

LMA StoneBreaker™ Pneumatic Lithotripter

2009 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for medical procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement when utilizing the Cook Medical LMA StoneBreaker.

Coverage

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (<http://www.cms.hhs.gov/mcd/search.asp?>), and are encouraged to contact their local carrier medical director (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

Endoscopic Lithotripsy

52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)
52325	Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electro-hydraulic technique)
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)

Percutaneous Lithotripsy

50080	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm
50081	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm

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Inpatient Hospital

Hospitals use ICD-9-PCS codes to describe procedures performed during hospital admissions. Following are two examples of procedure codes that may be pertinent for a given hospital admission.

Facilities coding for transurethral removal of a calculus from the ureter, renal pelvis or bladder should consider:

56.0	Transurethral removal of obstruction from ureter and renal pelvis
57.0	Transurethral clearance of bladder

Facilities coding for percutaneous removal of renal calculus:

55.04	Percutaneous nephrostomy with fragmentation
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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which may include, but are not limited to, the CPT, ICD-9 and MS-DRG coding systems; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, AHA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.

Primary Diagnosis Codes (ICD-9-CM)

Calculus	592.0, 592.1, 592.9, 594.0, 594.1, 594.8, 594.9
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Submitting a claim with procedure code 55.04 and one of the above primary diagnoses (listed for illustrative purposes only) will typically group into one of the following DRGs:

MS-DRG	2009 Medicare Inpatient Reimbursement Description	Inpatient Facility (National Medicare Avg) ^{1,2}
DRG 659	Kidney and Ureter Procedures for Non-neoplasm with Major Comorbidity or Complication	\$17,090.92
DRG 660	Kidney and Ureter Procedures for Non-neoplasm with Comorbidity and Complication	\$9,690.54
DRG 661	Kidney and Ureter Procedures for Non-neoplasm without Comorbidity or Complication or Major Comorbidity or Complication	\$6,436.45

Submitting a claim with procedure code 56.0 and one of the above primary diagnoses (listed for illustrative purposes only) will typically group into one of the following DRGs:

MS-DRG	2009 Medicare Inpatient Reimbursement Description	Inpatient Facility (National Medicare Avg) ^{1,2}
DRG 668	Transurethral Procedures with Major Comorbidity or Complication	\$11,468.77
DRG 669	Transurethral Procedures with Comorbidity or Complication	\$6,164.85
DRG 670	Transurethral Procedures without Comorbidity or Complication or Major Comorbidity or Complication	\$3,935.66

Submitting a claim with procedure code 57.0 and one of the above primary diagnoses (listed for illustrative purposes only) will typically group into one of the following DRGs:

MS-DRG	2009 Medicare Inpatient Reimbursement Description	Inpatient Facility (National Medicare Avg) ^{1,2}
DRG 693	Urinary Stones without ESW Lithotripsy with Major Comorbidity or Complication	\$6,113.60
DRG 694	Urinary Stones without ESW Lithotripsy without Major Comorbidity or Complication	\$3,361.71



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Payment

2009 MEDICARE REIMBURSEMENT FOR SELECTED LITHOTRIPSY PROCEDURES

CPT Code	Procedure Description	Ambulatory Surgery Center		Outpatient Facility	Physician Services	
		ASC Facility Fee (National Medicare Avg) ³	APC	Facility Fee Schedule (National Medicare Avg) ⁴	Fee When Procedure Is Performed in Hospital (National Medicare Avg) ⁵	Fee When Procedure Is Performed in Office (National Medicare Avg) ⁵
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	\$678.73	0162	\$1,690.26	\$367.16	\$981.37
52318	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; complicated or large (over 2.5 cm)	\$733.83	0162	\$1,690.26	\$500.24	\$500.24
52325	Cystourethroscopy (including ureteral catheterization); with fragmentation of ureteral calculus (e.g., ultrasonic or electro-hydraulic technique)	\$823.54	0162	\$1,690.26	\$337.94	\$337.94
52353	Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)	\$1,030.98	0163	\$2,369.29	\$446.50	\$446.50
50080	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm	This service is not included on Medicare's list of approved procedures		\$3,026.08	\$903.11	N/A
50081	Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm	This service is not included on Medicare's list of approved procedures		\$3,026.08	\$1,326.17	N/A

1. Hart A, ed. Appendix E. In: *DRG Expert: A Comprehensive Guidebook to the DRG Classification System*. 25th ed. Eden Prairie, MN: Ingenix; 2009.
2. Individual hospital payment levels differ based on, but not limited to, geographic location, bed size, teaching status and the percentage of low-income patients.
3. 2009 Medicare Ambulatory Surgery Center Fee Schedule
4. 2009 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule
5. 2009 Medicare Physician Fee Schedule

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2009 physician fees for your local area can be found at the following CMS links:

<http://www.cms.hhs.gov/PFSlookup/>

or

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/>



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