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GUIDEPOINT
Reimbursement Resources

Percutaneous Nephrostolithotomy (PCNL)

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

As the primary PCNL procedures, CPT® Codes 50080 and 50081 are mutually exclusive and can never be billed together.

The following codes are thought to be relevant to PCNL procedures and are referenced throughout this guide.

CPT® Code[1]	Code Description
50080	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction: up to 2 cm
50081	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction: over 2 cm
50561	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
50395	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureterospyelography, exclusive or radiologic service
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
74420	Urography, retrograde, with our without KUB
74475	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation

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
50080	**See Note**				15.74	7.46	1.76	**24.96**
50081	**See Note**				23.50	10.52	2.63	**36.65**
50561	7.58	5.15	0.84	**13.57**	7.58	2.92	0.84	**11.34**
50392	**See Note**				3.37	1.49	0.33	**5.19**
50395	**See Note**				3.37	1.47	0.35	**5.19**
52005	2.37	4.87	0.27	**7.51**	2.37	1.19	0.27	**3.83**
52332	2.82	10.65	0.32	**13.79**	2.82	1.34	0.32	**4.48**
74420-26	**See Note**				0.36	0.13	0.02	**0.51**
74475-26	**See Note**				0.54	0.18	0.03	**0.75**

Note: There are no current Medicare valuations for CPT Codes 50080, 50081, 50392, 50395, 74420-26 and 74475-26 when performed in the physician office setting.

See important notes on the uses and limitations of this information on page 2.

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Payment – Medicare

Outpatient payments for secondary procedures (excluding 74420 & 74475) will be reduced by 50%.

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

	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]
50080	N/A	$892	0163	$3,113	$1,707
50081	N/A	$1,310	0163	$3,113	$1,707
50561[5]	$485	$405	0162	$2,084	$1,143
50392[5]	N/A	$186	0161	$1,227	$673
50395[5]	$106	$51	0162	$2,084	$1,143
52005[5]	$269	$137	0162	$2,084	$1,143
52332[5]	$493	$160	0162	$2,084	$1,143
74420 -26[6,7]	N/A	$18	0278	$265	N/A
74475 -26[6,7]	N/A	$27	0161	$1,227	N/A

Hospital Inpatient Allowed Amounts – Medicare

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Possible MS-DRG Assignment[7,8]	Reimbursement
55.03 – Percutaneous nephrostomy without fragmentation 55.04 – Percutaneous nephrostomy with fragmentation	592.0 – Calculus of kidney 592.9 – Urinary calculus, unspecified	659 –Kidney & ureter procedures for non-neoplasm with major complication or comorbidity (MCC)	$19,833
		660 – Kidney & ureter procedures for non-neoplasm with complication or comorbidity (CC)	$11,079
		661 – Kidney & ureter procedures for non-neoplasm without CC/MCC	$7,915

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges, and modifiers for services that are rendered. Boston Scientific recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label.

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. Codes subject to Medicare's multiple procedure discount and may be subject to an endoscopic base code payment reduction.
6. Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight Source: November 11, 2014 Federal Register. CMS-1613-FC.
7. 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.
8. The patient's medical record must support the existence and treatment of the complication or comorbidity.

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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