



2008 CRYOSURGERY FOR RENAL TUMORS

Endocare Reimbursement Assessment

CRYOSURGERY FOR RENAL TUMORS

Cryosurgery is a means for surgical destruction of diseased tissue with lethal temperatures. Renal Cryosurgery involves the targeted destruction of renal masses. The procedure is done either via an "open", laparoscopic or percutaneous approach.

PAYER MIX ASSESSMENT

Medicare	40%
Private Pay	47%
Other	13%

COVERAGE

Medicare One Medicare carrier (Noridian Administrative Services, LLC) has adopted a positive coverage decision for renal cryoablation (open and laparoscopic approaches) effective March 15, 2007.

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)

ICD-9 Diagnosis Codes

189.0	Malignant neoplasm of kidney except pelvis	233.9	Carcinoma in situ, other and unspecified urinary organs
198.0	Secondary malignant neoplasm of kidney	236.91	Neoplasm of uncertain behavior of kidney and ureter
223.0	Benign neoplasm of kidney, except pelvis	239.5	Neoplasm of unspecified nature, other genitourinary organs

ICD-9 Principal Procedure Codes

55.32	Open ablation of renal lesion or tissue
55.33	Percutaneous ablation of renal lesion or tissue
55.34	Laparoscopic ablation of renal lesion or tissue

DRG Codes		Hospital Nat'l Avg Pmt
1656	Kidney and Ureter Procedures for Neoplasm with 2MCC	\$13,016.85
1657	Kidney and Ureter Procedures for Neoplasm with 2CC	\$9,295.23
1658	Kidney and Ureter Procedures for Neoplasm without 2CC/MCC	\$8,100.00

¹DRG's 656, 657, & 658 replace DRG 303 Effective October 1, 2007

²CC: 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 50541	Laparoscopy, surgical; ablation of renal cysts. *Do not report when procedure converts to open.	**\$906.09	0130	Level I Laparoscopy (Inclusive of Guidance)	\$2,191.81
36X 50542	Laparoscopy, surgical; ablation of renal mass lesion(s). *Do not report when procedure converts to open.	**\$1,146.42	0132	Level III Laparoscopy (Inclusive of Guidance)	\$4,437.26
36X 50250	Ablation, open, one or more renal mass lesion(s), cryosurgical, <i>including intraoperative ultrasound, if performed</i>	**\$1,202.03	N/A		Inpatient Procedure Only



MEDICARE PHYSICIAN AND HOSPITAL OUTPATIENT CODING & REIMBURSEMENT - Continued

Revenue CPT Codes	CPT Codes	Description	Physician Nat'l Avg Pmt	APC Codes	Description	Hospital Nat'l Avg Pmt
36X	50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy (See Note to Hospitals and Physicians below)	**\$446.66	0423	Level II Percutaneous Abdominal and Biliary Procedures (Inclusive of Guidance)	\$2,738.71
350	77013	Computerized tomography guidance for, and monitoring of, parenchymal tissue ablation	**\$195.39	N/A		N/A
402	76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation. *Do not report with 50250	**\$105.12	N/A		N/A
610	77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	**\$209.48	N/A		N/A
27X	C2618	Probe, Cryoablation	N/A	N/A	Probe, Cryoablation (See Note to Hospitals below)	N/A

Pre and Post Procedure Diagnostic Imaging

352	74150	Computed tomography, abdomen; without contrast material	**\$58.27	0332	Computed Tomography without Contrast	\$191.78
352	74160	Computed tomography, abdomen; with contrast material(s)	**\$62.46	0283	Computed Tomography with Contrast	\$277.48
352	74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	**\$68.56	0333	Computed Tomography without Contrast followed by Contrast	\$325.64
402	76700	Ultrasound, abdominal, real time with image documentation complete	**\$39.61	0266	Level II Diagnostic and Screening Ultrasound	\$96.14
402	76705	Ultrasound, abdominal real time with image documentation; limited	**\$28.95	0266	Level II Diagnostic and Screening Ultrasound	\$96.14
610	74181	Magnetic resonance (e.g., proton) imaging, abdomen; without contrast material	**\$71.22	0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	\$343.52
610	74182	Magnetic resonance (e.g., proton) imaging, abdomen; with contrast material(s)	**\$84.93	0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast	\$397.13
610	74183	Magnetic resonance (e.g., proton) imaging, abdomen; without contrast material followed by with contrast material(s) and further sequences	**\$110.07	0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast	\$525.24

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.

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:

Effective January 1, 2008, CPT code 50593 replaces Category III code 0135T.

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