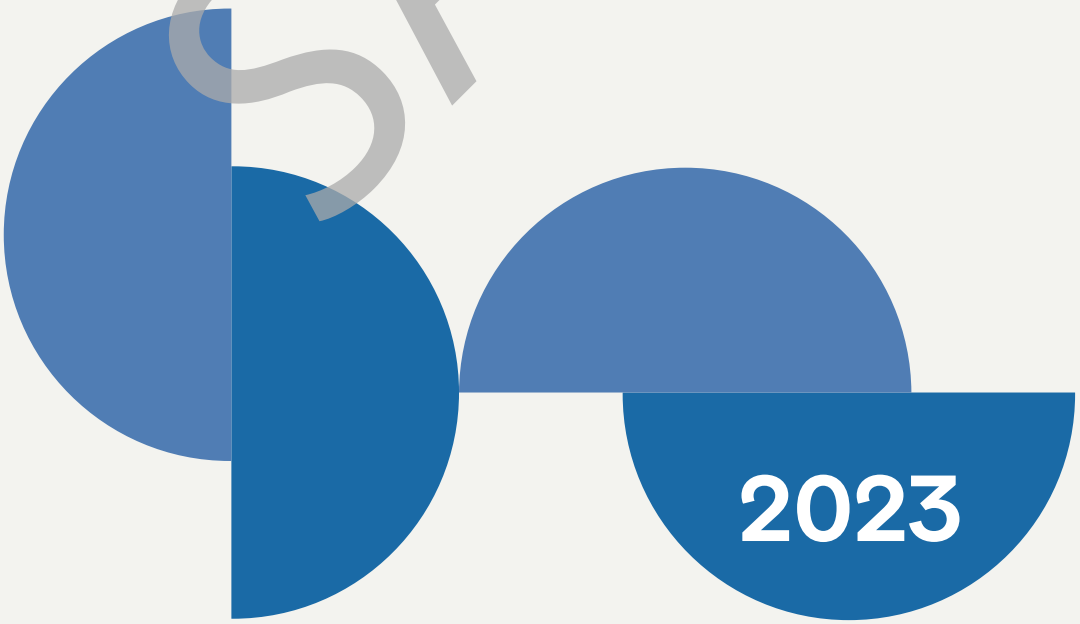
Optum

Coding Companion

Urology/Nephrology

A comprehensive illustrated guide to coding and reimbursement



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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 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 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 Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. 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. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:

- HCPCS
- 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 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 XX.X, 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 CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is http://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXXX.** 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 xiv 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.

36415-36416

36415 Collection of venous blood by venipuncture
36416 Collection of capillary blood specimen (eg, finger, heel, ear stick)

Capillary blood is collected.
The specimen is typically collected by finger stick

Explanation

A needle is inserted into the skin over a vein to puncture the blood vessel and withdraw blood for venous collection in 36415. In 36416, a prick is made into the finger, heel, or ear and capillary blood that pools at the puncture site is collected in a pipette. In either case, the blood is used for diagnostic study and no catheter is placed.

Coding Tips

These procedures do not include laboratory analysis. If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For venipuncture, younger than 3 years of age, femoral or jugular vein, see 36400; scalp or other vein, see 36405–36406. For venipuncture, age 3 years or older, for non-routine diagnostic or therapeutic purposes, necessitating the skill of a physician or other qualified healthcare professional, see 36410. Do not append modifier 63 to 36415 as the description or nature of the procedure includes infants up to 4 kg. Medicare and some payers may require HCPCS Level II code G0471 to report this service when provided in an FQHC.

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.

Associated HCPCS Codes

G0471 Collection of venous blood by venipuncture or urine sample by catheterization from an individual in a skilled nursing facility (SNF) or by a laboratory on behalf of a home health agency (HHA)

AMA: **36415** 2019,Aug,8; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13;

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
36415	0.0	0.0	0.0	0.0
36416	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
36415	0.0	0.0	0.0	0.0
36416	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
36415	N/A	X	2(3)	N/A	N/A	N/A	N/A	None
36416	N/A	B	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

blood vessel. Tubular channel consisting of arteries, veins, and capillaries that transports blood throughout the body.

capillary. Tiny, minute blood vessel that connects the arterioles (smallest arteries) and the venules (smallest veins) and acts as a semipermeable membrane between the blood and the tissue fluid.

catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.

diagnostic. Examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.

pipette. Small, narrow glass or plastic tube with both ends open used for measuring or transferring liquids.

specimen. Tissue cells or sample of fluid taken for analysis, pathologic examination, and diagnosis.

venipuncture. Piercing a vein through the skin by a needle and syringe or sharp-ended cannula or catheter to draw blood, start an intravenous infusion, instill medication, or inject another substance such as radiopaque dye.

venous. Relating to the veins.

1. CPT Codes and Descriptions

This edition of *Coding Companion* is updated with CPT codes for year 2023.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ 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 telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. 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 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.

- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

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 the most 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 Optum360 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
- ♂ Male only
- ♀ Female Only
- ☑ 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 2022.

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 (modifier26) component of a procedure is provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

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, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 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 no longer used when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, 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. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

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** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	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*	

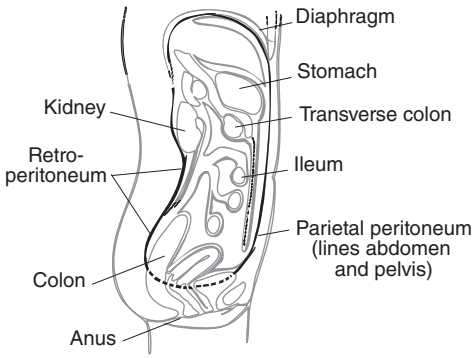
* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a provider/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider based clinic or emergency department, within the past three years.

49185

49185 Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed



Fluid collection is treated with sclerotherapy

Explanation

Sclerotherapy is the therapeutic use of sclerosing agents (e.g., ethanol, povidone-iodine, tetracycline, doxycycline, bleomycin, talc, or fibrin glue) to systematically destroy undesired fluid collections such as cysts, lymphoceles, or seromas. This procedure is usually performed with the patient under moderate conscious sedation and involves a minimally invasive, percutaneous approach; depending on the size of the cyst or lymphocele, treatment may involve catheter drainage by gravity for approximately one day with subsequent administration of a sclerosing agent, such as ethanol, into the fluid collection under fluoroscopic guidance. For larger fluid collections, a catheter is placed using ultrasound or fluoroscopy and ethanol is administered via the catheter daily until the fluid collection has been reduced. The process involves percutaneous placement of a catheter over a guidewire into the area of fluid collection where the catheter is left in place and the sclerosing agent(s) is administered via the catheter as the patient remains in the supine position. The patient may be asked to change positions after the sclerosing agent has been injected in order to allow the entire area where the fluid collection is located to have contact with the sclerosing agent. Drainage of the sclerosing agent may take between 15 minutes and one hour depending on the agent used. Occasionally, depending on the size of the fluid collection, two catheters may be used. Aspirated fluid from the lymphocele, seroma, or cyst is sent for histopathology. The catheter is removed.

Coding Tips

For access or drainage using a needle, see 10160 or 50390; using a catheter, see 10030, 49405-49407, or 50390. Exchange of an existing catheter before or prior to sclerotherapy is reported with 49423 or 75984. Sclerotherapy treatment of a lymphatic or vascular malformation is reported with 37241. For sclerotherapy of veins or endovenous ablation of incompetent veins of an extremity, see 36468, 36470-36471, 36475-36476, and/or 36478-36479. Pleurodesis is reported with 32560. To report treatment of multiple lesions in a single session, via separate access, append modifier 59 or an X{EPSU} modifier to each additional, treated lesion. Do not report 49185 with 49424 or 76080.

ICD-10-CM Diagnostic Codes

B67.0	Echinococcus granulosus infection of liver
B67.5	Echinococcus multilocularis infection of liver
B67.99	Other echinococcosis
K76.89	Other specified diseases of liver
K86.2	Cyst of pancreas
N28.1	Cyst of kidney, acquired
N75.1	Abscess of Bartholin's gland ♀
Q44.6	Cystic disease of liver
Q45.2	Congenital pancreatic cyst
Q61.01	Congenital single renal cyst
Q61.02	Congenital multiple renal cysts
Q61.11	Cystic dilatation of collecting ducts
Q61.19	Other polycystic kidney, infantile type
Q61.2	Polycystic kidney, adult type
Q61.8	Other cystic kidney diseases
T79.2XXA	Traumatic secondary and recurrent hemorrhage and seroma, initial encounter
T88.8XXA	Other specified complications of surgical and medical care, not elsewhere classified, initial encounter

AMA: **49185** 2018,Jan,8; 2017,Jan,8; 2016,Mar,10

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
49185	2.35	35.74	0.22	38.31
Facility RVU	**Work**	**PE**	**MP**	**Total**
49185	2.35	0.87	0.22	3.44

	FUD	Status	MUE	Modifiers				IOM Reference
49185	0	A	2(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.

contrast material. Any internally administered substance that has a different opacity from soft tissue on radiography or computed tomograph; includes barium, used to opacify parts of the gastrointestinal tract; water-soluble iodinated compounds, used to opacify blood vessels or the genitourinary tract; may refer to air occurring naturally or introduced into the body; also, paramagnetic substances used in magnetic resonance imaging. Substances may also be documented as contrast agent or contrast medium.

cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

drainage. Releasing, taking, or letting out fluids and/or gases from a body part.

guidewire. Flexible metal instrument designed to lead another instrument in its proper course.

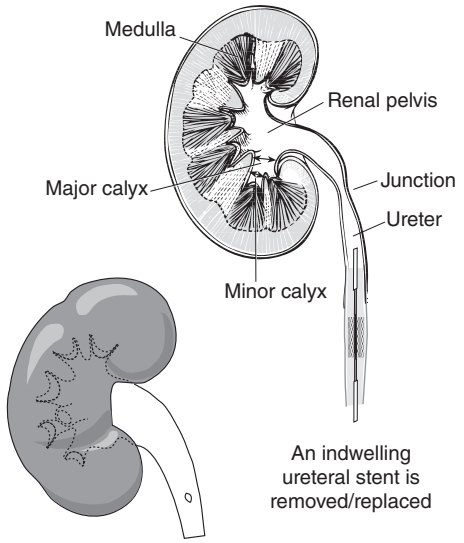
sclerotherapy. Injection of a chemical agent that will irritate, inflame, and cause fibrosis in a vein, eventually obliterating hemorrhoids or varicose veins.

seroma. Swelling caused by the collection of serum, or clear fluid, in the tissues.

50382-50384

50382 Removal (via snare/capture) and replacement of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation

50384 Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation



Explanation

The physician percutaneously removes an internally dwelling ureteral stent through the renal pelvis in 50384. With the patient under moderate sedation, a long, thin needle is advanced into the renal calyx under imaging guidance and the position is confirmed with contrast and fluoroscopy. A guidewire is threaded over the needle into the renal pelvis, the needle is removed, and a sheath placed over the guidewire. A snare device is threaded through the sheath into position, the indwelling stent is grasped, and pulled out partially through the sheath until the proximal end is outside the ureter. A guidewire is threaded through the stent, which is guided completely out. In 50382, the physician replaces the indwelling ureteral stent after removal of the old stent. The guidewire is left in place, the length of the old stent is noted, and the replacement stent is advanced into the ureter until the distal end is in the bladder and the distal loop is deployed. Stent position is confirmed with the proximal loop in the renal pelvis. The instruments are removed.

Coding Tips

Do not report 50382-50384 with 50436-50437. These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Percutaneous introduction of a guidewire into the renal pelvis and ureter is included in these codes. For removal and replacement of an internally dwelling ureteral stent placed via a transurethral approach, see 50385.

ICD-10-CM Diagnostic Codes

T83.112A Breakdown (mechanical) of indwelling ureteral stent, initial encounter

T83.113A Breakdown (mechanical) of other urinary stents, initial encounter

T83.122A Displacement of indwelling ureteral stent, initial encounter

T83.123A Displacement of other urinary stents, initial encounter

T83.192A Other mechanical complication of indwelling ureteral stent, initial encounter

T83.193A Other mechanical complication of other urinary stent, initial encounter

T83.592A Infection and inflammatory reaction due to indwelling ureteral stent, initial encounter

T83.593A Infection and inflammatory reaction due to other urinary stents, initial encounter

T83.82XA Fibrosis due to genitourinary prosthetic devices, implants and grafts, initial encounter

T83.83XA Hemorrhage due to genitourinary prosthetic devices, implants and grafts, initial encounter

T83.84XA Pain due to genitourinary prosthetic devices, implants and grafts, initial encounter

T83.85XA Stenosis due to genitourinary prosthetic devices, implants and grafts, initial encounter

T83.86XA Thrombosis due to genitourinary prosthetic devices, implants and grafts, initial encounter

T83.89XA Other specified complication of genitourinary prosthetic devices, implants and grafts, initial encounter

AMA: **50382** 2018,Jan,8; 2017,Jan,8; 2016,Jan,3; 2016,Jan,13; 2015,Jan,16
50384 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2016,Jan,3; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
50382	5.25	26.8	0.48	32.53
50384	4.75	22.04	0.44	27.23
Facility RVU	**Work**	**PE**	**MP**	**Total**
50382	5.25	1.63	0.48	7.36
50384	4.75	1.43	0.44	6.62

	FUD	Status	MUE	Modifiers				IOM Reference
50382	0	A	1(3)	51	50	N/A	N/A	None
50384	0	A	1(3)	51	50	N/A	N/A	

* with documentation

Terms To Know

percutaneous approach. Method used to gain access to a body organ or specific area by puncture or minor incision through the skin or mucous membrane and/or any other body layers necessary to reach the procedure site.

renal calyces. Cuplike structures formed by the papilla, where urine is collected for transfer via the renal pelvis out of the kidney and into the ureter.

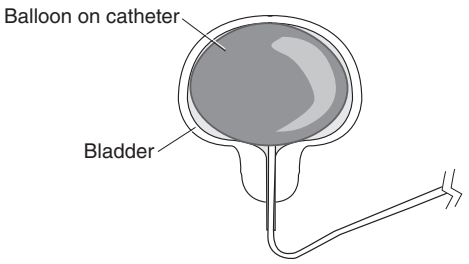
stent. Tube to provide support in a body cavity or lumen.

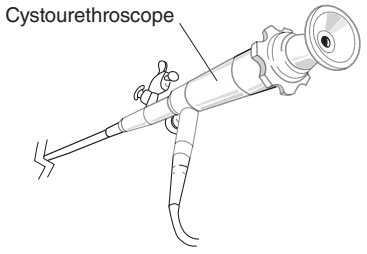
 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

52260-52265

52260 Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia

52265 local anesthesia





Physician uses balloon to distend bladder, relieving chronic inflammation

Explanation

The physician examines the urinary collecting system with a cystourethroscope passed through the urethra and bladder and dilates the bladder with a balloon to relieve chronic inflammation of the bladder (interstitial cystitis). The physician removes the instrument and cystourethroscope. If general or spinal anesthesia is administered to the patient, use 52260. If the procedure is performed using local anesthesia, use 52265.

Coding Tips

When 52260 or 52265 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. Note that 52260 is for dilation of the bladder under general or spinal anesthesia and 52265 is for local anesthesia. 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

N30.10 Interstitial cystitis (chronic) without hematuria

N30.11 Interstitial cystitis (chronic) with hematuria

AMA: **52260** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **52265** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
52260	3.91	1.72	0.47	6.1
52265	2.94	8.19	0.38	11.51
Facility RVU	**Work**	**PE**	**MP**	**Total**
52260	3.91	1.72	0.47	6.1
52265	2.94	1.4	0.38	4.72

	FUD	Status	MUE	Modifiers				IOM Reference
52260	0	A	1(2)	51	N/A	N/A	N/A	100-03,230.12
52265	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

chronic interstitial cystitis. Persistently inflamed lesion of the bladder wall, usually accompanied by urinary frequency, pain, nocturia, and a distended bladder.

dilation. Artificial increase in the diameter of an opening or lumen made by medication or by instrumentation.

dysuria. Pain upon urination.

hematuria. Blood in urine, which may present as gross visible blood or as the presence of red blood cells visible only under a microscope.

inflammation. Cytologic and chemical reactions that occur in affected blood vessels and adjacent tissues in response to injury or abnormal stimulation from a physical, chemical, or biologic agent.

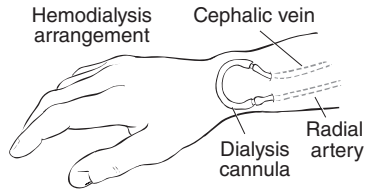
urethra. Small tube lined with mucous membrane that leads from the bladder to the exterior of the body.

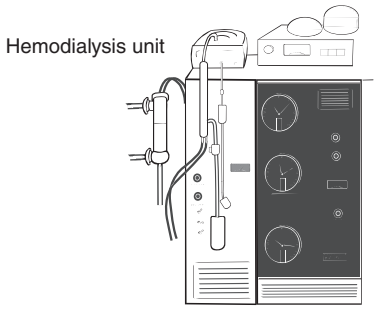
 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

90935-90937

90935 Hemodialysis procedure with single evaluation by a physician or other qualified health care professional

90937 Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription





Explanation

Hemodialysis is a process to remove toxins from the blood and to maintain fluid and electrolyte balance when the kidneys no longer function. The procedure involves using a previously placed catheter in an artery or a vein to withdraw the patient's blood, mechanically circulating the blood through a dialysis machine to remove the toxins and wastes, and transfusing the blood back to the patient. Code 90935 applies to one hemodialysis treatment that includes a single physician or other qualified health care provider's evaluation of the patient and 90937 is for a hemodialysis procedure when patient re-evaluation(s) must be done during the procedure, with or without substantial revision of the dialysis prescription.

Coding Tips

These codes include the hemodialysis procedure and all evaluation and management services provided that are related to the patient's renal disease on the day of the procedure. Any E/M services that are separately identifiable and unrelated to the dialysis or renal failure are reported separately with modifier 25. For home visit hemodialysis services performed by a nonphysician health care professional, see 99512. For prolonged physician or other qualified health care provider attendance, see 99354-99360.

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

Z49.31 Encounter for adequacy testing for hemodialysis

AMA: **90935** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **90937** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90935	1.48	0.53	0.09	2.1
90937	2.11	0.78	0.13	3.02
Facility RVU	**Work**	**PE**	**MP**	**Total**
90935	1.48	0.53	0.09	2.1
90937	2.11	0.78	0.13	3.02

	FUD	Status	MUE	Modifiers				IOM Reference
90935	0	A	1(3)	N/A	N/A	N/A	80*	100-02,1,10; 100-02,11,20; 100-03,130.8; 100-04,3,100.6; 100-04,4,200.2
90937	0	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

cannula. Tube inserted into a blood vessel, duct, or body cavity to facilitate passage.

catheter. Flexible tube inserted into an area of the body for introducing or withdrawing fluid.

chronic kidney disease. Decreased renal efficiency resulting in reduced ability of the kidney to filter waste. The National Kidney Foundation's classification includes clinical stages based on the glomerular filtration rate (GFR). The stages of CKD are as follows: stage 1, some kidney damage with a normal GFR of 90 or above; stage 2, mild kidney damage with a GFR of 60 to 89; stage 3a, mild to moderate kidney damage with a GFR of 45 to 59; stage 3b, moderate to severe kidney damage with a GFR of 30 to 44; stage 4, severe kidney damage with a GFR of 15 to 29; and stage 5, kidney failure with a GFR of less than 15. Dialysis or transplantation is required when kidney failure progresses to end stage renal disease.

ESRD. End stage renal disease. Progression of chronic renal failure to lasting and irreparable kidney damage that requires dialysis or renal transplant for survival.

hemodialysis. Cleansing of wastes and contaminating elements from the blood by virtue of different diffusion rates through a semipermeable membrane, which separates blood from a filtration solution that diffuses other elements out of the blood.

qualified health care professional. Educated, licensed or certified, and regulated professional operating under a specified scope of practice to provide patient services that are separate and distinct from other clinical staff.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

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	0.47	0.01	0.66
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 ☑

85004

85004 Blood count; automated differential WBC count

Explanation

This test may be ordered as a blood count with automated differential. The specimen is whole blood. Method is automated cell counter. The blood count typically includes a measurement of normal cell constituents including white blood cells or leukocytes, red blood cells, and platelets. In addition, this test includes a differential count of the white blood cells or "diff" in which the following leukocytes are differentiated and counted automatically: neutrophils or granulocytes, lymphocytes, monocytes, eosinophils, and basophils.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
85004	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
85004	0.0	0.0	0.0	0.0

85007-85008

85007 Blood count; blood smear, microscopic examination with manual differential WBC count

85008 blood smear, microscopic examination without manual differential WBC count

Explanation

These tests may be ordered as a manual blood smear examination, RBC smear, peripheral blood smear, or RBC morphology without differential parameters in 85008 and with manual WBC differential in 85007. The specimen is whole blood. The method is manual testing. A blood smear is prepared and microscopically examined for the presence of normal cell constituents, including white blood cells, red blood cells, and platelets. In 85008, the white blood cell and platelet or thrombocyte counts are estimated and red cell morphology is commented on if abnormal. In 85007, a manual differential of white blood cells is included in which the following leukocytes are differentiated: neutrophils or granulocytes, lymphocytes, monocytes, eosinophils, and basophils.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
85007	0.0	0.0	0.0	0.0
85008	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
85007	0.0	0.0	0.0	0.0
85008	0.0	0.0	0.0	0.0

85009

85009 Blood count; manual differential WBC count, buffy coat

Explanation

This test may be ordered as a buffy coat differential or as a differential WBC count, buffy coat. Specimen is whole blood. Other collection types (e.g., finger stick or heel stick) do not yield the volume of blood required for this test. Method is manual testing. The whole blood is centrifuged to concentrate the white blood cells, and a manual WBC differential is performed in which the following leukocytes are differentiated: neutrophils or granulocytes, lymphocytes, monocytes, eosinophils, and basophils. This test is usually performed when the number of WBCs or leukocytes is abnormally low and the presence of abnormal white cells (e.g., blasts or cancer cells) is suspected clinically.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
85009	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
85009	0.0	0.0	0.0	0.0

85013

85013 Blood count; spun microhematocrit

Explanation

This test may be ordered as a microhematocrit, a spun microhematocrit, or a "spun crit." The specimen (whole blood) is by finger stick or heel stick in infants. The sample is placed in a tube and into a microcentrifuge device. The vials can be read manually against a chart for the volume of packed red cells or a digital reader in the centrifuge device. A spun microhematocrit only reports the volume of packed red cells. It is typically performed at sites where limited testing is available, the patient is a very difficult blood draw, or on infants.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
85013	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
85013	0.0	0.0	0.0	0.0

85014

85014 Blood count; hematocrit (Hct)

Explanation

This test may be ordered as a hematocrit, Hmt, or Hct. The specimen is whole blood. Method is automated cell counter. The hematocrit or volume of packed red cells (VPRC) in the blood sample is calculated by multiplying the red blood cell count or RBC times the mean corpuscular volume or MCV.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
85014	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
85014	0.0	0.0	0.0	0.0

85018

85018 Blood count; hemoglobin (Hgb)

Explanation

This test may be ordered as hemoglobin, Hgb, or hemoglobin concentration. The specimen is whole blood. Method is usually automated cell counter but a manual method is seen in labs with a limited test menu and blood bank drawing stations. Hemoglobin is an index of the oxygen-carrying capacity of the blood.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
85018	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
85018	0.0	0.0	0.0	0.0

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

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

0421T 00910, 00914-00916, 0213T, 0216T, 0499T, 0596T-0597T, 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, 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, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378, 99446-99449, 99451-99452, 99495-99496, G0463, G0471, J2001, P9612

0559T 76376-76377

0560T 76376-76377

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0562T 76376-76377

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