Codify by AAPC

Outpatient Facility Coding Alert

CPT® 2104: One New Code Will Stop Your 52332 /52353 Combo Coding

Plus: Hospital based coders, say good-bye to 50021 and 58823.

CPT® 2014, which takes effect on Jan. 1, 2014, will bring numerous changes to ASC/outpatient coding. If urologists perform cystos at your facility, read on for the lowdown on important additions and deletions.

Get Accustomed to New Code 52356

CPT® 2014 adds one code that experts say will have a significant impact on urology coding. You find new code 52356 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent [e.g., Gibbons or double-J type]) in your 2014 manual.

Old way: Currently when you bill for ureteroscopic fragmentation of a renal pelvic or ureteral stone followed by a double J stent insertion, you report 52353 (Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy [ureteral catheterization is included]) and 52332 (Cystourethroscopy, with insertion of indwelling ureteral stent [eg, Gibbons or double-J type]). These two codes are separately billable and payable.

New way: As of January 1, for the same procedures, you'll only be able to bill 52356. This change was originally slated to take effect in mid-2013, but will now be implemented in the new year.

"These are very common procedure for urologists to perform at the same operative session," says Michael A. Ferragamo, MD, FACS, clinical assistant professor of urology at the State University of New York at Stony Brook. "Most times when a urologist ureteroscopically fragments a stone, he places a stent to ensure passage of fragments without causing obstruction," he explains.

Note: If your urologist performs the cystourethroscopy with lithotripsy but does not place a stent, you'll still report just 52353.

"Since this is a common code combination, it appears they are trying to combine the 52353 and 52332 procedures as they've done with other procedures in the past," explains Becky Boone, CPC, CUC, urology surgery coder for The Coding Network and cardiology coder for the University of Missouri Internal Medicine Department in Columbia.

"This new code is another example of Medicare looking at two procedures performed together very frequently and creating a compound code," Ferragamo agrees.

It isn't clear yet what relative value units (RVUs) Medicare will assign to this new code.

"I am not sure if the reimbursement will make up for adding the stent into the procedure," says Chandra L. Hines, practice supervisor of Wake Specialty Physicians in Raleigh, N.C. "I can't say that I did not expect this to happen soon."

"We don't know the payment yet, but it will likely pay less than the combination of 52353 and 52332," Ferragamo says. "So, physicians are going to see a significant impact on their reimbursement."

"I like that this is the only real change for urology this coming year with all of the ICD-10 changes we will see starting 2014," Boone adds.

Additionally: There is one other new code that you might use in the new year 10030 (Image-guided fluid collection

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drainage by catheter [eg, abscess, hematoma, seroma, lymphocele, cyst], soft tissue [eg, extremity, abdominal wall, neck], percutaneous) which would provide a code to use when your physician needs to drain a fluid collection using catheterization.

3 Codes Replace 50021, 58823

CPT® 2014 also deletes 50021 (Drainage of perirenal or renal abscess; percutaneous) and 58823 (Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous ([g, ovarian, pericolic]). But three new codes seem to replace the two deleted codes:

- 49405 (Image-guided fluid collection drainage by catheter [eg, abscess, hematoma, seroma, lymphocele, cyst]; visceral [eg, kidney, liver, spleen, lung/mediastinum], percutaneous)
- 49406 (... peritoneal or retroperitoneal, percutaneous)
- 49407 (... peritoneal or retroperitoneal, transvaginal or transrectal).

These codes may be used in urology and urogynecology, Ferragamo says. Also, remember that codes 50021 and 58823 are not considered to be ASC qualified services for freestanding facilities, but are paid under OPPS for hospital-based facilities.

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