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GUIDEPOINT
Reimbursement Resources

Ureteroscopic Stone Management and Stent Insertion

2015 Coding & Payment Quick Reference

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[1]	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 2015 Physician Fee Schedule effective January 1, 2015

	Office-Based[1]				Facility-Based			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
52332	2.82	10.65	0.32	**13.79**	2.82	1.34	0.32	**4.48**
52352	6.75	N/A	0.76	**See Note**	6.75	2.71	0.76	**10.22**
52353	7.50	N/A	0.83	**See Note**	7.50	2.96	0.83	**11.29**
52356*	8.00	N/A	0.88	**See Note**	8.00	3.09	0.88	**11.97**

Note: There are no current Medicare valuations for these procedures performed in the physician office setting.

*New CPT® Code, effective January 1, 2014

See important notes on the uses and limitations of this information on page 3.

Effective: 1JAN2015
Expires: 31DEC2015
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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 52356 in conjunction with 52332, 52353 when performed together on the same side.

All rates shown are 2015 Medicare national averages; actual rates will vary geographically and/or by individual facility.

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[1]			Facility	
CPT® Code	MD In-Office Medicare Allowed Amount	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
52332	$493	$160	0162	$2,084	$1,143
52352	N/A	$365	0162	$2,084	$1,143
52353	N/A	$404	0163	$3,113	$1,707
52356*	N/A	$428	0163	$3,113	$1,707

*New CPT® Code, effective January 1, 2014

Scenario 1: Ureteroscopic Stone Removal with Lithotripsy with Stent Insertion

CPT® Code	Description	Physician Medicare Allowed Amount[1,2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare 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)	$428	0163	$3,113	$1,707
	TOTAL	**$428**		**$3,113**	**$1,707**

*New CPT® Code, effective January 1, 2014

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

CPT® Code	Description	Physician Medicare Allowed Amount[1,2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	$404	0163	$3,113	$1,707
	TOTAL	**$404**		**$3,113**	**$1,707**

See important notes on the uses and limitations of this information on page 3.

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

CPT® Code	Description	Physician Medicare Allowed Amount[1,2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	$365	0162	$2,084	$1,143
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	$80	0162	$1,042	$572
	TOTAL	**$445**		**$3,126**	**$1,715**

Hospital Inpatient Allowed Amounts – Medicare

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Possible MS-DRG Assignment[5,6]	Reimbursement
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)	$14,657
		669 – Transurethral procedures with complication or comorbidity (CC)	$7,427
		670 – Transurethral procedures without CC/MCC	$5,254

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1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 8, 2015 revised release, RVU15A file http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU15A.html?DLPage=1&DLSort=0&DLSortDir=descending. The 2015 National Average Medicare physician payment rates have been calculated using a 2015 conversion factor of $35.7547 which reflects changes for January 1, 2015 through March 31, 2015 as a result of the April 1, 2014 Protecting Access to Medicare Act of 2014 (H.R. 4302). 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. Hospital outpatient payment rates are 2015 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2015 revised release, CMS-1613-CN-Addendum-B_REV file http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2015-Jan-Addendum-B.html?DLPage=1&DLSort=2&DLSortDir=descending.
4. ASC payments rates are 2015 Medicare ASC national averages. ASC rates are from the 2015 Ambulatory Surgical Center Covered Procedures List – Addendum AA. Source: January 2015 revised release, CMS-1613-CN-Addendum-AA-BB-DD1-DD2-EE- file http://www.cms.gov/apps/ama/license.asp?file=/ascpayment/downloads/CMS-1613-CN-CY-2015-Addendum-AA-BB-DD1-DD2-EE.zip
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 ($5,865.48). Source: August 22, 2014 Federal Register; CMS-1607-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2015 Rates.

Sequestration Disclaimer
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, 2015.

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