

ICD-10-CM Specialty Code Set Training Urology

2014

Module 2



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Clinical Examples Used in this Book

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual*, *redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially they are as one would find them in a coding setting.

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Commonly Coded

Urologists treat patients with a variety of conditions and diseases. Some of the most commonly coded conditions for urology have already been covered and will not be repeated here. Instead, other commonly coded conditions will be addressed: erectile dysfunction; hypospadias; urinary incontinence; hematuria and other abnormal urologic findings; calculus; hydrocele and spermatocele; neurogenic bladder; and benign prostatic hypertrophy,

Erectile Dysfunction (ED)

Erectile dysfunction is defined as being unable to achieve or keep an erection adequate for sexual activity. There are two types of erectile dysfunction: psychological and physiological. If the dysfunction develops abruptly, but the patient is able to have an erection while masturbating, or has early morning erections, the ED most likely has a psychological component. If the dysfunction develops gradually and persistently, the ED is most likely physiological.

Psychological factors are responsible for erectile dysfunction between 10-20 percent of the time, most commonly caused by:

- Stress: Job-related, money-related, marital issues, etc;
- Anxiety: If a man experiences erectile dysfunction once, he may become worried about it happening again, may have fear of sexual failure, leading to recurrence of the condition;
- Guilt: Patient may feel guilt that he is not satisfying his partner;
- Depression: Depression affects a person physically and psychologically and is a common cause of ED;
- Low self-esteem: May be related to a prior bout of ED or other issues; and
- Indifference: May be due to problems in a couple's relationship or a result of age and subsequent loss of interest.

There is one code in ICD-10-CM for psychological erectile dysfunction, F52.21 *Male erectile disorder*. There is an Excludes2 listing for category F52 *Sexual dysfunction not due to a substance of known physiological condition* for dhat syndrome. According to the guidelines (I.A.12.b), this indicates that dhat syndrome is not part of the conditions represented by category F52 codes, but a patient may have both conditions at the same time. When that occurs, it is acceptable to report both codes when the documentation supports it.

Physiologic conditions are responsible for erectile dysfunction approximately 80-85 percent of the time. Category N52 contains the codes for male physiological erectile dysfunction:

- N52.01 Erectile dysfunction due to arterial insufficiency: ED due to insufficient arterial blood supply to the cavernous bodies;

- N52.02 Corporo-venous occlusive erectile dysfunction: ED due to vasculogenic occlusion of the corpus cavernosum (two columns of erectile tissues within the penis) for any reason (disease, trauma, etc);
- N52.03 Combined arterial insufficiency and corporo-venous occlusive erectile dysfunction: ED due to combined arterial insufficiency and corporo-venous occlusion;
- N52.1 Erectile dysfunction due to diseases classified elsewhere:
 - There is an instructional note for this code that states to code first the underlying disease;
- N52.2 Drug-induced erectile dysfunction: Common medications that cause ED are antihypertensives, antidepressants, antihistamines, chemotherapy, or hormonal medications;
- Post-surgical erectile dysfunction;
 - N52.31 Following radical prostatectomy
 - N52.32 Following radical cystectomy
 - N52.33 Following urethral surgery
 - N52.34 Following simple prostatectomy
 - N52.39 Other surgery; and
- N52.8 Other male erectile dysfunction.

EXAMPLE

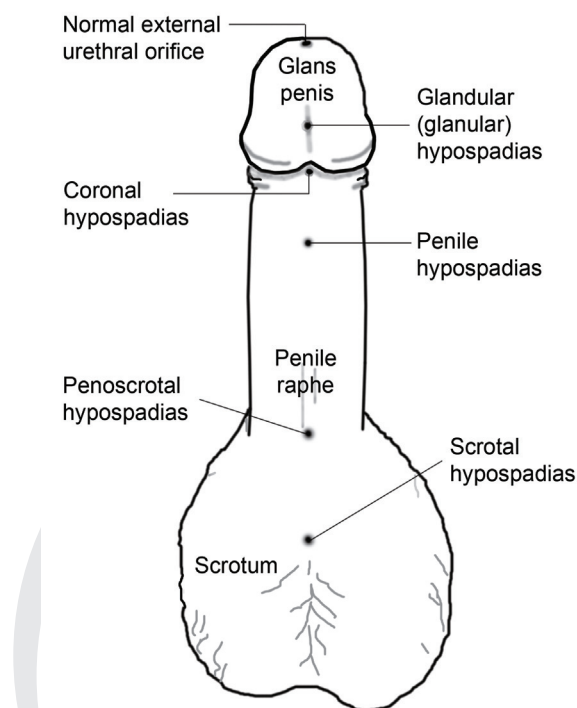
Paul presents for evaluation. He began taking a selective serotonin reuptake inhibitor (SSRI) anti-depressant last month and shortly after began suffering erectile dysfunction. He states that he takes the medication as prescribed. He is determined to have drug-induced erectile dysfunction.

N52.2 Drug-induced erectile dysfunction

T43.225A Adverse effect of selective serotonin reuptake inhibitor, initial encounter

Hypospadias

The penis serves as both a pathway for urine and semen to exit the body through the meatus (urethral opening). During the ninth through twelfth week of development in pregnancy, male hormones act to stimulate the formation of the urinary channel and foreskin. Various problems with hormone action can result in hypospadias. Hypospadias is a common congenital anomaly in which the meatus does not form completely to the tip of the penis, but opens somewhere on the underside. This anomaly occurs in about every four in 1,000 births. Hypospadias may be proximal (behind the scrotum), middle (shaft), or distal (near the head of the penis). About 80 percent of those affected have distal hypospadias.



Source: AAPC

Codes for hypospadias are in chapter 17, *Congenital Malformations, Deformations, and Chromosomal Abnormalities*, in category Q54. The codes are broken down by site of the urethral opening:

- Q54.0 Hypospadias, balanic: Malposition of urethral meatus on the ventral glans penis, including the glans penis, glanular/glandular, and coronal;
- Q54.1 Hypospadias, penile: Malposition of urethral meatus on the shaft of the penis;
- Q54.2 Hypospadias, penoscrotal: Malposition of urethral meatus at the junction of the penis and the scrotum;
- Q54.3 Hypospadias, perineal: Malposition of urethral meatus in the perineum near the anus;
- Q54.4 Congenital chordee: Condition where the penis curves upward or downward. Commonly seen in males with hypospadias; and
- Q54.8 Other hypospadias: The example listed in the code is hypospadias with intersex state.

EXAMPLE

A 1 1/2-year-old presents to the operating room for hypospadias repair (TIP repair and flap relocation) and Nesbit tuck chordee release. He has penoscrotal hypospadias and congenital chordee.

Q54.2 Hypospadias, penoscrotal

Q54.4 Congenital chordee

Urinary Incontinence (UI)

Urinary incontinence is the inability to control the release of urine from the bladder and affects both males and females, but females experience UI twice as often as men. Causes of temporary incontinence include alcohol, overhydration, caffeine, bladder irritation, urinary tract infections, constipation, and medications. Urinary incontinence may also be a persistent condition caused by underlying physical problems or changes, including pregnancy and childbirth; changes with aging; enlarged prostate; and neurologic disorders.

Most codes for urinary incontinence are located in category N39, but there are a few codes in other chapters:

- R32 Unspecified urinary incontinence;
- R39.81 Urinary incontinence associated with cognitive impairment: Dementia, lack of orientation, decline in physical function may be responsible for urinary incontinence. This is often seen in nursing homes; and
- F98.0 Enuresis not due to a substance or known physiological condition: urinary incontinence not caused by underlying conditions.

The main listing of codes is located in category N39 *Other disorders of urinary system*:

- N39.3 Stress incontinence (female) (male): Loss of urine when pressure is exerted on the bladder (coughing, sneezing, laughing, exercising, or lifting heavy objects). It occurs when the sphincter muscle of the bladder is weakened. In women, this could be caused by childbirth or menopause; In men, removal of the prostate can lead to stress incontinence.
 - There is an instructional note for this code that states to code also any associated overactive bladder (N32.81);
- N39.41 Urge incontinence: Sudden urge to urinate followed by an involuntary loss of urine. The bladder muscle contracts and may only give a few seconds to a minute “warning” to get to the toilet. Patients need to urinate often, even throughout the night. May be caused by UTI, bladder irritants, stroke, or injury. If no known cause can be found, it is called overactive bladder;
- N39.42 Incontinence without sensory awareness: This occurs when a patient is unable to feel the need to urinate and therefore is incontinent;
- N39.43 Post-void dribbling: Post-void dribbling occurs in men when a small amount of urine escapes from the meatus up to several minutes after voiding. Sometimes the patient is not aware that it is occurring. It is usually caused by pooling of urine in the bulbar urethra;
- N39.44 Nocturnal enuresis: Nighttime urinary incontinence, also called bedwetting or sleepwetting;
- N39.45 Continuous leakage: Most common in men with enlarged prostates;
- N39.46 Mixed incontinence: Patients that experience more than one type of incontinence (eg, urge and stress);
- N39.490 Overflow incontinence: The inability to empty the bladder. May occur in patients with a damaged bladder, blocked urethra, prostate issues, or nerve damage; and
- N39.498 Other specified urinary incontinence: Examples include reflex incontinence (involuntary bladder contractions without the urge to urinate) and total incontinence (continuous leakage day and night, or the periodic total loss of control of large volumes of urine).

There is an instructional note for subcategory N39.4- *Other specified urinary incontinence* which states to code also any associated overactive bladder. This indicates that when present, both conditions should be reported, with the order of the codes driven by the reason for the encounter.

EXAMPLE

Patient presents for cystoscopy with a diagnosis of recurring bladder infections and urge incontinence, not helped by Detrol LA. The flexible scope is placed through the meatus into the bladder. The bladder was systematically scanned with no abnormal findings of erythema, tumor, or foreign body.

N39.41 Urge incontinence

Z87.440 Personal history of urinary (tract) infections

Hematuria and Other Abnormal Urologic Findings

Chapter 18, *Symptoms, Signs, and Abnormal Clinical Findings*, there is a block of codes specifically related to symptoms and signs involving the genitourinary system: R30-R39. It includes common conditions that are seen in Urology.

Hematuria

Category R31 contains the codes for hematuria:

- R31.0 Gross hematuria,
- R31.1 Benign essential microscopic hematuria: microscopic hematuria for which no cause has been determined,
- R31.2 Other microscopic hematuria, and
- R31.9 Hematuria, unspecified.

EXAMPLE

Patient is seen for gross, painless hematuria in which her urine is red with clots. She denies any associated abdominal, back, flank, or pelvic pain. No fever or chills are reported. Chemstix of urine positive for 3+nonhemolyzed blood with microscopic U/A with 50-100 RBCs. Patient to be scheduled for cystoscopy.

R31.0 Gross hematuria

There are also codes for hematuria combined with the underlying conditions that are located in chapter 14, *Diseases of the Genitourinary System*, including:

- N02.0, Recurrent and persistent hematuria with minor glomerular abnormality: Glomeruli are the tiny filters in the kidneys that remove excess fluid, electrolytes and waste from the bloodstream and pass them into the urine;
- N02.1 Recurrent and persistent hematuria with focal and segmental glomerular lesions;
- N02.2 Recurrent and persistent hematuria with diffuse membranous glomerulonephritis: Glomerulonephritis is nephritis with inflammation of the capillary loops in the renal glomeruli. Membranous glomerulonephritis is characterized by thickening of the membrane and resembles chronic glomerulonephritis;

- N02.3 Recurrent and persistent hematuria with diffuse mesangial proliferative glomerulonephritis: Chronic, slowly progressive glomerulonephritis caused by enlargement of the glomeruli by proliferation of the mesangial cells and thickening of the capillary walls, narrowing the capillary lumina;
- N02.4 Recurrent and persistent hematuria with diffuse endocapillary proliferative glomerulonephritis: Type of glomerulonephritis commonly seen with various types of systemic inflammatory diseases, including lupus, vasculitis syndromes, and infectious processes;
- N02.5 Recurrent and persistent hematuria with diffuse mesangiocapillary glomerulonephritis: Glomerulonephritis characterized by proliferation of mesangial and endothelial cells and expansion of the mesangial matrix and thickening of the capillary walls;
- N02.6 Recurrent and persistent hematuria with dense deposit disease: Dense deposit disease is a rare autoimmune disorder that affects the kidneys and the eyes;
- N02.7 Recurrent and persistent hematuria with diffuse crescentic glomerulonephritis: This type of glomerulonephritis with glomerular crescent (mononuclear cells extending at least half way around the glomerular tuft) formation in more than 50 percent of the glomeruli;
- N02.8 Recurrent and persistent hematuria with other morphologic changes;
- N02.9 Recurrent and persistent hematuria with unspecified morphologic changes; and
- Category N30 Cystitis: Covered in previous section, this category has codes from N30.00-N30.91 that include choices of with hematuria and without hematuria. There is an instructional note for category N30 that states to use an additional code to identify the infectious agent.

EXAMPLE

Patient presents for renal biopsy results. She had originally presented with a history of persistent rust colored urine, but no bright red blood or clots in the urine. CT scan negative for kidney stones. Renal biopsy results indicate ten glomeruli were present with crescents in eight of them. The glomerular sections evaluated showed no electron-dense deposits in the filtration membrane or mesangium. She is diagnosed with diffuse crescentic glomerulonephritis with persistent hematuria.

N02.7 Recurrent and persistent hematuria with diffuse crescentic glomerulonephritis

Other Abnormal Urologic Findings

The other categories and stand-alone codes contained in the code block R30-R39 include:

- Category R30, Pain associated with micturition: This category includes dysuria and vesical tenesmus (Straining to urinate that is ineffectual and often painful);
- Category R33, Retention of urine: This category has three codes, two of which contain instructional notes:
 - R33.0 Drug-induced retention of urine - Use an additional code for adverse effect, if applicable, to identify the drug (T36-T50 with fifth or sixth character 5);
 - R33.8 Other retention of urine - Code first, if applicable, any causal condition, such as enlarged prostate (N40.1);

- Code R34, Anuria and oliguria: Failure of the kidneys to produce urine or the production of abnormally small amounts of urine;
- Category R35, Polyuria: This category includes frequency and nocturia:
 - There is an instructional note with this category that states to code first, if applicable, any causal condition, such as enlarged prostate;
- Category R36, Urethral discharge: This category includes urethral discharge without blood and hematospermia;
- Category R39, Other an unspecified symptoms and signs involving the genitourinary system:
 - Code R39.0 Extravasation of urine: Collection of urine in other cavities;
 - Subcategory R39.1-, Other difficulties with micturition: Includes hesitancy, poor stream, feeling of incomplete bladder emptying, and straining to void.
 - » There is an instructional note for this subcategory that states to code first, if applicable, any causal condition, such as enlarged prostate (N40.1); and
 - Code R39.2, Extrarenal uremia: Retention in the bloodstream of waste products normally excreted in the urine due to a cause outside the kidney (for instance, congestive heart failure or severe alkalosis).

EXAMPLE

A 70-year-old male patient presents with nocturia and dysuria without trauma or provocation. He states this has been occurring off and on, becoming more persistent. Considering patient's age, may be BPH. Will obtain UA with culture, PSA, and ultrasound.

R35.1 Nocturia

R30.0 Dysuria

Calculus

A calculus is an abnormal concretion in the body, usually formed of mineral salts and most commonly found in the gallbladder, kidney, or urinary bladder. Urolithiasis is the general term used for calculus in the urinary tract. They may be in the kidney, ureter, bladder, urethra, or multiple areas.

Each year more than a million visits are made to providers' offices and people present to emergency departments over 300,000 times for kidney stone problems. The peak age for kidney stones is between 20 and 50-years-old. According to the U.S. Department of Health and Human Services, they are one of the most common disorders of the urinary tract. In the U.S., 8.8 percent of the population (one in 11 people), have had a kidney stone. There are four major types of kidney stones:

- **Calcium stones:** The most common type and occur in two major forms: calcium oxalate and calcium phosphate. Calcium oxalate stones are more common. Calcium oxalate stone formation may be caused by high calcium and high oxalate excretion. Calcium phosphate stones are caused by the combination of high urine calcium and alkaline urine, meaning the urine has a high pH;
- **Uric acid stones:** Occur when urine is persistently acidic. If uric acid becomes concentrated in the urine, it can settle and form a stone by itself or along with calcium;

- **Struvite stones:** Result from kidney infections; and
- **Cystine stones:** Result from a genetic disorder that causes cystine to leak through the kidneys and into the urine, forming crystals that tend to accumulate into stones.

Ureteral stones have passed the kidney and moved into the ureter. Depending on the size and location of the stone, it may pass on its own, or need to be removed surgically. Ureteral stones are usually found at the top of the ureter, 2/3 of the way down the ureter, or near the bladder.

Stones in the urinary bladder are usually caused by another condition in the urinary system, such as: bladder diverticulum, enlarged prostate, neurogenic bladder, or urinary tract infection. They almost always occur in men.

- Urethral stones cause obstruction of the urethra with a potential for causing rupture of the bladder or perforation of the urethra and leaking of urine into subcutaneous or retroperitoneal sites. They are uncommon because the urethra is wider than the ureter, so if a stone has made its own way down to the urethra, it usually passes out of the body.

The codes for urolithiasis are located mainly in categories N20 through N22, broken down by site of the calculus:

- N20.0 Calculus of kidney;
- N20.1 Calculus of ureter;
- N20.2 Calculus of kidney with calculus of ureter;
- N20.9 Urinary calculus, unspecified;
- N21.0 Calculus in bladder;
- N21.1 Calculus in urethra;
- N21.8 Other lower urinary tract calculus;
- N21.9 Calculus of lower urinary tract, unspecified; and
- N22 Calculus of urinary tract in diseases classified elsewhere
 - There is an instructional note with this code that states to code first underlying disease, such as: gout or schistosomiasis.

EXAMPLE

Urology is called to the ED when a male patient presents with sharp pain in the lower back that comes in waves and pain on urination. CT indicates large right ureteral stone.

N20.1 Calculus of ureter

EXAMPLE

Brian presents to the clinic. He has chronic idiopathic gout in the right foot that has flared up. He was referred for evaluation as he now has kidney stones.

M1A.0710 Idiopathic chronic gout, right ankle and foot without tophus

N22 Calculus of urinary tract in diseases classified elsewhere

Other codes that relate to calculus of the urinary system are:

- Q63.8 Other specified congenital malformations of kidney: congenital kidney stones;

- N13.2 Hydronephrosis with renal and ureteral calculous obstruction: Swelling of the kidneys that occurs when urine flow is obstructed in any part of the urinary tract, in this case, due to calculus; and
- N13.6 Pyonephrosis: Urinary tract obstruction, may be from calculus, with infection
 - There is an instructional note with this code to use an additional code (B95-B97) to identify infectious agent.

There is an Excludes2 listing with category N13, *Obstructive and reflux uropathy*, which includes: calculus of kidney and ureter without hydronephrosis; congenital obstructive defects of renal pelvis and ureter; hydronephrosis with ureteropelvic junction obstruction; and obstructive pyelonephritis. According to the guidelines (I.A.12.b), this indicates that the conditions listed are not part of the conditions represented by category 13 codes, but a patient may have both conditions at the same time. When that occurs, it is acceptable to report both codes when the documentation supports it.

EXAMPLE

Male patient that self-catheterizes presented with discoloration of his urine, back pain, and night sweats. Ultrasound revealed right kidney appeared hydronephrotic with a dilated renal pelvis. Microbiology of the urine showed growth of *Pseudomonas aeruginosa*. Patient was diagnosed with pyonephrosis.

N13.6 Pyonephrosis

B96.5 *Pseudomonas (aeruginosa) (mallei) (pseudomallei)* as the cause of diseases classified elsewhere

Hydrocele and Spermatocoele

A hydrocele is a fluid-filled sack in the scrotum commonly seen in newborns. They usually disappear without treatment within the first year of life. In older males, hydroceles may develop due to inflammation or injury within the scrotum. ICD-10-CM contains codes for congenital and noncongenital hydrocele:

- P83.5 Congenital hydrocele: Normally, the testes descend from the developing baby's abdominal cavity into the scrotum in utero. The processus vaginalis accompanies each testicle, allowing fluid to surround the testes. In most cases, each sac closes and the fluid is absorbed, but if fluid remains after the sac closes, the condition is termed a noncommunicating hydrocele. If the sac remains open, it is termed a communicating hydrocele;
- N43.0 Encysted hydrocele: Hydrocele that does not communicate with the peritoneal cavity (noncommunicating), sometimes confused for hernia or cord tumor;
- N43.1 Infected hydrocele
 - There is an instructional note with this code to use and additional code (B95-B97) to identify the infectious agent;
- N43.2 Other hydrocele: Example may be funicular hydrocele, a communicating hydrocele;
- N43.3 Hydrocele, unspecified;
- N90.89 Other specified noninflammatory disorders of vulva and perineum: This code can be used to report a hydrocele of the vulva in a female, which is rare; and

- N94.89 Other specified conditions associated with female genital organs and menstrual cycle: This code can be used to report a hydrocele of the round ligament or other areas (except the vulva) in a female. The round ligament is attached to the uterus near the origin of the fallopian tube.

EXAMPLE

A mother brings her 2-month-old son in for evaluation after noting a swelling in his right groin. The boy was full-term without any complications. On exam, testes were descended and nontender. A soft swelling was palpated in the right inguinal canal, and reduced with gentle manipulation; however, it recurred. Scrotal ultrasound was performed which indicated anechoic fluid collection in the region of the right inguinal canal above the right testicle. Diagnosis of congenital communicating hydrocele is made.

P83.5 Congenital hydrocele

EXAMPLE

A male patient presents with swelling in the groin. He admits to no trauma and states he noticed it a couple of days ago. On exam, swelling was noted in the left inguinal region that moved downward when the testis was gently pulled downward. Ultrasound confirmed encysted hydrocele.

N43.0 Encysted hydrocele

A spermatocele is a benign cystic accumulation of sperm that arises from the head of the epididymis (tube in each testis that carries sperm to vas deferens). They are typically asymptomatic and often found incidentally on testicular self-examination or routine physical. No treatment is usually required, unless discomfort, pain or progressive enlargement is noted. Spermatoceles vary in size and may be single or multiple, unilateral or bilateral. They are the most common cystic condition encountered within the scrotum.

There are three noncongenital codes for spermatocele in ICD-10-CM:

- N43.40 Spermatocele of epididymis, unspecified
- N43.41 Spermatocele of epididymis, single
- N43.42 Spermatocele of epididymis, multiple

The code for congenital spermatocele is Q55.4, Other congenital malformations of vas deferens, epididymis, seminal vesicles, and prostate.

EXAMPLE

Paul, a 60-year-old male patient presents for ultrasound results. He had presented with heaviness in his right testicle with some discomfort. Transillumination was performed and indicated possible spermatocele. Patient was sent for an ultrasound and is informed today that the ultrasound confirms unilateral spermatocele.

N43.41 Spermatocele of epididymis, single

Neurogenic Bladder

The two main functions of the bladder are to store and empty urine. This is accomplished by coordinated activity by the central and peripheral nervous system. Nerves carry messages from the bladder to the brain, and then from the brain to the muscles of the bladder signaling them to tighten or release. Neurogenic bladder, sometimes termed neuropathic bladder, is abnormal bladder function due to a nervous system disease or disorder. Causes include stroke, multiple sclerosis, spina bifida, traumatic spinal cord injury, and cerebral palsy.

Category N31, *Neuromuscular dysfunction of bladder, not elsewhere classified*, contains the codes for neurogenic bladder, broken down by type:

- N31.0 Uninhibited neuropathic bladder, not elsewhere classified: Bladder dysfunction in which normal inhibitory control of the detrusor muscle by the central nervous system is impaired or underdeveloped, resulting in uncontrolled urination, retention of urine, or both;
- N31.1 Reflex neuropathic bladder, not elsewhere classified: Bladder dysfunction in which the bladder involuntarily contracts, causing incomplete bladder emptying and overactive bladder function;
- N31.2 Flaccid neuropathic bladder, not elsewhere classified: Bladder dysfunction in which the bladder does not contract fully, causing urine leakage;
- N31.8 Other neuromuscular dysfunction of bladder; and
- N31.9 Neuromuscular dysfunction of bladder, unspecified.

There is an instructional note for all category N31 codes that states to use an additional code for any associated urinary incontinence (N39.3-, N39.4-).

EXAMPLE

A patient presents for treatment options with a reflex neurogenic bladder with stress incontinence. After review of diagnostic studies and physical examination, treatment options were discussed. Treatment started with bethanechol 25 mg orally four times a day.

N31.1 Reflex neuropathic bladder, not elsewhere classified

N39.3 Stress incontinence (male) (female)

Benign Prostatic Hypertrophy (BPH)

The prostate is divided into several lobes and three zones. The lobes are:

- The anterior, which is devoid of glandular tissue;
- The median, which sits between the two ejaculatory ducts and the urethra;
- The lateral (right and left) form the main portion of the prostate and are separated by the prostatic urethra; and
- The posterior, which is the portion that is felt upon digital rectal examination (DRE).

The three zones of the prostate all open into the urethra and are:

- The central zone (CZ), which makes up 25 percent of the gland's volume, mostly made up of mucosal glands;
- The peripheral zone (PZ), which makes up 70 percent of the gland's volume and is the main site for prostate cancer; and
- The transitional zone (TZ), which is the site where most BPH originates, made up of submucosal glands.

BPH, also called benign prostatic hypertrophy, is a common condition caused by the nonmalignant enlargement of the prostate gland as men get older. The average size of normal prostate is 20–25 g. As the gland grows, it can cause urination and bladder problems due to the pressure on the urethra. The cause of prostate enlargement is unknown, but aging, obesity, lack of physical activity, erectile dysfunction, and family history of BPH are risk factors.

The American Urologic Association developed a diagnostic tool to help assess the severity of a patient's irritative and obstructive voiding symptoms. It includes seven questions regarding urinary symptoms and how much they affect the patient and a quality of life question. The tool consists of a 1–5 rating for each question, that when added up indicates a severity from mild to severe. The tool called International Prostate Symptom Score (IPSS) contains the same questions with the same ratings, but add a quality of life question with a 1–6 rating. A physician may use multiple tools to reach a diagnosis, including a digital rectal exam (DRE), urinalysis, PSA (to screen for prostate cancer), uroflowmetry, pressure flow studies, and cystoscopy.

In ICD-10-CM, codes for enlarged prostate are located in category N40 and are divided by type (enlarged and nodular) and whether lower urinary tract symptoms (LUTS) are present. Although BPH can be asymptomatic, most patients experience LUTS. Lower urinary tract symptoms are can be divided into three basic categories:

- Storage symptoms, which include frequency, nocturia, urgency, urinary incontinence, stress incontinence, and urge incontinence;
- Voiding symptoms, which include slow stream, splitting or spraying, intermittent stream, hesitancy, and straining; and
- Postmicturition symptoms, which include feeling of incomplete emptying and postmicturition dribble.

Nodular prostate is glandular and stromal hyperplasia that results in nodules forming that may increasingly obstruct the urethra. There are two codes for enlarged prostate and two codes for nodular prostate:

- N40.0 Enlarged prostate without lower urinary tract symptoms (LUTS),
- N40.1 Enlarged prostate with lower urinary tract symptoms (LUTS),
- N40.2 Nodular prostate without lower urinary tract symptoms (LUTS), and
- N40.3 Nodular prostate with lower urinary tract symptoms (LUTS).

Codes N40.1 and N40.3 have instructional notes that state to use additional code(s) for associated symptoms (LUTS), when specified:

- Incomplete bladder emptying (R39.14),

- Nocturia (R35.1),
- Straining on urination (R39.16),
- Urinary frequency (R35.0),
- Urinary hesitancy (R39.11),
- Urinary incontinence (N39.4-),
- Urinary obstruction (N13.8),
- Urinary retention (R33.8),
- Urinary urgency (R39.15), and
- Weak urinary stream (R39.12).

This instruction is the same as in ICD-9-CM, where it is an exception to the guideline of not assigning a code for a sign or symptom once a definitive diagnosis has been reached.

There is also an Excludes2 note with category N40 that lists malignant neoplasm of prostate (C61). According to the guidelines (I.A.12.b), this indicates that prostate cancer is not part of the conditions represented by enlargement of the prostate, but a patient may have both conditions at the same time. When that occurs, it is acceptable to report both codes when the documentation supports it.

EXAMPLE

A 58-year-old man presents for follow-up. He presented originally for urinary frequency, hesitancy, weak stream, and nocturia for over 2 years with recent progression. Physical exam revealed soft and enlarged prostate at 30 g. His IPSS score was 18 (moderate). We discussed his labs today, showing normal U/A and PSA of 1.2 ng/mL. He states there is no change in his symptoms. Patient diagnosed with enlarged prostate with LUTS and started on alpha-blockers.

N40.1 Enlarged prostate with lower urinary tract symptoms (LUTS)

R35.0 Frequency of micturition

R39.11 Hesitancy of micturition

R39.12 Poor urinary stream

R35.1 Nocturia

EXAMPLE

A 60-year-old patient presents for check-up of his nodular prostate and erectile dysfunction (ED). He states that his nocturia and urgency have improved. He states his ED is still present, but is improving as his other symptoms are improving. UA, PSA, and BUN all within normal limits.

N40.3 Nodular prostate with lower urinary tract symptoms (LUTS)

R35.1 Nocturia

R39.15 Urgency of urination

N52.9 Male erectile dysfunction, unspecified