2017 Coding and Reimbursement Survival Guide

Chapter 20: Urology

CPT® Changes: Key Into Guideline Updates for Successful Procedure Coding in 2017

Plus: New coding tips also will help keep you on track.

In last month’s issue of Urology Coding Alert, we shared that initial information from the American Medical Association (AMA) about CPT® 2017 made it appear that most changes specific to urology would apply to guidelines rather than code descriptors. Now we can confirm that’s true, and can even share a few specifics as you prep for the new edition in January.

Follow Guideline Updates to Stay Compliant

Every coder knows that the descriptors aren’t the only things that keep you on track with reporting. Guidelines, tips, and other notes the AMA shares help ensure that you’re submitting the correct codes for each encounter – which is why you should always pay close attention to them.

The following constitute previously reported “Coding Tips” and two new tips which could affect how you submit claims in 2017.

Coding tip example 1: Code 52005 (Cystourethroscopy with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service) has the following Coding Tip, Restrictions for Reporting Temporary Catheter Insertion and Removal with Cystourethroscopy. The guideline states, “The insertion and removal of a temporary ureteral catheter (52005) during diagnostic or therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy is included in 52320-52356 and should not be reported separately.”

Coding tip example 2: Codes 52310 (Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder [separate procedure]; simple) and 52315 (... complicated) also follow a special Coding Tip, Instructions for Reporting Stent Removal. The guideline states, “To report cystourethrocopic removal of a self-retaining, indwelling ureteral stent, see 52310, 52315, and append modifier 58, if appropriate.” When the stent removal procedure – 52310 for simple or 52315 for complicated - is within the 90-day global of an initial stone removal procedure during which the stent was first placed such after an ESWL (50590, Lithotripsy, extracorporeal shock wave) or PCNL (50080, Percutaneous nephrolithotomy or pyelolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm, or 50081, ... over 2 cm), including modifier 58 (Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period) indicates the removal of the stent as a staged procedure to complete the care of a urinary stone and ensures payment for the stent removal.

Remember to include in the first operative report a note that the stent will be removed in the office at a later date. This emphasizes that the removal of the stent was indeed part of a staged procedure and treatment of the urinary calculus.

Coding tip example 3: Code 52320 (Cystourethroscopy [including ureteral catheterization]; with removal of ureteral calculus) will include the tip, the insertion and removal of a temporary ureteral catheter (52005) during diagnostic or therapeutic cystourethroscopy with ureteroscopy and/or pyeloscopy is included in 52320-52356 and should not be reported separately.

Guideline example 1: Codes 52601 (Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete [vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included]) and 52630 (Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete [vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included]) will add the guideline, For transurethral waterjet ablation of prostate, use 0421T. Remember, however, that 0421T (Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete [vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed]) is not an ASC approved procedure.
This category III code does not have assigned relative value units, RVUs, or a scheduled fee assignment.

Guideline example 2: Code 55700 (Biopsy, prostate; needle or punch, single or multiple, any approach) will have two guideline changes. The first is the deletion of the guideline. If imaging guidance is performed, use 76942. The second is the addition of the guideline, if imaging guidance is performed, see 76942, 77002, 77012, and 77021.

These types of guideline changes will apply to common procedures such as:

- Removal and replacement of ureteral stent or nephroureteral catheter
- Injections for antegrade nephrostogram and/or ureterogram
- Nephrostomy catheter placement or conversion of a nephrostomy catheter to a nephroureteral catheter
- Ureter or renal pelvis biopsy, including percutaneous renal biopsy
- Percutaneous ureteral stent placement
- Ureteral embolization or occlusion
- Balloon dilation of a ureteral stricture.

Important: All updates to codes, descriptors, and guidelines are not final until the AMA releases the official CPT® changes information in November. Keep reading Urology Coding Alert for the latest news, and how you will incorporate the changes day-to-day.

ICD-10: Pinpoint the Reason Behind Urethral Stricture to Code Correctly

Your most common choices will fall in three code families.

Urethral stricture is not an uncommon diagnosis for urologists to see, which means you need to be familiar with the multiple coding possibilities. As long as you remember to check the reason behind the stricture, you should be able to pinpoint the correct code without too many problems.

Remember: A urethral stricture is a narrowing of the urethra. It can be caused by injury, instrumentation, infection, and certain non-infectious forms of urethritis. Symptoms can include bloody or dark urine, discharge from the urethra, a strong urge to urinate, frequent urination with a decreased urinary stream, pain in the lower abdomen or pelvic area, and others.

When the urologist diagnoses urethral stricture, most of your code choices focus on the cause of the stricture and the stricture location. Note that the diagnoses are also specific to males or females.

Your current ICD-10 choices for post-traumatic urethral stricture include:

- N35.010 – Post-traumatic urethral stricture, male, meatal
- N35.011 – Post-traumatic bulbous urethral stricture
- N35.012 – Post-traumatic membranous urethral stricture
- N35.013 – Post-traumatic anterior urethral stricture
- N35.014 – Post-traumatic urethral stricture, male, unspecified
- N35.021 – Urethral stricture due to childbirth
- N35.028 – Other post-traumatic urethral stricture, female.

If the urologist determines that an infection contributed to the stricture, you have a different set of diagnoses:

- N35.111 – Postinfective urethral stricture, not elsewhere classified, male, meatal
- N35.112 – Postinfective bulbous urethral stricture, not elsewhere classified
- N35.113 – Postinfective membranous urethral stricture, not elsewhere classified
- N35.114 – Postinfective anterior urethral stricture, not elsewhere classified
- N35.119 – Postinfective urethral stricture, not elsewhere classified, male, unspecified
- N35.12 – Postinfective urethral stricture, not elsewhere classified, female.

Your current ICD-10 choices for post-procedural urethral stricture include:

- N99.110- Postprocedural urethral stricture, male, meatal
- N99.111- Postprocedural bulbous urethral stricture
- N99.112- Postprocedural membranous urethral stricture
• N99.113- Postprocedural anterior bulbous urethral stricture
• N99.114- Postprocedural urethral stricture, male, unspecified
• N99.15- Postprocedural fossa navicularis urethral stricture
• N99.12- Postprocedural urethral stricture, female.

If the patient’s clinical circumstances do not fall into one of these diagnostic categories or if the record does not have enough detail to determine the most appropriate code, ICD-10 gives you a “catch-all” choice: N35.8 (Other urethral stricture).

Reader Question: Remember All Diagnoses to Fully Report Patient’s Condition

Question: I’m coding for a patient who has acute pyelonephritis (Proteus) with a right upper ureteral stone, a right mid-ureteral stricture with moderate hydronephrosis and a large blood clot in the right renal pelvis and calices. What are the correct diagnoses?

Answer: You’ll need to submit several ICD-10 diagnoses to fully report the patient’s condition. These include:

• N10 (Acute pyelonephritis) for the acute pyelonephritis; note that you are directed to include an additional code from B95-B97 to identify the infectious agent. In this case add B96.4 (Proteus [mirabilis] [morganii] as the cause of diseases classified elsewhere)
• N20.1 (Calculus of ureter) for the right upper ureteral stone
• N13.1 (Hydronephrosis with ureteral stricture not classified elsewhere) for the right mid-ureteral stricture and hydronephrosis
• N28.89 (Other specified disorders of kidney and ureter) for the large blood clot in the right renal pelvis and calices.

Reader Question: Code 51700 Can Apply for a Voiding Trial With an Existing Catheter

Question: We sometimes have patients come into our office for a voiding trial when they already have an indwelling urinary catheter in place. The nurse does a fill and then removes the catheter. Then we have the patient void. Can we bill 51700 for this even though the catheter was already in place?

Answer: Yes, you can report 51700 (Bladder irrigation, simple, lavage and/or instillation) for a voiding trial under these circumstances. The definition for code 51700 does not mention catheter insertion. CPT® also instructs you to not report 51701-51702 when catheter insertion is an inclusive component of another procedure. Therefore, one is able to bill for the bladder filling whether a catheter was inserted at the time of the filling or via a previously placed catheter. No modifiers are necessary.

Reader Question: Work of 52310 Includes Basket to Remove Stone

Question: The urologist performed a cystoscopy and used a basket to remove a small stone from the patient’s bladder. Everything was intact; no crushing, fragmentation, laser, or fulguration was involved. The operative report reads, “... the scope was then retroflexed (in the bladder) and beneath the median lobe, there was a small bladder stone seen. I then placed a basket through the flexible cystoscope and was able to grab the stone and then pulled intact atraumatically without irritating the prostate or urethra itself.” I’m thinking code 52310 is appropriate, but also wonder if we should include an additional code due to the use of the basket. Or, would we do better to report 52344 since explanations with it mention using instruments through the cystoscope to perform procedures such as stone removal? What do you recommend?

Answer: Code 52310 (Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder [separate procedure]; simple) is absolutely correct for the procedure you describe. Additional instruments can be passed through the cystoscope to allow the physician to perform procedures, such as stone removal, bladder biopsy, resection of a bladder or prostate tumor, and cauterization. These additional instruments could include a basket, so using the basket does not necessitate another code.

The other code choice you mention, 52344 (Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture [eg, balloon dilation, laser, electrocautery, and incision]), is a ureteroscopic procedure that is diagnostically driven to treat a ureteral stricture. If you don’t have documentation of ureteral stricture leading to the procedure, and no ureteroscopy was performed at the encounter, 52344 would be an inappropriate code to bill for the above clinical scenario.
Reader Question: Local Anesthesia for Catheter Pain Is Not Separately Billable

**Question:** Can we bill a 51703 when the provider and/or staff uses glydo jelly as an anesthetic agent before passing a urethral catheter?

**Answer:** No, you should not bill 51703 (Insertion of temporary indwelling bladder catheter; complicated [eg, altered anatomy, fractured catheter/balloon]) when the provider uses glydo jelly as an anesthetic agent. The use of local anesthesia such as glydo is not separately billable.

Code 51703 only when the urologist has difficulty inserting or removing a urethral catheter.

Clarification: Compare Your ICD-10 Options for Stent Removal

Recently a reader contacted Urology Coding Alert and questioned the ICD-10 diagnosis we chose for the double J stent removal in the “You be the Coder” titled “Stent Removal Diagnosis” in the Vol. 17, No. 11 issue.

The published answer: In the reader question, we instructed you to use an ICD-10 code from the T19 family, such as T19.1XXA (Foreign body in bladder, initial encounter), for the removal of a ureteral stent.

The reader suggested using the diagnoses N20.1 (Calculus of ureter) instead, with or without Z46.6 (Encounter for fitting and adjustment of urinary device).

Response: Although the reader reached the diagnosis N20.1 using the alphabetic list and the tabular list of the ICD-10 manual, and this diagnostic scenario may be applicable for stent removal, it is probably more accurately descriptive of diagnoses for stent exchange in the treatment of a ureteral calculus (procedure code 52332, Cystourethroscopy, with insertion of indwelling ureteral stent [eg, Gibbons or double-J type]).

Thank you to the reader for their coding suggestion, allowing us to clarify and offer coders the options that might apply to different stent removal scenarios.

Incident-To Billing: Understand 'New Problem' Terminology To Accurately Bill Incident-to Services

Check state laws, too.

Your urology practice can increase the number of patients you can see without taxing your urologists by employing nonphysician practitioners (NPPs) or mid-level providers (MLPs), such as physician assistants (PAs) or certified registered nurse practitioners (CRNPs).

But billing for the NPP’s services can be tricky. If you’re not correctly identifying the patient’s problem as new or previously established, you could be mistakenly billing encounters incident-to the physician to those payers who follow Medicare guidelines.

One coder posed a question to our experts about the key phrase “new medical condition” in the CMS incident-to billing guidelines. Read on to see our experts’ advice to ensure your practice is on the right track.

Review the Question

Billing representative, Sherry McCain, with a practice in Colorado, wrote in to ask: “Our office is in desperate need of clarification on incident-to. We need understanding for the following: ‘The physician should establish the care plan for the new patient to the practice or any established patient with a new medical condition. NPPs may implement the established plan of care.’ What does ‘new medical condition’ mean?”

Start with the Basics
The guideline above, from CMS, means that an NPP in your practice cannot see a patient with a new problem and bill incident-to under the physician’s national provider identifier (NPI) for 100 percent payment. Incident-to only applies when the NPP is seeing a patient for a problem for which the physician has already established a plan of care.

**Remember:** If the NPP’s scope of practice and state laws allow, the NPP can initially see a patient for a new problem, but in these cases bill directly under her own NPI for 85 percent reimbursement.

For example, if a patient has urinary retention and the urologist sees the patient about the urinary retention when it is new (first diagnosed) and establishes a plan of care, the patient can then see the NPP in follow-up, and the office can bill the encounter incident to the physician for 100 percent payment (assuming all other criteria for incident to billing are met). However, if the NPP sees the patient for urinary retention which is a new problem, and the physician has never seen the patient nor established a plan of care, this scenario does not meet incident-to requirements.

**Examine “Condition’ vs. ‘Problem’**

To get to the bottom of the reader’s question we must dig deeper. McCain continues, by asking: “Is there a difference between a medical condition and a problem?”

In the CMS incident-to guidelines, there is no distinction between a medical “condition” and a “problem,” “if you think about what ‘incident to’ actually means, that the services are incidental to the physician’s services, it may make more sense as to what the circumstances must be to bill an NPP’s services under the name/NPI of a physician.”

**Define ‘New’ Problem**

The final piece of the puzzle is what actually qualifies as a new problem. Is there a distinction between chronic conditions ... and acute conditions ...? What about when patients are seen repeatedly for [a problem]? When are those considered new problems? Or are they?

**Chronic problems:** For patients with chronic problems, you can bill incident to if the NPP is seeing the patient to follow through on the treatment plan established by the physician and is not making any changes to that plan. The physician must have already seen the patient for the chronic condition and set up the plan of care. In these cases of chronic care, it may be wise to also have the physician periodically see the patient to show his continuing care of the patient and his periodic review and reconfirmation of the plan of care. A clinical example of this would be a patient on long term Lupron therapy seeing a NPP for long term care.

**Acute problems:** For patients coming in with an acute problem, if the NPP sees the patient for that acute condition, the encounter doesn’t qualify for incident-to billing. If the NPP sees the patient for the acute condition, by their very nature, treatment of these acute conditions are not incident to a physician’s service.

**Recurrent conditions:** If providers in your practice are seeing a patient repeatedly for acute recurrent conditions, such as urinary tract infections, whether or not an NPP’s visit for the patient who comes in again with the same acute recurrent problem qualifies as incident to will depend on the particular circumstances. It may meet the criteria if there is a formal standing order outlining the steps or changes in treatment the NPP is to follow based on defined criteria. If, however, the NPP sees a patient, say, for the third infection and she switches the antibiotic to a different spectrum on her own, the services are not incident to.

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