



Urology Coding Alert

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

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HCPCS 2012

Q2043: New HCPCS Code Will Bring You \$32,000 x 3 — If You Bill It Properly

Include proper primary and secondary diagnosis codes to ensure payment.

If your urologist performs a new treatment for asymptomatic or minimally symptomatic metastatic castrate resistant (hormone refractory) carcinoma of the prostate using the drug Provenge or Sipuleucel-T, take note of a new HCPCS code for 2012.

Get to Know the Procedure

Medicare allows a patient one treatment with Provenge in their lifetime, which includes three separate infusions within a two week period, says **Michael A. Ferragamo, MD, FACS**, clinical assistant professor of urology at the State University of New York at Stony Brook.

“Blood is taken from the patient and exposed to prostate cancer cells, sensitizing the patient’s white blood cells to attack the cancer cells when reinfused into the patient,” Ferragamo explains. “This also stimulates a recruitment of additional white blood cells to destroy the tumor. Provenge is the first in a new class of therapy that is designed to activate a patient’s own antigen-presenting cells to stimulate an immune response against prostate cancer.”

Report the New Code 3 Times For Full Treatment

The 2012 code for this procedure is Q2043 (*Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion*). This code represents the anti-neoplastic treatment for this particular type of tumor.

Note that the code descriptor states “per infusion,” meaning if the patient receives three infusions during the two-week treatment period, you should report Q2043 three separate times. “You bill this once for each infusion, and Medicare will reimburse you \$32,000 per infusion,” Ferragamo says. “The purchased price for the drug is about \$30,189 per treatment. Medicare will reimburse this cost plus a six percent increase/profit.”

Don't miss: When you report Q2043 for this cancer treatment, remember that this code includes all other preparatory procedures, such as the collection of cells from the patient, the preparation and transportation of the cells to a specialized lab, and the infusion itself.

Support Claim With Proper Diagnostic Codes

When reporting Q2043, the diagnosis codes must include 185 (*Malignant neoplasm of prostate*) as the primary diagnosis and at least one metastatic diagnostic code as the secondary diagnosis, Ferragamo says. Possible secondary diagnostic codes include the following:

- » 196.1 — *Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes*
- » 196.2 — *... intra-abdominal lymph nodes*

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- » 196.5 — ... *lymph nodes of inguinal region and lower limb*
- » 196.6 — ... *intrapelvic lymph nodes*
- » 196.8 — ... *lymph nodes of multiple sites*
- » 197.0 — *Secondary malignant neoplasm of lung*
- » 198.1 — ... *other urinary organs*
- » 198.5 — ... *bone and bone marrow*
- » 198.7 — ... *adrenal gland*
- » 198.82 — ... *genital organs*. □

ICD-10

Urogynecology Repairs Won't Require Too Much Diagnosis Conversion Work

Enterocoele, rectocoele, urethrocele, and cystocoele codes will have 1-1 crosswalks.

If your urologist performs urogynecology and prolapse procedures, such as anterior colporrhaphies or paravaginal defect repairs, he may also perform a repair of an enterocoele, rectocoele, urethrocele, or cystocoele during the procedures.

With ICD-9 you have just one code to report a vaginal enterocoele (618.6, *Vaginal enterocoele congenital or acquired*), one code for a urethrocele (618.03, *Prolapse of vaginal walls without mention of uterine prolapse; urethrocele*), and one code for a rectocoele (618.04, *Prolapse of vaginal walls without mention of uterine prolapse; rectocoele*).

For a cystocoele (when the patient is not pregnant and without uterine prolapse), choose from the following codes:

- » 618.01 — *Cystocoele, midline*
- » 618.02 — *Cystocoele, lateral*

ICD-10: Once ICD-10 is implemented on Oct. 1, 2013, you'll still have one code for enterocoeles, one code for urethroceles, and one code for rectocoeles. You'll use N81.5 (*Vaginal enterocoele*) to report a vaginal enterocoele, N81.0 (*Urethrocele*) for a urethrocele, and N81.6 (*Rectocoele*) for a rectocoele.

With regard to cystocoele coding, when your diagnosis code system changes you'll choose from the following options:

- » Code 618.01 will become N81.10 (*Cystocoele, unspecified*) or N81.11 (*Cystocoele, midline*).
- » Code 618.02 will become N81.12 (*Cystocoele, lateral*).

Physician documentation: Your urologist should already be documenting the type of prolapse the patient has, but ensure that is the case going forward. With the one-to-one crosswalk for the enterocoele, rectocoele, urethrocele, and cystocoele codes, you probably won't need to make additional room on your superbill for these ICD-10 diagnostic codes. □

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CPT® 2012

Avoid 57283 With Other Procedures Involving Enterocele Repair, CPT® Warns

You can rejoice that there will be only a few CPT® 2012 changes affecting your urology practice.

Every year at this time, coders face the challenge of learning new codes and new regulations while also wondering what sort of financial changes the new fee schedules might bring.

The good news: “There will be no new or revised CPT® changes for urology procedure coding in 2012,” says **Michael A. Ferragamo, MD, FACS**, clinical assistant professor of urology at the State University of New York at Stony Brook. “In other words, there are no changes between CPT® codes 50010 and 55980.”

However, if your urologist performs urogynecology procedures, there’s one change you should pay attention to. Read on to get the scoop before the new codes go into effect on Jan. 1, 2012.

Check the Other Procedures Before Billing 57283

There is one 2012 change for urogynecology that you should note, but this change does not involve a new or revised code. Rather, the change is a new parenthetical remark for 57283 (*Colpopexy, vaginal; intra-peritoneal approach [uterosacral, levator myorrhaphy]*).

“This approach in the past has been called a Mayo-McCall or McCall colpopexy or colpoplasty,” Ferragamo explains. The

2012 CPT® manual warns you to not report 57283 with the following codes:

- » 57556 — *Excision of cervical stump, vaginal approach; with repair of enterocele*
- » 58263 — *Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele*
- » 58270 — *... with repair of enterocele*
- » 58280 — *Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele*
- » 58292 — *Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele*
- » 58294 — *... with repair of enterocele.*

“The common denominator here appears to be the enterocele repair,” Ferragamo explains. “A Mayo-McCall colpoplasty (57283), according to CPT®, if performed with any of the above listed codes, should not be billed as an additional procedure,” he warns.

Pointer: You can find the exact CPT® wording about this new guidance under code 57283 in your 2012 CPT® manual. □

CPT® 2012

Easier Initial Observation Coding Will Come Your Way in January

New typical time assignments will mirror subsequent observation codes.

When CPT® 2011 debuted the subsequent observation care codes 99224-99226 (*Subsequent observation care, per day, for the evaluation and management of a patient ...*), many coders were left scratching their heads at the fact that those new codes featured typical times associated with them, even though the initial observation care codes 99218-99220 (*Initial observation care, per day, for the evaluation and management of a patient ...*) did not have typical times.

Good news: The new edition of your CPT® manual, which takes effect on Jan. 1, 2012 will remedy that problem.

Get to Know the Time Designations

CPT® 2012 adds the following typical time guidelines:

- » 99218 — *...Physicians typically spend 30 minutes at the bedside and on the patient’s hospital floor or unit*

- » 99219 — *...Physicians typically spend 50 minutes at the bedside and on the patient’s hospital floor or unit*
- » 99220 — *...Physicians typically spend 70 minutes at the bedside and on the patient’s hospital floor or unit.*

The addition of typical times will open the door for coding based on time, consistent with the other codes in the observation care series, as was introduced on the 2011 subsequent observation care codes, says **Gabrielle K.**, claims assistant for a practice in East Setauket, NY.

Learn When You Can Bill Based on Time

“There are only two ways that you can use time as a basis for selecting an E/M code,” says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC**, president of

(Continued on next page)

CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. “If counseling/coordination of care takes up 50 percent or more of the visit, and if the code has a typical time associated with it. So by these codes now having a time reference, it sounds like we may have a way to reference time used if counseling or coordination of care takes up at least 50 percent of a visit.”

“In addition, this could open the door to collecting for prolonged service times if the time the doctor spends exceeds 30 minutes more than the allotted time, and the visit notes are documented as such,” Cobuzzi says.

How it works: According to CPT®, you’ll use the inpatient prolonged service codes +99356-+99367 (*Prolonged physician service in the inpatient setting, requiring unit/floor time beyond the usual service ...*) when you bill initial (99218-99220) or subsequent (99224-99226) observation codes, says **Michael A. Ferragamo, MD, FACS**, clinical assistant professor of urology at the State University of New York at Stony Brook.

Warning: Medicare, however, will not reimburse for any prolonged service codes when billed with observation codes. On the other hand, CPT® rules indicate you may code this way and be paid, but again, remember Medicare will not pay you. Therefore, take note of the payer you are billing before adding 99354-99357 to your observation claims.

Bonus: “You can use prolonged services codes +99354-+99357 (*Prolonged physician service ...*) when billed not only by the physician, but now in 2012, also by other qualified healthcare professionals which include the non-physician providers, like physician assistants (PA) or nurse practitioners,” Ferragamo says. “This information has come out now at the end of the

2011 year,” he adds. “This is something you need to know for proper coding in 2012.”

Inpatient Guidelines Means You Can Count Non-Face-to-Face Time

The observation care codes are outpatient site of service, but time guidelines are based on unit time, using inpatient time requirements. When prolonged service codes are applied to observation codes, CPT® also directs that the inpatient prolonged services codes should be used as noted above. Therefore, time for observation and associated prolonged services would be floor time, more liberal than the face-to-face outpatient time requirements.

This is inconsistent and confusing, but is a positive step in the use of time-based coding for observation services, experts say. “I do believe it to be a positive step in the use of time-based coding for observation services,” Gabrielle says. “I say this because it allows for the time spent outside of straight face-to-face time spent.”

Remember: Inpatient time criteria includes time you spend reviewing the chart before you see the patient, talking to the nurse, reviewing test results, and other time on the unit that goes beyond outpatient face-to-face patient/physician time requirements, Gabrielle reminds. “I think it is a good thing to count time spent at bedside and on hospital floor or unit,” she adds. “I work for a surgeon and while he may end up for many consecutive hours in the operating room, he is still reachable when it comes to a nurse on the floor or other physician needing to reach him in regards to test results and or findings. He is constantly back and forth from the OR to the floor reviewing and writing orders for his patients. To be able to use this prolonged service time instead of face-to-face time allows him to code more appropriately for his time.” □

CPT® 2012

Look Forward to ‘Other Qualified Healthcare Professional’ Clarification

Watch out: The new definition isn’t all good news.

If you’ve wondered what “other qualified healthcare professional” means when you see this phrase in a particular code or modifier description, such as for modifier 78 (*Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional*

following initial procedure for a related procedure during the postoperative period), CPT® 2012 has the answer.

At the request of many physicians, CPT® 2012 now defines this terminology. Here’s what you need to know.

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Don't Miss Errata Clarifications

Although this definition didn't make it into the 2012 manual, the AMA lists it as part of the "CPT® 2012 Errata" on its Web site (www.ama-assn.org/resources/doc/cpt/cpt-2011-corrections.pdf) with the definition as follows:

"A 'physician or other qualified health care professional' is an individual who by education, training, licensure/regulation, and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports a professional service. These professionals are distinct from 'clinical staff.' A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service. Other policies may also affect who may report specified services."

Important: Checking the AMA errata for such corrections is very important, says **Denae M. Merrill, CPC, HCC** coding specialist in Holland, Mich.

Beware What the Definition Doesn't Include

You may be disappointed that RNs and LPNs aren't included in the definition.

Here's why: Leaving RNs and LPNs out of the definition means that CPT® will now preclude RNs and LPNs from reporting certain codes that are meant only for physicians and "other qualified healthcare professionals," says **Richard Tuck, MD, FAAP**, pediatrician at PrimeCare of Southeastern Ohio in Zanesville. For example, you won't be able to bill a surgical correction of a postoperative complication in the global period with modifier 78 if a nurse performs the service.

Good news: If your practices doesn't use nurses for many services, you may not have any issues with the new wording. "In our office, that definition would not affect coding," says **Nina Berrier, LPN**, office manager at Watershed Urology in Carlisle, Penn. "As far as the RN and LPNs go, we are only allowed to do procedures such as insert catheters, instill BCG for bladder cancer, etc. whenever the doctor is in the office. If he is not in the office, but tells me what to do, then I can go ahead and do it but we cannot charge for that." □

Fee Schedule News

Start Hoping for Congress to Step In, Or You'll Face a 27 Percent Pay Cut

The wait-and-worry game starts now.

Get ready for another year of nail-biting to find out whether your Medicare payments will be dramatically reduced. "The calendar year 2012 Physician Fee Schedule conversion factor is \$24.6712," notes the 2012 Medicare Physician Fee Schedule Final Rule, printed in the *Federal Register* that was published on Nov. 1.

This amounts to a dismal 27.4 percent cut compared to the current rate of \$33.9764. Here are the details you need to know to start bracing for the looming cuts.

Hope that Congress Steps in to Alter Cuts

CMS acknowledges that this massive cut may not be set in stone, stating, "While Congress has provided temporary relief from these reductions every year since 2003, a long-term solution is critical. We will continue to work with Congress to fix this untenable situation so doctors and beneficiaries no longer have to worry about the stability and adequacy of their payments from Medicare under the Physician Fee Schedule."

As most practices know, last December, Congress voted to not only stave off a 25 percent cut to your Medicare payments but also kept the cuts at bay through Dec. 31 of this year — and that

date is right around the corner. Unless Congress intervenes to reverse the cuts effective Jan. 1, 2012 your Medicare pay is set to drop again based on the new 2012 Fee Schedule information.

Experts lament: Physician advocacy organizations were quick to decry the cuts. "Payments for Medicare physician services have fallen so far below increases in medical practice costs that there is a 20 percent gap between Medicare payment updates and the cost of caring for seniors," said AMA president **Peter W. Carmel, MD**, in a Nov. 1 statement.

(Continued on next page)

You Be the Coder

Switch From 40818 to 20926 or 15240 For Buccal Graft Excision

Question:

My urologist performed a urethroplasty along with a buccal graft. How should I report this procedure?

California Subscriber

Answer: See page 87. □

Even CMS officials agreed that the 27.4 percent cut would be devastating, but remained hopeful that the government might rectify the situation before the pay cuts kick in. “This payment rate cut would have dire consequences that should not be allowed to happen,” said CMS administrator **Donald Berwick, MD**, in a Nov. 1 statement. “We need a permanent SGR fix to solve this problem once and for all. That’s why the President’s Budget and his Plan for Economic Growth and Deficit

Reduction call for permanent, fiscally responsible reform and why we are committed to working with the Congress to achieve a permanent and sustainable fix.”

The complete Fee Schedule will be posted in the Nov. 28 *Federal Register*, but is being published online ahead of print for a limited time at www.ofr.gov/%28X%281%29S%28ytexwtfdtdqyv0r35jiuojpv%29%29/OFRUpload/OFRData/2011-28597_PI.pdf □

Reader Questions

041.4 Requires a Fifth Digit Now

Question:

Has there been a change to 041.4? We keep getting denials and I can't figure out why.

Florida Subscriber

Answer:

There was a change to 041.4 on Oct. 1, 2011. The code now requires a fifth digit as follows:

- » 041.41 — *Shiga toxin-producing Escherichia coli [E. coli] (STEC) O157*
- » 041.42 — *Other specified Shiga toxin-producing Escherichia coli [E. coli] (STEC)*
- » 041.43 — *Unspecified Shiga toxin-producing Escherichia coli [E. coli] (STEC), unspecified*
- » 041.49 — *Other and unspecified Escherichia coli [E. coli].*

When your urologist reports that a patient has an infection, such as cystitis (595) you need to use an additional code to

report the organism causing the infection. Often that organism is *E. coli* and you'll now report 041.41-041.49 rather than four-digit 041.4 to indicate the type of *E. coli*.

Background: Many *E. coli* bacteria are harmless, but certain strains can cause digestive problems ranging from diarrhea to hemorrhagic colitis. These strains are known as Shiga-toxin producing *E. coli* (STEC), and labs identify them by culture or other tests to detect the Shiga-toxin or the genes that produce the toxin. The most common STEC in the U.S. is *E. coli* O157:H7. If the lab isolates this strain in a culture, no further testing is needed to call the organism STEC. When the culture isolates non-O157 *E. coli* strains, or *E. coli* O157 with the H antigen not identified as H7, the lab will perform other tests before the organism can be identified as STEC.

Depending on the test results, you'll choose from the four new ICD-9 codes to report the findings, starting Oct. 1. According to **Jeffrey Linzer Sr., MD, FAAP, FACEP**, at the ICD-9-CM Coordination and Maintenance Committee Meeting (proposals, summaries, and presentation slides available at www.cdc.gov/nchs/icd/icd9cm_maintenance.htm), many inclusion terms represented in the proposed new codes will be seen in the medical record, including microbiology laboratory results. □

Never Report Incorrect Codes Just to Ensure Payment

Question:


I work in the office for a urologist who also performs laparoscopic procedures. When he assists other urologists during laparoscopic procedures, we obtain the billing information from the other urologist's coders to bill as the assistant surgeon.

Sometimes there is incorrect billing pertaining to the CPT® codes and ICD-9 codes billed, according to the documentation from the operative report. There is contact made to have them verify and correct, but corrections are not always followed by the other office.

In an effort to get the claim submitted in a timely matter I have submitted the claim for my doctor as the assistant. I have done it in two ways: 1) submitted as billed by the other office and urologist, making notes on the account for the errors/problems and 2) submitting the claim with the correct billing information.

What is the correct way to handle this problem?

New York Subscriber



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Answer:

You should never knowingly send in the wrong codes just to get paid. That is a clear coding and compliance violation.

Your practice of contacting the other surgeon's coder and trying to explain why you will be submitting different coding is a good start. If they don't agree or follow through with the proper coding, however, you should still submit the codes you believe are correct.

"I encountered this all of the time when I had my billing company," says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "I, like the writer, would contact the primary surgeon and tell them that they coded the case incorrectly and tell them how it should be coded and why. They would not want to listen to me ... they submitted it their way. But I would not submit the coding wrong for my doctor. That is a compliance violation," she adds.

Tip: Send an email to the lead urologist's practice explaining the codes you will be submitting and why. This ensures you

You Be the Coder

Switch From 40818 to 20926 or 15240 For Buccal Graft Excision

(Question on page 85)

Answer:

First, you'll report the urethroplasty based on your urologist's documentation using one of the following codes:

- » 53410 — *Urethroplasty, 1-stage reconstruction of male anterior urethra*
- » 53415 — ... *transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra*
- » 53430 — ... *reconstruction of female urethra.*

In the past, when the surgeon performed a urethroplasty and used a graft fashioned from buccal mucosa—meaning the removal of the lining of the mouth to make a graft—you would report 40818 (*Excision of mucosa of vestibule of mouth as donor graft*) for the graft excision.

"However, in June 2011, the American Urological Association (AUA) Coding Hotline stated that instead of using 40818 for the graft, you should now use CPT® code 20926, (*Tissue grafts, other [eg, paratenon, fat, dermis]*) or CPT® code 15240 (*Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less*)," says **Michael A. Ferragamo, MD, FACS**, clinical assistant professor of urology at the State University of New York at Stony Brook. □

have your contact with the other coder in writing, and shows you informed them that you intended to submit different codes.

You won't likely know what the other urologist ends up submitting or if they get paid—but it's not really your concern, Cobuzzi explains. As long as you are compliant and bringing in the reimbursement your surgeon deserves, you're doing your job correctly.

Warning: Getting paid might be a bit more challenging when the other urologist is submitting different codes. You may need to appeal a denial that results from both urologists submitting different codes, but during the appeal process if your coding is correct, you should get paid.

"We got paid," Cobuzzi says. "Not always the first pass, sometimes it required sending in the documentation with an appeal. I would appeal with my documentation and show that my coding was correct."

Bottom line: You should always code correctly and avoid knowingly submitting an incorrect claim just to match the other urologist's billing. "If you think about it, when there is an assistant surgeon, there are three sets of codes the payer gets: the primary surgeon, the assistant surgeon, and the facility and not all three are always in sync," Cobuzzi says. "Facilities and surgeons don't discuss the coding and work together to make sure they have the same outcome. Each independently codes the case. Why shouldn't the assistant surgeon do the same, in particular if they have a highly qualified coder." □

Need More Than 1 PQRS Code? Go Ahead

Question:

Can we report more than one PQRS code measure on the same claim?

Iowa Subscriber

Answer:

Yes. You aren't limited to reporting just one Physician Quality Reporting System (PQRS) code per visit.

"EPs [eligible professionals] may submit multiple codes for more than one measure on a single claim," CMS says in its PQRS Implementation Guide. "Multiple CPT® Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim," CMS adds.

You can read the complete Implementation Guide at www.cms.gov/PQRS/Downloads/2010_PQRI_ImplementationGuide_02-10-2010_Final.pdf. □

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

Urology

C O D I N G A L E R T

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