Ureteroscopic Stone Management and Stent Insertion

2014 Coding and Payment Quick Reference Guide

Boston Scientific

GuidePoint
Simplifying Reimbursement

Urology

CODING

- Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.
- The following codes are thought to be relevant to ureteroscopic stone removal (including ureteral stent insertion) and are referenced throughout this guide.

CPT® Code	Code Description
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
52356*	**Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)**

*New CPT® Code, effective January 1, 2014

PHYSICIAN RELATIVE VALUE UNITS (RVUs)

- Physician Relative Value Units (RVUs) are based on the Medicare 2014 Physician Fee Schedule effective January 1, 2014.

	Facility Based				Office Based			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	**Total RVUs**	Work RVU	Practice RVU	Malpractice RVU	**Total RVUs**
52332	2.82	1.34	0.27	**4.43**	2.82	10.49	0.27	**13.58**
52352	6.75	2.70	0.63	**10.08**	6.75	NA	0.63	**See Note**
52353	7.50	2.95	0.69	**11.14**	7.50	NA	0.69	
52356*	**8.00**	**3.09**	**0.74**	**11.83**	**8.00**	**NA**	**0.74**	

Note: There is no current Medicare valuation for the procedure to be performed in the physician office setting.

*New CPT® Code, effective January 1, 2014

See last page for important information about the uses and limitations of this document.

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PAYMENT - MEDICARE

- In response to the AMA/Specialty Society RVS Update Committee (RUC) five-year Review Identification Workgroup analysis to combine codes that are frequently reported together, bundled code 52356 was established to report cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type).
- Effective January 1, 2014, when a ureteral stent is placed in conjunction with ureteroscopy with lithotripsy the new combined code 52356 must be reported.
- Do not report 52536 in conjunction with 52332, 52353 when performed together on the same side.
- All rates shown are 2014 Medicare national averages; actual rates will vary geographically.
- Identified are three (3) common coding/reimbursement scenarios relating to ureteroscopic stone management performed in a hospital outpatient and ambulatory surgery setting.
- Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

PHYSICIAN, HOSPITAL OUTPATIENT & ASC MEDICARE ALLOWED AMOUNTS

	Physician[1]		Facility	
CPT® Code	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
52332	$159	0162	$2,007	$1,109
52352	$361	0162	$2,007	$1,109
52353	$399	0163	$2,905	$1,605
52356*	**$424**	**0429**	**$3,304**	**$1,825**

*New CPT® Code, effective January 1, 2014; rate includes stent insertion and 52332 should not be reported with 52356.

SCENARIO 1: Ureteroscopic Stone Removal with Lithotripsy with Stent Insertion

CPT® Code	Code Description	Physician Medicare Allowed Amount[1,2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	Ambulatory Surgery Center Allowed Amount[2,4]
52356*	**Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)**	$424	0429	$3,304	$1,825
	TOTAL:	**$424**		**$3,304**	**$1,825**

*New CPT® Code, effective January 1, 2014; rate includes stent insertion and 52332 should not be reported with 52356.

SCENARIO 2: Ureteroscopic Stone Removal with Lithotripsy (without Stent Insertion)

CPT® Code	Code Description	Physician Medicare Allowed Amount[1,2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	Ambulatory Surgery Center Allowed Amount[2,4]
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	$399	0163	$2,905	$1,605
	TOTAL:	**$399**		**$2,905**	**$1,605**

See last page for important information about the uses and limitations of this document.

SCENARIO 3: Ureteroscopic Stone Removal (without Lithotripsy) with Stent Insertion

CPT® Code	Code Description	Physician Medicare Allowed Amount[1,2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	Ambulatory Surgery Center Allowed Amount[2,4]
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	$361	0162	$2,007	$1,109
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	$80	0162	$1,004	$555
	TOTAL:	**$441**		**$3011**	**$1664**

HOSPITAL INPATIENT ALLOWED AMOUNTS - MEDICARE

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Possible MS-DRG Assignment
56.0 – Transurethral removal of obstruction from ureter or renal pelvic	**592.0 –** Calculus of kidney **592.1 –** Calculus of ureter **592.9 –** Urinary calculus, unspecified	**668** – Transurethral procedures with major complication or comorbidity (MCC) $14,831[5,6] **669** – Transurethral procedures with complication or comorbidity (CC) $7,361[5,6] **670** – Transurethral procedures without CC/MCC $4,845[6]

ENDNOTES:

[1] Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – December 27, 2013 revised release, RVU14A file. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU14A.html?DLPage=1&DLSort=0&DLSortDir=descending. The 2014 National Average Medicare physician payment rates have been calculated using a 2014 conversion factor of $35.8228 which reflects the 0.5 percent update for January 1, 2014 through March 31, 2014, as adopted by section 101 of the Pathway for SGR Reform Act of 2013. Rates subject to change.

[2] "Allowed Amount" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance, etc.

[3] The hospital outpatient payment rates are 2014 Medicare national averages. Source: November 27, 2013 Federal Register, CMS-1601-FC.

[4] The ASC payments rates are 2014 Medicare national averages. ASC rates are from the 2014 Ambulatory Surgical Center Covered Procedures List – Addendum AA. Source: November 27, 2013 Federal Register, CMS-1601-FC.

[5] The patient's medical record must support the existence and treatment of the complication or comorbidity.

[6] National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,799.59). Source: August 19, 2013 Federal Register; CMS-1599-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2014 Rates.

Sequestration
Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2014.

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