Optum

Coding Companion

Urology/ Nephrology

A comprehensive illustrated guide to coding and reimbursement

2025

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/HCPCS code description, followed by an easy-to-understand explanation.

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

- HCPCS
- E/M
- 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 29.3, 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 2025 edition password is: **XXXXXX.** 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 xv 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 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ 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 services that may be performed via telehealth. 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	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
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 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

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 nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices,

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.

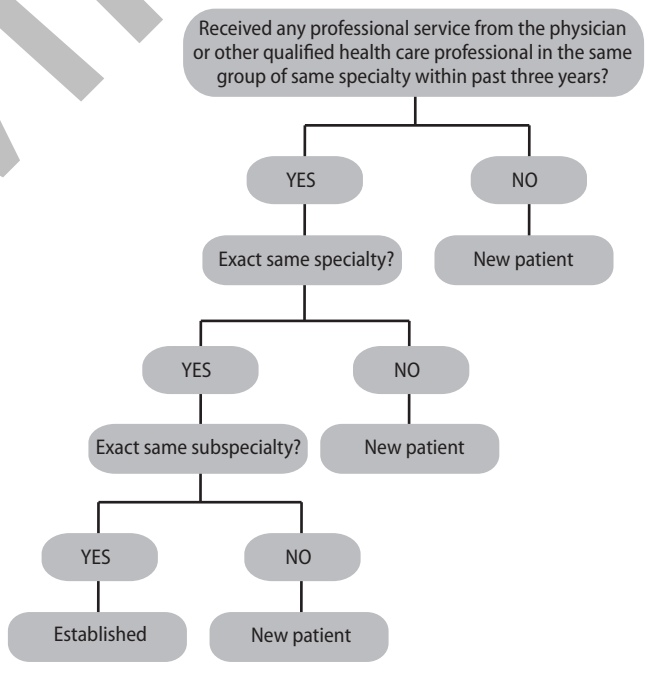
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the 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



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

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 total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

▲★**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 total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

▲★**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 total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

▲★**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 total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

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, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 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. Alternatively, 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. Medicare and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place of service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

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** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 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 **99203** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 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 **99204** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 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 **99205** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 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

Relative Value Units/Medicare Edits

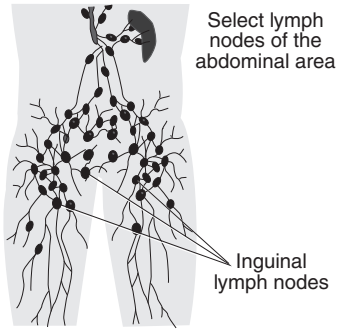
Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,11,40.1.3; 100-04,12,30.6.4; 100-04,12,30.6.10; 100-04,12,190.7; 100-04,12,230; 100-04,12,230.1; 100-04,18,80.2; 100-04,32,12.1
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

38500-38505, 38531

38500 Biopsy or excision of lymph node(s); open, superficial
38505 by needle, superficial (eg, cervical, inguinal, axillary)
38531 open, inguinofemoral node(s)



Explanation

The physician performs a biopsy on or removes one or more superficial lymph nodes. The physician makes a small incision through the skin overlying the lymph node. The tissue is dissected to the node. A small piece of the node and surrounding tissue are removed, or the node may be removed. The incision is repaired with a layered closure. Report 38505 if a needle is used. For biopsy or excision of the inguinofemoral nodes, report 38531.

Coding Tips

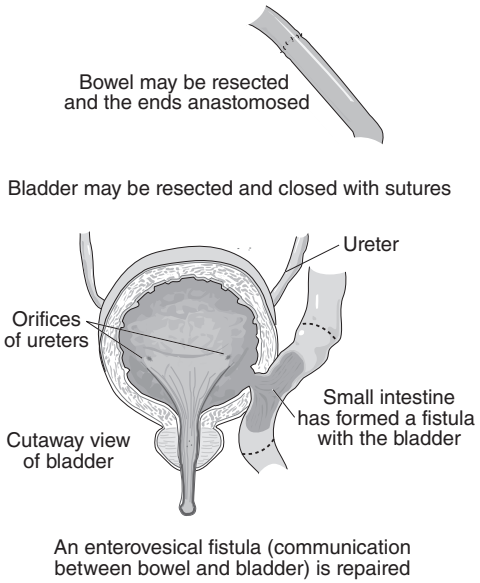
Code 38531 is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Do not report 38500 with 38700–38780. When imaging guidance is performed, see 76942, 77002, 77012, or 77021. For fine needle aspiration, see 10004–10012 and 10021. For evaluation of fine needle aspirate, see 88172–88173. For injection of a sentinel node for identification, see 38792.

ICD-10-CM Diagnostic Codes

C60.0 Malignant neoplasm of prepuce ♂
C60.1 Malignant neoplasm of glans penis ♂
C60.2 Malignant neoplasm of body of penis ♂
C60.8 Malignant neoplasm of overlapping sites of penis ♂
C61 Malignant neoplasm of prostate ♂
C62.11 Malignant neoplasm of descended right testis ♂ ☑
C62.12 Malignant neoplasm of descended left testis ♂ ☑
C63.01 Malignant neoplasm of right epididymis ♂ ☑
C63.02 Malignant neoplasm of left epididymis ♂ ☑
C63.11 Malignant neoplasm of right spermatic cord ♂ ☑
C63.12 Malignant neoplasm of left spermatic cord ♂ ☑
C63.2 Malignant neoplasm of scrotum ♂
C77.4 Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C79.82 Secondary malignant neoplasm of genital organs
C81.05 Nodular lymphocyte predominant Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.15 Nodular sclerosis Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.25 Mixed cellularity Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.35 Lymphocyte depleted Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.45 Lymphocyte-rich Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C81.75 Other Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
C82.05 Follicular lymphoma grade I, lymph nodes of inguinal region and lower limb
C82.15 Follicular lymphoma grade II, lymph nodes of inguinal region and lower limb
C82.35 Follicular lymphoma grade IIIa, lymph nodes of inguinal region and lower limb
C82.45 Follicular lymphoma grade IIIb, lymph nodes of inguinal region and lower limb
C82.55 Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.65 Cutaneous follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.85 Other types of follicular lymphoma, lymph nodes of inguinal region and lower limb
C83.15 Mantle cell lymphoma, lymph nodes of inguinal region and lower limb
C83.35 Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.55 Lymphoblastic (diffuse) lymphoma, lymph nodes of inguinal region and lower limb
C83.75 Burkitt lymphoma, lymph nodes of inguinal region and lower limb
C83.85 Other non-follicular lymphoma, lymph nodes of inguinal region and lower limb
C84.05 Mycosis fungoides, lymph nodes of inguinal region and lower limb
C84.41 Peripheral T-cell lymphoma, not elsewhere classified, lymph nodes of head, face, and neck
C84.44 Peripheral T-cell lymphoma, not elsewhere classified, lymph nodes of axilla and upper limb
C84.45 Peripheral T-cell lymphoma, not elsewhere classified, lymph nodes of inguinal region and lower limb
C84.48 Peripheral T-cell lymphoma, not elsewhere classified, lymph nodes of multiple sites
C84.49 Peripheral T-cell lymphoma, not elsewhere classified, extranodal and solid organ sites
C84.65 Anaplastic large cell lymphoma, ALK-positive, lymph nodes of inguinal region and lower limb
C84.75 Anaplastic large cell lymphoma, ALK-negative, lymph nodes of inguinal region and lower limb
C84.Z5 Other mature T/NK-cell lymphomas, lymph nodes of inguinal region and lower limb
C85.25 Mediastinal (thymic) large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C85.85 Other specified types of non-Hodgkin lymphoma, lymph nodes of inguinal region and lower limb
D86.84 Sarcoid pyelonephritis
I88.1 Chronic lymphadenitis, except mesenteric
L04.8 Acute lymphadenitis of other sites

44660-44661

44660 Closure of enterovesical fistula; without intestinal or bladder resection
44661 with intestine and/or bladder resection



An enterovesical fistula (communication between bowel and bladder) is repaired

Explanation

The physician closes a connection between the small bowel and bladder (enterovesical fistula). The physician makes an abdominal incision. Next, the enterovesical fistula is identified and divided. The ends of the fistula are closed with sutures. In 44661, the connection of the fistula to the bladder is resected and the bladder is closed with sutures; the segment of intestine containing the fistula is resected and the ends are reapproximated. The incision is closed.

Coding Tips

For closure of an intestinal cutaneous fistula, see 44640; enteroenteric or enterocolic, see 44650; renocolic, abdominal approach, see 50525; thoracic approach, see 50526; gastrocolic, see 43880; rectovesical, see 45800–45805.

ICD-10-CM Diagnostic Codes

N32.1	Vesicointestinal fistula
N32.2	Vesical fistula, not elsewhere classified
N49.8	Inflammatory disorders of other specified male genital organs ♂
Q64.73	Congenital urethrorectal fistula
Q64.79	Other congenital malformations of bladder and urethra
Q64.8	Other specified congenital malformations of urinary system
T81.83XA	Persistent postprocedural fistula, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
44660	23.91	11.4	4.28	39.59
44661	27.35	12.86	5.61	45.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
44660	23.91	11.4	4.28	39.59
44661	27.35	12.86	5.61	45.82

	FUD	Status	MUE	Modifiers				IOM Reference
44660	90	A	1(3)	51	N/A	62*	80	None
44661	90	A	1(3)	51	N/A	62*	80	

* with documentation

Terms To Know

anastomosis. Surgically created connection between ducts, blood vessels, or bowel segments to allow flow from one to the other.

enterovesical fistula. Abnormal communication between the small intestine and the bladder.

incision. Act of cutting into tissue or an organ.

peritonitis. Inflammation and infection within the peritoneal cavity, the space between the membrane lining the abdominopelvic walls and covering the internal organs.

regional enteritis. Chronic inflammation of unknown origin affecting the ileum and/or colon.

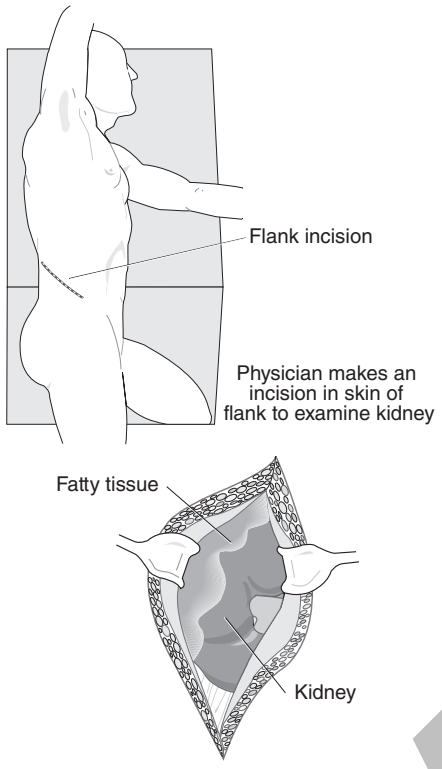
resection. Surgical removal of a part or all of an organ or body part.

suture. Numerous stitching techniques employed in wound closure: ***1)*** Buried suture: Continuous or interrupted suture placed under the skin for a layered closure. ***2)*** Continuous suture: Running stitch with tension evenly distributed across a single strand to provide a leak-proof closure line. ***3)*** 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. ***4)*** Purse-string suture: Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen. ***5)*** 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.

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

50010

50010 Renal exploration, not necessitating other specific procedures



Explanation

The physician examines the kidney and renal pelvis. To access the kidney, the physician makes an incision in the skin of the flank, cuts the muscles, fat, and fibrous membranes (fascia) overlying the kidney, and sometimes removes a portion of the eleventh or twelfth rib. The physician clears away the fatty tissue surrounding the kidney, explores the area, and performs a layered closure.

Coding Tips

Nephrotomy with exploration is reported with 50045; pyelotomy, see 50120. For retroperitoneal exploration, see 49010. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report.

ICD-10-CM Diagnostic Codes

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 ☑
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis ☑
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis ☑
C7A.093	Malignant carcinoid tumor of the kidney
C80.2	Malignant neoplasm associated with transplanted organ
D09.19	Carcinoma in situ of other urinary organs
D30.01	Benign neoplasm of right kidney ☑
D30.02	Benign neoplasm of left kidney ☑
D30.11	Benign neoplasm of right renal pelvis ☑
D30.12	Benign neoplasm of left renal pelvis ☑
D3A.093	Benign carcinoid tumor of the kidney
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 ☑
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
K66.1	Hemoperitoneum
N13.0	Hydronephrosis with ureteropelvic junction obstruction
N13.1	Hydronephrosis with ureteral stricture, not elsewhere classified
N13.2	Hydronephrosis with renal and ureteral calculous obstruction
N13.39	Other hydronephrosis
N28.0	Ischemia and infarction of kidney
N28.1	Cyst of kidney, acquired
N28.81	Hypertrophy of kidney
N28.83	Nephroptosis
N28.89	Other specified disorders of kidney and ureter
Q61.01	Congenital single renal cyst
Q61.02	Congenital multiple renal cysts
Q61.19	Other polycystic kidney, infantile type
Q61.2	Polycystic kidney, adult type
Q61.4	Renal dysplasia
Q61.5	Medullary cystic kidney
Q61.8	Other cystic kidney diseases
Q62.0	Congenital hydronephrosis
Q62.39	Other obstructive defects of renal pelvis and ureter
S37.011A	Minor contusion of right kidney, initial encounter ☑
S37.012A	Minor contusion of left kidney, initial encounter ☑
S37.021A	Major contusion of right kidney, initial encounter ☑
S37.022A	Major contusion of left kidney, initial encounter ☑
S37.041A	Minor laceration of right kidney, initial encounter ☑
S37.042A	Minor laceration of left kidney, initial encounter ☑
S37.051A	Moderate laceration of right kidney, initial encounter ☑
S37.052A	Moderate laceration of left kidney, initial encounter ☑
S37.061A	Major laceration of right kidney, initial encounter ☑
S37.062A	Major laceration of left kidney, initial encounter ☑
S37.091A	Other injury of right kidney, initial encounter ☑
S37.092A	Other injury of left kidney, initial encounter ☑
T79.5XXA	Traumatic anuria, initial encounter

Relative Value Units/Medicare Edits

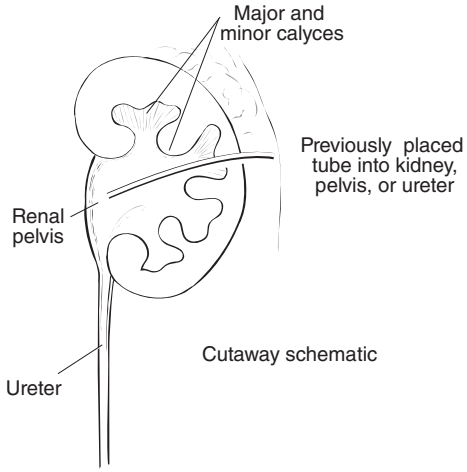
Non-Facility RVU	Work	PE	MP	Total
50010	12.28	7.63	2.25	22.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
50010	12.28	7.63	2.25	22.16

	FUD	Status	MUE	Modifiers				IOM Reference
50010	90	A	1(2)	51	50	62*	80	None

* with documentation

50606

+ **50606** Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)



Explanation

A nonendoscopic endoluminal biopsy of the ureter and/or renal pelvis is accomplished by incision into the skin overlying the target area. The patient is anesthetized and the incision is made. The target area is visualized by imaging guidance. A guidewire is inserted into the biopsy site followed by a sheath over the wire. A forceps device is inserted along the wire until it reaches the biopsy site and the sheath is withdrawn exposing the forceps. With the wings of the forceps open, the device is inserted into the target area where the wings are closed trapping the tissue sample. The device is pulled back with the biopsy sample intact. Another method uses a brush biopsy to retrieve the sample. The brush may be inserted through a scope until it reaches the target area. Biopsy is obtained with rubbing of the brush within the lumen. Upon removal, the sample is retrieved from the brush for examination. The guidewire is removed and any other instruments used in the primary procedure are also removed. The incision site is closed with sutures. This code includes procurement of biopsy sample, imaging guidance, and radiological supervision and interpretation. The biopsy may be performed via transrenal access, existing renal/ureteral access, transurethral access, an ileal conduit, or ureterostomy. This code reports the biopsy only; the procedure performed for access to the biopsy site is reported separately.

Coding Tips

Report 50606 with 50382, 50384–50387, 50389, 50430–50435, 50684, 50688, 50690, 50693–50695, and 51610. Do not report 50606 with 50555, 50574, 50955, 50974, 52007, or 74425 for the same renal collecting system and/or associated ureter. This code describes endoluminal biopsy using nonendoscopic imaging guidance and may be reported once per ureter per day. The biopsy work, imaging guidance, and radiological supervision and interpretation required to accomplish the biopsy are included. Diagnostic pyelography/ureterography is not included in this code and may be reported separately. This code is reported once for each renal collecting system/ureter accessed.

ICD-10-CM Diagnostic Codes

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
50606	3.16	11.06	0.37	14.59
Facility RVU	**Work**	**PE**	**MP**	**Total**
50606	3.16	0.53	0.37	4.06

	FUD	Status	MUE	Modifiers				IOM Reference
50606	N/A	A	1(3)	N/A	50	N/A	N/A	None

* with documentation

Terms To Know

add-on code. CPT code representing a procedure performed in addition to the primary procedure and designated with a + symbol in the CPT book. Add-on codes are never reported as a stand-alone service but are reported secondarily in addition to the primary procedure.

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

forceps. Tool used for grasping or compressing tissue.

guidewire. Flexible metal instrument designed to lead another instrument in its proper course.

imaging. Radiologic means of producing pictures for clinical study of the internal structures and functions of the body, such as x-ray, ultrasound, magnetic resonance, or positron emission tomography.

lumen. Space inside an intestine, artery, vein, duct, or tube.

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

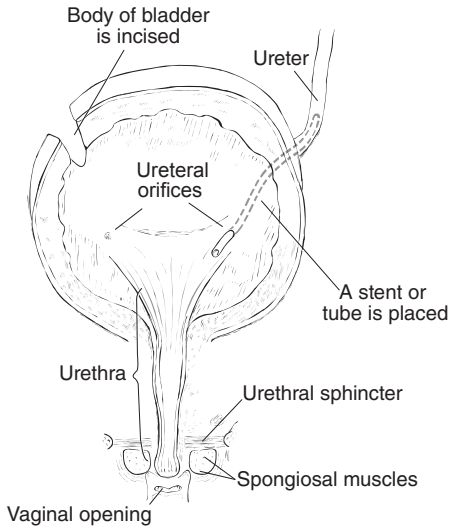
supervision and interpretation. Radiology services that usually contain an invasive component and are reported by the radiologist for supervision of the procedure and the personnel involved with performing the examination, reading the film, and preparing the written report.

tissue. Group of similar cells with a similar function that form definite structures and organs. Tissue types include epithelial tissue, muscle tissue, connective tissue, and nervous tissue.

ureter. Tube leading from the kidney to the urinary bladder made up of three layers of tissue: the mucous lining of the inner layer; the smooth, muscular middle layer that propels the urine from the kidney to the bladder by peristalsis; and the outer layer made of fibrous connective tissue. Each ureter leaves the kidney from the hilum, a concave notch on the middle surface, and enters the bladder through a narrow valve-like orifice that prevents the backflow of urine to the kidney.

51045

51045 Cystotomy, with insertion of ureteral catheter or stent (separate procedure)



Explanation

The physician makes an incision in the bladder to insert a catheter or slender tube (stent) into the ureter. To access the bladder and ureters, the physician makes a midline incision in the skin of the abdomen and cuts the corresponding muscles, fat, and fibrous membranes (fascia). The physician incises the bladder (cystotomy) and inserts a stent or catheter in the ureter. Insertion of a ureteral catheter requires that the physician bring the tube end out through the urethra or bladder incision. The physician inserts a drain tube and performs a layered closure.

Coding Tips

This 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 cystotomy or cystostomy for the destruction of lesions, see 51020–51030. For cystotomy, cystostomy with drainage, see 51040. For cystotomy for the removal of a calculus, see 51050 and 51065. For cystotomy for excision of the vesical neck, see 51520; excision of the bladder diverticulum, see 51525; or excision of a bladder tumor, see 51530. For cystotomy for repair of a ureterocele, see 52300–52301.

ICD-10-CM Diagnostic Codes

C66.1	Malignant neoplasm of right ureter ☑
C66.2	Malignant neoplasm of left ureter ☑
D30.21	Benign neoplasm of right ureter ☑
D30.22	Benign neoplasm of left ureter ☑
D41.21	Neoplasm of uncertain behavior of right ureter ☑
D41.22	Neoplasm of uncertain behavior of left ureter ☑
N11.1	Chronic obstructive pyelonephritis
N13.4	Hydroureter
N13.5	Crossing vessel and stricture of ureter without hydronephrosis
N13.8	Other obstructive and reflux uropathy
N20.1	Calculus of ureter
N28.89	Other specified disorders of kidney and ureter
Q62.0	Congenital hydronephrosis
Q62.11	Congenital occlusion of ureteropelvic junction
Q62.12	Congenital occlusion of ureterovesical orifice
Q62.2	Congenital megaureter
Q62.31	Congenital ureterocele, orthotopic
Q62.32	Cecoureterocele
Q62.39	Other obstructive defects of renal pelvis and ureter
S37.12XA	Contusion of ureter, initial encounter
S37.13XA	Laceration of ureter, initial encounter
S37.19XA	Other injury of ureter, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
51045	7.81	5.77	1.32	14.9
Facility RVU	**Work**	**PE**	**MP**	**Total**
51045	7.81	5.77	1.32	14.9

	FUD	Status	MUE	Modifiers			IOM Reference
51045	90	A	2(3)	51	N/A	N/A	80 None

* with documentation

Terms To Know

calculus. Abnormal, stone-like concretion of calcium, cholesterol, mineral salts, or other substances that forms in any part of the body.

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

cystotomy. Surgical incision into the gallbladder or urinary bladder.

fistula. Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.

hydroureter. Abnormal enlargement or distension of the ureter with water or urine caused by an obstruction.

neoplasm. New abnormal growth, tumor.

occlusion. Constriction, closure, or blockage of a passage.

stent. Tube to provide support in a body cavity or lumen.

stricture. Narrowing of an anatomical structure.

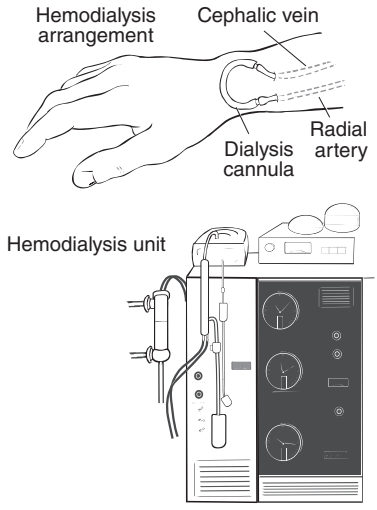
tube. Long, hollow cylindrical instrument or body structure.

ureter. Tube leading from the kidney to the urinary bladder made up of three layers of tissue: the mucous lining of the inner layer; the smooth, muscular middle layer that propels the urine from the kidney to the bladder by peristalsis; and the outer layer made of fibrous connective tissue. Each ureter leaves the kidney from the hilum, a concave notch on the middle surface, and enters the bladder through a narrow valve-like orifice that prevents the backflow of urine to the kidney.

90935-90937

90935 Hemodialysis procedure with single evaluation by a physician or other qualified health care professional

90937 Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription



Explanation

Hemodialysis is a process to remove toxins from the blood and to maintain fluid and electrolyte balance when the kidneys no longer function. The procedure involves using a previously placed catheter in an artery or a vein to withdraw the patient's blood, mechanically circulating the blood through a dialysis machine to remove the toxins and wastes, and transfusing the blood back to the patient. Code 90935 applies to one hemodialysis treatment that includes a single physician or other qualified health care provider's evaluation of the patient and 90937 is for a hemodialysis procedure when patient re-evaluation(s) must be done during the procedure, with or without substantial revision of the dialysis prescription.

Coding Tips

These codes include the hemodialysis procedure and all evaluation and management services provided that are related to the patient's renal disease on the day of the procedure. Any E/M services that are separately identifiable and unrelated to the dialysis or renal failure are reported separately with modifier 25. For home visit hemodialysis services performed by a nonphysician health care professional, see 99512. For prolonged physician or other qualified health care provider attendance, see 99360.

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
O90.49	Other postpartum acute kidney failure M
Z49.31	Encounter for adequacy testing for hemodialysis

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90935	1.48	0.53	0.1	2.11
90937	2.11	0.77	0.12	3.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90935	1.48	0.53	0.1	2.11
90937	2.11	0.77	0.12	3.0

	FUD	Status	MUE	Modifiers				IOM Reference
90935	0	A	1(3)	N/A	N/A	N/A	80*	100-02,1,10; 100-02,11,20; 100-03,130.8; 100-04,3,100.6; 100-04,4,200.2
90937	0	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

cannula. Tube inserted into a blood vessel, duct, or body cavity to facilitate passage.

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

chronic kidney disease. Decreased renal efficiency resulting in reduced ability of the kidney to filter waste. The National Kidney Foundation's classification includes clinical stages based on the glomerular filtration rate (GFR). The stages of CKD are as follows: stage 1, some kidney damage with a normal GFR of 90 or above; stage 2, mild kidney damage with a GFR of 60 to 89; stage 3a, mild to moderate kidney damage with a GFR of 45 to 59; stage 3b, moderate to severe kidney damage with a GFR of 30 to 44; stage 4, severe kidney damage with a GFR of 15 to 29; and stage 5, kidney failure with a GFR of less than 15. Dialysis or transplantation is required when kidney failure progresses to end stage renal disease.

ESRD. End stage renal disease. Progression of chronic renal failure to lasting and irreparable kidney damage that requires dialysis or renal transplant for survival.

hemodialysis. Cleansing of wastes and contaminating elements from the blood by virtue of different diffusion rates through a semipermeable membrane, which separates blood from a filtration solution that diffuses other elements out of the blood.

qualified health care professional. Educated, licensed or certified, and regulated professional operating under a specified scope of practice to provide patient services that are separate and distinct from other clinical staff.

G0102

G0102 Prostate cancer screening; digital rectal examination

Explanation

This code reports a prostate cancer screening performed manually by the physician as a digital rectal exam in order to palpate the prostate and check for abnormalities.

Coding Tips

This screening service is covered by Medicare once every 12 months for men who are 50 years of age or older. A minimum of 11 months must have passed following the month in which the last Medicare-covered screening digital rectal examination was performed.

ICD-10-CM Diagnostic Codes

Z12.5 Encounter for screening for malignant neoplasm of prostate ♂

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0102	0.18	0.5	0.01	0.69
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0102	0.18	0.07	0.01	0.26

	FUD	Status	MUE	Modifiers				IOM Reference
G0102	N/A	A	1(2)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

malignant neoplasm. Any cancerous tumor or lesion exhibiting uncontrolled tissue growth that can progressively invade other parts of the body with its disease-generating cells.

prostate. Male gland surrounding the bladder neck and urethra that secretes a substance into the seminal fluid.

rectal. Pertaining to the rectum, the end portion of the large intestine.

screening test. Exam or study used by a physician to identify abnormalities, regardless of whether the patient exhibits symptoms.

G0168

G0168 Wound closure utilizing tissue adhesive(s) only

Explanation

Wound closure done by using tissue adhesive only, not any kind of suturing or stapling, is reported with this code. Tissue adhesives, such as Dermabond, are materials that are applied directly to the skin or tissue of an open wound to hold the margins closed for healing.

Coding Tips

This code is reported when a Medicare patient undergoes a superficial repair or closure using a tissue adhesive only. This includes instances where sutures have been used for the repair of deeper layers and tissue adhesive is used to close the superficial layer. Payment for this service is at the discretion of the carrier.

ICD-10-CM Diagnostic Codes

S30.812A Abrasion of penis, initial encounter ♂

S30.813A Abrasion of scrotum and testes, initial encounter ♂

S30.814A Abrasion of vagina and vulva, initial encounter ♀

S31.010A Laceration without foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.030A Puncture wound without foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.050A Open bite of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.110A Laceration without foreign body of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter ☑

S31.111A Laceration without foreign body of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter ☑

S31.112A Laceration without foreign body of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter

S31.113A Laceration without foreign body of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter ☑

S31.114A Laceration without foreign body of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter ☑

S31.115A Laceration without foreign body of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.130A Puncture wound of abdominal wall without foreign body, right upper quadrant without penetration into peritoneal cavity, initial encounter ☑

S31.131A Puncture wound of abdominal wall without foreign body, left upper quadrant without penetration into peritoneal cavity, initial encounter ☑

S31.132A Puncture wound of abdominal wall without foreign body, epigastric region without penetration into peritoneal cavity, initial encounter

S31.133A Puncture wound of abdominal wall without foreign body, right lower quadrant without penetration into peritoneal cavity, initial encounter ☑

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

Correct Coding Initiative Update 29.3

❖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, 99211-99215, 99221-99223, 99231-99239, 99242-99245, 99252-99255, 99291-99292, 99304-99310, 99315-99316, 99347-99350, 99374-99375, 99377-99378, 99446-99449, 99451-99452, 99495-99496, C9769, G0463, G0471, J2001, P9612

0559T 0694T, 76376-76377

0560T 0694T, 76376-76377

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