

Part B Insider (Multispecialty) Coding Alert

Transmittals: Prepare To Lose RVUs When You Perform

Multiple cystourethroscopy procedures receive massive pay cut

Once again, the **Centers for Medicare & Medicaid Services** has muddied the waters on low osmolar contrast material.

After announcing in Transmittal 45 (Jan. 23, 2004) that it was bringing back codes A4644-A4646, CMS has now given those codes a procedure status of "E" for "excluded," meaning Medicare won't cover them after all. Replacement code A9525 has a procedure status of "I," meaning "not valid for Medicare purposes."

These changes, in Transmittal 105, issued Feb. 20, are probably the result of confusion on CMS' part that will be sorted out soon. But they show the perils of trying to make coding changes at the last minute.

The Transmittal also clarifies that the "multiple endoscopy rule" now applies to cystourethroscopy codes 52001, 52005, 52234, 52235, 52240 and 52400. These codes will all have 52000 (cystourethroscopy [separate procedure]) as their base code, meaning that they now belong to the same "family" as regards the multiple endoscopies rule.

Usually, when a surgeon performs multiple surgeries, Medicare will pay for 50 percent of the RVUs of the second through fifth procedures. But Medicare applies the "multiple endoscopies" rule to some endoscopy procedures. This rule says that for multiple endoscopic procedures in the same "family," you receive "the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy."

So for example, if you perform both 52001 (which has 11.01 total non-facility RVUs) and 52235 (which has 7.73 non-facility RVUs) then you'll receive the full 11.01 RVUs for 52001. But for 52235, you'll only receive the difference between its 7.73 RVUs and 52000's 5.53 RVUs, or 2.20 RVUs. Previously, you would have received 50 percent of each additional surgery.

When applying the multiple endoscopies rule, avoid using the -51 modifier (multiple procedures) or you could end up applying a double discount, say experts.

CMS changed the bilateral surgery indicator for 63048 (laminectomy, facetectomy and foraminotomy, each additional segment) from "2" to "1," and the indicator for 47525 (change of percutaneous biliary drainage catheter) from "0" to "1." This means the 150 percent adjustment for bilateral procedures now applies to both codes, and you can use the "RT" and "LT" modifiers or a "2" in the units field to boost reimbursement.

But if you [bill 92136](#) with the -26 modifier as a bilateral procedure, you now can receive the lower of actual charges for each side or the full fee schedule amount for each side, thanks to a status change from CMS. (Multiple procedures rules may still apply if you perform this alongside other procedures.)