Bladder Tumor Procedures
2014 Coding and Payment Quick Reference Guide

Boston Scientific

GuidePoint
Simplifying Reimbursement

Urology

CODING

- For Medicare cases, the physician should bill the code that accurately reflects the largest lesion treated.
- For Private Payers, the physicians should sum up the size of all lesions treated, and bill the code that most closely describes the aggregate lesion size.
- 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 bladder tumor procedures and are referenced throughout this guide.

CPT® Code	Code Description
52204	Cystourethroscopy, with biopsy(s)
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)
52235	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; LARGE bladder tumor(s)

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
52204	2.59	1.19	0.25	**4.03**	2.59	7.38	0.25	**10.22**
52214	3.50	1.19	0.32	**5.01**	3.50	14.45	0.32	**18.27**
52224	4.05	1.38	0.38	**5.81**	4.05	14.71	0.38	**19.14**
52234	4.62	1.94	0.42	**6.98**	4.62	NA	0.42	**See Note**
52235	5.44	2.25	0.51	**8.20**	5.44	NA	0.51	**See Note**
52240	7.50	2.95	0.70	**11.15**	7.50	NA	0.70	**See Note**

Note: There are no current Medicare valuations for CPT Codes 52234, 52235 and 52240 performed in the physician office setting.

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

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PAYMENT - MEDICARE

- All rates shown are 2014 Medicare national averages; Actual rates will vary geographically.

PHYSICIAN, HOSPITAL OUTPATIENT & ASC MEDICARE ALLOWED AMOUNTS

	Physician[1]			Facility	
CPT® Code	MD In-Office Medicare Allowed Amount[2]	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
52204	$366	$144	0162	$2,007	$1,109
52214	$654	$179	0162	$2,007	$1,109
52224	$686	$208	0162	$2,007	$1,109
52234	NA[5]	$250	0162	$2,007	$1,109
52235	NA[5]	$294	0162	$2,007	$1,109
52240	NA[5]	$399	0162	$2,007	$1,109

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[6,7] **669** – Transurethral procedures with complication or comorbidity (CC) $7,361[6,7] **670** – Transurethral procedures without CC/MCC $4,845[6]

END NOTES

[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] "NA" in the 2014 "MD-In-Office Medicare Allowed Amount" column means that there is no in-office differential.
[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.
[7] The patient's medical record must support the existence and treatment of the complication or comorbidity.

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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