	62*	80	None
51575	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

bilateral. Consisting of or affecting two sides.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

chronic. Persistent, continuing, or recurring.

cystitis. Inflammation of the urinary bladder. Symptoms include dysuria, frequency of urination, urgency, and hematuria.

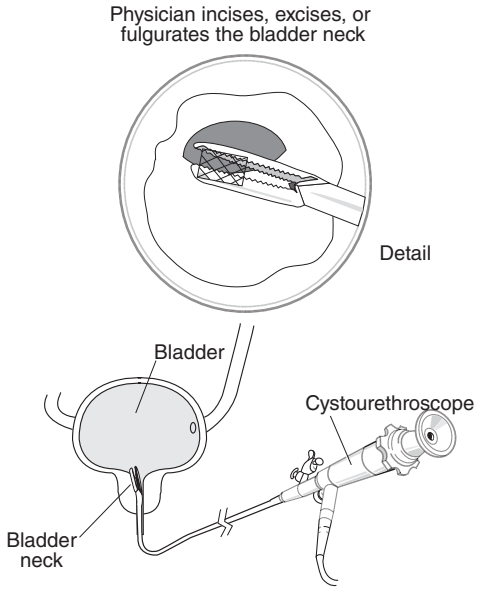
lymphadenectomy. Dissection of lymph nodes free from the vessels and removal for examination by frozen section in a separate procedure to detect early-stage metastases.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

neoplasm. New abnormal growth, tumor.

52640

52640 Transurethral resection; of postoperative bladder neck contracture



Explanation

Contracture of the bladder neck outlet usually results from scarring after a transurethral resection of the prostate gland. After preliminary cystourethroscopy, the physician passes the resectoscope under direct vision up the urethra to the region of the bladder neck contracture. Meatotomy, cutting to enlarge the opening of the urethra, and dilation of the urethra may be necessary to allow the passage of the resectoscope. The scar tissue is incised at one to three sites or resected, using a cutting electrocautery knife. The operative site is inspected for bleeding, which is controlled by fulguration. A catheter is passed into the bladder at the end of the procedure and left in place for the postoperative period.

Coding Tips

For transurethral resection of obstructive prostate tissue, residual or regrowth, see 52630. For transurethral waterjet ablation of prostate, see 0421T. For transurethral resection of the bladder neck, see 52500.

ICD-10-CM Diagnostic Codes

N32.0 Bladder-neck obstruction

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
52640	4.79	4.05	0.57	9.41
Facility RVU	**Work**	**PE**	**MP**	**Total**
52640	4.79	4.05	0.57	9.41

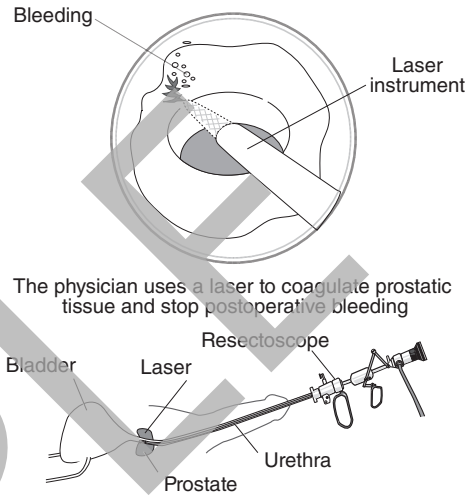
	FUD	Status	MUE	Modifiers				IOM Reference
52640	90	A	1(2)	51	N/A	N/A	N/A	None

* with documentation

52647-52648

52647 Laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included if performed)

52648 Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)



Explanation

The physician uses a laser to coagulate or vaporize the prostate through an endoscope or resectoscope inserted through the urethra. Dilation of the urethra may be necessary to permit endoscope insertion. The entire prostate is treated. To accomplish this, vasectomy, meatotomy, cystourethroscopy, and internal urethrotomy may be necessary. Once the laser treatment is complete, a urinary catheter is inserted. Report 52647 if prostatic tissue is coagulated and 52648 if it is vaporized.

Coding Tips

During these procedures, the physician may need to perform a vasectomy, meatotomy, cystourethroscopy, urethral calibration/dilation, and an internal urethrotomy in any combination. These procedures are included in 52647 and 52648 and are not separately reported. For transurethral resection of the prostate by an electrocautery knife, also including vasectomy, meatotomy, cystourethroscopy, urethral calibration/dilation, and an internal urethrotomy, see 52601. For open excisional procedures on the prostate gland, see 55801–55845.

ICD-10-CM Diagnostic Codes

N40.0 Benign prostatic hyperplasia without lower urinary tract symptoms A ♂

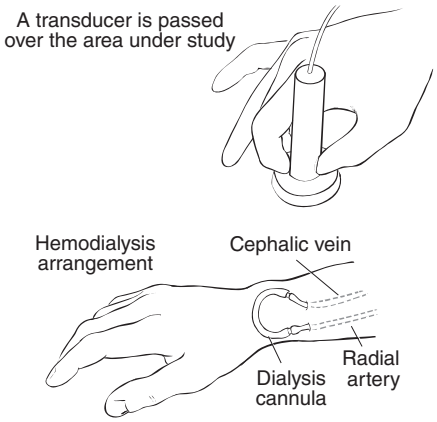
N40.1 Benign prostatic hyperplasia with lower urinary tract symptoms A ♂

N40.2 Nodular prostate without lower urinary tract symptoms A ♂

N40.3 Nodular prostate with lower urinary tract symptoms A ♂

90940

90940 Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method



Explanation

A hemodialysis access flow study is performed to determine blood flow in a graft or arteriovenous fistula. The health care provider performs the test after approximately 30 minutes of treatment and after turning off ultrafiltration. In the direct dilution method, also known as the urea-based measurement of recirculation, arterial and venous line samples are drawn and the blood rate is reduced to 120 mL/minute. The blood pumped is turned off 10 seconds after reducing the blood flow rate and an arterial line is clamped above the sampling port. Systemic arterial samples are drawn, the line is disconnected, and dialysis is resumed. Measurements of BUN in the arterial, venous, and arterial sample are taken and the percent recirculation is calculated. This code includes the hook-up, measurement, and disconnection.

Coding Tips

For a duplex scan of hemodialysis access, see 93990. For external cannula declotting without balloon catheter, see 36860; with balloon catheter, see 36861. For declotting of an implanted vascular access device or catheter by thrombolytic agent, see 36593.

ICD-10-CM Diagnostic Codes

I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
I13.11	Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease
I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
I16.0	Hypertensive urgency
I16.1	Hypertensive emergency
N17.0	Acute kidney failure with tubular necrosis
N17.1	Acute kidney failure with acute cortical necrosis
N17.2	Acute kidney failure with medullary necrosis
N17.8	Other acute kidney failure
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease
T82.318A	Breakdown (mechanical) of other vascular grafts, initial encounter
T82.328A	Displacement of other vascular grafts, initial encounter
T82.338A	Leakage of other vascular grafts, initial encounter
T82.398A	Other mechanical complication of other vascular grafts, initial encounter
T82.41XA	Breakdown (mechanical) of vascular dialysis catheter, initial encounter
T82.42XA	Displacement of vascular dialysis catheter, initial encounter
T82.43XA	Leakage of vascular dialysis catheter, initial encounter
T82.49XA	Other complication of vascular dialysis catheter, initial encounter
T82.510A	Breakdown (mechanical) of surgically created arteriovenous fistula, initial encounter
T82.511A	Breakdown (mechanical) of surgically created arteriovenous shunt, initial encounter
T82.514A	Breakdown (mechanical) of infusion catheter, initial encounter
T82.520A	Displacement of surgically created arteriovenous fistula, initial encounter
T82.521A	Displacement of surgically created arteriovenous shunt, initial encounter
T82.524A	Displacement of infusion catheter, initial encounter
T82.528A	Displacement of other cardiac and vascular devices and implants, initial encounter
T82.530A	Leakage of surgically created arteriovenous fistula, initial encounter
T82.531A	Leakage of surgically created arteriovenous shunt, initial encounter
T82.534A	Leakage of infusion catheter, initial encounter
T82.590A	Other mechanical complication of surgically created arteriovenous fistula, initial encounter
T82.591A	Other mechanical complication of surgically created arteriovenous shunt, initial encounter
T82.594A	Other mechanical complication of infusion catheter, initial encounter
Z49.31	Encounter for adequacy testing for hemodialysis

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90940	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90940	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
90940	N/A	X	1(3)	N/A	N/A	N/A	N/A	None

* with documentation

 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

80053

80053 Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)

Explanation

A comprehensive metabolic panel includes the following tests: albumin (82040), total bilirubin (82247), total calcium (82310), carbon dioxide (bicarbonate) (82374), chloride (82435), creatinine (82565), glucose (82947), alkaline phosphatase (84075), potassium (84132), total protein (84155), sodium (84295), alanine amino transferase (ALT) (SGPT) (84460), aspartate amino transferase (AST) (SGOT) (84450), and urea nitrogen (BUN) (84520). Blood specimen is obtained by venipuncture. See the specific codes for additional information about the listed tests.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
80053	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
80053	0.0	0.0	0.0	0.0

80069

80069 Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)

Explanation

A renal function panel includes the following tests: albumin (82040), total calcium (82310), carbon dioxide (bicarbonate) (82374), chloride (82435), creatinine (82565), glucose (82947), inorganic phosphorus (phosphate) (84100), potassium (84132), sodium (84295), and urea nitrogen (BUN) (84520).

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
80069	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
80069	0.0	0.0	0.0	0.0

80158

80158 Cyclosporine

Explanation

This drug is also known as Sandimmune. It is an immunosuppressant and is often monitored. Test specimens are frequently collected at the trough period, which is typically about 12 hours after the last dose when serum concentration is at its lowest. Method is high performance liquid chromatography (HPLC) or fluorescence polarization immunoassay (FPIA).

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
80158	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
80158	0.0	0.0	0.0	0.0

81000

81000 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy

Explanation

This type of test may be ordered by the brand name product and the analytes tested. Although screens are considered to show the presence of an analyte (qualitative), some newer products are semi-quantitative. Many are plastic strips that contain sites impregnated with chemicals that react with urine when the strip is dipped into a specimen. The result is a color change that is compared against a standardized chart. Most strips will test for numerous analytes, as well as for pH and specific gravity. Tablets work in a similar fashion. A drop of urine is placed on the tablet and a chemical reaction causes a color change that is compared to a standard chart. Usually only a single analyte is under consideration, per tablet. Code 81000 involves a manual (nonautomated) test and includes a microscopic examination. Microscopy involves examination of the urine sediments or solids. The urine is first centrifuged in a graduated tube to concentrate the sediments. Samples (either wet or dry) are examined, usually under both high and low power, and abnormal constituents are noted. These may include a wide range of biological abnormalities, such as blood cells, casts, and bacteria, as well as chemical anomalies, such as crystals.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
81000	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
81000	0.0	0.0	0.0	0.0

81001

81001 Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy

Explanation

This type of test may be ordered by the type of processor used and the analytes tested. The testing methodology is similar to the manual strips, except that the color change caused by the chemical reaction with urine is processed and read mechanically. The strip is exposed to the urine sample and is mechanically fed through a processor that reads the colors emitted by the reaction. The unit will be calibrated according to international standards and readings have a high degree of accuracy. The result may be displayed on a monitor, but is always printed or recorded in some form. Code 81001 also includes a microscopy. Microscopy involves examination of the urine sediments or solids. The urine is first centrifuged in a graduated tube to concentrate the sediments. Samples (either wet or dry) are examined, usually under both high and low power, and abnormal constituents are noted. These may include a wide range of biological abnormalities, such as blood cells, casts, and bacteria, as well as chemical anomalies, such as crystals.

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0421T 00910, 00914-00916, 0213T, 0216T, 0499T, 0596T-0597T, 0708T-0709T, 11000-11006, 11042-11047, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51040, 51102, 51700-51703, 52000-52005, 52204-52240, 52270-52276, 52281, 52283, 52287, 52305-52315, 52400, 52441, 52500, 52630, 52700, 53000-53025, 53600-53621, 53855, 55000, 55200-55250, 55700-55705, 61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 76000, 76872, 76942, 76998, 77001-77002, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378, 99446-99449, 99451-99452, 99495-99496, C9769, G0463, G0471, J2001, P9612

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0561T 0694T, 76376-76377

0562T 0694T, 76376-76377

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