

To: Urology Residents and Fellows

From: Brian Lane
Resident Member, Review Committee for Urology

Date: June 2009

Several important changes regarding entering cases into surgical logs are being implemented beginning July 1, 2009. First, the ACGME Review Committee (RC) for Urology is changing the way that surgical case logs are used in decisions regarding accreditation of residency programs. Rather than comparing each resident's volume and variety of operative experience against national averages, each log will be evaluated based on participation in *at least* a minimum number of several categories of urologic surgery. The categories and minimum numbers are displayed below. This practice reflects our concern that the changes in urologic practice may lead to a moving target with respect to the number of individual cases performed for a given indication (e.g., ureteroscopy vs. SWL) and that training should provide a sufficient number of cases to each resident to allow for competence.

In order to be recorded as **Surgeon**, a resident must be present for all critical portions of the case and must perform a significant number of the critical steps of the procedure. Any lesser involvement while a **first assistant** should be coded as **Assistant**. **In general, only one resident should record any procedure for credit—activity as “second assistant” should not be recorded.** When a senior resident acts as a **Teaching Assistant**, directing and overseeing the major portions of the case, while the supervising staff physician functions as an assistant or observer, a second resident may then also record the case for credit as Surgeon. If two residents each do one side of a bilateral procedure (e.g., orchidopexy, ureteral reimplant, nephrectomy), each resident may record the procedure as Surgeon.

The Urology RC has also re-examined the 2008 and 2009 CPT code books and updated the classification of each of these codes. Most of the commonly-used CPT codes will “count” towards the total resident surgical volume, but some procedures are no longer being totaled. Some notable changes include the requirement to participate and interpret urodynamic studies and the elimination of cystoscopy as an index case in adults. **Because adult cystoscopy is no longer an index case, logging these is no longer necessary.**

Many indexed surgical cases now contribute towards the required minimums in more than one category; for example, a single CPT 51797 adds one case towards the requirements for General Urology and Urodynamics while CPT 51596 contributes to the required minimums in Oncology, Pelvic, Bladder, Reconstruction, and Intestinal Diversion. A list of common CPT codes is displayed below and the full list of CPT codes and categories for adult and pediatric urology is accessible at the ACGME website.

Unbundling of cases is now discouraged, so that logging of surgical cases parallels billing codes more closely. **Some of the accepted examples of unbundling that had been detailed previously are no longer recommended.** The coding examples detailed in 2007 are now re-visited with the changes mentioned above in mind (see below).

We hope that these changes will enable residents and program directors to evaluate progress more effectively and make case-logging less burdensome.

Sincerely,

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Index Categories, Minimum Numbers, and Common CPT Codes for Urology Residents
(Prepared by ACGME Residency Review Committee for Urology)

	Min	Common CPT codes
ADULT UROLOGY		
General Urology	200	
Transurethral resection	100	52224 (bladder bx); 52234,25,40 (TURBT s/m/l); 52601 (TURP); 52648 (PVP)
TRUS/prostate biopsy	25	55700 (and 76872 for TRUS)
Scrotal/inguinal surgery	40	54530 (inguinal orchiectomy); 55040 (hydrocelec); 55250 (vasectomy); 55400 (vaso-vaso); 54900 (vaso-epi); 55530 (varicocele ligation)
Urodynamics (participate and interpret)	10	51797
Endourology/Stone Disease	100	
Shock wave lithotripsy	10	50590
Ureterscopy	40	52344 (stricture); 52345 (UPJ obstruction); 52352 (stone removal); 52353 (laser); 52354 (tumor bx); 52355 (resection)
Percutaneous renal	10	50080 (<2cm); 50081 (>2cm); perc cryo (50593)
Laparoscopy	20	automatically counted
Reconstruction	60	50544 (lap pyeloplasty); 50780 (reimplant)
Male	15	
<i>Penile/incontinence</i>	10	54360 (plication); 54405 (IPP); 54440 (penile fx); 53440 (male sling); 53445 (AUS)
<i>Urethra</i>	5	53410 (urethroplasty); 53215 (urethrectomy)
Female	15	57288 (sling); 57260 (AP repair); 53500 (urethrolysis); 53230 (diverticulectomy); 57320 (VVF repair)
Intestinal diversion	8	automatically counted with cystectomy; otherwise use 50820 (ileal conduit); 51960 (augment); etc.
Oncology	100	
Pelvic	40	
<i>Prostate</i>	25	55866 (lap/robot RP); 55840/55842/55845 (RRP with no/limited/extended PLND)
<i>Bladder</i>	8	51595 (RC/conduit); 51596 (RC/continent diversion); 51597 (pelvic exent); 51550 (partial cx)
Retroperitoneal	40	38780 (RPLND); 60650 (lap Ax); 60540 (open Ax)
<i>Kidney</i>	30	50230 (ORN); 50240 (OPN); 50542 (lap tumor ablation); 50543 (LPN); 50545 (LRN); 50547 (lap donor); 50548 (lap NU)
PEDIATRIC UROLOGY		
Minor	30	
Endoscopy	5	52000 (cysto); 52005 (RPG); 52300 (ureterocele); 52327 (sting); 52332 (stent); 52400 (PUV); any ureteroscopy (see adult list)
Hydrocele/hernia	10	49496 (<6m); 49500 (6m-5y); 49505 (>5y)
Orchiopexy	10	54640/50/92 (orchiopexy via ing/abd/lap); 54600 (fixation for torsion)
Major	15	50220 (total Nx); 50240 (partial Nx); 50400 (pyeloplasty); 50845 (appendicoves)
Hypospadias	5	54322 (distal); 54324 (distal with flap); 54332 (prox)
Ureter	5	50780 (reimplant); 50782 (duplicated)

June 2009

**Examples from 2007 Resident Letter Revisited:
Modified in Accordance with Revised Coding Principles (June 2009)**

The initial text has been supplemented with notes (italics). Strike-through indicates coding practices that are not recommended (single) or incorrect (double).

Example A: Resident performing sling procedure with cystourethroscopy

Patient	Resident	USOL Entry	CPT Code	Procedure	Role
A	1	1	57288	Sling	Surgeon
A	1	1	52000	Cysto	Surgeon

Note: Since cystoscopy is no longer “counted” as a surgical case in adults, 52000 could be omitted. Also, unbundling is discouraged.

Example B: Resident performing cystourethroscopy, retrograde pyelogram, and stent placement for patient with newly-diagnosed hydronephrosis and suspicion for UPJ obstruction

Patient	Resident	USOL Entry	CPT Code	Procedure	Role
B	1	1	52332	Cysto, stent	Surgeon
B	1	1	52005*	Retrograde pyelogram	Surgeon

** Code only when done for diagnostic purposes (majority of cases); do not code if contrast was only instilled to confirm the location of the pelvis prior to stent placement*

Note: Cystoscopy is no longer “counted” as a surgical case in adults, so the resident no longer needs to log these cases.

Example C: Junior resident places stent prior to laparoscopic partial nephrectomy, but does not feel qualified as Surgeon for the remainder of the procedure (only “drives camera” for staff surgeon and/or fellow).

Patient	Resident	USOL Entry	CPT Code	Procedure	Role
C	1	1	52332	Cysto	Surgeon
C	1	2	50543	Lap partial nx	Assistant

Note: Since cystoscopy is no longer “counted” and since the laparoscopic case would “count” whether the resident served as Surgeon or First Assistant, the resident should definitely code 50543, and do so as “Assistant”.

Example D: Senior and junior resident assisting staff on radical prostatectomy and bilateral PLND, both present for entire case ~~and junior resident acting as surgeon for one PLND~~

Patient	Resident	USOL Entry	CPT Code	Procedure	Role
D	1	1	55840, 38770	RP, PLND	Surgeon
D	1	2	38770	PLND	Assistant
D	2	1	55840, 38770	RP, PLND	Assistant
D	2	2	38770	PLND	Surgeon
D 1	1	1	55842	RP, PLND	Surgeon
D 2	1	1	55842	RP, PLND	Teaching Assistant
D 2	2	1	55842	RP, PLND	Surgeon

Note: In the new system, unbundling is discouraged. This enables the resident to use only a single code to reflect their surgical experience: (RP with limited PLND) or 55845 (RP with extended PLND) instead of 55840 and 38770. The 2nd assistant should NOT code for the RP

(D 1) unless the senior resident served as teaching assistant, in which case both residents could code 55842 (D 2).

Example E: Radical cystectomy, bilateral PLND, urinary diversion should be coded as ~~3 different procedures~~ a single procedure.

Patient	Resident	USOL Entry	CPT Code	Procedure	Role
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E	1	1	51570, 38770, 51596	RC, PLND, continent diversion	Surgeon
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Note: The single code 51596 will automatically give the resident credit towards five required minimums: Oncology; Oncology-Pelvic; Oncology-Pelvic-Bladder; Reconstruction; and Reconstruction-Intestinal diversion. Unbundling is no longer necessary to receive credit for cystectomy and urinary diversion, and PLND is no longer an indexed case.

Example F: Senior and junior resident assisting staff on radical cystectomy, bilateral PLND, and urinary diversion. Only one resident can code as Surgeon for the unilateral procedures (cystectomy and urinary diversion), enabling several acceptable options for coding. Two acceptable alternatives are displayed (F1 and F2).

Patient	Resident	USOL Entry	CPT Code	Procedure	Role
F1	1	1	51570, 38770, 51596	RC, PLND, continent diversion	Surgeon
F1	1	2	38770	PLND	Assistant
F1	2	1	51570, 38770, 51596	RC, PLND, continent diversion	Assistant
F1	2	2	38770	PLND	Surgeon
F2	1	1	51570, 38770	RC, PLND	Surgeon
F2	1	2	38770, 51596	PLND, continent diversion	Assistant
F2	2	1	51570, 38770	RC, PLND	Assistant
F2	2	2	38770, 51596	PLND, continent diversion	Surgeon
F 3	1	1	51596	RC, PLND, continent diversion	Surgeon
F 4	1	1	51596	RC, PLND, continent diversion	Teaching Assistant
F 4	2	1	51596	RC, PLND, continent diversion	Surgeon

Note: This example is greatly simplified (only 51596) since unbundling is no longer encouraged. Only the 1st assistant should code the case as surgeon (F 3), unless this senior resident served as teaching assistant for a 2nd resident surgeon (F 4).