

2009

Targeted Cryoablation of the Prostate Endocare Reimbursement Assessment

CRYOSURGERY FOR PROSTATE TUMORS

Cryosurgery is a means for surgical destruction of diseased tissue with lethal temperatures. Prostate Cryoablation involves the targeted destruction of prostate tissue. The procedure is performed via percutaneous access through the perineum under ultrasonic guidance.

COVERAGE

Medicare

Medicare's Clarification on Billing for Cryosurgery of the Prostate Gland publication includes details regarding Coverage, Billing, & Payment Requirements. Please refer to this Transmittal or webpage for explicit instructions.

Pub 100-04 Medicare Claims Processing Transmittal 1111, issued November 9, 2006 (pages 11-13);

<http://www.cms.hhs.gov/transmittals/downloads/R1111CP.pdf>

Primary Treatment – Medicare National Coverage Policy effective July 1, 1999

"Cryosurgery is safe, effective, as well as medically necessary and appropriate in certain patient populations – specifically, those patients with Stages T1- T3 prostate cancer. It has demonstrated effectiveness through an absolute analysis, as well as, through a comparative analysis. Its results are comparable to brachytherapy and external beam radiation."

National Coverage Decision for Cryosurgery of Prostate, Issued July 1, 1999 (TN 110) and revised July 1, 2001 (TN 140);

http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=230.9&ncd_version=1&basket=ncd%3A230%2E9%3A1%3ACryosurgery+of+Prostate

Salvage Treatment – Medicare National Coverage Policy effective July 1, 2001

Medicare revised the national non-coverage policy for cryosurgical salvage therapy to allow coverage only for those patients with localized disease who:

- Have recurrent localized prostate cancer;
- Have failed a trial of radiation therapy as their primary treatment; and
- Meet one of the following conditions: Stage T2B or below, Gleason score <9, PSA < 8 ng/ml;

National Coverage Decision for Cryosurgery of Prostate, Issued July 1, 2001;

<http://www.cms.hhs.gov/transmittals/downloads/R140CIM.pdf>

Private Payers

Coding and coverage will vary per private payer, per benefit package and contract between hospital/physician with the payer.

MEDICARE INPATIENT CODING & REIMBURSEMENT (Valid October 1, 2008 through September 30, 2009)

ICD-9 Diagnosis Codes

185	Malignant neoplasm of Prostate	222.2	Benign Neoplasm of Prostate
198.82	Secondary malignant neoplasm of Genital Organs	236.5	Neoplasm of uncertain behavior of Prostate
233.4	Carcinoma in situ, Prostate		

ICD-9 Diagnosis Codes (*Other Possible Complications)

601.2	Abscess of prostate		
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes		
599.0	Urinary tract infection, site unspecified		

ICD-9 Principal Procedure Code	DRG		Hospital Nat'l Avg Pmt
60.62	707	Major male pelvic procedures w CC/MCC ¹	\$8,994.44 ²
	708	Major male pelvic procedures w/o CC/MCC ¹	\$6,539.69 ²

¹CC: Complications or Comorbidities/MCC: Major Complications or Comorbidities

²The DRG National Average Payments are provided as referenced within the DRG Expert 25th Edition 2009 © Ingenix and have been adjusted to include the capital portion.



MEDICARE PHYSICIAN AND HOSPITAL OUTPATIENT CODING & REIMBURSEMENT
 (Valid January 1, 2009 through December 31, 2009)

Revenue Codes	CPT Codes	Description	Physician Nat'l Avg Pmt	APC Codes	Description	Hospital Nat'l Avg Pmt
36X	55873	Cryosurgical Ablation of the Prostate (includes ultrasonic guidance for interstitial cryosurgical probe placement). See Note	**\$1,184.07	0674	Cryoablate Prostate	\$8,060.88
27X	C2618	Probe, Cryoablation	N/A	N/A	Effective for services provided on or after January 1, 2005, CMS requires hospitals to include device category codes on claims when devices are used in conjunction with procedures billed and paid for under OPPTS. CMS is requiring use of these device codes for reporting all such devices effective January 1, 2005. CMS implemented the edits contained in table 19 until April 1, 2005. Published in CMS Final Rule with comment period: http://www.cms.hhs.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=ascending&itemID=CMS051449&intNumPerPage=10	
Pre and Post Procedure Diagnostic Imaging						
402	76872	Ultrasound, transrectal	**\$36.43	0266	Level II Diagnostic and Screening Ultrasound	\$97.77

References & Disclaimer

Hospital and Physician Coding/Reimbursement:

*Disclaimer: The information herein is provided as a courtesy for educational purposes only to ensure correct coding compliance, claim submission to payers, and reimbursement process. The information has been reviewed for accuracy by Princeton Reimbursement Group (www.prgweb.com). This is not a comprehensive list of all available codes. It is not intended to maximize reimbursement. This information does not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding including knowledge of status indicators which determine final reimbursement lies with the provider of services. Please contact your local payer for interpretation of the appropriate codes to use for specific procedures.

Medicare Coverage Database: National Coverage Determinations (NCD's) are updated "real time" except the NCD download, which is updated weekly. The Local Coverage Determinations (LCD's) are updated on a weekly basis: <http://www.cms.hhs.gov/mcd/overview.asp> Review of the LCD is imperative as non-adherence to the guidelines could negatively affect coverage. Individual LCD's may be accessed via the Medicare Coverage Database: <http://www.cms.hhs.gov/mcd/search.asp?from2=search.asp&>

Note to Hospitals:

Review existing agreements or consult with Private Payers directly to verify if it is necessary to submit claims with HCPCS C2618.

Note to Physicians:

**The 2009 Physician payment rates are displayed in the CMS Federal Register effective October 31, 2008 with a proposed publication date of November 19, 2008. Endocare has provided the unadjusted 2009 payment rates based on the information currently provided by CMS. You may access this information via the following link: <http://www.cms.hhs.gov/PhysicianFeeSched/PFSFRN/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=4&sortOrder=descending&itemID=CMS1216674&intNumPerPage=10>

For Individual rates, the formula and calculation are published by CMS. CMS also provides an option to search for individual rates and provides a Physician Fee Schedule Search. You may access this information via the following link: http://www.cms.hhs.gov/PFSlookup/03_PFS_Document.asp#TopOfPage

Note to Hospitals & Physicians:

CPT Code 55873 (Cryoablation of the prostate) includes Ultrasound Guidance and is not billable with CPT Code 76940 (Ultrasound guidance for, and monitoring of, parenchymal tissue ablation).

All claims submitted to CMS must satisfy the coverage requirements as described within 180.1 Coverage Requirements. In addition, all claims must be submitted with the applicable codes (ICD-9 dx, ICD-9 px, CPT/HCPCS, & Revenue codes) and TNM staging (T1-T3) as described within 180.2 CMS Billing Requirements. Payment Requirements are provided within 180.3. Claims submitted for Primary Treatment with Gleason Scores may be confused for Salvage Treatment and therefore subject to denial. 180.1, 180.2, & 180.3 are provided within Pub 100-04 Medicare Claims Processing Transmittal 1111; issued November 9, 2006 (pages 11-13). <http://www.cms.hhs.gov/transmittals/downloads/R1111CP.pdf>

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