

Office Urological Procedures

Common Office Procedures

Several common office procedures present coding problems, potentially with loss of revenue. Proper coding can eliminate the possibility of this loss of revenue.

Catheterizations: Three CPT codes and 1 HCPCS code can be used by the urologist for the various clinical scenarios involving catheterizations. Use CPT code 51701, *insertion of non indwelling bladder catheter*, any time a urologist passes a urethral catheter into the bladder, drains the bladder, and removes the catheter. This service pays a 2007 unadjusted Medicare standard fee of \$57.42. An example of this would be a straight catheterization to determine a post-void residual (PVR) urine volume.

Any time a urologist places a Foley catheter and leaves it indwelling, use CPT code 51702, *insertion of a temporary indwelling bladder catheter; simple (Foley)*. This service pays a 2007 unadjusted Medicare standard fee of \$93.99. This seemingly high fee includes the office expenses for performing this procedure and also the cost of the provided Foley catheter. Do not charge the patient separately for the catheter or give him a prescription to purchase a replacement catheter for your office. This would be considered double billing.

If the urologist has difficulty inserting a catheter because of an anatomic problem (such as a urethral stricture, a false passage, or a bladder neck contracture) or has difficulty removing an already indwelling catheter, use CPT code 51703, *complicated catheter insertion or removal*. CPT code 51703 should be used when inserting the catheter over a guide-wire, using a catheter guide, using a Council tipped catheter guide, using a Coude catheter, using several decreasing French numbered sized catheters, or when instilling lubricating jelly into the urethra-each technique used to accomplish a difficult catheter passage. These scenarios all allow for the coding of CPT 51703. Also note that this code is used when the urologist has difficulty removing a Foley catheter and must cut the inflation limb or disrupt the catheter balloon for its removal whether or not a new catheter is placed. This service pays an unadjusted Medicare standard fee of \$158.79. Remember that the simple removal of a Foley catheter is included in an E/M service as there is no particular CPT code for simple catheter removal.

For Medicare only, use HCPCS code P9612, *catheterization for urine specimen*, to obtain a clean urine for urinalysis or culture. This has a 2007 standard Medicare fee of \$3.00. For non-Medicare carriers continue to use CPT code 51701 to bill a catheterization for a specimen. Note: Code in addition an E/M service if provided with the specific catheterization code, and remember to append modifier-25 to the E/M service to insure its payment. Also remember that one may bill only one of the CPT codes 51701-51703 and P9613 at one time. Medicare will pat the lesser of these codes if more than one is billed.

Urethral dilations: In both male and female patient, urethral dilations performed in the office are coded using initial dilation and subsequent dilation CPT codes. For the male patient, use code 53600 for the initial dilation and 53601 for a subsequent dilation; for the female patient, use code 53600 for the initial dilation and 53661 for a subsequent dilation. The initial and subsequent dilation codes are used for each separate individual course of treatment.

Once a patient has had an initial dilation, it does not follow that from the time on all dilations performed should be coded as subsequent dilations. A patient may undergo a urethral dilation with a proposed plan to dilate the stricture to 24F. The initial dilation code is used for the first dilation of the planned therapy, and the subsequent dilation code is used for all dilations after this initial dilation until the planned dilation size is 24F is reached. If the patient subsequently returns 3 months later and undergoes urethral dilations for another planned dilation to 24F, the initial code is 53600, is billed again first followed by subsequent dilation (code 53601) billings until the 24F dilation is reached. For male patients, initial dilations reimburse about \$3.00 to \$5.00 more than subsequent dilations.

CPT code 52281 should be used for the coding of any combination or sequencing of cystoscopy and urethral dilation/calibration when the urologist performs these 2 procedures during the same encounter. Note that the diagnosis or medical necessity for this procedure is usually urethral stricture disease (ICD-9 codes 598.00-598.9). Use of this CPT code may also include *with or without meatotomy, or with or without injection procedure for cystography, male or female*. The 2007 unadjusted standard Medicare office fee for this procedure is \$361.71. To maximize payment and remain compliant, use code 52281 in the following clinical scenarios:

The urologist performs a cystourethroscopy, passage of a guide-wire, urethral dilation, and insertion of a Foley catheter over the guide-wire.

The urologist performs a meatal calibration, meatotomy, meatal dilation, and cystoscopic examination.

Prostate biopsy: Coding for office needle biopsy of the prostate continues to be challenging for urologists. Medicare and most private and commercial carriers will reimburse for several codes. A urologist should code 55700, *needle or punch biopsy, single or multiple, any approach*; 76942, *ultrasonic guidance for needle placement...;* and 76872, *ultrasound, transrectal, examination of the prostate*. Needle biopsy of the prostate, code 55700, has a zero-day surgical global period, so if the patient returns to your office the day after a biopsy with bleeding this is a chargeable service that should be billed and paid.

Diagnostic ICD-9 payable codes include code 790.93, elevated PSA, 236.5, a previous non diagnostic biopsy; 239.5, a prostatic nodule, possibly malignant; and 233.4, prostatic grade 3 PIN. Some commercial carriers will bundle CPT code 76872 with CPT code 76942 and pay for only one of these procedures. Under these circumstances, add

modifier-59 to code 76872 and provide a different diagnosis such a code 600.00 or 600.01, BPH without and with obstruction, and resubmit the claim. Some carriers will then reverse their initial denial.

In addition, there has always been the question of whether a urologist can bill and be reimbursed for local anesthesia administered at the time of the biopsy. Note that for Medicare there is not reimbursement for any anesthesia administered by the operating urologist. However, there are some private and commercial carriers who will reimburse for anesthesia. For these carriers code 64450 for peri-prostatic infiltration and 64430 for pudendal nerve block with infiltration at the base of the prostate (proximal prostate) lateral to the seminal vesicles. If an endoscopic cold cup biopsy of the prostatic urethra is performed in the office, code it with CPT code 52204. For this procedure it is acceptable to code ICD-9 diagnosis 293.5, path pending, other GU organs, when the diagnosis is unknown at the time of coding. This should be a payable diagnosis.

Gold seed marker placement prior to radiation therapy, a relatively new procedure, is now being performed in urology offices. There is a new 2007 CPT code for this procedure, CPT code 55876, placement of interstitial device(s) for radiotherapy guidance (fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple. In the office, this code is also billed with ultrasonic guidance, code 76942, and a TRUS, code 76872, and for non-Medicare carriers HCPCS code A4649, a supply code for the marker kit. Remember when billing private carriers for the markers to include the payment invoice. Unfortunately, Medicare includes the cost of the markers in the fee for the service (code 55876), and will not reimburse separately for the markers, making this office procedure not cost effective. To avoid this problem, many urologists obtain the marker kit from the referring radiation oncologist, who often will purchase and supply the marker kit without charge to the urologist. The marker kit usually ranges in cost from \$195 to \$260 for CPT code 55876 performed in the office, Medicare pays the urologist a 2007 unadjusted standard fee of \$153.48.

Office ultrasonography: Because many young urology graduates have received specific training and have the experience to comfortably perform urological ultrasound (US) studies, many urology offices have begun to perform these procedures on an outpatient basis. Bladder US and PVR measurements, as well as scrotal and renal US, have become everyday procedures in many urology offices.

If the urologist performs bladder US to view the anatomy, the architecture, or the morphology of the full bladder, as well as to determine PVR after voiding, use CPT code 76857. In the documentation of this study in the medical records the urologist should mention the bladder wall thickness, the presence of bladder diverticula, any intravesical prostatic protusion or pathology, the prostatic size as measured transabdominally, and may also report on the presence of residual urine. However, if the main intent of the study is to determine the PVR, then only report CPT code 51798 regardless of the technology used. Although code 51798 appears as a CPT code surgical code beginning with the number 5, this is a radiology code and has no associated global period. Therefore, this code can be used during a global period as well as with other E/M or

surgical codes without the necessity of appending a modifier. Be aware, however, that there are some private carriers who will treat this code as a surgical code, therefore requiring a 25 modifier on an E/M service billed with code 51798 as well as modifier 51 appended to code 51798 when billed with another surgical service, or modifier 79 appended to code 51798 when billed within a global period. Most private carriers will also accept code 51798 for bladder US and for sonographic determination of the PVR. Use CPT code 76856 when doing a full pelvic US study, non-obstetrical, including the above documentation as well as commenting on pelvic organs and any other pelvic pathology outside of the bladder.

In 2001 the AUA Terminology Committee indicated that CPT code 76775, limited retroperitoneal study, would be the proper code for a renal sonogram, unilateral or bilateral. CPT code 76770, full retroperitoneal study, should be only used if the urologist views sonographically and documents examining the kidneys, aorta, bifurcation of the aorta and common iliac vessels, vena cava, and any abnormalities, masses or nodes in the retroperitoneum. Recently the AUA and CPT have suggested that if urinary symptoms or complaints are present, and because of this the urologist performs both a renal and a bladder US and looks for any dilation of the ureter, this type of study would constitute a “sonographic KUB” and should be billed with CPT code 76770 alone, indicating a full retroperitoneal study. However, some private carriers (such as Cigna) and HMO’s will not reimburse the urologist for CPT code 76770 and consequently it will be necessary for the urologist to bill both studies, codes 76775 and 76857 to receive full reimbursements when studying both organs. It is important to remember that for US procedures, as well as any other diagnostic studies, there must be a diagnosis that reveals medical necessity. If the study results are positive, the choice of diagnosis for the study should be based on the findings for the imaging study. For a renal stone, code 592.0; for urinary retention ,code 788.20; and for hydronephrosis, code 591. If the study results are negative, then the diagnosis should be the reason for the study. List the patient’s symptoms that prompted the study. For renal colic, code 788.0; for microhematuria, code 599.7; and for dysuria, code 788.7.