

# 2008

## Targeted Cryoablation of the Prostate

### Endocare Reimbursement Assessment

#### CRYOSURGERY FOR PROSTATE TUMORS

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Cryosurgery is a means for surgical destruction of diseased tissue with lethal temperatures. Prostate Cryoablation involves the targeted destruction of prostate tissue. The procedure is performed via percutaneous access through the perineum under ultrasonic guidance.

#### PAYER MIX ASSESSMENT

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Medicare	85%
Private Pay	15%

#### COVERAGE

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##### Medicare

Medicare's Clarification on Billing for Cryosurgery of the Prostate Gland publication includes details regarding Coverage, Billing, & Payment Requirements. Please refer to this Transmittal or webpage for explicit instructions.

Pub 100-04 Medicare Claims Processing Transmittal 1111, issued November 9, 2006 (pages 11-13);

<http://www.cms.hhs.gov/transmittals/downloads/R1111CP.pdf>

##### **Primary Treatment – Medicare National Coverage Policy effective July 1, 1999**

"Cryosurgery is safe, effective, as well as medically necessary and appropriate in certain patient populations – specifically, those patients with Stages T1- T3 prostate cancer. It has demonstrated effectiveness through an absolute analysis, as well as, through a comparative analysis. Its results are comparable to brachytherapy and external beam radiation."

Cryosurgery Ablation of the Prostate / Issue # CAG-00031N / Decision Memorandum Issued February 1, 1999;

[http://www.cms.hhs.gov/mcd/viewnca.asp?from=nca&nca\\_id=81](http://www.cms.hhs.gov/mcd/viewnca.asp?from=nca&nca_id=81)

##### **Salvage Treatment – Medicare National Coverage Policy effective July 1, 2001**

Medicare revised the national non-coverage policy for cryosurgical salvage therapy to allow coverage only for those patients with localized disease who:

- Have recurrent localized prostate cancer;
- Have failed a trial of radiation therapy as their primary treatment; and
- Meet one of the following conditions: Stage T2B or below, Gleason score <9, PSA < 8 ng/ml;

<http://www.cms.hhs.gov/transmittals/downloads/R140CIM>.

##### Private Payers

Coding and coverage will vary per private payer, per benefit package and contract between hospital/physician with the payer.

#### MEDICARE INPATIENT CODING & REIMBURSEMENT (Valid October 1, 2007 through September 30, 2008)

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##### ICD-9 Diagnosis Codes

185	Malignant neoplasm of Prostate	222.2	Benign Neoplasm of Prostate
198.82	Secondary malignant neoplasm of Genital Organs	236.5	Neoplasm of uncertain behavior of Prostate
233.4	Carcinoma in situ, Prostate		

##### ICD-9 Diagnosis Codes (\*Other Possible Complications)

601.2	Abscess of prostate
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
459.0	Hemorrhage, unspecified
599.0	Urinary tract infection, site unspecified
599.7	Hematuria



ICD-9 Principal Procedure Code	DRG Codes	Hospital Nat'l Avg Pmt
60.62 Perineal Prostatectomy (includes Cryoablation of prostate, Cryoprostatectomy, Cryosurgery of prostate, Radical cryosurgical ablation of prostate – RCSA)	1707	Major male pelvic procedures w <sup>2</sup> CC/MCC
	1708	Major male pelvic procedures w/o <sup>2</sup> CC/MCC

<sup>1</sup>DRG 707 replaces DRG 334 and DRG 708 replaces DRG 335 Effective October 1, 2007

<sup>2</sup>CC: Complications or Comorbidities/MCC: Major Complications or Comorbidities

#### MEDICARE PHYSICIAN AND HOSPITAL OUTPATIENT CODING & REIMBURSEMENT

(Valid January 1, 2008 through December 31, 2008)

Revenue CPT Codes	Description	Physician Nat'l Avg Pmt	APC Codes	Description	Hospital Nat'l Avg Pmt
36X 55873	Cryosurgical Ablation of the Prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement). See Note	**\$1,131.18	0674	Cryoablate Prostate	\$7,816.10
27X C2618	Probe, Cryoablation	N/A	N/A		
Pre and Post Procedure Diagnostic Imaging					
402 76872	Ultrasound, transrectal	**\$34.28	0266	Level II Diagnostic and Screening Ultrasound	\$96.14

Effective for services provided on or after January 1, 2005, CMS requires hospitals to include device category codes on claims when devices are used in conjunction with procedures billed and paid for under OPPTS. CMS is requiring use of these device codes for reporting all such devices effective January 1, 2005. CMS implemented the edits contained in table 19 until April 1, 2005.  
 Published in CMS Final Rule with comment period:  
<http://www/c.s/jjs/gpv/providers/hopps/2005fc/cms1427fc.pdf>

#### References & Disclaimer

##### Hospital and Physician Coding/Reimbursement:

\*Disclaimer: The information herein is provided as a courtesy for educational purposes only to ensure correct coding compliance, claim submission to payers, and reimbursement process. This is not a comprehensive list of all available codes. It is not intended to maximize reimbursement. This information does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. Please contact your local payer for interpretation of the appropriate codes to use for specific procedures.

##### Note to Physicians:

\*\*The 2008 Physician payment rates were published in the Federal Register by CMS on November 27, 2007, and updated by Congressional action on December 29, 2007. Endocare has provided the 2008 payment rates utilizing the formula and calculation published by CMS.

[http://www.cms.hhs.gov/PFSlookup/03\\_PFS\\_Document.asp#TopOfPage](http://www.cms.hhs.gov/PFSlookup/03_PFS_Document.asp#TopOfPage).

##### Note to Hospitals:

Review existing agreements or consult with Private Payors directly to verify if it is necessary to submit claims with HCPCS C2618.

##### Note to Hospitals & Physicians:

CPT Code 55873 (Cryoablation of the prostate) includes Ultrasound Guidance and is not billable with CPT Code 76940 (Ultrasound guidance for, and monitoring of, parenchymal tissue ablation).

All claims submitted to CMS must satisfy the coverage requirements as described within 180.1 Coverage Requirements. In addition, all claims must be submitted with the applicable codes (ICD-9 dx, ICD-9 px, CPT/HCPCS, & Revenue codes) and TNM staging (T1-T3) as described within 180.2 CMS Billing Requirements. Payment Requirements are provided within 180.3. Claims submitted for Primary Treatment with Gleason Scores may be confused for Salvage Treatment and therefore subject to denial. 180.1, 180.2, & 180.3 are provided within Pub 100-04 Medicare Claims Processing Transmittal 1111; issued November 9, 2006 (pages 11-13).  
<http://www.cms.hhs.gov/transmittals/downloads/R1111CP.pdf>

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