

GUIDEPOINT
Reimbursement Resources

Ureteroscopic Stone Management and Stent Insertion
2016 Coding & Payment Quick Reference

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

The following codes are thought to be relevant to ureteroscopic stone removal (including ureteral stent insertion) and are referenced throughout this guide.

CPT® Code ¹	Description
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
52356*	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

*New CPT® Code, effective January 1, 2015

Physician Relative Value Units (RVUs)

Physician Relative Value Units (RVUs) are based on the Medicare 2016 Physician Fee Schedule effective January 1, 2016

CPT® Code	Office-Based ¹				Facility-Based ¹			
	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
52332	2.82	10.66	0.32	13.80	2.82	1.34	0.32	4.48
52352			See Note		6.75	2.69	0.76	10.20
52353			See Note		7.50	2.95	0.85	11.30
52356*			See Note		8.00	3.08	0.90	11.98

Note: There are no current Medicare valuations for these procedures performed in the physician office setting.

*New CPT® Code, effective January 1, 2015

Payment – Medicare

In response to the AMA/Specialty Society RVS Update Committee (RUC) five-year Review Identification Workgroup analysis to combine codes that are frequently reported together, bundled code 52356 was established to report cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type).

Effective January 1, 2014, when a ureteral stent is placed in conjunction with ureteroscopy with lithotripsy the new combined code 52356 must be reported.

Do not report 52356 in conjunction with 52332, 52353 when performed together on the same side.

All rates shown are 2016 Medicare national averages; actual rates will vary geographically and/or by individual facility.

Identified are three (3) common coding/reimbursement scenarios relating to ureteroscopic stone management performed in a hospital outpatient and ambulatory surgery setting.

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CPT® Code	Physician ¹		APC	Facility	
	MD In-Office Medicare Allowed Amount ^{1,2,5}	MD In-Facility Medicare Allowed Amount ²		Hospital Outpatient Medicare Allowed Amount ^{2,3}	ASC Medicare Allowed Amount ^{2,4}
52332	\$494	\$161	5374	\$2,243	\$1,255
52352	N/A	\$365	5374	\$2,243	\$1,255
52353	N/A	\$405	5375	\$3,394	\$1,744
52356*	N/A	\$429	5375	\$3,394	\$1,744

*New CPT® Code, effective January 1, 2015

Scenario 1: Ureteroscopic Stone Removal with Lithotripsy with Stent Insertion

CPT® Code	Description	Physician Medicare Allowed Amount ^{1,2}	APC	Hospital Outpatient Medicare Allowed Amount ^{2,3}	ASC Medicare Allowed Amount ^{2,4}
52356*	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	\$429	5375	\$3,394	\$1,744
TOTAL		\$429		\$3,394	\$1,744

*New CPT® Code, effective January 1, 2015

Scenario 2: Ureteroscopic Stone Removal with Lithotripsy (without Stent Insertion)

CPT® Code	Description	Physician Medicare Allowed Amount ^{1,2}	APC	Hospital Outpatient Medicare Allowed Amount ^{2,3}	ASC Medicare Allowed Amount ^{2,4}
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	\$405	5375	\$3,394	\$1,744
TOTAL		\$405		\$3,394	\$1,744

Scenario 3: Ureteroscopic Stone Removal (without Lithotripsy) with Stent Insertion

CPT® Code	Description	Physician Medicare Allowed Amount ^{1,2}	APC	Hospital Outpatient Medicare Allowed Amount ^{2,3}	ASC Medicare Allowed Amount ^{2,4}
52352	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)	\$365	5374	\$2,243	\$1,255
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	\$161	5374	\$2,243	\$1,255
	TOTAL	\$526		\$4,486	\$2,510

Hospital Inpatient Allowed Amounts – Medicare

ICD-10-PCS Procedure Code	Description
0TC37ZZ	Extirpation of matter from right kidney pelvis, via opening
0TC38ZZ	Extirpation of matter from right kidney pelvis, endo
0TC47ZZ	Extirpation of matter from left kidney pelvis, via opening
0TC48ZZ	Extirpation of matter from left kidney pelvis, endo
0TC67ZZ	Extirpation of matter from right ureter, via opening
0TC68ZZ	Extirpation of matter from right ureter, endo
0TC77ZZ	Extirpation of matter from left ureter, via opening
0TC78ZZ	Extirpation of matter from left ureter, endo

ICD-10-CM Diagnosis Code	Description
N20.0	Calculus of kidney
N20.1	Calculus of ureter
N20.9	Urinary calculus, unspecified

Possible MS-DRG Assignment ⁶	Description	Reimbursement ⁷
668	Transurethral procedures with major complication or comorbidity (MCC)	\$14,479
669	Transurethral procedures with complication or comorbidity (CC)	\$7,742
670	Transurethral procedures without CC/MCC	\$5,436

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved.

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1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2016 release, RVU16A file <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending> The 2016 National Average Medicare physician payment rates have been calculated using a 2016 conversion factor of \$35.8279. Rates subject to change.
2. "Allowed Amount" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance, etc.
3. Hospital outpatient payment rates are 2016 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2016 release, CMS-1633-FC <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>
4. ASC payments rates are 2016 Medicare ASC national averages. ASC rates are from the 2016 Ambulatory Surgical Center Covered Procedures List - Addendum AA. Source: January 2016 release, CMS-1633-FC; CMS-1607-F2 <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>
5. "NA" in the 2016 "MD-In-Office Medicare Allowed Amount" column means that there is no in-office differential.
6. The patient's medical record must support the existence and treatment of the complication or comorbidity.
7. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,904.74). Source: August 17, 2015 Federal Register; CMS-1632-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2015 Rates.

Sequestration Disclaimer

Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2016.

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