2020 UROLOGY SURGERY MEDICARE REIMBURSEMENT CODING GUIDE

Effective January 1, 2020

2020 Medicare Physician, Hospital Outpatient, ASC Coding and Payment

Medicare National Average Rates and Allowables (Not Adjusted for Geography)

		PHYSICIAN[3]	HOSPITAL OUTPATIENT[4]		ASC[4]
CPT® CODE[1]/ HCPCS CODE[2]	CODE DESCRIPTION	MEDICARE NAT'L AVG FACILITY SETTING	APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
	CYSTECTOMY				
51550	Cystectomy, partial; simple	$1,004	Inpatient only, not reimbursed for hospital outpatient or ASC		
51555	Cystectomy, partial; complicated (eg, postradiation, previous surgery, difficult location)	$1,320	Inpatient only, not reimbursed for hospital outpatient or ASC		
51565	Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)	$1,357	Inpatient only, not reimbursed for hospital outpatient or ASC		
51570	Cystectomy, complete (separate procedure)	$1,538	Inpatient only, not reimbursed for hospital outpatient or ASC		
51575	Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	$1,900	Inpatient only, not reimbursed for hospital outpatient or ASC		
51580	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations	$1,976	Inpatient only, not reimbursed for hospital outpatient or ASC		
51585	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations, with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	$2,200	Inpatient only, not reimbursed for hospital outpatient or ASC		
51590	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis	$2,017	Inpatient only, not reimbursed for hospital outpatient or ASC		
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	$2,281	Inpatient only, not reimbursed for hospital outpatient or ASC		
51596	Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder	$2,453	Inpatient only, not reimbursed for hospital outpatient or ASC		
	NEPHRECTOMY				
50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection	$1,094	Inpatient only, not reimbursed for hospital outpatient or ASC		
50225	Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney	$1,253	Inpatient only, not reimbursed for hospital outpatient or ASC		

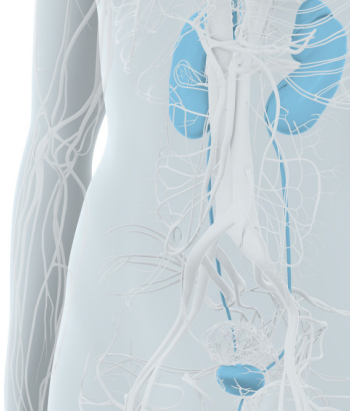
Medtronic

CPT® CODE[1]/ HCPCS CODE[2]	CODE DESCRIPTION	PHYSICIAN[3]	HOSPITAL OUTPATIENT[4]		ASC[4]
		MEDICARE NAT'L AVG FACILITY SETTING	APC AND APC DESCRIPTION	MEDICARE NAT'L AVG	MEDICARE NAT'L AVG
50230	Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	$1,337	Inpatient only, not reimbursed for hospital outpatient or ASC		
50234	Nephrectomy with total ureterectomy and bladder cuff; through same incision	$1,358	Inpatient only, not reimbursed for hospital outpatient or ASC		
50236	Nephrectomy with total ureterectomy and bladder cuff; through separate incision	$1,527	Inpatient only, not reimbursed for hospital outpatient or ASC		
50240	Nephrectomy, partial	$1,382	Inpatient only, not reimbursed for hospital outpatient or ASC		
50543	Laparoscopy, surgical; partial nephrectomy	$1,552	5362, Level 2 Laparoscopy	$8,413	N/A for ASC
50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	$1,395	Inpatient only, not reimbursed for hospital outpatient or ASC		
50546	Laparoscopy, surgical; nephrectomy, including partial ureterectomy	$1,255	Inpatient only, not reimbursed for hospital outpatient or ASC		
50548	Laparoscopy, surgical; nephrectomy with total ureterectomy	$1,403	Inpatient only, not reimbursed for hospital outpatient or ASC		
	PROSTATECTOMY				
55801	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	$1,141	Inpatient only, not reimbursed for hospital outpatient or ASC		
55810	Prostatectomy, perineal radical	$1,366	Inpatient only, not reimbursed for hospital outpatient or ASC		
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	$1,677	Inpatient only, not reimbursed for hospital outpatient or ASC		
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	$1,838	Inpatient only, not reimbursed for hospital outpatient or ASC		
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages	$911	Inpatient only, not reimbursed for hospital outpatient or ASC		
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal	$986	Inpatient only, not reimbursed for hospital outpatient or ASC		
55840	Prostatectomy, retropubic radical, with or without nerve sparing	$1,220	Inpatient only, not reimbursed for hospital outpatient or ASC		
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	$1,221	Inpatient only, not reimbursed for hospital outpatient or ASC		
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	$1,421	Inpatient only, not reimbursed for hospital outpatient or ASC		
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	$1,505	5362, Level 2 Laparoscopy	$8,413	N/A for ASC
	ROBOTIC ASSISTANCE[5]				
S2900	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)	N/A			

NOTES:

1. 2020 CPT® Professional Edition. American Medical Association. Copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
2. Centers for Medicare and Medicaid Services. Centers for Medicare & Medicaid Services. Alpha-numeric HCPCS. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS-Items/2020-Alpha-Numeric-HCPCS-File
3. Centers for Medicare & Medicaid Services. Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule; Final Rule, Federal Register 84 Fed. Reg. No. 221 (62568-63563) 42 CFR Parts 403, 409, 410, 411, 414, 415, 416, 418, 424, 425, 489 and 498. https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other Published November 15, 2019.
4. Centers for Medicare & Medicaid Services. Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Revisions of Organ Procurement Organizations Conditions of Coverage; Prior Authorization Process and Requirements for Certain Covered Outpatient Department Services; Potential Changes to the Laboratory Date of Service Policy; Changes to Grandfathered Children's Hospitals-Within-Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots. Final Rule, Federal Register (84 Fed. Reg. No. 218 61142 - 61492) 42 CFR Parts 405, 410, 412, 414, 416, 419, and 486. https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf. Published November 12, 2019. Addendum B, AA. See also correction notice CMS-1717-CN; Addendum B, AA https://federalregister.gov/d/2019-28364. Published January 3, 2020.
5. HCPCS II S-Codes cannot be reported to Medicare. They are used only by non-Medicare payers, which may cover and price them according to their own requirements

HOSPITAL INPATIENT PROCEDURE CODING FOR UROLOGY SURGERY



ICD-10-PCS procedure codes[1] are used by hospitals to report surgeries and procedures performed in the inpatient setting.

All ICD-10-PCS codes have seven digits, each digit representing a specific character associated with procedures. Code assignment in ICD-10-PCS is a process of "constructing" the code by selecting values from a code table for each of the seven standard characters. Key characters are discussed below.

CHARACTER	DESCRIPTION
3: Root Operation	The two main root operations for removal of tissue are B-Excision and T-Resection. By definition, B-Excision involves removing a portion of the body part and T-Resection involves removing the entire body part.[2] For example, partial cystectomy uses B-Excision and complete cystectomy uses T-Resection. Note that physicians may use these terms more broadly. It's the coder's responsibility to determine what the physician's documentation equates to in terms of ICD-10-PCS definitions. The physician is not expected to document using ICD-10-PCS code descriptions, and the coder is not required to query the physician in these circumstances.[2]
5: Approach	Different codes are constructed depending on the approach: **0-**Open involves an open incision to directly expose the surgical site **4-**Percutaneous Endoscopic is used for procedures performed via laparoscopy.

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
CYSTECTOMY	
> Partial cystectomy	
0TBB0ZZ	Excision of bladder, open approach
0TBB4ZZ	Excision of bladder, percutaneous endoscopic approach
> Total cystectomy	
0TTB0ZZ	Resection of bladder, open approach
0TTB4ZZ	Resection of bladder, percutaneous endoscopic approach
> Radical cystectomy	
Radical cystectomy involves complete removal of the bladder with diversion of the ureters, sometimes with extensive lymphadenectomy. Removal of the bladder is coded to total cystectomy, as above. Additional codes are then assigned to capture the ureteral diversion and lymphadenectomy as performed.	
NEPHRECTOMY	
> Partial nephrectomy	
0TB00ZZ	Excision of right kidney, open approach
0TB04ZZ	Excision of right kidney, percutaneous endoscopic approach
0TB10ZZ	Excision of left kidney, open approach
0TB14ZZ	Excision of left kidney, percutaneous endoscopic approach
> Total nephrectomy	
0TT00ZZ	Resection of right kidney, open approach
0TT04ZZ	Resection of right kidney, percutaneous endoscopic approach
0TT10ZZ	Resection of left kidney, open approach
0TT14ZZ	Resection of left kidney, percutaneous endoscopic approach
> Nephroureterectomy	
Nephroureterectomy involves complete removal of the kidney with complete removal of the ureter. Removal of the kidney is coded to total nephrectomy as above. One or more of the codes below are then assigned additionally to capture the total ureterectomy.	
0TT60ZZ	Resection of right ureter, open approach
0TT64ZZ	Resection of right ureter, percutaneous endoscopic approach
0TT70ZZ	Resection of left ureter, open approach
0TT74ZZ	Resection of left ureter, percutaneous endoscopic approach
> Radical nephrectomy	
Radical nephrectomy involves complete removal of the kidney, typically with extensive lymphadenectomy and/or removal of the adrenal gland. Removal of the kidney is coded to total nephrectomy, as above. Additional codes are then assigned additionally to capture the lymphadenectomy and adrenalectomy as performed.	
PROSTATECTOMY	
> Excision of prostate lesion, subtotal or partial prostatectomy (suprapubic, retropubic, perineal)	
0VB00ZZ	Excision of prostate, open approach
0VB04ZZ	Excision of prostate, percutaneous endoscopic approach
0VB07ZZ	Excision of prostate, via natural or artificial opening
0VB08ZZ	Excision of prostate, via natural or artificial opening endoscopic approach
> Total prostatectomy (suprapubic, retropubic, perineal)	
0VT00ZZ	Resection of prostate, open approach
0VT04ZZ	Resection of prostate, percutaneous endoscopic approach
0VT07ZZ	Resection of prostate, via natural or artificial opening
0VT08ZZ	Resection of prostate, via natural or artificial opening endoscopic approach

ICD-10-PCS PROCEDURE CODE	PROCEDURE CODE DESCRIPTION
> Radical prostatectomy	
Radical nephrectomy involves complete removal of the prostate, typically with complete removal of the seminal vesicles, partial removal of the vas deferens, and/or extensive lymphadenectomy. Removal of the prostate is coded to total prostatectomy, as above. Additional codes are then assigned to capture removal of the seminal vesicles and vas deferens and the lymphadenectomy as performed.	
ROBOTIC ASSISTANCE[3]	
8E0W0CZ	Robotic assisted procedure of trunk region, open approach
8E0W4CZ	Robotic assisted procedure of trunk region, percutaneous endoscopic approach

Notes:

1. Centers for Medicare & Medicaid Services. 2020 ICD-10 PCS Code Tables and Index. https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS
2. Centers for Medicare & Medicaid Services. ICD-10-PCS Official Guidelines for Coding and Reporting. https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-ICD-10-PCS-Guidelines.pdf
3. Codes for robotic assistance are assigned separately in addition to the primary procedure code.

HOSPITAL INPATIENT DRGS FOR UROLOGY SURGERY

DRG Assignment FY2020—effective October 1, 2019

Under Medicare's MS-DRG methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Each MS-DRG has a relative weight that is then converted to a flat payment amount. Implanted devices are typically included in the flat payment and are not paid separately. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. MS-DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

W MCC in MS-DRG titles refer to the secondary diagnosis codes that are designated as major complications or comorbidities. MS-DRGs have at least one major secondary complication or comorbidity. Similarly, W CC in MS-DRG titles refer to secondary diagnosis codes designated as other (non-major) complications or comorbidities. MS-DRGs WO CC/MCCs have no secondary diagnoses that are designated as complications or comorbidities, major or otherwise. Note that some secondary diagnoses are only designated as CCs or MCCs when the conditions were present on admission, and do not count as CCs or MCCs when the conditions are acquired during the stay.

In addition, Post-Acute Care Transfer (PACT) status refers to selected DRGs in which payment to the hospital may be reduced when the patient is discharged by being transferred out. The DRGs impacted are those marked "Yes" and the patient must be transferred out before the geometric mean length of stay to certain post-acute care providers, including rehabilitation hospitals, long term care hospitals, skilled nursing facilities, or to home under the care of a home health agency. When these conditions are met, the DRG payment is converted to a per diem and payment is made as double the per diem rate for the first day plus the per diem rate for each remaining day up to the full DRG payment.

MS-DRG[1]	MS-DRG TITLE[1]	FY 2020 RELATIVE WEIGHT[1]	FY 20120 GEOMETRIC MEAN LENGTH OF STAY[1]	FY 2020 SUBJECT TO PACT?[1]	FY 2020 MEDICARE NATIONAL AVERAGE[1]
	CYSTECTOMY The DRG clusters vary depending on whether the principal diagnosis is related to the urinary tract (DRGs 653-655, 665-667), the male reproductive system (DRGs 707-708), or the female reproductive system (DRGs 749-750).				
653	Major Bladder Procedures W MCC	5.5365	10.4	Yes	$34,653
654	Major Bladder Procedures W CC	2.8122	5.8	Yes	$17,601
655	Major Bladder Procedures W/O CC/MCC	2.0624	3.6	Yes	$12,908
707	Major Male Pelvic Procedures W CC/MCC	1.8699	2.4	No	$11,704
708	Major Male Pelvic Procedures W/O CC/MCC	1.4520	1.4	No	$9,088
749	Other Female Reproductive System O.R. Procedures W CC/MCC	2.5922	5.5	No	$16,224
750	Other Female Reproductive System O.R. Procedures W/O CC/MCC	1.3312	2.3	No	$8,332
	NEPHRECTOMY				
656	Kidney and Ureter Procedures for Neoplasm W MCC	3.2606	5.6	No	$20,408
657	Kidney and Ureter Procedures for Neoplasm W CC	1.9342	3.4	No	$12,106
658	Kidney and Ureter Procedures for Neoplasm W/O CC/MCC	1.5699	2.2	No	$9,826
659	Kidney and Ureter Procedures for Non-Neoplasm W MCC	2.6798	6.0	Yes	$16,773
660	Kidney and Ureter Procedures for Non-Neoplasm W CC	1.4207	3.1	Yes	$8,892
661	Kidney and Ureter Procedures for Non-Neoplasm W/O CC/MCC	1.0901	1.9	Yes	$6,823
	PROSTATECTOMY Codes 0VB00ZZ, 0VB4ZZ for excision of prostate lesion or subtotal prostatectomy group to DRGs 715-718 when they are the only procedure performed.				
665	Prostatectomy W MCC	2.9685	7.5	No	$18,580
666	Prostatectomy W CC	1.7691	4.1	No	$11,073
667	Prostatectomy W/O CC/MCC	0.9387	2.0	No	$5,875
707	Major Male Pelvic Procedures W CC/MCC	1.8699	2.4	No	$11,704
708	Major Male Pelvic Procedures W/O CC/MCC	1.4520	1.4	No	$9,088

Reference:

1. Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; Final Rule, Federal Register (84 Fed Reg. No. 159 42044 – 42701) 42 CFR Parts 412, 413, and 495. https://www.govinfo.gov/content/pkg/FR-2019-08-16/pdf/2019-16762.pdf Published August 16, 2019. See also – Correction Notice, Federal Register (84 Fed. Reg. No. 195 53603 – 53630) 42 CFR Parts 412, 413, and 495. https://www.govinfo.gov/content/pkg/FR-2019-10-08/pdf/2019-21865.pdf. Published October 8, 2019.

Medtronic
5920 Longbow Drive
Boulder, CO 80301
USA
T: (303) 530-2300
US: (800) 255-8522

medtronic.com

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