Chapter 12

Section Review 12.1

1. A. Kidneys

RATIONALE: The renal pelvis receives urine from the kidney, travels through the ureters on the way to the bladder, but urine is formed in the kidney.

2. C. Urethra

RATIONALE: The urine travels from the kidneys to the ureters, to the bladder, where it is stored and expelled through the urethra.

3. D. Testes

RATIONALE: The testes are the reproductive glands, the seminal vesicles contribute fluid to the ejaculate, and the vas deferens transports the sperm, where it exits through the urethra.

4. C. Spleen

RATIONALE: The organs making up the urinary system consist of the kidneys, bladder, urethra, and ureters.

5. A. Prostate

RATIONALE: The prostate gland is the gland that is partly muscular and glandular.

Section Review 12.2

1. C. 592.0

RATIONALE: Documentation of calculus of the kidney and ureter are very specific to the organ site involved. Though most stones are calcium based, coding a disorder of calcium metabolism would be incorrect. Calculus of the urethra and ureter are not correct because the documentation states "nephrolithiasis (kidney). Kidney stones, or nephrolithiasis, is coded 592.0

2. C. 599.71

RATIONALE: Although there is documentation that the patient previously had a TURP, there is no documentation of continuing BPH (a condition for which a TURP routinely is performed). Because documentation states "gross" hematuria, microscopic or unspecified hematuria would be inappropriate codes. Gross hematuria 599.71 is the correct answer.

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3. C. 866.02

RATIONALE: There is no specific information available regarding an "open" wound into the cavity; diagnosis 866.11 is not applicable. 866.0 is an incomplete code because a fifth digit is required for the codes within the 866 series. A fractured kidney is a laceration connecting to two cortical surfaces. Look in the Index to Diseases for Laceration/ kidney. A diagnosis code within the "E" series also should be added.

4. A. 600.01, 788.20

RATIONALE: In the ICD-9-CM Index to Diseases, look for Enlargement, enlarged, /prostate prostate/with urinary retention and you are directed referred to 600.01. There is a note under 600.01 to use an additional code to identify the urinary retention. Urinary retention is coded with 788.20.

5. D. 594.0

RATIONALE: A prime example of (incorrectly) choosing a code from the index without accessing the tabular list, would be if you chose 562.10 diverticulosis. 596.3 *Bladder diverticulum* would be the correct code for bladder diverticulum, alone, and 594.1 describes a bladder stone within the bladder, but not within the bladder diverticulum. Calculi in diverticulae of the bladder is coded 594.0.

6. D. 590.10

RATIONALE: Acute pyelonephritis is coded 590.10, unless mention of a lesion of renal medullary necrosis is documented. You would not use chronic pyelonephritis because the documentation clearly states "acute;" nor would you use 590.0 because this is an incomplete code and must be coded to the fifth digit. Remember that all ICD-9-CM codes must be coded to the highest specificity.

7. D. 788.32

RATIONALE: Female stress incontinence is documented using ICD-9-CM 625.6 and is specific to the female gender. Incontinence unspecified is coded as 788.30; because documentation clearly states stress incontinence, this code would be inappropriate. Mixed urinary incontinence is a combination of urge and stress incontinence; because there is no mention of urge incontinence, this code would be incorrect. Male stress incontinence is coded using 788.32.

8. B. 185

RATIONALE: Because this patient still has documented disease, V10.46 personal history of prostate cancer would not be correct. Unspecified neoplasm of the prostate, 239.5, would not be coded because there is a specific diagnosis of prostate cancer; therefore, 185 would be the correct code. Uncertain behavior of prostate neoplasm, as well as uncertain behavior of other neoplasms, should be coded only when the pathological report states "uncertain."

9. A. 223.0

RATIONALE: When assigning this code, you would look up oncocytoma in the index of ICD-9-CM, which tells you to "see Neoplasm, by site, benign." *Neoplasm, kidney, benign* is 223.0, which is the correct code to assign. Renal cancer, 189.0 and 189.1, would be incorrect because there is no documentation of malignancy and 223.1 is specific to the calcyx, hilus, and pelvis of the kidney.

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10. D. 599.0

RATIONALE: Urinary hesitancy (788.41), urinary frequency (788.63) and dysuria (788.1) are all symptoms of a urinary tract infection. Because the diagnosis of UTI was confirmed by microscopic analysis, 599.0 urinary tract infection would be correct. If there was no confirmed diagnosis of UTI, the appropriate codes to note would be the presenting symptoms.

Section Review 12.3

1. D. 52235

RATIONALE: Look in the CPT® Index for Fulguration/Cystourethroscopy with/Tumor. You are referred to 52234–52240. When different size bladder tumors are removed in one surgical session, the code selection is based on the largest tumor size. In this example, the largest tumor removed is 3.0 cm. Only one code is reported regardless of the number of tumors removed.

2. B. 52630

RATIONALE: As a previous TURP was performed, CPT® 52601 would not be the appropriate because this code is used for the initial TURP. CPT® 52648 is described as laser vaporization of the prostate, and would not be coded. CPT® 52500 is described as "transurethral resection of bladder neck;" because the prostate was resected, not the bladder neck, this would not be appropriate. CPT® 52630 describes TURP of residual or regrowth of obstructive prostate tissue, which is the appropriate code. Had the patient needed a "repeat" TURP within the global period of his initial TURP, CPT® 52630 would be reported with modifier 78 appended.

3. B. 51040

RATIONALE: Aspiration of bladder with insertion of suprapubic catheter (51102) does not describe an "open" suprapubic tube insertion. Suprapubic catheter change is reported using CPT® 51705; therefore, this code would not be reported for an insertion procedure. Because 51045 describes a ureteral catheter or stent, this code would not be appropriate for a suprapubic catheter change. CPT® 51040 "Cystostomy, cystotomy with drainage" describes the suprapubic tube placement.

4. D. 51500

RATIONALE: Umbilical hernia repair codes are reported 49580–49587 and are differentiated by the age of the patient and whether the hernia is reducible, or incarcerated/strangulated. A reducible hernia is one that can be replaced to a normal position. An incarcerated or strangulated hernia is one that cannot be replaced to a normal position without surgical intervention. The description of CPT® 51500 "Excision of urachal cyst or sinus, with or without umbilical hernia repair" includes the umbilical hernia repair. Hernia repair would not be reported separately; therefore, CPT® 51500 is the correct answer.

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5. B. 52005

RATIONALE: Placement of the ureteral catheters was performed via cystoscopy; therefore, CPT® 50605 would not be appropriate because this code is for an open insertion of indwelling stent into the ureter. CPT® 52332 describes the insertion of indwelling ureteral stents and would not be reported for temporary catheter insertion. CPT® 52310 describes the removal of ureteral stents, but does not cover the insertion of the catheters. CPT® 52005 "Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation or ureteropyelography, exclusive of radiologic services" would be the correct. There would be no additional code reported for removal of these catheters.

Section Review 12.4

1. D. 54060

RATIONALE: Surgical excision of condyloma(s) of the penis are reported using CPT® 54060. You would report this procedure only once because the description includes multiple condyloma excision during a single surgical setting. CPT® 11420 describes excision of a benign lesion of the genitalia, but the diameter of the lesion excision is stated as 0.5 cm or less. CPT® 11421 describes a benign lesion excised from the genitalia 0.6 cm to 1.0 cm, and would be appropriate had there not been a clear and concise code for condyloma excision. CPT® 11621 describes a malignant lesion excision and would not be reported because there is no documentation of a malignant lesion excision. Tip: When ascertaining the specific code to report, the body system or organ should be accessed first, before using the integumentary codes.

2. C. 55250

RATIONALE: Although CPT® 55250 is the correct code to report, no modifiers would be reported with the vasectomy code because the descriptor clearly states "unilateral or bilateral;" therefore, modifier 53 and 52 are inappropriate. The procedure was not terminated due to the well-being of the patient (modifier 53), nor would you report a decreased service (modifier 52).

3. A. 55250-58

RATIONALE: Using modifier 76 on the left vasectomy would not be appropriate because modifier 76 denotes a return to the operating room on the same day as the initial procedure. Modifier 58 would be appropriate because the vasectomy is a follow-up to the initial vasectomy (staged or related procedure).

4. C. 54840

RATIONALE: The spermatocele excision (spermatocelectomy) states, with or without epididymectomy; therefore, the epididymectomy codes would not be reported. Epididymectomy codes are described as unilateral (54860) or bilateral (54861). Because a lesion was not removed from the epididymis, CPT® 54830 would be incorrect.

5. A. 54150

RATIONALE: In the CPT® Index, look for Circumcision, surgical excision, newborn. You are directed to 54150, 54160. A Plastibell is a type of clamp used in circumcision. Code 54150 is correct.

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Section Review 12.5

1. B. 52

RATIONALE: Modifiers 52 is used to report reduced services. This would be used when a bilateral procedure is performed unilaterally.

2. A. 76

RATIONALE: Sometimes it is necessary for a physician to repeat a procedure. When this occurs, modifier 76 should be appended.

3. A. TC

RATIONALE: Some CPT® codes have a technical component and a professional component. Modifier 26 is appended when the professional component is provided and modifier TC is appended when the technical component is provided. Professional services are those in which the physician performs an interpretation and report. Technical services includes ownership of the equipment, space, and employment of the technicians or nurses who performed the study.

4. D. B or C

RATIONALE: Depending upon the insurer, either modifier 50 or RT and LT would be appended to the surgical procedure.

5. B. 53

RATIONALE: When a procedure is terminated to preserve the well-being of the patient, modifier 53 is appended to the procedure code.

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