Optum

Coding Companion

Urology/ Nephrology

A comprehensive illustrated guide to coding and reimbursement

2027

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, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

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 32.3, 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 2027 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 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

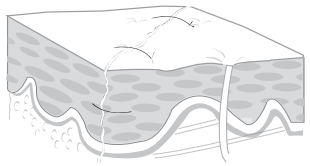
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

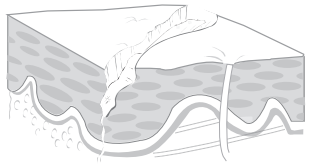
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

12020-12021 1

12020 Treatment of superficial wound dehiscence; simple closure
12021 with packing



Example of a simple closure involving only one skin layer



Example of a wound left open with packing due to infection

Explanation 3

There has been a breakdown of the healing skin either before or after suture removal. The skin margins have opened. The physician cleanses the wound with irrigation and antimicrobial solutions. The skin margins may be trimmed to initiate bleeding surfaces. Report 12020 if the wound is sutured in a single layer. Report 12021 if the wound is left open and packed with gauze strips due to the presence of infection. This allows infection to drain from the wound and the skin closure will be delayed until the infection is resolved.

Coding Tips 4

For extensive or complicated secondary wound closure, see 13160. For wound closure by tissue adhesive(s) only, see HCPCS Level II code G0168. To report extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocation(s), resulting from penetrating and/or blunt trauma, see 11042–11047. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes 5

T81.328A Disruption or dehiscence of closure of other specified internal operation (surgical) wound, initial encounter
T81.33XA Disruption of traumatic injury wound repair, initial encounter

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only 6

AMA: **12020** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov **12021** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov 7

Relative Value Units/Medicare Edits 8

Non-Facility RVU	Work	PE	MP	Total
12020	2.67	5.94	0.42	9.03
12021	1.89	3.15	0.31	5.35
Facility RVU	**Work**	**PE**	**MP**	**Total**
12020	2.67	2.57	0.42	5.66
12021	1.89	2.05	0.31	4.25

	FUD	Status	MUE	Modifiers				IOM Reference
12020	10	A	2(3)	51	N/A	N/A	N/A	None
12021	10	A	3(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know 9

closure. Repairing an incision or wound by suture or other means.

dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers.

drain. Device that creates a channel to allow fluid from a cavity, wound, or infected area to exit the body.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

margin. Boundary, edge, or border, as of a surface or structure.

packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

wound repair. Surgical closure of a wound is divided into three categories: simple, intermediate, and complex. ***simple repair:*** Surgical closure of a superficial wound, requiring single layer suturing of the skin epidermis, dermis, or subcutaneous tissue. ***intermediate repair:*** Surgical closure of a wound requiring closure of one or more of the deeper subcutaneous tissue and non-muscle fascia layers in addition to suturing the skin; contaminated wounds with single layer closure that need extensive cleaning or foreign body removal. ***complex repair:*** Repair of wounds requiring more than layered closure (debridement, scar revision, stents, retention sutures).

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2027.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2027.
- ▲ This CPT code description is revised for 2027.
- ✚ 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. Note: This icon is not appended to the synchronous audio-video visit codes 98000-98007.

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	96041
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 a 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
- ☑ 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 2026.

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, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier 26) component of a procedure is provided.

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 has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services 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** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 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 **99203** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 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 **99204** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 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 **99205** 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.16	0.08	2.17
99203	1.6	1.59	0.16	3.35
99204	2.6	2.18	0.24	5.02
99205	3.5	2.79	0.33	6.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.4	0.08	1.41
99203	1.6	0.68	0.16	2.44
99204	2.6	1.13	0.24	3.97
99205	3.5	1.57	0.33	5.4

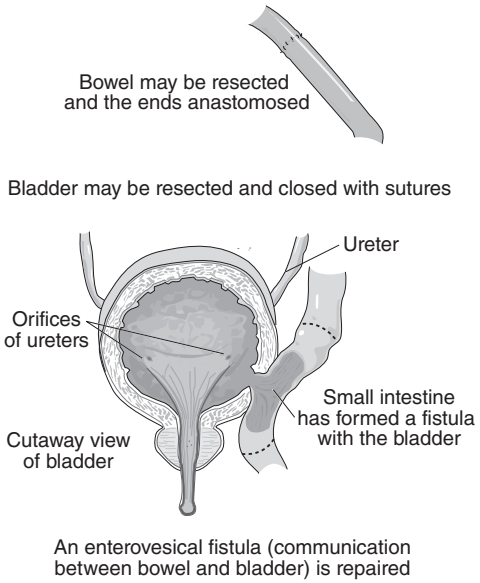
	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

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	11.45	4.66	40.02
44661	27.35	12.89	5.68	45.92
Facility RVU	**Work**	**PE**	**MP**	**Total**
44660	23.91	11.45	4.66	40.02
44661	27.35	12.89	5.68	45.92

	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.

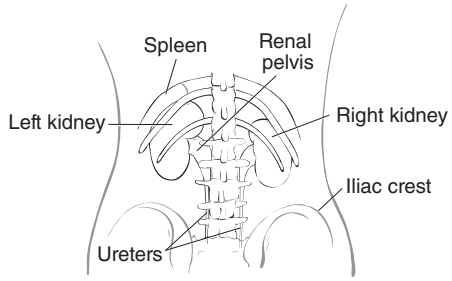
regional enteritis. Chronic inflammation of unknown origin affecting the ileum and/or colon.

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

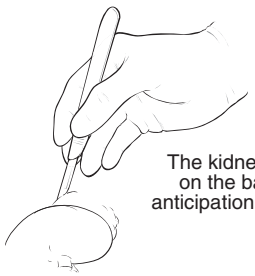
suture. Numerous stitching techniques employed in wound closure: ***1)*** Buried suture: Continuous or interrupted suture placed under the skin for a layered closure. ***2)*** Continuous suture: Running stitch with tension evenly distributed across a single strand to provide a leak-proof closure line. ***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.

50325

50325 Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary



A donor kidney (from a living donor) has been procured and is prepared for transplantation



The kidney is prepared on the backbench in anticipation of a transplant

Explanation

The physician performs a standard backbench preparation of the kidney following procurement from a living donor. Backbench or back table preparation refers to procedures performed on the donor organ following procurement to prepare the donor organ for transplant. In a separately reportable procedure, the physician removes the kidney and upper ureter from a living donor. The kidney is flushed with a cold electrolyte solution to rinse any remaining donor blood from the kidney and lower its temperature. When the kidney is procured from a living donor, only minimal backbench preparation is required because most of the dissection is performed in situ during the nephrectomy. During the backbench preparation any excess perinephric fat and other tissue attachments are removed from the graft, taking care to leave fibrofatty tissue around the ureter to ensure its blood supply. Further separation of the renal artery or arteries from the renal veins is performed. The arterial and venous separation prevents the technical inconvenience of side-by-side anastomosis in the recipient. To reduce the risk of postoperative complications, the transplant ureter is shortened as needed leaving the vascularized periureteral fat intact. When all residual soft tissue has been removed and the blood vessels and ureters prepared, the kidney is ready for transplant.

Coding Tips

For donor nephrectomy from a living donor, see 50320. For laparoscopic donor nephrectomy, see 50547. For renal allotransplantation, see 50360–50365.

ICD-10-CM Diagnostic Codes

This code is not identified as an add-on code by CPT® but is performed at the same time as another primary procedure. Refer to the corresponding primary procedure code for ICD-10-CM diagnosis code links.

AMA: **50325** 2021,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
50325	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
50325	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
50325	N/A	C	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

allograft. Graft from one individual to another of the same species.

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

backbench preparation. Procedures performed on a donor organ following procurement to prepare the organ for transplant into the recipient. Excess fat and other tissue may be removed, the organ may be perfused, and vital arteries may be sized, repaired, or modified to fit the patient. These procedures are done on a back table in the operating room before transplantation can begin.

dissection. (dis. apart; -section, act of cutting) Separating by cutting tissue or body structures apart.

donor. Person from whom tissues or organs are removed for transplantation.

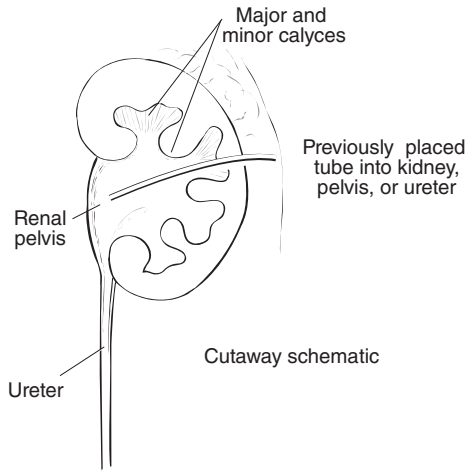
in situ. Located in the natural position or contained within the origin site, not spread into neighboring tissue.

transplantation. Grafting or movement of an organ or tissue from one site or person to another.

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.

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)



Cutaway schematic

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	10.72	0.39	14.27
Facility RVU	**Work**	**PE**	**MP**	**Total**
50606	3.16	0.51	0.39	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.

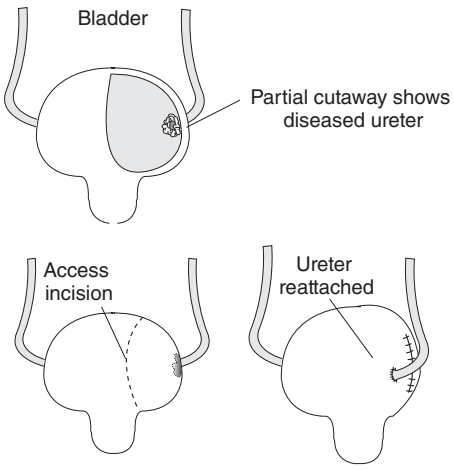
supervision and interpretation. Radiology services that usually contain an invasive component and are reported by the radiologist for supervision of the procedure and the personnel involved with performing the examination, reading the film, and preparing the written report.

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.

51565

51565 Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)



The physician removes diseased or damaged bladder tissue close to the ureteral orifice

Explanation

The physician removes diseased or damaged bladder tissue close to the ureteral orifice, and reimplants ureter(s) into the bladder (ureteroneocystostomy). 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 mobilizes the bladder, ureter(s), and the major vesical blood vessels, and may incise the bladder wall to access the diseased or damaged bladder tissue. The physician removes the diseased or damaged bladder tissue, requiring removal of the ureteral orifice and/or ureteral division. The physician brings the cut end of the ureter through a stab wound in the bladder and sutures the ureter to the bladder. To provide support during healing, the physician inserts a ureteral catheter, bringing the tube end out through the urethra or bladder incision. The physician inserts a drain tube and performs a layered closure.

Coding Tips

Report 51550–51555 for removal of diseased or damaged bladder tissue not requiring reimplantation of the ureter. For implantation of the ureter into the bladder without removal of diseased or damaged bladder tissue, see 50780–50785. Report 50830 if the physician performs a ureteroneocystostomy to restore urethral continuity after surgical diversion. For ureteroneocystostomy following plastic reconstruction on the bladder and urethra (cystourethroplasty), see 51820.

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
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
D48.7	Neoplasm of uncertain behavior of other specified sites
D49.4	Neoplasm of unspecified behavior of bladder
N30.10	Interstitial cystitis (chronic) without hematuria
N30.11	Interstitial cystitis (chronic) with hematuria
N32.1	Vesicointestinal fistula
N32.3	Diverticulum of bladder
N80.A1	Superficial endometriosis of bladder
N80.A2	Deep endometriosis of bladder
N82.0	Vesicovaginal fistula

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
51565	23.68	11.74	2.87	38.29
Facility RVU	**Work**	**PE**	**MP**	**Total**
51565	23.68	11.74	2.87	38.29

	FUD	Status	MUE	Modifiers				IOM Reference
51565	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

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.

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

diverticulum. Pouch or sac in the walls of an organ or canal.

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

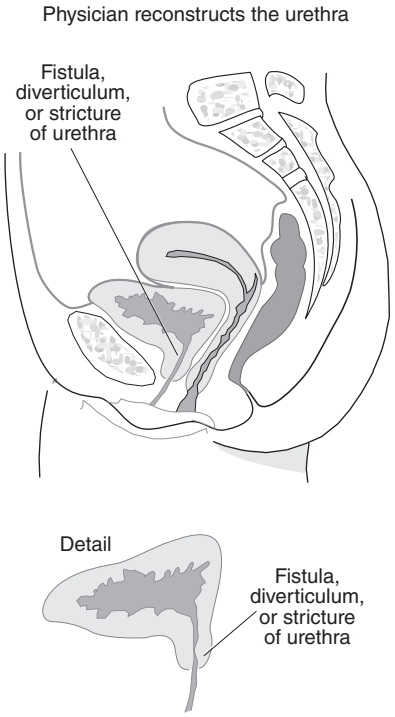
malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

neurogenic bladder. Dysfunctional bladder due to a central or peripheral nervous system lesion that may result in incontinence, residual urine retention, infection, stones, and renal failure.

53400-53405

53400 Urethroplasty; first stage, for fistula, diverticulum, or stricture (eg, Johannsen type)

53405 second stage (formation of urethra), including urinary diversion



Explanation

The physician reconstructs the urethra in two stages. In the first stage (53400), the area of the stricture is identified by a catheter and urethrography and its location is marked with ink or dye. The incision is made over the stricture area and targeted tissue is removed. Otherwise, the stricture is opened widely and the normal skin of the male or female is sutured to the edge of the mucosa on each side. In those areas in which mucosa had to be removed, the skin is sutured edge-to-edge. Six to eight weeks are required for complete healing of this stage. In the second stage (53405), the physician makes parallel incisions around the defect and continues around the urethral opening both proximally and distally. The lateral skin edges are closed over an indwelling catheter to create a new urethra. The corpora and muscles are closed, respectively, becoming the new urethra structure.

Coding Tips

Report 53410 for reconstruction of the male anterior urethra in one stage. Report 53430 for reconstruction of the female urethra in one stage. See 54300–54352 for repair of hypospadias. Supplies used when providing these procedures may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

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

N35.016 Post-traumatic urethral stricture, male, overlapping sites

N35.111 Postinfective urethral stricture, not elsewhere classified, male, meatal

N35.112 Postinfective bulbous urethral stricture, not elsewhere classified, male

N35.113 Postinfective membranous urethral stricture, not elsewhere classified, male

N35.114 Postinfective anterior urethral stricture, not elsewhere classified, male

N35.116 Postinfective urethral stricture, not elsewhere classified, male, overlapping sites

N35.811 Other urethral stricture, male, meatal

N35.812 Other bulbous urethral stricture, male

N35.813 Other membranous urethral stricture, male

N35.814 Other anterior urethral stricture, male

N35.816 Other urethral stricture, male, overlapping sites

N35.82 Other urethral stricture, female

N36.0 Urethral fistula

N36.1 Urethral diverticulum

N37 Urethral disorders in diseases classified elsewhere

N99.110 Postprocedural urethral stricture, male, meatal

N99.111 Postprocedural bulbous urethral stricture, male

N99.112 Postprocedural membranous urethral stricture, male

N99.113 Postprocedural anterior bulbous urethral stricture, male

N99.115 Postprocedural fossa navicularis urethral stricture

N99.116 Postprocedural urethral stricture, male, overlapping sites

Q64.32 Congenital stricture of urethra

Q64.39 Other atresia and stenosis of urethra and bladder neck

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
53400	14.13	8.03	1.74	23.9
53405	15.66	8.49	1.9	26.05
Facility RVU	**Work**	**PE**	**MP**	**Total**
53400	14.13	8.03	1.74	23.9
53405	15.66	8.49	1.9	26.05

	FUD	Status	MUE	Modifiers				IOM Reference
53400	90	A	1(2)	51	N/A	62*	80	None
53405	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

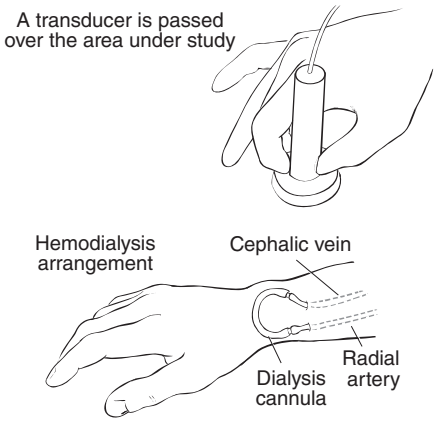
diverticulum. Pouch or sac in the walls of an organ or canal.

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

stricture. Narrowing of an anatomical structure.

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

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	0.51	0.01	0.7
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 ☑

Correct Coding Initiative Update 32.3

❖Indicates Mutually Exclusive Edit

0421T 00910, 00914-00916, 0213T, 0216T, 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, 52283-52284, 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, P9612

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0562T 0694T, 76376-76377

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