Outpatient Facility Coding Alert

Urology: Understand What 'Stent' Really Means in Multi-Physician Urology Encounters

Hint: Don't automatically turn to 52332.

Urologists routinely place stents for their own outpatient surgical procedures as well as for other surgeons. Being involved in another surgeon's case can lead to coding trip-ups, but keeping three things in mind can help you avoid miscoding.

Scenario: A gynecologist asks the urologist to place a bilateral catheter for surgical aid during a procedure. The urologist removes the stent at the end of the surgery."

The question: Do you report 52332-50, or is there a more appropriate CPT® code for placing stents for surgical aid?

Draw the Line Between Stents and Catheters

When you see "stent" in the urologist's documentation that doesn't mean you automatically report a stent code such as 52332 (Cystourethroscopy, with insertion of indwelling ureteral stent [e.g., Gibbons or double-J type]) or 52332-50 (Bilateral procedure) if the urologist does the procedure on both sides.

Here's why: There are really two types of "stents" a urologist will use temporary and permanent. Temporary stents aren't actually stents at all. The device is actually a ureteral catheter, placed during surgery and then usually removed by the urologist after surgery, before the patient leaves the operating room.

If your urologist placed ureteral catheters instead of stents (as in the scenario above), you wouldn't use 52332-50, says **Elizabeth Hollingshead, CPC, CUC, CMC, CMSCS,** corporate billing/coding manager of Northwest Columbus Urology Inc. in Marysville, Ohio. Instead, report 52005 (Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiological service).

How it works: When another surgeon, such as a gynecologist or colorectal surgeon, asks the urologist to place "stents" for ureteral identification and safety during a complex pelvic surgical procedure (with the intent of removing those "stents" at the end of the procedure), they are not true stents. They're actually ureteral catheters, such as "whistle" or "olive" tipped ureteral catheters.

"Our urologists are often called into surgery to place a 'stent'/ureteral catheters (52005) prior to surgery," says **Christy Shanley, CPC,** department administrator for the University of California, Irvine department of urology. "They are meant to protect/ identify the ureter during surgery. They are removed after the procedure is completed. I believe 'true stents' (52332) are left in for a period of time, and are either exchanged (52332) or removed cystoscopically (52310, Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder [separate procedure]; simple)."

Know What Warrants 52332

The second type of stent is a "permanent" stent. These types of stents are placed after surgery for drainage, and are

indwelling and self retaining. The patient leaves the operative room with the stent in place, and the stent will be removed at a later date.

While temporary stents that are often placed as part of an endoscopic procedure (52320-52355) cannot be reported in addition to the primary procedure because they are bundled with the primary procedure, an indwelling stent, which is placed during the procedure to keep the ureter open and to assist recovery after the procedure, can be billed separately.

When the urologist documents that he placed a double-J stent for postoperative drainage, you should make sure to also report 52332.

Watch for Diagnosis Confusions

Once you determine the best procedure code and appropriate modifiers, your next step is choosing the associated diagnosis code.

Road block: Often in these cases, there are no urological symptom**s** or findings (such as 593.4, Other ureteric obstruction) mentioned in the body of the operative report**.** Therefore, submitting a urological diagnosis for the temporary stent insertion may not be appropriate. You could use the reason for the primary surgery, such as diverticulitis (562.10-562.13). Some payers, including CMS, have suggested following this coding methodology of using the primary surgical diagnosis used by the general surgeon as your primary diagnosis as well.

Problem: Some other payers, however, will not reimburse for 52005 without a urological diagnosis and will not accept an intestinal diagnosis, such as 562.10, as the reason for the procedure.

Option 1: You should use V07.8 (Other specified prophylactic or treatment measure) as your primary diagnosis and the reason for the surgery as a secondary.

"You can use V-codes as primary and they are reimbursed," explains **Sally Kouw, CPC,** billing coordinator with HH Service-Bates/Urology in Holland, Mich. "In this instance, you would use the V07.8."

"You can review the ICD-9 diagnosis coding guidelines in your ICD-9 manual," Kouw says. "The guidelines explain that you can use V codes as primary diagnosis codes on a claim," she explains. According to the ICD-9-CM Official Guidelines for Coding and Reporting, "V codes may be used as either a first listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter."

Option 2: You can also bill the diagnosis code 591 (Hydronephrosis) as the primary diagnosis and V07.8 as the secondary diagnosis. This sequencing of diagnostic codes indicates that the ureteral catheter has been inserted prophylactically to avoid hydronephrosis. Some experts, including **Michael A. Ferragamo, MD, FACS,** clinical assistant professor at the State University of New York at Stony Brook, feel that this option is best. "Option 2 is the most accurate and the more likely acceptable diagnoses by most carriers," Ferragamo says.