

2009

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.

COVERAGE

Medicare Medicare Carriers have special coverage requirements. Refer to [Hospital and Physician Coding/Reimbursement Guidelines](#) (Footnote).

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, 2008 through September 30, 2009)

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 Code

| ICD-9 Principal Procedure Code | DRG | Description | Hospital Nat'l Avg Pmt |
|--------------------------------|-----|---|--|
| 55.32 | 656 | Open ablation of renal lesion or tissue | Kidney and Ureter Procedures for Neoplasm with MCC ¹ \$18,202.57 ² |
| 55.33 | 657 | Percutaneous ablation of renal lesion or tissue | Kidney and Ureter Procedures for Neoplasm with CC ¹ \$10,342.18 ² |
| 55.34 | 658 | Laparoscopic ablation of renal lesion or tissue | Kidney and Ureter Procedures for Neoplasm without CC/MCC ¹ \$7,643.27 ² |

¹CC: Complications or Comorbidities/MCC: Major Complications or Comorbidities

²The DRG National Average Payments are provided as referenced within the DRG Expert 25th Edition 2009 © Ingenix and have been adjusted to include the capital portion.

MEDICARE PHYSICIAN AND HOSPITAL OUTPATIENT CODING & REIMBURSEMENT (Valid January 1, 2009 through December 31, 2009)

| Revenue CPT Codes | 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. | **\$953.24 | 0130 | Level I Laparoscopy | \$2,502.89 |
| 36X | 50542 | Laparoscopy, surgical; ablation of renal mass lesion(s). *Do not report when procedure converts to open. | **\$1,208.95 | 0174 | Level IV Laparoscopy | \$7,908.83 |
| 36X | 50250 | Ablation, open, one or more renal mass lesion(s), cryosurgical, including intraoperative ultrasound, if performed | **\$1,267.38 | N/A | Inpatient Procedure Only | N/A |
| 36X | 50593 | Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy | **\$477.88 | 0423 | Level II Percutaneous Abdominal and Biliary Procedures (Inclusive of Guidance) | \$3,071.83 |
| 50593 is a unilateral procedure. For bilateral procedure, report 50593 with modifier 50. | | | | | | |
| 350 | 77013 | Computerized tomography guidance for, and monitoring of, parenchymal tissue ablation | **\$205.22 | N/A | Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. | N/A |
| 402 | 76940 | Ultrasound guidance for, and monitoring of, parenchymal tissue ablation. *Do not report with 50250 | **\$108.20 | N/A | Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. | N/A |
| 27X | C2618 | Probe, Cryoablation | N/A | N/A | Probe, Cryoablation (See Note) | N/A |

Pre Procedure Diagnostic Procedure and Imaging

| | | | | | | |
|--|-------|---|------------|------|---|----------|
| 36X | 50200 | Renal biopsy; percutaneous, by trocar or needle (See Note) | **\$146.43 | 0685 | Level II Needle Biopsy/Aspiration Except Bone Marrow (See Note) | \$632.75 |
| For radiological supervision and interpretation, see 76942, 77002, 77012, 77021. | | | | | | |
| 402 | 76942 | Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation | **\$34.26 | N/A | Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. | N/A |

MEDICARE PHYSICIAN AND HOSPITAL OUTPATIENT CODING & REIMBURSEMENT - Continued

| Revenue Codes | CPT Codes | Description | Physician Nat'l Avg Pmt | APC Codes | Description | Hospital Nat'l Avg Pmt |
|---------------|-----------|--|-------------------------|-----------|---|------------------------|
| 320 | 77002 | Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) | **\$26.69 | N/A | Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. | N/A |
| 352 | 77012 | Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation | **\$59.51 | N/A | Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. | N/A |
| 610 | 77021 | Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation | **\$77.54 | N/A | Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment. | N/A |

Pre and Post Procedure Diagnostic Imaging

| | | | | | | |
|-----|-------|--|------------|------|---|----------|
| 352 | 74150 | Computed tomography, abdomen; without contrast material | **\$60.59 | 0332 | Computed Tomography without Contrast | \$194.39 |
| 352 | 74160 | Computed tomography, abdomen; with contrast material(s) | **\$65.28 | 0283 | Computed Tomography with Contrast | \$307.80 |
| 352 | 74170 | Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections | **\$71.41 | 0333 | Computed Tomography without Contrast followed by Contrast | \$340.96 |
| 402 | 76700 | Ultrasound, abdominal, real time with image documentation complete | **\$41.12 | 0266 | Level II Diagnostic and Screening Ultrasound | \$97.77 |
| 402 | 76705 | Ultrasound, abdominal real time with image documentation; limited | **\$30.30 | 0266 | Level II Diagnostic and Screening Ultrasound | \$97.77 |
| 610 | 74181 | Magnetic resonance (e.g., proton) imaging, abdomen; without contrast material | **\$74.30 | 0336 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast | \$348.06 |
| 610 | 74182 | Magnetic resonance (e.g., proton) imaging, abdomen; with contrast material(s) | **\$88.36 | 0284 | Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast | \$427.41 |
| 610 | 74183 | Magnetic resonance (e.g., proton) imaging, abdomen; without contrast material, followed by with contrast material(s) and further sequences | **\$115.05 | 0337 | Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast | \$538.70 |

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. The information has been reviewed for accuracy by Princeton Reimbursement Group (www.prgweb.com). 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 including knowledge of status indicators which determine final reimbursement lies with the provider of services. Please contact your local payer for interpretation of the appropriate codes to use for specific procedures.

Medicare Coverage Database: National Coverage Determinations (NCD's) are updated "real time" except the NCD download, which is updated weekly. The Local Coverage Determinations (LCD's) are updated on a weekly basis: <http://www.cms.hhs.gov/mcd/overview.asp> Review of the LCD is imperative as non-adherence to the guidelines could negatively affect coverage. Individual LCD's may be accessed via the Medicare Coverage Database: <http://www.cms.hhs.gov/mcd/search.asp?from2=search.asp&>

For Example, at time of preparation, three Medicare Carriers: **Noridian Administrative Services, LLC** (LCD #L23676 & #L24570), **Palmetto GBA** (LCD #L27683 & #L28231), and **Wisconsin Physicians Service Insurance Corporation** (LCD #L26649) have adopted a Local Coverage Determination (LCD) for renal cryoablation (open and laparoscopic approaches). Coverage includes AK, AZ, CA, HI (including American Samoa, Guam, and Northern Mariana Islands), IA, KS, MO (Including Northeast, Northwest, & Southern), MT, ND, NE, NV, OR, SD, UT, WA, and WY.

Note to Hospitals:

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

Note to Physicians:

**The 2009 Physician payment rates are displayed in the CMS Federal Register effective October 31, 2008 with a proposed publication date of November 19, 2008. Endocare has provided the unadjusted 2009 payment rates based on the information currently provided by CMS. You may access this information via the following link:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS1216674&intNumPerPage=10>
For Individual rates, the formula and calculation are published by CMS. CMS also provides an option to search for individual rates and provides a Physician Fee Schedule Search. You may access this information via the following link:
http://www.cms.hhs.gov/PFSlookup/03_PFS_Document.asp#TopOfPage

Note to Hospitals and Physicians:

50200 Renal biopsy; percutaneous, by trocar or needle is billable with Renal Cryosurgery in accordance with CMS guidelines (CCI/ME edits). For related radiological supervision and interpretation, refer to 76942, 77002, 77012, and 77021. Confer with CMS guidelines (CCI/ME edits) associated with the radiological supervision/ interpretation and primary cryosurgery procedure for required modifiers.

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