Coding and Reimbursement
2018

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Objectives

Understand how the AUA impacts on Public Policy and provides Practice support
Understand CPT Code Development
Understand Code Value Determination and the RUC Process
Review modifiers in the Urology practice
Review new and deleted CPT codes for 2018
Present coding challenges from the AUA Coding Hotline
How physicians get paid for what they do?

The Reimbursement Process

• Physicians must have the capability of communicating with third party payors for reimbursement of medical claims

• This communication is called medical coding
  – Current Procedural Terminology (CPT) coding = service(s) performed for the patient
  – International Classification of Diseases (ICD) coding = signs, symptoms & diagnosis that represent medical necessity
CPT Code Development

• Suggestion to AUA from:
  • Manufacturer/Physician/Coding & Reimbursement Committee (CRC)/CMS
    • What is the CRC?
      • AUA volunteers from every section and urologic specialty who reviews coding and reimbursement issues affecting urology
        Approximately 20 volunteers consisting of voting members and consultants
CPT Code Development

• AUA (CRC) Reviews Recommendations
  • Code must meet AMA requirements:
    • that the service/procedure has received approval from the Food and Drug Administration (FDA) for the specific use of devices or drugs;
    • that the suggested procedure/service is a distinct service performed by many physicians/practitioners across the United States;
    • that the clinical efficacy of the service/procedure is well established and documented in U.S. peer review literature;
    • that the suggested service/procedure is neither a fragmentation of an existing procedure/service nor currently reportable by one or more existing codes; and
    • that the suggested service/procedure is not requested as a means to report extraordinary circumstances related to the performance of a procedure/service already having a specific CPT code.
CPT Literature Requirements

- Identify whether this is a U.S. based journal or a non-U.S. based journal, and identify whether the population studied is U.S. or non-U.S. or both;

- Identify the number of patients studied (total of all group(s) including controls) and indicate whether study is a prospective study;

- Provide a concise “relevance statement”.

- **General Guidelines for inclusion of the articles are noted in the following:**

  - Abstracts are allowed to supplement application but will not be accepted in substitution of full length journal articles.

  - Foreign journals will be permitted if published in the English language.

  - List up to 5 references, of which at least 3 report the procedure/service in a U.S. patient population. Of these, at least 2 articles must report different patient populations or have different authors (no overlapping patient populations or no overlapping authors).

  - At least 1 of the publications meets or exceeds the criteria for evidence level III (i.e. obtained from well-designed, non-experimental descriptive studies such as comparative studies, correlation studies, and case control studies). However, Code Change Applications requesting editorial changes to existing Category I codes and applications for bundled codes to describe unchanged existing Category I services (when provided together) need not meet this requirement.
CPT Code Development

• Code Change Proposal sent to the American Medical Association

• AMA CPT Advisory Committee Members review the application for appropriateness

• CPT Editorial Panel meets three times per year to review CCPs
  • Composed of 17 members (11 Specialty Societies, BC/BS Association, America's Health Insurance Plans, the American Hospital Association, the Centers for Medicare and Medicaid Services (CMS) and CPT Health Care Professionals Advisory Committee )
  – No – back to the drawing board
  – Yes – onto the next step – Assigning work RVUs to the CPT code
“Results, Potential Effects and Implementation Issues of the Resource-Based Relative Value Scale”

Wm Hsiao, Ph.D., Peter Braun, M.D.
JAMA, Oct. 28, 1988, Vol. 260, No. 16

• “Standardize Payments, Rationalize Incentives and Influence Physician Decisions.”

• “Provide a Neutral Incentive Structure”

• “Enhance Cost Effectiveness and Ameliorate Manpower Shortage in Primary Care.”
OBRA 1989 Changed Everything

• In the Omnibus Budget Reconciliation Act (OBRA) of 1989, Congress reformed Medicare’s methodology for paying physicians with the adoption of the Medicare **Resource Based Relative Value Scale** fee schedule (RBRVS).

• The previous methodology—“customary, prevailing, and reasonable charges”—based “Medicare-allowed” payment on past payments for the service.

• In contrast, the new Medicare fee schedule attempts to “rationalize payments, basing them on the **resource costs** necessary to provide the service.”
The AMA Relative Value Update Committee known as the “RUC” Started in 1992

• Relative Value Units for Physician “Work”
• Relative Value Units for “Practice Expense”
• Must review relative values of all CPT codes every 5 years
• Does not consider the “efficacy” of procedures – yet ...
• Infighting between specialties as they try to keep their relative values (= $$) from decreasing
RVS Update Committee (RUC)

• Composition: 29 members – 23 seats filled by professional societies (including AUA)

• RUC solicits survey data regarding individual codes or families of codes. Administered by the appropriate professional society (AUA, ACOG, AANS etc.)

• RUC meets 3 time a year

• Data is presented to the RUC, specialties defend, the RUC votes

• RUC makes recommendations to CMS for final valuation; CMS accepts over 95% of RUC recommendations.
Survey Results = Reimbursement

• Survey allows AUA to collect objective data to supply to AMA and CMS for the appropriate valuation of the physician work involved in the procedure
• The work value translates into reimbursement for the procedures performed and associated E & M services prior and after the surgery
• Also a separate valuation is performed by AUA RUC Panel members for the practice expense needed to perform the service or associated E & M service(s) in the office
Who Gets Surveys?

- Respondents selected by AUA by random sampling
- May be sub-specialty, e.g. prosthetics
- May be general, e.g. cysto with dilation
- Private practice (small & large), hospital-based, and academic
- Need at least 30-50 responses
- Want >100 responses
Survey Tips

• Be honest

• No premium on speed, this is not a contest

• Think of “typical patient” in your practice

• Remember co-morbidities.

• Get help from others – your partners or practice admin.

• With the opportunity to have a major impact, comes the responsibility to do a good job.
Components of a CPT Code

- Practice Expense: 44%
- Total Work: 52%
- Malpractice: 4%
Work RVU

Pre-service time – prior to surgery
   Writing/reviewing records
   Discussion with other physicians
   Scrub, Dress, Wait
Intra-service work –
   Office – patient encounter time
   Surgical - open to close time
Post-service time – recovery room, ICU, hospital follow up & office visits
Components of a CPT Code

Physician work

- Time required to perform service
- Technical skill & physical effort
- Mental effort & judgment
- Psychological stress associated with the risk of surgery
Practice Expense

• Cysto with dilation (CPT 52281) – **Supplies**
  • Catheter, foley (1) = $7.82
  • Pack, minimum multispecialty (1) = $1.14
  • Drape, sterile towel (3) $0.85 (3) = $2.55
  • Chux, (1) = $0.23
  • Pack, urology cysto (1) = $24.69
  • Patient education booklet (1) = $1.55
  • Guide wire (1) = $35.60
  • Pack, cleaning and disinfecting cystoscope (1) = $15.25
Practice Expense

- Cysto with dilation (CPT 52281) – **Equipment**
  - Endoscope, flexible (3 year life) = $7,408
  - Light source, Xenon (5 year life) = $6,723
  - Table, power (10 year life) = $6,154
  - Instrument table = $634
Practice Expense
Cysto with dilation (CPT 52281) – **Clinical Staff Time - minutes**

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<thead>
<tr>
<th>Pre-Service</th>
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<tbody>
<tr>
<td>Complete forms</td>
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<tr>
<td>Coordinate Services</td>
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<tr>
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<tr>
<td>Follow-up phone calls</td>
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<td>Review Charts</td>
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<tr>
<td>Obtain vital signs</td>
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</tr>
<tr>
<td>Prepare room / Equipment</td>
<td>2</td>
</tr>
<tr>
<td>Set Up Cystoscope</td>
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<tr>
<td>Prepare &amp; position patient</td>
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</tr>
<tr>
<td>Assist Physician with procedure</td>
<td>16</td>
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<tr>
<td>Clean room &amp; equipment</td>
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</tr>
<tr>
<td>Clean Cystoscope</td>
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<tr>
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<tbody>
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<td>Phone Calls &amp; Call-in Prescriptions</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
</tr>
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</table>
The Formula and Impact of Practice Expense

What you are paid is determined by four components of a formula:

1. RVU “physician work”
2. RVU “practice expense”
3. RVU “medical liability insurance”
4. GPCI “your geographic location”
How the Reimbursement Amount Is Determined!

- RUC makes recommendations to CMS
- CMS – approves or revises suggested RUC values
- Federal Register – Publishes final RVU Values in November
- Codes are published in annual CPT Book
- Article on AUA Web site in Coding Tips and in the AUA Health Policy Brief
Reimbursement Process

CPT code (with vignette)

Survey sent to members
(typical work)

Presented at the RUC

Value assigned

CMS: accept (or not)

(x Conversion Factor)
= payment
Modifiers in the Urology Practice
What is a Modifier?

• Essential coding tool

• Allows communication to a payor that a service or procedure provided was altered by specific circumstances, but not changed in definition or code
Types of Modifiers

• Evaluation and Management Services

• Surgery/Procedures
E&M Modifiers

• Modifiers -24, -25, -57

• Need to understand Global Periods to understand E/M Modifiers
Global Periods

• 000: Postoperative care not included in the payment, but related E/M work is included if done on the same day

• 010: 10 days postop care included in the payment

• 090: 90 days postop care included (and one day pre-op)
Examples of Global Periods

• 000: cystoscopy for stone, tumor; bcg treatment of tumor
• 010: change SP tube, scrotal abscess drainage
• 090: Major surgeries, vasectomy, TURP’s, UPJ
Modifier -24

• A separate diagnosis is necessary
  • Supported by documentation

• Not for complications

• Example: kidney stone within 90 days of a radical prostatectomy
Modifier -25

• Applies to -0 and -10 day global procedures
  • Above and beyond usual pre- and post-op work
  • Medically necessary

• Different diagnoses not required

Note: Modifier -25 is not used to report an E/M service that resulted in a decision to perform surgery. See modifier ‘-57’.
Modifier -25: Example

• Patient undergoes cystoscopy for hematuria. The test results show a bladder tumor, so the problem and treatment options are discussed

• Can bill “established patient visit” the same day

• Complete note; code can be based upon visit or time (place of service error risk)
Modifier -57

*Initial Decision* for Surgery (made within global period of -90 day global):

• *Initial* decision for surgery the same day or within 24 hours of procedure

• Example: testicular mass and orchiectomy; trauma and nephrectomy
Procedural Modifiers

- Append to surgical and procedural CPT codes
CPT Modifiers

- -26 Professional Component
- -47 Anesthesia by Surgeon
- -50 Bilateral Procedure
- -51 Multiple Procedures
- -52 Reduced Services
- -53 Discontinued Procedure
- -54 Surgical Care Only
- -55 Post-op Management Only
- -56 Pre-op Management Only
- -58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
- -59 Distinct Procedural Service

- -63 Procedure Performed on an Infant
- -66 Surgical Team
- -76 Repeat Procedure by Same Physician
- -77 Repeat Procedure by Another Physician
- -78 Return to the Operating Room for a Related Procedure During the Postoperative Period
- -79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period
- -80 Assistant Surgeon
- -82 Assistant Surgeon (resident not available)
Modifier -22

Increased Procedural Service:

• Work to provide service is substantially greater than typical
• Automatic manual review
• Wait until request for information from payer and then provide documentation of complexity
  • Trauma with complication, intra-op complication
  • Significant scarring /adhesions requiring extra time and work
Modifier -58

*Staged* or *related* procedure or service by the same physician during the postoperative period

- Planned prospectively: dictate
- More Extensive than original
- Therapy following diagnostic procedure
- *Should be documented in original operative report that something else may be necessary*
- Resets global
Modifier -78

Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period

- **Unplanned** Procedure
- Complication
- Operating Room or Designated Procedure Room only
- Pays Work Value Only
Modifier -79

Unrelated procedure or service by the same physician during the postoperative period

- Use New Diagnosis
- Resets Global
Modifier -50

Bilateral procedure:

• Procedures performed on both sides of the body or identical anatomical sites, aspects or organs during same operative session
• Mirror images
Modifier -51

• Procedures performed during the same operative session by the same physician

• Append -51 to lower value CPT code(s)

• Some carriers (including Medicare) have computer software to automatically rank RVU and a -51 is not required
Multiple Procedure Billing

Is one procedure an integral part or component of the other?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Do not Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>Charge</td>
</tr>
</tbody>
</table>

If bundled and separately identifiable, use appropriate modifier to unbundle
Examples (do not bill)

Getting To Pathology:
- Cysto (TURBT/URS)
- Urethral meatus dilation
- Balloon dilation of ureteral orifice
- Ureteroscopy (unless diagnostic only)
- Diagnostic laparoscopy
- Lysis of Adhesions

Cleaning Up:
- Catheter or drain placement
- Cauterization of bleeding
- Repair/tailor bladder neck (at time of prostatectomy)
- Nephropexy at partial nephrectomy
- Bladder neck reconstruction with radical prostatectomy

(Exception: stent placement)
Modifier -59

Distinct procedural service:

• Multiple procedures reported are distinct or independent from each other

• Documentation: different session, incision, lesion, injury, or organ
Modifier -52 vs. -53

Modifier -52 “Reduced”

• Service or procedure is partially reduced at discretion of physician

• Procedure was started but not completed

• Intra-op consultation

• Means of reporting without disturbing basic CPT descriptor

Modifier -53 “Discontinued”

• Physician terminates procedure due to extenuating circumstances

• After a procedure is started or anesthesia is induced

• Payment established by percentage of procedure completed

• Example: EKG changes after induction
Modifier -62

Co-surgeons:

• Both surgeons must dictate operative note for their individual portion performed based upon their expertise
• Both surgeons use *same CPT code*
• Fee is raised to 125% and reimbursement is split 50%
Modifier -80 vs. -82:

Assistant Surgeon

**Modifier -80**

- Non-teaching setting
- Procedure must allow assistants (check with Medicare/local carriers)

**Modifier -82**

- When qualified resident not available
- Teaching facility (not necessarily “University”)
Modifier -26

Professional component (PC)
• Certain procedures have both PC and Technical Component (TC)

• PC: physician’s supervision and interpretation (work in providing the service)
  • TC: cost of machine ownership
Procedures with PC and TC

- Office Urodynamics (UDS)
  - Urologist that performs UDS charges –TC
  - Urologist that interprets charges -26
  - If MD both performs and interprets, then code(s) can be billed globally without modifiers

- Hospital Imaging
  - 74420-26 for interpretation of a retrograde pyelogram (when applicable)
New CPT Code 2018

- **55874** Transperineal placement of biodegradable material, periprostatic, single or multiple injections(s), including image guidance, when performed
  - As imaging is included, do not report 55874 in conjunction with 76942 (US guide needle placement)
- “Space OAR”
- Replaces CPT Category III code 0438T
New CPT Code 2018

• **38573** Laparoscopic Total Pelvic Lymphadenectomy with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling, peritoneal washings, peritoneal biopsy(ies), omentectomy, and diaphragmatic washings, including diaphragmatic and other serosal biopsy(ies), when performed.
  • Do not report 38573 in conjunction with 38562, 38564, **38570, 38571, 38572**, 38589, 38770, 38780, 49255, 49320, 49326, 58541, 58542, 58543, 58544, 58548, 58550, 58552, 58553, 58554)
  
  Note: Do not report with any other lymph node dissection codes
• This code requested by gynecology for laparoscopic surgical staging of an ovarian malignancy.
Other Laparoscopic Lymph Node Dissection Codes

- **38570** Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple
- **38571** Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy
- **38572** Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple
Abdominal X-ray CPT code changes

**New**
- 74018 Radiologic examination, abdomen; 1 view
- 74019 Radiologic examination, abdomen; 2 view
- 74021 Radiologic examination, abdomen; 2 or more views

**Deleted**
- 74000 has been deleted. To report use 74018
- 74010 has been deleted. To report, see 74019, 74021
- 74020 has been deleted. To report, see 74019, 74021
Revised CPT Code 2018

- Colporrhaphy with Cystourethroscopy family: revised to include cystourethroscopy when performed; do not report cystoscopy 52000 with the following codes:
  - 57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, *including cystourethroscopy, when performed.*
  - 57260 Combined anterioposterior colporrhaphy, *including cystourethroscopy, when performed;*
  - 57265 with enterocele repair
• **Neurostimulators**: Guidelines have been added to the Neurostimulators (Peripheral Nerve) section instructing users to report codes 64553 (cranial nerve), 64555 (peripheral nerve), and 64561 (sacral nerve) for the placement of temporary or permanent percutaneous electrode arrays. It was determined that there was no difference in work and practice expense when placing a temporary or permanent electrode array. Different codes for permanent versus temporary were not needed.

• *Note*: There are no changes to reporting 64561 temporary lead or 64581 tined lead.
New Category III Code 2018

• **0499T** Cystourethroscopy, with mechanical dilation and urethral therapeutic drug deliver for urethral stricture or stenosis, including fluoroscopy, when performed
  • Do not report 0499T in conjunction with 52281, 52283
  • Drug is included
Deleted CPT Codes 2018

- **55450** Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

- **64565** Percutaneous implantation of neurostimulator electrode array; neuromuscular
Looking ahead to 2019

• CPT 50395 will be deleted, replaced with:

  • **New Code - Dilation of nephrostomy tract (existing access):** percutaneous, for an endourologic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation], as well as post procedure tube placement, when performed

  • **Dilation of nephrostomy tract (new access):** percutaneous, for an endourologic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation], as well as post procedure tube placement, when performed **including new access into the renal collecting system**
Looking ahead to 2019

• **New Code:** Transurethral destruction of prostate tissue; by radiofrequency - generated water vapor thermotherapy
  REZUM procedure
Rezum

• As you may be aware, the AUA suggested CPT 53852 Transurethral destruction of prostate tissue; by radiofrequency thermotherapy.

• However, at the June 2017 American Medical Association CPT Editorial Panel meeting, there was a discussion on the appropriateness of this code to report water vapor or steam thermotherapy of the prostate. Since the result of the meeting discussion has not been made public as yet, the AUA advises that you check with your insurer before submitting the claim using the Rezum technology.
New HCPCS Outpatient/ASC Facility

• These codes are used to report the facility fees for procedures performed in the outpatient and ASC setting
  • **New Code:** C9738 Adjunctive blue light cystoscopy with fluorescent imaging agent (List separately in addition to code for primary procedure)
  • **New Code:** C9747 Ablation of prostate tissue using transrectal delivered high intensity focused ultrasound (HIFU), and includes image guidance
  • **New Code:** C9748 Transurethral destruction of prostate tissue; by radiofrequency-generated water vapor thermotherapy
Coding challenges
• **Question:**
  Is there a different CPT code for White Light vs Blue Light Cystoscopy? Or does CPT code 52000 cover both?

• **Answer:**
  • CPT code 52000 would cover both.

  • **Add C9738** Adjunctive blue light cystoscopy with fluorescent imaging agent (list separately in addition to code for primary procedure)
Coding for HIFU

• In October 2015, the Food and Drug Administration (FDA) approved high-intensity focused ultrasound (HIFU) for the sole indication of tissue ablation of the prostate.

• Most insurance companies do not cover HIFU for prostate cancer and consider this experimental and investigational.

• Since FDA approval, some companies are trying to establish treatment centers within the United States. If facilities are performing HIFU for treatment of prostate cancer, they would be doing so as an off-label use.

• There is no CPT code for HIFU at this time. Unlisted code 55899 could be used. If HIFU is being performed for anything other than prostate cancer, there may be coverage. Otherwise, for Medicare an Advanced Beneficiary Notice should be obtained with patient’s signature to notify them that this procedure isn’t covered and patient will be responsible for charges.
MRI Fusion of the Prostate

• Currently, for the MRI/ultrasound image fusion, there is no CPT code to report this.

• Urologists should not bill CPT code 77021 Magnetic resonance guidance for needle placement (e.g., for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation.

• One may try to bill 76498 Unlisted Magnetic Resonance procedure, (e.g., diagnostic, interventional) for the additional work of fusing the MRI and the ultrasound, but it is unlikely to be reimbursed. It may be appropriate to check with the insurance provider for their reimbursement/coverage policy.
Imaging Guidance Documentation

• When imaging guidance or imaging supervision and interpretation is included in a surgical procedure, guidelines for image documentation and report, included in the guidelines for Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) will apply.

• A written report (eg, handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation.
Imaging Guidance Documentation

• When imaging is not included in a surgical procedure, image guidance codes or codes labeled “radiological supervision and interpretation” may be reported for the portion of the service that requires imaging.

• Both services require image documentation and radiological supervision, interpretation, and report services require a separate interpretation.
TRUS & Ultrasonic Needle Guidance

• July 2016 NCCI edit bundled transrectal ultrasound at the time of ultrasonic guided prostate needle biopsy

• 76872 – ultrasound, transrectal

• 76942 – ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging supervision and interpretation
Voiding Pressure Study Using Penile Cuff

• Report if performed and documented
  • 51784 EMG
  • 51741 Complex uroflowmetry

• No CPT code available for voiding pressure study using penile cuff

• 51728-52 is not appropriate to report the voiding pressure study.
Bladder Ultrasound

• If the urologist performs bladder US to view the anatomy, the architecture, or the morphology of the full bladder, as well as to determine PVR after voiding, use CPT code 76857.

• In the documentation of this study in the medical records the urologist should mention the bladder wall thickness, the presence of bladder diverticula, any intravesical prostatic protrusion or pathology, the prostatic size as measured transabdominally, and may also report on the presence of residual urine
Post Void Residual

• However, if the main intent of the study is to determine the PVR, then only report CPT code 51798 regardless of the technology used.

• Supervision and interpretation should be separately documented and found in patient’s chart
Cystourethroscopy via Conduit

• Because cutaneous urinary diversions utilizing ileum or colon serve as functional replacements of a native bladder, endoscopy of such bowel segments, as well as performance of secondary procedures can be captured by using the cystourethroscopy codes.

• For example, endoscopy of an ileal loop with removal of ureteral calculus would be coded as cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus (52320).
Endoscopy

• 52353- Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
• 52332- Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

If these procedures are not performed during the same operative session, report what procedure is performed
Endoscopy

• If ureteroscopy with lithotripsy, basket extraction, and stent insertion is performed during the same operative session, report:

• 52356 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
Radical Nephrectomy

- **50545**: Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)

Do all tissues in the parenthetical need to be removed?
- No: only Gerota’s fascia
- Not necessary to perform adrenalectomy and/or removal of the regional lymph nodes

**50230**: Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy

Still only report 50230 (only) if performing IVC thrombectomy (open)
Laparoscopic Simple Prostatectomy

• **For benign prostatic hyperplasia (BPH)**

  • 55821 Prostatectomy, (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal
  
  • or 55831 Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal

Depending how the laparoscopic simple prostatectomy is performed and documented.

Code is not approach dependent (open or laparoscopic)

**Article published in Policy and Advocacy Brief to use 55821 for laparoscopic simple prostatectomy procedures for benign prostatic hyperplasia (BPH)**
Laparoscopic Cystectomy

• No specific code to report a laparoscopic radical cystectomy.

• Guidance was given to use CPT code 51999 Unlisted laparoscopy procedure, bladder.

• The AUA CRC reviewed the current CPT code(s) available for cystectomy (CPT 51550-51596) and determined that these codes are not approach dependent. There are no current vignettes or description of service.
Intra Operative: call to evaluate ureter

• No code for intra operative; but you can bill for the service.

• Append modifier 52
  • 49000 Exploratory laparotomy,
  • 49010 Exploration, retroperitoneal area
• Question:
• If we remove some vaginal mesh in a patient, which CPT code would we use? I do not have a specific patient, just in general. We would go in through the vagina to remove the mesh.

• Answer:
• In regards to your scenario, if the procedure is being done in the office for a small piece of mesh that is exposed and is going to be removed, we recommend CPT code 10120. If the patient has to be taken to the hospital to perform the procedure because the mesh is in deeper tissue we recommend that you use CPT code 10121.
• This recommendation is not for revisions or a more detailed surgical procedure.
HP Updates

• Anthem WAS going to start reducing E/M services when submitted with modifier 25, rescinded last week!

• Bipartisan Budget Act of 2018: includes language to fully repeal the Independent Payment Advisory Board, or IPAB.

• Consensus Statement on Improving the Prior Authorization Process
• Selective Application of Prior Authorization.

• Prior Authorization Program Review and Volume Adjustment.

• Transparency and Communication Regarding Prior Authorization.

• Automation to Improve Transparency and Efficiency.

• Continuity of Patient Care.
New Medicare Cards start 4/2018

- New Medicare cards to reduce risk of fraud
- Remove social security numbers from insurance cards
- Replaced with Medicare Beneficiary Identifier (MBI).
- Cards will be mailed in **April 2018** and all beneficiaries should have received their new card by the congressional deadline of April 2019.
- There will be a 21-month transition period in which providers should submit claims using the new identifier number
Medicare
Summary

Provided an understanding of:
How the AUA impacts on Public Policy and provides Practice support
CPT Code Development, Code Value Determination and the RUC Process
Modifiers in the Urology practice
New and deleted CPT codes for 2018
Coding challenges from the AUA Coding Hotline