Urology Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in urology practices

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CCI 15.0 Update:

Ease the Burden of CCI 2009 Round 1 By Learning These 3 Themes

▶ ***Checking the modifier indicator is your key to navigating the new edits.***

As of Jan. 1, you should be using new CPT 2009 codes — but learning the new codes and when you should report them isn't the end of the story.

The Correct Coding Initiative (CCI), version 15.0, applies a slew of bundles to your coding practice, homing in on the new codes, and limiting what services you can report in conjunction with them. CCI 15.0 sets its sights on the new 2009 codes rather than adding many new edits for your established codes. Best of all, none of these edits should take a serious toll on your reimbursement bottom line. Here's what you need to know.

1. New Drug Administration Code Bundles Bring Mixed News

CCI bundles the new revised therapeutic, prophylactic, and diagnostic administration CPT codes 96360 (*Intravenous infusion, hydration; initial, 31 minutes to 1 hour*), 96365 (*Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour*), 96372-96375 (*Therapeutic, prophylactic, or diagnostic injection [specify substance or drug] ...*) into most of the urological procedures in the 50010 to 55920 series.

Good news: The modifier indicator for all of these new bundles is "1," meaning that you can override these edits with a modifier under the proper circumstances. (For more on overriding CCI bundling edits, see "Learn When You Can Override CCI Edits, Legitimately" on page 19.)

Additionally: CCI 15.0 also bundles these administration codes with urogynecological procedure codes 57200 to 57335, as well as most codes found in the female genital system section of the CPT manual. As above, these bundles also have a modifier indicator of "1."

Same bundles, different codes: "These therapeutic, prophylactic, and diagnostic administration codes are replacing the 2008 CPT intravenous and injection codes 90760, 90765, 90772, 90774, and 90775," explains **Michael A. Ferragamo MD, FACS,** assistant clinical professor of urology, State University of New York, University Hospital, Stony Brook, N.Y. "The bundling for the changed administration codes

continue the same bundlings that were present for the old 2008 drug administration codes. However, these are new bundlings in the sense that there are now new (changed) administration codes."

2. Revised TURP Codes Get Hit, Too

Incorporate some new bundles for the 2009 revised "repeat" transurethral resection of the prostate (TURP) code 52630 (*Transurethral resection; residual or regrowth of obstructive prostate tissue including control of postoperative bleeding, complete [vasectomy, meatotomy, cystourethroscopy, urethral calibration and /or dilation, and internal urethrotomy are included]*) into your coding.

In addition to previously cited CCI edits, 52630 now includes codes 52214 (*Cystourethroscopy, with fulguration [including cryosurgery or laser surgery] of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands*), 52275 (*Cystourethroscopy, with internal urethrotomy; male*), 52276 (*Cystourethroscopy with direct vision internal urethrotomy*), and 55250 (*Vasectomy, unilateral or bilateral [separate procedure], including postoperative semen examination[s]*). The indicator for these recent edits is "1," Ferragamo points out.

Bad news: These new bundlings may make your job more difficult, even though you can use a modifier to break the bundles, says **Becky Boone, CPC, CPC-URO,** certified reimbursement assistant for the University of Missouri Department of Surgery in Columbia.

Coders and physicians will have to "prove that [the procedures] are separate when they should not be bundled at all in my opinion," Boone says. "This, from a coding standpoint, is going to be an issue as they continue to get rid of everyday codes. Take 52276: Why should this be bundled with 52630 when it is for DVIU [direct vision internal urethrotomy] and not prostatic regrowth? These areas are close but are two different areas, so they should not be considered bundled."

Boone also cites the 52630/55250 bundle as questionable. "Why are they bundling 52630 with a vasectomy (55250)?" she asks. "Again, this makes little sense since they are clearly two different areas. This is just another way that the doctors are going to be cut on billing and income amounts. Some insurers will make it extremely hard to bill for these codes together even if you can show they are separate, because the groundwork has been set" by the CCI edits, Boone laments.

3. Avoid Reporting Saturation Biopsies With Catheterization Codes

The new 2009 code 55706 (*Biopsies, prostate, needle, transperineal, stereotactic template guided saturation*

CONTACT INFORMATION

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sampling, including imaging guidance) now bundles with many codes (see the chart on page 20 for details). In particular, you should pay attention to the new bundles between 55706 and the three catheterization codes (51701 to 51703). CCI now bundles all three with 55706, and also now bundles the simple needle biopsy of the prostate (55700) into 55706.

"We hardly ever bill for a cath placement using 55700, but when we do we should be allowed to get paid for this," Boone says. "Now we have to prove they are separate just because the cath is placed at the same time as the biopsy (55706) is done."

Plus: Also newly bundled with 55706 are codes 76942 (*Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation*) and 77002 (*Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]*).

Important: You also won't be able to report +69990 (*Microsurgical techniques, requiring use of an operating microscope [List separately in addition to code for primary procedure]*) with 55706 in 2009, thanks to CCI 15.0.

All of the new 55706 edits have an indicator of "1," except the bundle with +69990. This bundle has an indicator of "0," meaning that you can never override this edit.

CCI 15.0 also includes edit deletions involving codes 52606, 52612, 52614, 52620, 53853, 61793, 90760-90779, and category III code 0137T. See the chart on page 20 for details on these deletions.

Want to learn more? To download a free copy of CCI 15.0 (or past CCI versions) go online to the CMS Web site at www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp. ❑

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Learn When You Can Override CCI Edits, Legitimately

▶ *Get reimbursement for bundled codes in 3 simple steps.*

There are times when you can override Correct Coding Initiative (CCI) edits and achieve separate reimbursement for bundled codes. Follow these steps if you have distinct services:

1. Check the modifier indicator. Each CCI code pair edit includes a correct coding modifier indicator of "0" or "1." A "0" indicator means that you may not unbundle the edit combination under any circumstances, according to CCI guidelines. But an indicator of "1" means that you may use a modifier to override the edit if the procedures are separate and distinct from one another.

2. Verify that the procedures are independent and distinct. You should attempt to override CCI code pair edits only if the paired procedures are separate and unrelated. For instance, the provider may have provided the services/procedures at different sessions, at different anatomic locations, or for different diagnoses.

3. Append modifier 59. You must append modifier 59 (*Distinct procedural service*) or another appropriate modifier to the column 2 code to indicate to the payer that the billed procedures are distinct and separately identifiable. Without modifier 59 or another appropriate modifier, the payer will simply apply the CCI edits and deny payment. ❑

You Be the Coder

Terminated Sling Procedure With Cysto Exam

Question: *My urologist was scheduled to perform a sling procedure (57288). His operative notes state: "Initial finger dissection on the right had entered the mid-urethra rather than the periurethral space. Removed Foley and proceeded with a cystoscopic examination; bladder was intact but was able to visualize my fingertip at 6 o'clock position in the urethra. Injury was repaired. Decision made to not proceed with the sling." How should I code this*?

Virginia Subscriber

Answer: See page 21. ❑

Clip and Save:

Here's Your Handy Guide to the 15.0 CCI Edits

▶ *Save this useful list to help troubleshoot when you're dealing with these changes.*

If you get confused and frustrated sorting through all the lines of edits in the Correct Coding Initiative (CCI) files, you're not alone. Refer to this easy-to-decipher chart to know what new code pairs you may separate with a modifier, and what codes carriers will never pay for. *Note:* The code in the left column (column 1) represents the comprehensive code. The bundled codes are in column 2, and the modifier indicator is in column 3. ❑

Additions

Column 1	Column 2	Mod. Ind.
50010-50290, 50320, 50340-50548, 50551-50553, 50555-50948, 50951-50980, 51020-51795, 51800-51992, 52000-52700, 53000-53852, 54000-54450, 54500-54692, 54700-54901, 55000-55060, 55100-55180, 55200-55450, 55500-55550, 55600-55680, 55700-55876, 55920, 56405-56605, 56620-57265, 57268-57335	96360, 96365, 96372, 96374, 96375	1
52630	52214, 52275, 52276, 52276, 55250, 96360, 96365, 96372, 96374, 96375	1
55706	36000, 36410, 37202, 51701, 51702, 51703, 55700, 62318, 62319, 64415, 64416, 64417, 64450, 64470, 64475, 76942, 77002	1
55706	69990	0

Deletions

Column 1	Column 2	Mod. Ind.
52601	52606, 52612, 52614, 52620, 53853	0
52606	52614, 52620, 52630, 52640, 53853	0
52612	52606, 52614, 52620, 52630, 52640, 53853	0
52612	55873	1
52614	52620, 52630, 52640, 53853	0
52614, 52620	55873	1
52620	52640, 53853	0
52630	52620, 53853	0
52640	53853	0
52647, 52648, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845	52612, 52614, 52620, 53853	0
52649, 55866	52612, 52614, 52620	1
53852	52606, 52612, 52614, 52620, 53853, 53873	0
53853	53873	0
55873	0137T	1
0137T	10021, 10022, 36000, 36410, 37202, 43752, 62318, 62319, 64415, 64416, 64417, 64425, 64430, 64450, 64470, 64475, 76942, 77002, 90760, 90765, 90772, 90774, 90775, J2001	1
0137T	44950, 51701, 55700, 69990	0
61793	Many neurosurgical code edits	

Recognize Incident-To Services or Pay the 15-Percent Price

▶ *Knowing the rules determines 100 percent vs. 85 percent reimbursement.*

In the office setting, incident-to billing is an essential gear in a urology practice's reimbursement machine. Each time a nonphysician practitioner (NPP) provides services or treatment to a Medicare patient, you should be on the lookout for the opportunity to code the service incident-to the physician.

Why? Under incident-to rules, qualified NPPs can treat certain patients and still bill the visit under the urologist's National Provider Identifier (NPI), bringing in 100 percent of the assigned fee for the codes you report.

But if you aren't following the stringent incident-to billing rules, you're only setting your practice up for lost reimbursement and possible fraud charges. Make sure you're capturing every dollar your NPPs deserve with these expert tips.

1. NPP Has to Follow Established Plan of Care

To qualify for incident-to billing, the urologist must see the patient during an initial visit and establish a clear plan of care, reported **Sharlene Scott, CPC, CPC-H, CCS-P, CCP-P, PMCC,** during a presentation at The Coding Institute's multispecialty conference in Orlando, Fla. (www.codinginstitute.com).

If the NPP is treating a new problem for the patient, or if the urologist has not previously established a care plan for the patient, then you cannot report the visit incident-to.

Beware: An established patient with a plan of care who comes in for a new, unrelated condition is not an appropriate case to bill incident-to. For Medicare you cannot bill new patient visits, consultations, or services provided in the hospital as incident-to services.

Tip: The physician should document in his plan of care that the patient will follow up with the NPP for monitoring of that particular episode of care. That care could be for managing a urinary infection, symptomatic prostatic enlargement, urinary incontinence, or other urological or medical conditions. When there is a new problem, however, the physician must see the patient and modify the plan of care before the NPP can provide any follow-up care and bill the services as incident-to the physician.

2. Physician Presence Is Essential

Your first step in collecting for your practice's incident-to services is determining whether the services involved "direct" supervision. This means that the urologist must be in the immediate office suite while the NPP is performing the incident-to services.

Key: You should not use the term "direct" too loosely. Having the physician available by phone or having the urologist somewhere on the grounds in a large facility is not acceptable by Medicare standards. Also, you may want to check your state's practice requirements to see if your state has different supervision requirements.

"The physician must be present in the office suite in order to bill as incident-to," says **Nicole Martin, CPC,** owner of Innovative Coding Analysis in Coplay, Penn. "He does not have to be in the treatment room itself but in the office [suite]."

Example: A nurse practitioner in your office performs the physical exam for a patient, and the urologist calls in and does the history portion of the exam. The physician wants to bill this service incident-to.

In this scenario, "the service would be billed directly under the NP's own provider number and reimbursed at

(continued on next page)

You Be the Coder

Terminated Sling Procedure With Cysto Exam

__**Answer**__: Even though the physician did not complete the sling procedure, you should report 57288 (*Sling operation for stress incontinence [e.g., fascia or synthetic]*). Append modifier 53 (*Discontinued procedure*) to indicate that your urologist terminated the procedure before completion in the interest of the well-being of the patient.

Since the physician also repaired the urethral injury, which added to the time and complexity of the surgery, you also report 53502 (*Urethrorrhaphy, suture of urethral wound or injury, female*).

Pitfall: Do not report just the cystoscopy and do not try to separately report a cystoscopic examination. You should consider the cystoscopic procedure bundled into 57288. Attach ICD-9 code 625.6 (*Stress incontinence, female*) to 57288. With 53502 use diagnostic code 867.1 (*Injury to pelvic organs, bladder and urethra, with open wound into cavity*). ❑

the 85-percent level," Martin says. You cannot bill this service incident-to because the urologist was not providing direct supervision.

Good idea: Retain physicians' work schedules on file to prove they were present when incident-to services occurred. Keep in mind that some payers like to see the name of the supervising physician in the progress notes — especially if it is a different physician than the one who wrote the plan of care.

Remember: As of November 2004, the supervising physician can be different from the one who actually wrote the plan of care. The reimbursement must go to the physician who supervised the incident-to services on the day that the services were provided, however.

As long as a patient is an established patient with a predetermined plan of care, a nurse practitioner can submit a claim incident-to a supervising physician, even if that physician did not establish the initial evaluation and treatment plan. For accuracy and proper documentation, you need to record the initial evaluating physician's name and NPI in boxes 17 and 17A of the CMS 1500 form when another physician provides the supervision for subsequent office care.

Have a urology coding question?
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3. Don't Forego Pay If Physician Isn't Around

If the NPP service doesn't fit incident-to regulations, that doesn't mean you have to forego payment altogether. If you do not bill an NPP visit incident-to the physician, then you should code the service under the NPP's NPI number. Expect Medicare to reimburse you at 85 percent of the global, or full, fee.

Example: A PA sees an established patient with Medicare coverage, but none of the physicians are in the office at the time. This is not an incident-to billing situation under Medicare guidelines.

Instead: "You can bill for a PA's time, just not under any of the doctors'," says **Samantha Daily,** medical biller for Urologic Consultants PC in Portland, Ore. "You have to bill under the PA's name."

"PAs may bill under their own NPI," Martin agrees. "This would also depend on the payer. Some payers do not recognize mid-level providers. You can also confirm this by visiting the American Academy of Physician Assistants Web site" at www.aapa.org/gandp/3rdparty.html.

As stated above, Medicare will reimburse 85 percent of the global fee for NPP services that do not meet incident-to rules. Private or commercial payers, especially if they do not recognize incident-to rules or do not credential NPPs, usually pay full physician fees for NPP services provided the physician is available for "general" supervision. This is irrespective of the urologist's presence in the office or whether the patient is established, new, or a consultation.

Note: There are some payers who do not recognize mid-level providers and will not reimburse for their services at all. Be sure you check with each payer to determine which rules you should follow.

Important: If you spent hours poring over the 23-page incident-to guidelines that CMS had planned to implement on June 2, make sure you forget everything you learned, at least for now. On the very day that practices were supposed to start using the new incident-to guidelines, CMS rescinded Transmittal 87, noting that the document "will not be replaced at this time."

Possible rationale: Several medical associations expressed concern about the new guidelines, saying that practices didn't have enough time to learn all of the rules and nuances in the one-month period between the transmittal's publication (May 2) and the implementation date (June 2). So, for now, stick with the old rules. ❑

Reader Questions

Replace 61793 With 55899 for Cyberknife

Question: *I'm suddenly getting denials when my urologist performs a cyberknife procedure. I've always used 61793 for the stereotactic portion of the procedure. Why am I getting denied now*?

Tennessee Subscriber

Answer: The denials probably do not have to do with whether or not the payer will pay for cyberknife procedures, but rather with you using a now-invalid CPT code.

CPT 2009, which went into effect Jan. 1, deleted 61793 (*Stereotatic radiosurgery [particle beam, gamma ray, or linear accelerator] one or more sessions)*.

What now: If your urologists perform stereotactic radiosurgery, also known as gamma knife surgery (also known as the "cyberknife"), for the treatment of prostatic carcinoma, you should no longer report 61793. Instead, submit 55899 (*Unlisted procedure, male genital system*) as suggested by the American Urological Association (AUA) *Health Policy Brief*, Volume XVIII, Number 12 (December 2008).

❑

Consult CPT Errata and Update Your Manual

Question: *My CPT manual says that the definition for modifier 22 is "unusual procedural services." I thought this changed last year. Has the AMA changed the definition again?*

South Carolina Subscriber

Answer: You are correct that the definition of modifier 22 should not be "unusual procedural services". The correct definition is "increased procedural services."

Visit the American Medical Association (AMA) Web site to review all of the CPT 2009 errata information. Navigate to www.ama-assn.org/ama/pub/category /3896.html and click on "Corrections in CPT 2009."

Good practice: Have your CPT manual on hand and go through it, marking all of the fixes directly in your manual so that you're sure to be working with the most correct, up-to-date information when you're coding procedures.

❑

Bilateral Status Depends on the Payer

Question: *When an urologist performs bilateral retrogrades is it allowable to bill 52005-RT and 52005-LT? I know we can't use modifier 50, and the description says ureteral catheterization, but nothing is plural in the description.*

Ohio Subscriber

Answer: When you are billing Medicare, you use CPT code 52005 (*Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiological service*) for both unilateral and bilateral retrograde studies.

Alternative: For private or commercial payers, you can code as you suggested, using either 52005-LT (*Left side*) and 52005-50-RT (*Bilateral procedure; right side*). Some non-Medicare insurance companies will pay you for each side when you bill for the bilateral studies.

❑

Anatomy Matters for Washing Codes

Question: *My urologist performed a cystoscopy with bilateral kidney (renal pelvis) washings and bladder washings. I know the code for the bladder washing is 52005, but what would I use for the kidney washings?*

Ohio Subscriber

Answer: Ideally, you would report 52005 (*Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiological service*) for washings from the kidney pelvis and ureters, and use 51700 (*Bladder irrigation, simple, lavage and/or installation*) for bladder washings.

Bad news: Unfortunately, the Correct Coding Initiative (CCI) bundles the latter code into the former code. Since this bundle has a modifier indicator of "0," you cannot use a modifier to override the edit in any circumstance — you will not be able to report both codes.

Solution: Therefore, for Medicare in this scenario, you should only bill 52005 whether the washing are unilateral or bilateral. For private carriers you may need to report 52005-LT (*Left side*) and 52005-50-RT (*Bilateral procedure, right side*) for the bilateral washings of the upper tracts.

❑

HCPCS Codes Are Your Best Bet for BCG

Question: *How should I code for BCG treatments? Should I use 90586 rather than J9031? Do I use the instillation code also?*

Virginia Subscriber

Answer: You should report the appropriate J codes for the drug your urologist uses during a bladder instillation. You should report Bacille Calmette-Guerin (BCG) with J9031 (*BCG live [intravesical], per instillation*) for the full vial, including any portion that was instilled and any wasted portion.

Additionally: For bladder instillation of anticarcinogenic agents like BCG, you should report 51720 (*Bladder instillation of anticarcinogenic agent [including retention time]*).

Pointer: The diagnosis you report for the instillations should be 233.7 (*Carcinoma in situ of breast and genitourinary system, bladder*) or 188.x (*Malignant tumor of bladder*). Most payers will accept these diagnoses as proof of medical necessity for the instillations, but usually will not accept V10.51 (*Personal history of malignant neoplasm, urinary organs, bladder*). CPT coding policy dictates that you should use one of the above diagnoses even if your urologist administers the treatments prophylactically.

— *Answers to* Reader Questions *and* You Be the Coder *contributed by* ***Michael A. Ferragamo, MD, FACS,*** *clinical assistant professor of urology, State University of New York, Stony Brook.* ❑

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