AAPC

CUC™

Certified Urology Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CUC™

UROLOGY

AAPC

Contents

2026 Specialty Study Guide: CUC™ Introduction

The *Specialty Study Guide: CUC™* is designed to help urology coders, billers, and other medical office professionals prepare for the CUC™ examination. This guide is by no means comprehensive. Your primary resource for the exam will be your years of hands-on experience in coding for urology.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CUC™ shows your expertise in urology coding. Membership in AAPC lends integrity to your credentials and provides a large network of coders for support and allows you access to continuing education opportunities. The *Specialty Study Guide: CUC™* is designed to provide an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CUC™ examination.

We will review the importance of using the coding guidelines within ICD-10-CM and CPT® as well as emphasize the importance of correct evaluation and management (E/M) leveling. You will need 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books. These are the books you will need for the study guide and the CUC™ exam, as well.

ICD-10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determines health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends show that diagnoses will play a larger role in reimbursement in the future. It is important to code correctly, so you are prepared for that day.

We will discuss the major topics of diagnosis coding for urology. The examinee must become familiar with the ICD-10-CM Official Guidelines for Coding and Reporting. The examinee must know how to select the appropriate ICD-10-CM codes as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). This year's guidelines can be found at at https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf. The examinee must understand the Conventions, General Coding Guidelines, and Chapter-Specific Guidelines in the ICD-10-CM code book.

Evaluation and Management Coding

Office visits consume much of a physician's time in most practices and consequently represent the largest revenue source. Compliance is an increasing concern for practices, and the E/M material will focus on the E/M services for urology and underscore the importance of modifier use. An understanding of the AMA E/M guidelines and subsection notes is an important foundation for accurate code selection that is provided in your CPT® code book.

An E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service.

CPT® Coding

Surgical procedures specific to urology will be discussed in the Urology CPT® Coding chapter. Special attention will be paid to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions will be helpful as well. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor-intensive procedures. The codes with the highest relative value units (RVUs) are sequenced first.

Top 10 Missed Coding Concepts

We will review the Top 10 Missed Coding Concepts for the CUC™ certification exam. The list is not presented in any specific order. The information is determined after an evaluation by the AAPC exam department of the commonly missed questions on the exam.

Practice Exam

The practice exam and the exam itself are written by coders with extensive experience in urology. The practice exam mimics the format and structure of the CUC™ certification exam.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of expertise in their respective

specialty disciplines. Here is information on the CUC™ credential:

- CUC™ stands alone as a certification with no prerequisite that the examinee holds a CPC®, COC®, or CIC® credential.
- Exams aptly measure preparedness for real-world coding by being entirely operative/physician note based. These operative notes are redacted operative notes from real urology practices.

The CUC™ examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only. When you take the exam, remember that individual payer rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or exam question that the patient is covered by Medicare, you should follow CPT® coding guidelines.

The exam tests competency. The candidate most qualified to pass the exam will be proficient in understanding:

- Medical terminology and anatomy
- Medical physiology
- Teaching physician guidelines
- Incident-to guidelines
- Split/Shared Services
- HIPAA regulations
- Proper use of the Advanced Beneficiary Notice (ABN)
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 10000 Series
  - 30000 Series (Venipuncture)
  - 40000 Series
  - 50000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
  - Category III codes
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and the coding books is essential, as time is an important element in successfully completing the exam. Approach the exam as you would approach your work— by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice exam within the Specialty Study Guide: CUC™ course is highly representative of the subject matter and level of difficulty you will encounter in the full-length exam.

Test Answers and Rationales

The final chapter in the book contains the answers to the practice exam. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real exam, because they allow you a glimpse into the minds of the test's creators.

Examinees that pass the CUC™ certification examination will receive recognition in AAPC's monthly magazine *Healthcare Business Monthly* and will receive a diploma.

About AAPC

AAPC was founded in 1988 in an effort to elevate the standards of medical coding by providing training, certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. AAPC has expanded beyond outpatient coding to include training and credentials in documentation and coding audits, inpatient hospital/facility coding, regulatory compliance, and physician practice management. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

AAPC Member Code of Ethics

Members of AAPC shall be dedicated to providing the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

Introduction to ICD-10-CM Coding Guidelines

ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics. Healthcare providers must begin using the most recent ICD-10-CM code revisions on Oct. 1 of each year, with no grace period to transition to the changes.

All versions of the ICD-10-CM manual typically include the *ICD-10-CM Official Guidelines for Coding and Reporting*. These guidelines are an invaluable source for diagnosis coding information and provide instruction supplemental to that found in Tabular List and Alphabetic Index of the ICD-10-CM code book.

ICD-10-CM codes are utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs. Case-by-case success in achieving these goals requires an open line of communication between you and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that claim (individual dates of service must stand alone), and you must be mindful not to assume or extrapolate information from the medical record (for instance, coding a condition as chronic when it is not documented as such).

The Official Guidelines are divided into four sections:

- Section I lists ICD-10-CM Conventions, General Coding Guidelines, and Chapter-Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set (UHDDS) defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses (diagnoses, in addition to the principal diagnosis, that affect the patient's care).
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These include information about coding signs and symptoms, when to report chronic diagnoses, the use of 4th and 5th code digits, ambulatory surgery, routine outpatient prenatal visits, etc.

Diseases of the Urinary System

Cystitis (N30.-) is inflammation of the bladder, usually because of a urinary tract infection (UTI). Many diseases and procedures pertaining to the bladder begin with the prefix cyst-, such as cystitis (inflammation of the bladder). There are many forms of cystitis; they are classified as acute, chronic, interstitial, and trigonitis. Interstitial cystitis, also known as painful bladder syndrome, is a chronic inflammation of the bladder, usually with an unknown etiology (cause). People with interstitial cystitis usually cannot hold much urine in their bladders and may experience urinary frequency. Treatment for interstitialcystitis can include medication or hydrodistention of the bladder, which alleviates many of the symptoms.

Voiding disorders (N32.-) are conditions affecting normal functions of urinating and can include bladder neck obstruction, bladder diverticulum, neurogenic bladder, and detrusor instability. Urinary incontinence is probably the most common voiding disorder. Symptoms and signs involving the genitourinary system are found in R30-R39.

Types of incontinence are:

- **Urge incontinence:** Leakage of urine occurring immediately after an urgent, irrepressible need to void
- **Stress incontinence:** Leakage of urine due to abrupt increases in intra-abdominal pressure caused by coughing, sneezing, laughing, bending, or lifting
- **Overflow incontinence:** Dribbling of urine from an overly full bladder
- **Functional incontinence:** Urine loss due to cognitive or physical impairments such as stroke or dementia
- **Mixed incontinence:** Any combination of the above types of incontinence

Urinary tract infection (UTI) (N39.0) is a bacterial infection affecting any part of the urinary tract. When bacteria, usually E. coli, gets into the bladder or kidney and multiply in the urine, the result may be a UTI. UTIs usually present with dysuria (painful burning on urination), frequency of urination, urgency, and cloudy urine. Although uncomfortable, a UTI is treated easily with antibiotics. In the elderly, UTI frequency is equal in men and women, with increased incidence in men due partly to enlargement of the prostate. As the prostate enlarges, it can press on the urethra causing obstruction resulting in urination and bladder problems. When less urine is flushing the urethra, there is a higher incidence of E. coli colonization. Although there is no single cause for UTIs, a predisposition

for UTIs may run in families. Patients with diabetes and anatomical malformations of the urinary tract and paralysis may experience UTIs more frequently.

Congenital Malformations, Deformations, and Chromosomal Abnormalities

Congenital anomalies (birth defects) are abnormalities present at birth. Assign an appropriate code(s) from categories Q00-Q99 *Congenital Malformations, Deformations, and Chromosomal Abnormalities* when an anomaly is documented. A congenital anomaly may be the first-listed diagnosis on a record, or a secondary diagnosis. Use additional secondary codes from other chapters to specify conditions associated with the anomaly, if applicable.

Neoplasms

There are two ways to begin the search for neoplasm codes. If the histology is documented, look up the term in the Alphabetic Index. For example, if the patient is diagnosed with mixed basal-squamous cell carcinoma on the forehead, look for Carcinoma/basal-squamous cell, mixed. You are referred to see also Neoplasm, skin, malignant. This statement is referring you to the Table of Neoplasms located just after the Alphabetic Index.

Information in the table is organized alphabetically by site. Using the table, each site is broken into six categories: malignant primary, malignant secondary, CA in situ, benign, uncertain behavior, and unspecified.

A primary malignancy is where the cancer originates. A secondary malignancy results from metastasis and forms a new focus of malignancy elsewhere (such as the lymph nodes, liver, lungs, or brain), or develops when the primary cancer has invaded adjacent structures. For example, a patient has lung cancer that metastasizes to the spinal cord. In this case, the primary location is the lung, and the secondary location is the spinal cord.

In situ describes a malignancy confined to the origin site, without invading neighboring tissues. That is, the neoplasm is encapsulated (think of the yolk within the shell of an egg). This type of neoplasm may grow large enough to cause major problems.

The fourth column of the Table of Neoplasms identifies benign neoplasms that do not contain precancerous or cancerous cells.

If the pathology report returns with indications of atypia or dysplasia, the neoplasm is in transition from benign to malignant (precancerous). This is a neoplasm of uncertain behavior. It is not benign because benign has no precancerous cells, and it is not malignant because it has not become cancer yet. If the process continues and the mass is left untreated, the neoplasm could eventually become malignant.

"Unspecified" indicates the provider cannot, or has not, determined the neoplasm's nature. If the provider excises a neoplasm, but does not wait for the pathology report, you should select an unspecified code. It is recommended that you wait for the pathology report to select the most specific code.

Many kinds of neoplasms are excluded from the Table of Neoplasms. For example, lipomas, melanomas, neuroendocrine tumors, and Merkel cell carcinomas are not included in the Table of Neoplasms but are addressed in the Alphabetic Index. Some polyps and other conditions are indexed to benign neoplasms—but you would know this only by starting in the Alphabetic Index. The Alphabetic Index and the Table of Neoplasms each have instructions very useful to coders. Do not skip these steps.

For malignant neoplasms, determine the primary and secondary sites and then code first the site requiring patient care.

Sequencing of Neoplasms

Reason for Treatment	Sequencing
Primary malignancy	Primary malignancy is listed first, followed by any metastatic site(s)
Secondary malignancy	Secondary malignancy is listed first, followed by primary malignancy.
Pregnant patient with malignant neoplasm	A code from subcategory O9A.1- Malignant neoplasm complicating pregnancy, childbirth, and the puerperium is sequenced first followed by a code for the neoplasm.
Complication associated with a neoplasm	Complication is listed first, followed by the neoplasm code. An exception to this is anemia.
Complication from a surgical procedure for treatment of a neoplasm	The complication is the listed first, followed by a code for the neoplasm or history of neoplasm.
Pathologic fracture due to a neoplasm	When the pathologic fracture is the focus of the treatment, a code from subcategory M84.5 Pathologic fracture in neoplastic disease is sequenced first, followed by a code for the neoplasm. When the neoplasm is the focus of the treatment, the code for the neoplasm is first, followed by a code for the pathologic fracture.

Evaluation and Management Coding for Urology

This chapter examines the documentation requirements for the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CUC™ exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

An Introduction to the Documentation Requirements Associated with E/M Services

The E/M Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem was that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

Documentation Guidelines

There are three general principles regarding documentation to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While the history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT®

code book and refer back to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

EXAMPLE: OFFICE VISIT MDM TO CODE CORRELATION

New Patient Code	Established Patient Code	Level of MDM
	99211	N/A 99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211.
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	High

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

Number and Complexity of Problems

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

In this chapter, we will discuss procedures performed in a urology office. We will review common modifiers and HCPCS Level II codes. It is important for CUC™ coders to have a thorough understanding of medical terminology and anatomy of the genitourinary system. It is recommended to have your CPT® code book available as you read this chapter to refer to specific codes that will be reviewed.

Modifiers

Modifiers are appended to procedure codes to report additional supplemental information regarding the services provided. Modifiers add further details that enhance the complete picture of the procedure without altering or changing the CPT® code's definition. In some cases, multiple procedures may be performed during an encounter, or an evaluation and management (E/M) may be performed in addition to another separately billable service. We will review modifiers that are commonly used in the urology practice.

Modifier 24

Modifier 24 is used to report an unrelated E/M service by the same physician or other qualified healthcare provider during a postoperative period. The global period varies whether the procedure is considered minor or major. Minor procedures have a 0-10-day global period. Major procedures have a 90-day global period. Codes with a 000 global period are not applicable when using modifier 24.

EXAMPLE

A patient comes in for a postoperative appointment following his prostatectomy, and now, he has symptoms consistent with renal colic, possible kidney stones.

Select the E/M code based on the three key components with the new diagnosis and append modifier 24. This informs the payer that the patient is still under the global period for his prostatectomy for cancer, but now, he is being treated for a different, unrelated condition.

According to CPT® guidelines, typical postoperative care is included in the surgical package. If a patient comes in with a postoperative complication, depending on the payer, it may be a covered service. According to Medicare guidelines, for a postoperative complication to be covered, it requires a return to the operating room. If it is a related procedure, use modifier 78.

Modifier 25

Modifier 25 identifies a significant, separately identifiable E/M service. It should be used when an E/M service is above and beyond the preoperative and postoperative work of a minor procedure performed on the same day as an E/M service.

EXAMPLE

A patient presents for a scheduled appointment for a leuprolide (Lupron) shot and monitoring of his prostate cancer. During the encounter, the patient complains of urinary incontinence. In this case, there are two separate services: an E/M and an injection. Select an E/M code for the office visit and append modifier 25 in addition to the CPT® code for the injection and a HCPCS Level II code for the Lupron if the provider supplies it. If you fail to append modifier 25 to the E/M service, you will not be reimbursed for both services (the procedure and the E/M). Only use modifier 25 when an E/M and minor procedure or other service is performed on the same date of service. It is not appropriate to report an E/M with modifier 25 on the same date of service as a major surgery. See instructions provided for modifier 57 for an E/M service, which includes the decision for surgery performed on the same date as a major surgery.

Modifier 26

Modifier 26 is used to report when the provider performs only the professional component for a procedure that has both a professional and technical component. The professional component is the interpretation of the test. The technical component comprises the equipment, supplies, and the work of the technician who performs the test. An example is a prostate guided transrectal needle biopsy of the prostate performed in an outpatient setting, outpatient hospital, or ambulatory surgical center. If the provider performed the supervision and interpretation for this procedure, attach modifier 26 to code 76942. If you do not append modifier 26, you will receive an overpayment. You are requesting 100 percent of the reimbursement instead of a portion of reimbursement for the professional services. When performed in a facility, the provider performs and bills for the professional component and the facility bills for the technical component, which includes the equipment and staff of the facility. If the same service was performed in the physician's office and the physician owns or rents the equipment, you would bill for 100 percent, known as the global service. Report 76942 without a modifier if it is performed in the physician's office.

Modifier 50

Modifier 50 is reported when billing for a bilateral procedure. For example, a provider performs a bilateral needle biopsy of the testis. For the surgical procedure, report 54500 with modifier 50. Some payers prefer two-line items, 54500-LT and 54500-RT. Both methods indicate a bilateral procedure is performed. Check with your payers to determine the method they prefer. Be careful when applying modifier 50. If the description of the CPT® code includes "bilateral," do not append modifier 50. An example is code 55300 *Vasotomy for vasograms, seminal vesiculograms, or epididymograms, unilateral or bilateral*. If the description includes bilateral, do not append modifier 50 to this CPT® code.

Modifier 51

Modifier 51 is used to show that multiple procedures were performed during the same session. If a patient had a cystourethroscopy and a vaginoscopy, report 52000 for a cystourethroscopy and 57452 for the vaginoscopy with modifier 51 attached. When reporting multiple procedures, always list the codes in relative value unit (RVU) order. The proper sequencing for these procedures is 52000, 57452-51. The code for the cystoscopy has higher RVUs. Some payers request that you do not append modifier 51. Some payers will automatically assign the modifier when the claims are received. The multiple procedure concept is important. When multiple procedures are performed, there is a reduction in payment for the additional procedures. The first line item (code with the highest RVUs) is reimbursed at 100 percent; each additional line item is reimbursed at 50 percent.

Modifier 52

Modifier 52 is used to report that all the components of a surgical procedure were not performed. For example, when a patient is having a removal and replacement of a multi-component inflatable penile implant due to a malfunction of the pump and cylinders and these components need to be removed and replaced; however, the multi-component inflatable implant also includes the reservoir as well, but the reservoir is not replaced. In this case, report 54410 appending modifier 52 to indicate that all components were not replaced. There will be a reduction in payment based on this modifier.

Modifier 57

Modifier 57 is used when a decision for major surgery was made on the day before or the day of the surgery. For example, a patient presents to the office today with kidney stones. The provider schedules the patient for surgery the next day. The global package for major surgery includes the E/M service the day of and day before surgery. When the decision for surgery is made on the day of or day before, the provider is entitled to reimbursement for the service. To receive proper reimbursement, select the E/M code based on the three key components and append modifier 57. If you do not append modifier 57, the E/M service will be bundled with the surgery and you will not be reimbursed. Do not append modifier 57 to an E/M service performed on the same day as a minor surgery.

Modifier 58

Modifier 58 is used to report a staged or related procedure or service by the same provider during the postoperative period. For example, a patient had an extracorporeal shock wave lithotripsy (ESWL) performed with placement of an indwelling ureteral stent. The ESWL procedure has a 90-day global period. The surgeon notes that the patient will need to return to surgery in xxx number of days during the postoperative period for removal of the stent. In this case, append modifier 58 to the stent removal code to inform the payer that the second procedure is related to the prior surgery.

Modifier 59

Modifier 59 is used to indicate a distinct procedural service. It is used to indicate:

- Different surgical session
- Different procedure or surgery
- Different site or organ system
- Separate excision or incision
- Separate lesion or injury

For example, a patient has a cystourethroscopy with ureteral stent insertion on the right side and a cystourethroscopy with multiple clot evacuation from the left ureter. The clot evacuation is a component code of the placement of a stent. In this example, append modifier 59 to the code for the evacuation of the clots, indicating these codes are not usually reported together but are appropriate under the circumstances. The most common use of modifier 59 is for bundled procedures where documentation supports billing for both services. It is important to know the National Correct Coding Initiative (NCCI) edits.

Status indicator "0" indicates the code pair cannot be submitted separately. Modifier 59 cannot be used, no exceptions.

Status indicator "1" – The code pair can be submitted with a modifier if supported by the documentation.

Status indicator "9" – The code pair is not subject to NCCI edits.

Medicare allows placement of modifier 59 on either the column 1 or column 2 code of the edit pair. For consistency in the study guide and exam, place the modifier on the column 2 code.

Top 10 Missed Coding Concepts on CUC™ Examination

The concepts discussed are not in a particular order. The tips provided below are based on the AAPC examination department observations of the most missed coding concepts. The most missed concepts are based on the prior year's exam results.

1. **AMA E/M Guidelines for Selecting the Level for the Amount and/or Complexity of Data to be Reviewed:** When evaluating the *Amount and/or Complexity of Data* in MDM, whether a test can be counted depends on whether the test or study is separately reportable. If a diagnostic test is ordered, performed, or interpreted during the encounter and the provider bills separately for the professional interpretation with a CPT® code, that test does not count toward the E/M data element. Because when a provider orders a test that includes a distinct interpretation—such as an X-ray or ECG—performed in the office, it is assumed the provider will bill for the interpretation, so the ordering of that unique test is not counted. Tests that do not require a separate interpretation and provide immediate results (such as a dipstick urinalysis) may be counted as ordered or reviewed for MDM purposes. At a follow-up visit, reviewing the results of a test ordered at a prior encounter is not counted again, because the credit was already given when the test was originally ordered.
2. **Reporting two E/M codes on the same day:** The CPT® E/M Guidelines for Initial Hospital or Observation Care states: When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter in another site of service (eg, hospital, emergency department, office, nursing facility), the services in the initial site may be separately reported, modifier 25 may be added to the other evaluation and management service.
3. **Modifier 80:** Modifier 80 is used to report an assistant surgeon was involved with the surgery. For example, an assistant surgeon may be needed to perform a radical prostatectomy. To ensure proper coding and reimbursement for both surgeons, append modifier 80 on the claim for the assistant surgeon with the CPT® code for the radical prostatectomy code. If the assistant surgeon fails to report modifier 80, then one of the claims will be denied because it seems to the payer that two physicians are billing for the same service.
4. **Proper ICD-10-CM code selection for not otherwise specified (NOS) versus not elsewhere classifiable (NEC):** NOS is selected when there is not enough documentation to select a more specific code. NEC is selected when there isn't an ICD-10-CM code that succinctly describes the specific information documented for the diagnosis.
5. **AMA E/M Guidelines for Selecting the Number and Complexity of Problems Addressed:** E/M guidelines explain that "stable" is determined by whether the patient has met their individual treatment goals, not simply by whether the condition is unchanged. A chronic condition is not considered stable if the patient has not reached the desired therapeutic target, even when the condition shows no recent progression and there is no immediate threat to life or function. For example, a patient whose blood pressure remains persistently above goal is not considered stable, even if they feel well and their readings are not worsening. Likewise, a urology patient with benign prostatic hyperplasia (BPH) whose urinary symptoms remain bothersome and whose symptom scores (such as IPSS) have not improved despite medical therapy would also not be considered stable, because the patient has not met the treatment goals needed to prevent worsening obstruction and complications.
6. **Proper ICD-10-CM code selection for postoperative pain:** Postoperative pain is reported with G89.18 for acute pain or G89.28 for chronic pain. If the provider does not indicate whether the pain is acute or chronic, Section I.C.6.b.1 states, "If the pain is not specified as acute or chronic, post thoracotomy, post procedural, or neoplasm-related, do not assign codes from category G89." If the postoperative pain is due to a complication (for example, suprapubic pressure pain) report with T81.89X-.
7. **Surgical approach for an orchiopexy:** CPT® 54640 describes an orchiopexy performed through an inguinal or scrotal approach and is used when the testis is located in the inguinal canal or just outside of it. This is the most common approach for undescended testicles and may be reported bilaterally with modifier 50. In contrast, CPT® 54650 is reported when the testis is intra-abdominal, requiring an abdominal surgical approach, such as a Fowler-Stephens orchiopexy. Because the surgical

exposure, complexity, and anatomical location differ significantly, it is important to select 54640 for inguinal/scrotal repairs and 54650 for abdominal orchiopexies.

8. **Cystourethroscopy with foreign body or stent removal:** The code options for this procedure include simple or complicated. The procedure is reported as complicated due to previous surgery, or the size or condition of the foreign body, calculus, or ureteral stent.

9. **Read the entire operative report:** Do not rely only on the headers of the operative report. Sometimes, additional procedures are performed that are not listed in the header or the provider does not perform the procedure listed in the header. For example, the provider may indicate that a radical nephrectomy is performed. Review the operative report to make sure that regional lymphadenectomy and vena caval thrombectomy are performed.

10. **Unlisted Procedure:** An unlisted procedure is reported when a procedure code does not exist for the procedure performed. For example, Osmetech Microbial Analyzer is reported with an unlisted urinalysis code.

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the Test Your Knowledge practice exams.

Version A

CASE 1

Interval History and Physical

Patient Identification:

The patient is an 81-year-old male with a history of superficial bladder cancer, status post-transurethral resection of the bladder tumor earlier this morning. The patient went home without a catheter, voided, and passed some bright red blood and clots. The patient called me and I had him return to the surgery center. We evaluated him, and I recommended cystoscopy under anesthesia and fulguration of bleeding sites. The patient presents now for this procedure.

Past Medical History:

1. Unchanged from previous hospitalization.

There is no change in his history and physical examination.

Physical Examination:

General:

The patient is alert and in no acute distress.

Vital Signs:

Stable, blood pressure is 140/90. His heart rate is 84.

Abdomen: Nontender.

Impression:

1. Gross hematuria, status post-transurethral resection of bladder tumor.
2. History of superficial bladder cancer.

Plan:

Take the patient back to the operating suite at 123 Surgery Center for cystoscopy under anesthesia, fulguration of bleeding sites, and possible placement of a urethral catheter.

Informed Consent:

I have discussed the procedure and risks. The patient understands the possible need for a Foley catheter, and he wishes to proceed with the procedure as discussed.

1. What is the E/M code for this encounter?

   A. 99231
   B. 99213
   C. 99242
   D. E/M is not reported for this encounter.

2. What modifier should be reported with the cystoscopy and fulguration of bleeding sites?

   A. 58
   B. 77
   C. 78
   D. 79

3. What is the correct procedure code for a resection of a 2.5 cm bladder tumor?

   A. 52204
   B. 52224
   C. 52234
   D. 52235

CASE 2

Age: 55-year-old male.

Date: 10/29/xx.

Nurse Triage Notes: Penile swelling/discharge

History:

HPI/Chief Complaint: The patient is a 55-year-old man admitted to the hospital who presented to the emergency department last night for penile swelling/discharge. Dr. X verbally requested me to see the patient today. The patient has noticed increased penile discomfort and discharge. He has also noticed an increased difficulty urinating associated with dysuria. He denies fever but has experienced some chills. He also states that the penile swelling has increased and the penis bending slightly.

Social History:

Abuse: Denies history of physical, sexual abuse.

Alcohol: Denies.

Drug use: Denies.

Education: HS graduate.

Employment: Full-time.

Marital Status: Married.

STD: Denies history.

Family History: Family history reviewed—diabetes.

CUC™ Practice Examination –Answers and Rationales

After reviewing the answers and rationales, if you have further questions, please send them to mct@aapc.com

CASE 1

Interval History and Physical

Patient Identification:

The patient is an 81-year-old male with a history of superficial bladder cancer, status post–transurethral resection of the bladder tumor earlier this morning. [1] The patient went home without a catheter, voided, and passed some bright red blood and clots. The patient called me and I had him return to the surgery center. We evaluated him and I recommended cystoscopy under anesthesia and fulguration of bleeding sites. [2] The patient presents now for this procedure.

Past Medical History:

1. Unchanged from previous hospitalization.

There is no change in his history and physical examination.

Physical Examination:

General:

The patient is alert and in no acute distress.

Vital Signs:

Stable, blood pressure is 140/90. His heart rate is 84.

Abdomen: Nontender.

Impression:

1. Gross hematuria, status post-transurethral resection of bladder tumor.
2. History of superficial bladder cancer.

Plan:

Take the patient back to the operating suite at 123 Surgery Center for cystoscopy under anesthesia, fulguration of bleeding sites, and possible placement of a urethral catheter.

Informed Consent:

I have discussed the procedure and risks. The patient understands the possible need for a Foley catheter, and he wishes to proceed with the procedure as discussed.

[1] The patient is in a global period.

[2] The physician recommends return to surgery for the postoperative complication.

1. **Answer:** D. E/M is not reported for this encounter

   Rationale: The patient underwent surgery earlier in the day and returned to the surgery center for a cystoscopy because of a complication. However, the evaluation performed on the patient does not support additional significant work to justify reporting a separate E/M service.

2. **Answer:** C. 78

   Rationale: This is an unplanned return to the operating room for a complication during the global period of another procedure. This was not a planned/staged return for further surgery.

3. **Answer:** D. 52235

   Rationale: In the CPT® Index, look for Bladder/Tumor/Resection . Code 52235 is the correct code to report because the tumor being resected is 2.5 cm.

CASE 2

Age: 55-year-old male.

Date: 10/29/xx.

History:

HPI/Chief Complaint: The patient is a 55-year-old male admitted to the hospital who presented to the to the emergency department last night for penile swelling/discharge. Dr. X verbally requested me to see the patient today. [1] The patient has noticed increased penile discomfort and discharge. He has also noticed an increased difficulty urinating associated with dysuria. He denies fever but has experienced some chills. He also states that the penile swelling has increased and the penis bending slightly. [2]

Social History:

Abuse: Denies history of physical, sexual abuse.

Alcohol: Denies.

Drug use: Denies.

Education: HS graduate.

Employment: Full-time.

Marital Status: Married.

STD—Denies history.

Family History: Family history reviewed—diabetes.

PMH: Usual childhood illnesses, arthritis, BPH, diabetes, erectile dysfunction, hemorrhoids, hypertension, pneumonia.

Operations: Cystoscopy retrogrades, cystoscopy stone manipulation.

Medication:

Celebrex, furosemide, Glucotrol, Klor-Con, lisinopril, metformin hydrochloride, omeprazole, Pravachol, terazosin hydrochloride, Toprol XI (SIG: 1 tab QD), Demerol.

Allergies: NKDA

Physical Examination:

Vitals: T: 98.8 Pulse: 85 B/P: 130/85

Appearance: Alert and orientated × 3, well nourished, well developed. In mild distress.

Join the biggest team in healthcare information management.

As an AAPC member, you'll be part of a global network of 250,000+ career learners and working professionals. Our credentials are among the most highly sought after in the industry — in part because AAPC members are trained for more than passing an exam. They are trained to succeed on the job from day one.

"If you want to rise in the ranks of the Healthcare business portion of the medical field, I highly suggest that you become a member of AAPC and obtain your certifications through them. They will help you to advance and open the door of opportunity for you."

- Latisha Booker, CPC

"APPC has not only provided me with the opportunity to earn multiple credentials but has also opened important doors for me in my career."

- Mary Arnold, CPC, CPMA, CRC, RMA, HR-C

"While taking classes, I was introduced to AAPC. I became a member to help boost my career, and more than 20 years later, I'm still an AAPC member."

– Bradley Miller, CPC, CRC, CDEO

Whether you're just getting started or a seasoned pro, AAPC membership will give you the support, training, tools, and resources to help you launch and advance your career successfully,

Learn more at **aapc.com**

AAPC