Recent Coding Changes for the Urologist

Several Coding changes have been made by CPT and CMS for the new year, 2007. Three changes will be of keen interest to the urologist. On April 1, 2007 CPT and CMS have removed-discontinued the bundling of CPT code 52332, cystourethroscopy with insertion of indwelling ureteral stent (double J-type) into many of the endoscopic codes used daily by urologists 52332 will no longer be bundled into 52320, cystourethroscopy (including ureteral catheterization) with removal of ureteral calculus, 52330, with manipulation, without removal of ureteral calculus, 52341 to 52346, cystourethroscopy and treatment of ureteral strictures, and 52351 to 52354, ureteroscopic procedures. Therefore, when a ureteral JJ stent is placed after one of the above names surgical procedures, it will not longer be necessary to append modifier 59 to CPT code 52332 in order to receive payment. An example would be 52352, ureterscopic ureteral stone removal and 52332-51. Modifier 51 would still be required to indicate the multiple procedures performed during the same encounter. This change in the coding rules would apply to both Medicare and private/commercial carriers. However, check with the individual private carrier for their particular interpretation of this rule.

In 2007 a second rule change of interest to urologists was the change in the CPT definition of CPT code 52204. The definition of this code was changed from cystourethroscopy, **with biopsy** to cystourethroscopy, **with biopsy(s)**, and because of this change one should report this code, 52204, only once no matter how many bladder or urethral biopsies are performed. You will no longer be able to code or bill this code for each and every biopsy you perform as many offices have in the past. This change will apply for both Medicare and private/commercial carriers. Under unusual circumstances, prolonged operating time because of the number of biopsies obtained, one may append modifier 22 to 52204 to indicate this to the carrier and to request increased revenue for this extra work. You will need to submit a detailed operative report and a covering letter indicating what was done and why, and how much more reimbursement is requested for the extra work. The carrier will make a decision based on your documentation and appeal as to what would constitute an equitable fee. May times little to no increase is approved.

Another charge was brought to our attention by the American Urological Association (AUA) in August 2006. If one codes for a simple nephrectomy when performing a radical nephrectomy because the urologist does not remove the adrenal gland, you may be miscoding and losing reimbursement. Whether the physician performs a nephrectomy laparoscopically or as an open procedure either a radical or simple nephrectomy may be billed.

When the urologist performs a radical nephrectomy, but does not remove the adrenal gland, do not automatically code this as a simple nephrectomy, code 50220 (Nephrectomy, including rib section) or 50546 (Laparoscopy, surgical nephrectomy, including partial ureterectomy). In these cases you should still be selecting a radical nephrectomy code.

For a radical nephrectomy, choose one of the following codes based on the surgical approached and surgical components of the procedure:

- 50230- Nephrectomy, including partial ureterectomy, any open approach including rib resection, radical with regional lymphadenectomy and/or vena caval thrombectomy
- 50545- Laparoscopy, surgical, radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy).
- You should continue to use either of these two codes when a radical nephrectomy is performed whether or not the urologist removes the adrenal gland.
- When the urologist leaves the adrenal gland during a radical nephrectomy, one may be tempted to append modifier 52 (Reduced services) to the procedure code. The AUA has suggested reporting a radical nephrectomy without a modifier.
- Example: A urologist performs a laparoscopic radical nephrectomy, removing the kidney, Gerota's fascia, and the adrenal gland, and performs a localized lymphadenectomy. Another urologist may elect to do a laparoscopic radical nephrectomy, removing the kidney and surrounding fascia but leaving behind the adrenal gland. As explained above, in either case both urologists should be bill for a laparoscopic radical nephrectomy.