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Part B Insider (Multispecialty) Coding Alert

UROLOGY: Don't Miss Out On Guidance Codes, Or You May Lose All Reimbursement

Document ileal conduit to receive your proper reimbursement for tube removal

Confused by the new wealth of urology codes for 2006? Don't worry: Help is at hand.

CPT 2006 introduces a number of urology codes, including codes for ablation of tumors and lesions, and stent/tube replacement and removal codes. (See PBI, Vol. 6, No. 38). Here are some tips and tricks to help you receive the proper reimbursement for these new codes:

• **Modifier:** The **descriptor for 50592** (Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency) specifies "unilateral," meaning you can use a bilateral modifier if the physician performs the procedure on both sides, says **Margaret Atkinson**, business manager with **Centennial Surgery Center** in Voorhees, NJ.

Guidance: You can bill for CT, MRI or ultrasound guidance with 50592 using 76362, 76394 or 76940, says Atkinson.

To bill for nephrostomy-tube-removal code 50389, you must bill for fluoroscopic guidance separately, Atkinson stresses. If you don't bill 76000 for fluoroscopic guidance, the payor won't understand how you reached the nephrostomy tube. "The physician isn't going to go in blind," she adds.

There's one exception, however: In one out of 10 cases, the physician may use renal endoscopy to reach the tube instead, and in that case you can bill 50580 for the endoscopy, says Atkinson.

Sometimes the physician will leave the fluoroscopic guidance off his or her dictation, not realizing that it's both separately payable and essential. Other times, the physician may indicate the guidance by writing something like "TV guidance."

• **Ostomy bag:** You can't bill for 50688 (Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit) unless your physician documents that the patient has an ileal conduit, meaning an ostomy bag. The coder won't know from the documentation if the patient's stent was externally accessible otherwise, Atkinson says.

The physician's documentation may say something like, "ileal conduit created" and a date, or "the patient has an existing ostomy status," adds Atkinson.

The reimbursement will be higher for an externally dwelling stent because the change procedure tends to be more complicated and the risk to the patient is higher, Atkinson adds. The physician may have to make an incision and enlarge the patient's stoma, or else suture it.

• **Distinguish between revision and removal of vaginal mesh.** New code 57295 covers revision (including removal) of a prosthetic vaginal graft, Atkinson notes. This code is much more applicable to a simple revision to the vaginal graft, which is a much less involved procedure than that indicated by existing sling-removal/revision code 57287.

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