Part B Insider (Multispecialty) Coding Alert

Reader Question: Not All Modifier 59 Denials Warrant Appeals

Question: I have an insurance company that is not paying for a code, stating it is bundled into another code. We are billing 52353, 52352-59, and 52332-59.

My doctor is doing a cystourethroscopy with ureterscopy and/or pyeloscopy with a holmium laser lithotripsy. He is then doing a basket extraction of multiple stone fragments, not just irrigating the stones out. Then he is placing a stent in the ureter.

The insurance company is saying the 52352 is part of 52353. My doctor is saying this is a different procedure though it is the same anatomical site. I haven't had any problems billing this way with at least three other major insurance companies, but now one payer is denying my claims. Is that payer correct to deny the claim?

Answer: The payer is correct. As you know, the Correct Coding Initiative (CCI) bundles 52352 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus [ureteral catheterization is included]) into 52353 (...with lithotripsy [ureteral catheterization is included]). You can unbundle the codes in certain circumstances -- for example, when your doctor performs the two procedures on different sides. However, you should not, per CCI, be unbundling these two codes when both procedures are performed on the same side within the same renal pelvis and/or ureter.

Clinically it makes sense that your doctor would feel these procedures are two separate procedures, and there is certainly more work involved. Unfortunately, CCI and coding rules don't agree. Payers feel that you are breaking up the stone and removing the fragments as part of the complete lithotripsy procedure. It really doesn't matter how you remove them. You cannot bill for the lithotripsy and the extraction separately when performed on the same side.

However, if your doctor did the procedures on separate sides (each ureter or renal pelvis), you could bill 52353 and 52352 using the 59 (Distinct procedural service) modifier and the side modifiers: RT (Right side) and LT (Left side).

Watch out: You may see different payment policies for different payers, but any payer following the current CCI will follow this rule. Medicare especially should not be paying you on this. If you are billing a Medicare carrier using both codes and are getting paid, the carrier's system is most likely automatically assuming that you have separate side documentation**,** or there is an error in their system with this bundle. If the Medicare carrier ever asks for documentation to support these claims, you will be asked to repay any claims where you billed 52352 and 52353 together for the same side. Under CCI and Medicare rules, this is incorrect coding.

Alternative: Third-party payers may have different payment policies, and may not follow CCI rules. Therefore, you should always check the coding guidelines of other payers. Any payer that follows CCI, however, will view this as incorrect coding. However, if they do not follow CCI and Medicare rules, you may be able to continue billing 52352 and 52353 when performed on the same side.