



# HEALTHCON

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# THE INS AND OUTS OF UROLOGIC CODING

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# Agenda

- Introduction - Stephanie Stinchcomb, CPC
- CPT Coding Updates
- Urologic Procedures
- Challenges from AUA Coding Hotline – Susan Crews, CPC
- ICD-10-CM

# Agenda

- How to Use NCDs and LCDs
- Questions?
- Wrap Up

# 2017 New CPT Codes for Procedures

# 2017 New CPT Codes

## Moderate (Conscious) Sedation

- Appendix G of CPT Manual removed from CPT code set
- Moderate Sedation symbol has been removed from 180 codes; these now have the revision mark in CPT 2017

# 2017 New CPT Codes

- *84410 Testosterone; bioavailable, direct measurement(eg, differential precipitation)*
- Rationale: (Pathology and Laboratory/Chemistry): Code 84410 has been established in the Chemistry subsection to report measurement of bioavailable levels of testosterone. Previously, there was no specific code for this test. Therefore a new code was needed to describe the measurement of bioavailable testosterone levels, which may be used to differentiate secondary hypogonadism from primary testicular failure



# 2017 New CPT Codes

- Category III Code:

*0421T transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)*

*Also known as Aquabeam*

# 2017 New CPT Codes

*81539 Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2], utilizing plasma or serum, prognostic algorithm reported as probability score*

- **Clinical Example** (CPT changes 2017)

A 60-year-old male presents with an elevated PSA of 4.7ng/mL and a normal digital rectal exam. He is being considered for a prostate biopsy. The patient is reluctant to undergo the biopsy.

# Pathology & Laboratory

## CPT® Proprietary Laboratory Analyses (PLA) Codes

- New addition to the CPT® code set approved by the AMA CPT® Editorial Panel.
- Alpha-numeric CPT codes with a corresponding descriptor for labs or manufacturers that want to more specifically identify their test.
- Tests with PLA codes must be performed on human specimens and must be requested by the clinical laboratory or the manufacturer that offers the test.

# Medicare Changes Affecting Coding

# Pathology & Laboratory

- Section 216, Protecting Access to Medicare Act of 2014 (PAMA),
- Revises the Medicare payment system for clinical diagnostic laboratory tests starting January 2017
- Certain clinical labs report how much they receive from private insurers for lab tests as well as lab test volumes

Labs that receive at least \$12,500 a year in Medicare revenues from laboratory services paid under the CLFS and more than half of their Medicare revenues from laboratory and/or physician services

- CMS plans to calculate new Medicare payment rates under the Clinical Laboratory Fee Schedule (CLFS), beginning in 2018



# CMS Grants New HCPCS Supply Code for Fluciclovine F 18

- Axumin™ (fluciclovine F 18) injection is a diagnostic agent indicated for positron emission tomography (PET) imaging in men with suspected prostate cancer recurrence based on elevated blood prostate-specific antigen levels following prior treatment. Axumin received FDA approval on May 27, 2016
- CMS granted Axumin an A-code and transitional pass-through status, effective January 1, 2017. Beginning January 1, 2017, Axumin will have Medicare Pass-Through Status in the hospital setting and a permanent HCPCS code: A9588 fluciclovine F 18, diagnostic, 1 mCi. (Unit Alert: The descriptor for A9588 is per 1 mCi, not per study dose – be alert to the units billed on claims. The recommended dose of Axumin is 10 mCi)
- Additionally, as of January 1, 2017, all local Medicare Administrative Contractors (MACs) have determined that Axumin would be covered for its label indication

# 76942 Edit: Bundled with Diagnostic Ultrasound

- On July 1, 2016, an edit was implemented for CPT code 76942 *Ultrasonic guidance for needle placement* paired with CPT code 76872 – ultrasound, transrectal
- The AUA requested in a letter that the edit be removed, as these codes are generally not performed together and the edit will create erroneous denials
- A conference call was held with the National Correct Coding Initiative (NCCI) and CMS on June 9, 2016 to further appeal the removal of this edit.

# 76942 Edit: Bundled with Diagnostic Ultrasound

- After this call, the AUA was notified on August 1, 2016 that the CMS NCCI Workgroup kept the edit in place
- The AUA respectfully disagrees with this edit. Further written communication was sent to NCCI and CMS in hopes to have them overturn their decision
- CMS refused to delete the edit and changed the language in the CCI Policy Manual citing two ultrasounds performed on the same body area at the same encounter cannot be reported separately.



# Urinary Stone Treatments

The Centers for Medicare and Medicaid Services (CMS) has determined that when treatment of multiple urinary tract stones on the ipsilateral side of a Medicare patient is performed, these codes should not be reported separately using the 59 separate procedure modifier.

# Scenario One:

One stone in distal ureter and one stone in proximal ureter both were treated using *52353 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)*.

**Report CPT code 52353 once.**

## Scenario Two\*:

One stone in the ureter and one stone in the kidney, one treated with 50590 *Lithotripsy, extracorporeal shock wave* and the other with 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)*.

**Report only CPT code 50590.**

\*The AUA does not agree with the guidance established by CMS on scenario two. Modifier 59 guidance states that if two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures/surgeries on that date of service.

## Scenario Three:

One stone in ureter and one stone in the kidney, one treated with 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* and the other treated with 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)*.

**Report CPT code 52353 only.**

# Scenario Four:

One stone in the ureter, the stone is pushed into the kidney first 52352 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)* and then treated with 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)*.

**Report the 52353 only.**

# Scenario Five:

One stone in the kidney, the stone is treated with *50590 Lithotripsy, extracorporeal shock wave* and particles of stones were removed from the bladder by *52352 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included).*

**Report only CPT code 50590.**

# Urinary Stone Treatments

CMS only for Medicare claims.

Commercial insurers may not adhere to this guidance.

Check with your local insurer to verify coding guidance.

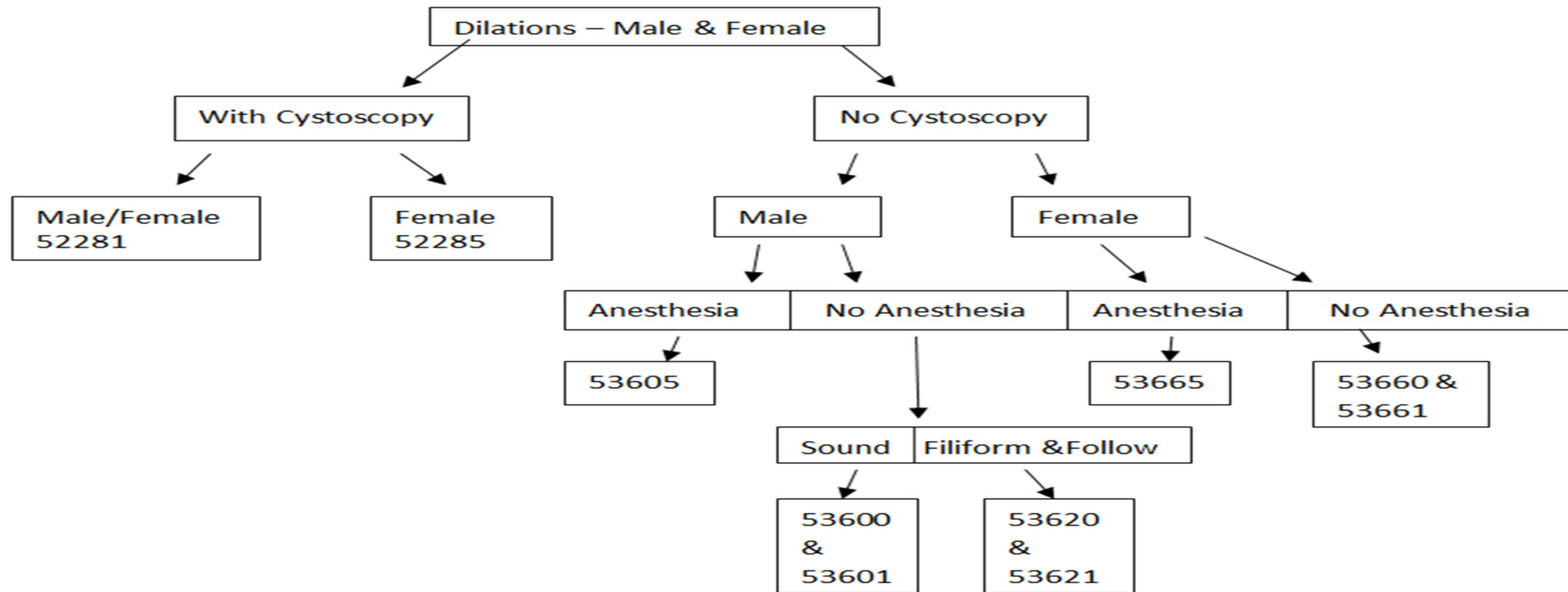
# Urologic Procedures



# Imaging Guidance

- When imaging guidance or imaging supervision and interpretation is included in a surgical procedure, guidelines for image documentation and report, included in the Radiology guidelines (Including Nuclear Medicine and Diagnostic Ultrasound) will apply.
- A written report (eg, handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation.

# Cysto/Dilation



# Cystourethroscopy via Conduit

## Guidelines

- *Because cutaneous urinary diversions utilizing ileum or colon serve as functional replacements of a native bladder, endoscopy of such bowel segments, as well as performance of secondary procedures can be captured by using the cystourethroscopy codes. For example, endoscopy of an ileal loop with removal of ureteral calculus would be coded as cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus (52320).*

# Cystourethroscopy Bladder Biopsy

52224 –Cystourethroscopy, with fulguration (including cryosurgery or laser surgery)or treatment of MINOR(**less than 0.5cm**)lesion(s) with or without bx

52234–Cystourethroscopy, with fulguration (including cryosurgery or laser surgery)and/or resection of; SMALL bladder tumor(s) (**0.5 up to 2.0cm**)

52235-MEDIUM bladder tumor(s) (**2.0 to 5.0cm**)

52240-LARGE bladder tumor(s) **over 5.0cm**

**Do not code from pathology report**

# Cystourethroscopy & Retrograde

- 52005 *Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;*
- 74420-26 *Urography, retrograde, with or without KUB*

Carrier makes payment to provider who submits claim first.



# Ureteroscopy Balloon Dilation

- **52344** Cystourethroscopy **with ureteroscopy**; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)
- **52345** with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)
- **52346** with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)

# Ureteroscopy/Lithotripsy and Stent Insertion

- 52353- Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)
- 52332- Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

If these procedures are not performed during the same operative session, report what procedure is performed

# Ureteroscopy with Stent Insertion

- If ureteroscopy with lithotripsy and stent insertion is performed during the same operative session, report:
- 52356 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)



# Endoscopic Injection

- **51715** Endoscopic injection of implant material into the submucosal tissues of the urethra and/or bladder neck
  - L8603 Collagen/Macroplastique
- **52287** Cystourethroscopy, with injection(s) for chemodenervation of the bladder
  - J0585 Botox

# Urodynamic Studies

- A separate report and interpretation should be provided for each of the services performed as part of the urodynamic study
- Additionally, all printed components of the test should be included in the patient's chart as supporting documentation for the technical component of the urodynamic test
- The report should include the results of the tests and the interpretation of the provider in order to bill the professional component of the CPT code

# Voiding Pressure Study Using Penile Cuff

Report if performed and documented

51784 EMG

51741 Complex uroflowmetry

No CPT code available for voiding pressure study using penile cuff

51728-52 is not appropriate to report the voiding pressure study.

# Bladder Ultrasound

- If the urologist performs bladder US to view the anatomy, the architecture, or the morphology of the full bladder, as well as to determine PVR after voiding, use CPT code 76857.
- In the documentation of this study in the medical records the urologist should mention the bladder wall thickness, the presence of bladder diverticula, any intravesical prostatic protusion or pathology, the prostatic size as measured transabdominally, and may also report on the presence of residual urine

# Post Void Residual

- However, if the main intent of the study is to determine the PVR, then only report CPT code 51798 regardless of the technology used.
- Supervision and interpretation should be separately documented and found in patient's chart

# MRI Fusion Prostate Biopsy

Currently, for the MRI/ultrasound image fusion, there is no CPT code to report this.

Urologists should not bill CPT code 77021 *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation*.

One may try to bill 76498 *Unlisted Magnetic Resonance procedure, (e.g., diagnostic, interventional)* for the additional work of fusing the MRI and the ultrasound, but it is unlikely to be reimbursed. It may be appropriate to check with the insurance provider for their reimbursement/coverage policy.



# Laparoscopic/Robotic Prostatectomy and Lymphadenectomy

- 55866- *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes **robotic assistance, when performed***
- 38571- *Laparoscopy, surgical; with bilateral total pelvic Lymphadenectomy*
- 38572 - *Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple*

*Do not submit S2900 Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)*

# Radical Nephrectomy

- 50545 *radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)*
- The Gerota's fascia is the only tissue that must be removed (along with the kidney) in order to report 50545; it is not necessary to perform an adrenalectomy or removal of the regional lymph nodes.



# Laparoscopic Cystectomy

- No specific code to report a laparoscopic radical cystectomy.
- Guidance was given to use CPT code 51999 Unlisted laparoscopy procedure, bladder.
- The AUA CRC reviewed the current CPT code(s) available for cystectomy (CPT 51550-51596) and determined that these codes are not approach dependent. There are no current vignettes or description of service.

# Percutaneous Nephrostolithotomy PCNL

- If the patient has no access, the urologist places access, dilates and removes stone and patient leaves with no tubes in place (tubeless): 50395 and 50080/81
- If the patient has no access, the urologist places access, dilates and removes stone and patient leaves with a nephrostomy in place: 50432 and 50080/81
- If the patient has a nephrostomy already in place, the urologist dilates and removes stone and patient leaves with a nephrostomy in place: 50435 and 50080/81

# Hotline Questions

# High-intensity focused ultrasound (HIFU)

In October 2015, FDA approved HIFU for the sole indication of tissue ablation of the prostate.

No coverage most insurance companies for prostate cancer

Considers HIFU experimental and investigational

Some companies are trying to establish treatment centers within the United States.

If facilities are performing HIFU for treatment of prostate cancer, they would be doing so as an off-label use.

# Radical Nephrectomy

*50545: Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)*

*50230 Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy*

Do all tissues in the parenthetical need to be removed?

No: only Gerota's fascia

Not necessary to perform adrenalectomy and/or removal of the regional lymph nodes

Still only report 50230 (only) if performing IVC thrombectomy (open)

# Laparoscopic Cystectomy

- No specific code exists
- In the past, CPT code 51999 Unlisted laparoscopy procedure, bladder was recommended
- The CRC reviewed this; in this case, codes are not approach dependent and no “vignette” exists. So OK to use current cystectomy codes by any approach:



# Laparoscopic Cystectomy

- 51550 Cystectomy, partial; simple
- 51555 Cystectomy, partial; complicated (eg, postradiation, previous surgery, difficult location)
- 51565 Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)
- 51570 Cystectomy, complete; (separate procedure)
- 51575 Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
- 51580 Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations;
- 51585 Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
- 51590 Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;
- 51595 Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
- 51596 Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder

# Laparoscopic Simple Prostatectomy

For benign prostatic hyperplasia (BPH)

55821 Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy) or 55831 Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal

Depending how the laparoscopic simple prostatectomy is performed and documented.

Code is not approach dependent (open or laparoscopic)

- Article published in Policy and Advocacy Brief to use 55821 for laparoscopic simple prostatectomy procedures for benign prostatic hyperplasia (BPH)



# ICD-10: Changes that Occurred in 10/2016 (Recap)

# Reporting Castrate Resistant Prostate Cancer

C61 Malignant neoplasm of prostate

Use additional code to identify

Hormone sensitivity status (Z19.1-Z19.2)

Rising PSA following treatment for malignant neoplasm of prostate (R97.21)

The hormone sensitivity status codes include:

Z19.1      Hormone sensitive malignancy status

Z19.2      Hormone resistant malignancy status  
(Castrate resistant)

# ICD-10-CM Diagnosis Codes

- N28.9 Disorder of kidney and ureter, unspecified (renal mass)
- Q62.5 Duplication of ureter
- Z53.31 Laparoscopic surgical procedure converted to open procedure

# ICD-10-CM Diagnosis Codes

- **Current malignancy versus personal history of malignancy** (Chapter 2: Neoplasms)
  - When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

# ICD-10-CM Diagnosis Codes

- **Current malignancy versus personal history of malignancy** (Chapter 2: Neoplasms)
  - When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

# ICD-10-CM Diagnosis Codes

- Congenital Malformations (Chapter 17)
  - Codes from this chapter may be used throughout the life of the patient.
  - If malformation has been corrected use personal history code to identify the history
    - (personal history code can be found in the Z87 section)
  - Whenever diagnosed by the physician, it is appropriate to assign a code from Q00-Q99

# ICD-10-CM Diagnosis Codes

- Congenital Malformations (Chapter 17)
  - A malformation code may be the principal/first-listed diagnosis or a secondary diagnosis.
  - When a unique code cannot be assigned use additional code(s) for any manifestations that may be present.



# ICD-10-CM Diagnosis Codes

- Use of a symptom code with a definitive diagnosis code.  
(Chapter 18 Symptoms, signs)
  - Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code.
  - Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification

# New ICD-10-CM Codes for October 1, 2017

## Pediatric Cryptorchidism

- Abdominal testis, unilateral, unspecified
- Abdominal testis, bilateral, unspecified

# Requested ICD-10-CM Diagnosis Codes for 2018

New sub-subcategory	Urethral stricture, other or unspecified etiology, male
New code	Urethral stricture, other or unspecified etiology, male, meatal
New code	Urethral stricture, other or unspecified etiology, male, bulbous
New code	Urethral stricture, other or unspecified etiology, male, membranous
New code	Urethral stricture, other or unspecified etiology, male, anterior
New code	Urethral stricture, other or unspecified etiology, male, overlapping sites
New code	Urethral stricture, other or unspecified etiology, male, unspecified
• Add	Pinhole meatus NOS
• New code	Urethral stricture, other or unspecified etiology, female

# LCDs and NCDs: How to use them in practice?

# What is a NCD & LCD?

National Coverage Determinations (aka NCD's) and Local Coverage Determination (aka LCD's) - decisions by Medicare and administrative contractors (MAC's) on coverage of services considered reasonable and necessary.

Medicare contractors develop LCDs to further define coverage in NCD or to define criteria for coverage of services.

The guidelines for LCD development are provided in Chapter 13 of the Medicare Program Integrity Manual.

This information is defined in Section 1869(f)(2)(B) of the Social Security Act (the Act).

# Supplemental Article (aka SA or Article)

Is a guidance document

Any non-reasonable and necessary language a Medicare contractor wishes to communicate to providers

At the end of an LCD that has an associated article, there is a link to the related article and vice versa

# NCD & LCD?

In the absence of a Local Coverage Determination (LCD), National Coverage Determination (NCD), or CMS Manual Instruction, Reasonable and Necessary guidelines still apply. Section 1862(a)(1)(A) of the Social Security Act (SSA) directs the following:

“No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Therefore, to be considered “reasonable and necessary” the patient’s medical record must clearly document all of the following:

The item or service is for the diagnosis or treatment, or to improve the functioning of a malformed body member

The item or service is appropriate for the symptoms and diagnosis or treatment of the patient’s condition, illness, disease or injury



- The item or service is furnished in accordance with current standards of good medical practice
  - The item or service is not primarily for the convenience of the patient or physician or health care provider
  - The item or service is the most appropriate supply or level of service that can be safely provided to the patient
  - The item or service is delivered in the most appropriate setting
  - The item or service is ordered and/or furnished by qualified personnel
- For any service reported to Medicare, medical record documentation must clearly demonstrate the service(s) meets all of the above criteria. All documentation must be maintained in the patient's medical record and be available to the contractor upon request

# How to review an LCD!

<< [Back to Local Coverage Determinations \(LCDs\) for First Coast Service Options, Inc. \(First Coast Service Options, Inc. \(09102, A and B MAC, J - N\)\)](#)



## Local Coverage Determination (LCD): Testosterone pellets (Testopel®) (L33412)

Select the **Print Complete Record**, **Add to Basket** or **Email Record** Buttons to print the record, add it to your basket or to email the record.

### Printing Note:

To print an entire document, including all codes in all code groups, use the **Need a PDF** Button or the **Print Complete Record** Button.

To print only the current visible page contents, use the **Print** Button in the page header.

**Need a PDF?** 

**Print Complete Record**

**Add to Basket**

**Email Record**

### Section Navigation

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[Expand All](#) | [Collapse All](#)

### Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09101 - MAC A	J - N	Florida
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09102 - MAC B	J - N	Florida
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09201 - MAC A	J - N	Puerto Rico Virgin Islands
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09202 - MAC B	J - N	Puerto Rico
<a href="#">First Coast Service Options, Inc.</a>	A and B MAC	09302 - MAC B	J - N	Virgin Islands

## LCD Information

### Document Information

**LCD ID**

L33412

**Original ICD-9 LCD ID**

L33004 

**LCD Title**

Testosterone pellets (Testopel®)

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For services performed on or after 10/01/2015

**Revision Effective Date**

For services performed on or after 10/01/2015

**Revision Ending Date**

N/A

**Retirement Date**

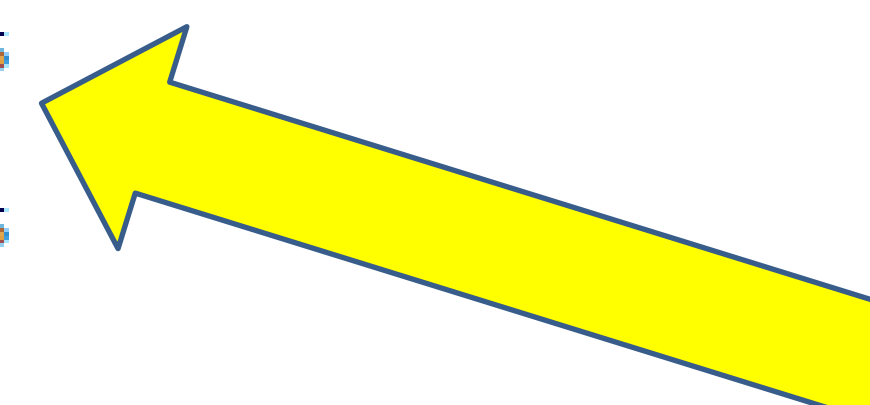
N/A

**Notice Period Start Date**

N/A

**Notice Period End Date**

N/A



### CMS National Coverage Policy

Language quoted from CMS National Coverage Determination (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

## CMS National Coverage Policy

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Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 17, Sections 10; 20; & 40

CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 13, Section 13.1.3

Social Security Act Section 1861 (t) (2) (B)

## Coverage Guidance

### Coverage Indications, Limitations, and/or Medical Necessity

Testosterone is an endogenous androgen. Endogenous androgens are responsible for the normal growth and development of the male sex characteristics. Testosterone levels vary from hour to hour; periodic declines below the normal range can occur in some otherwise normal men. An overall diurnal rhythm is also present, the highest levels of circulating testosterone occurring during the early morning hours. In certain medical conditions such as hypogonadism, the endogenous level of testosterone falls below normal levels. The diagnosis of androgen deficiency is made in men with consistent signs and symptoms and unequivocally low serum testosterone levels. Testosterone levels should be determined in the morning, and studies should be repeated in patients with subnormal levels.

Testosterone pellets (Testopel®) have been approved by the Food and Drug Administration (FDA) for the treatment of primary hypogonadism (congenital or acquired) and hypogonadotrophic hypogonadism (congenital or acquired). Primary hypogonadism includes such conditions as testicular failure due to cryptorchidism, bilateral torsion, orchitis, vanishing testes syndrome; or orchidectomy. Hypogonadotrophic hypogonadism (secondary hypogonadism) includes conditions such as idiopathic or gonadotropic luteinizing hormone releasing hormone (LHRH) deficiency or pituitary-hypothalamic injury from tumors, trauma or radiation.

### Indications:

Testosterone pellets (Testopel®) will be considered medically reasonable and necessary for the following indications:

- Second line testosterone replacement therapy in males with congenital or acquired endogenous androgen absence or deficiency associated with primary or secondary hypogonadism when other standard replacement [intramuscular (IM), buccal, transdermal] is not clinically effective; *OR*,
- For treatment of delayed male puberty

Testosterone pellets (Testopel®) method of administration is subcutaneously by a health care professional.

### Limitations:

Androgens are contraindicated in men with carcinomas of the breast or with known or suspected carcinomas of the prostate.

For patients that clearly meet the indication for testosterone replacement, the reason(s) for a transition to pellets from other effective replacement (IM, buccal, transdermal) must be specifically addressed in the medical record.

Clinical diagnosis of androgen deficiency (non-specific symptoms, low normal testosterone levels, and normal free testosterone) is not a covered indication. Office practices with high utilization of testosterone pellet implantations can be subject to pre- or post-payment review.

## Coding Information

### Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x	Hospital Inpatient (Including Medicare Part A)
013x	Hospital Outpatient
085x	Critical Access Hospital

### Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0636	Pharmacy - Drugs Requiring Detailed Coding
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### CPT/HCPCS Codes

**Group 1 Paragraph:** \* Providers must bill HCPCS code J3490 and CPT code 11980 on the same claim. If HCPCS code J3490 and CPT code 11980 are not billed on the same claim, the claim will be subject to prepayment review.

J3490\* Testosterone pellets (Testopel®)

11980\* Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)

### Group 1 Codes:

XX000	Not Applicable
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### ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:** N/A

### Group 1 Codes:

### CPT/HCPCS Codes

**Group 1 Paragraph:** \* Providers must bill HCPCS code J3490 and CPT code 11980 on the same claim. If HCPCS code J3490 and CPT code 11980 are not billed on the same claim, the claim will be subject to prepayment review.

J3490\* Testosterone pellets (Testopel®)

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#### Group 1 Codes:

XX000	Not Applicable
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### ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: N/A

#### Group 1 Codes:

Show entries: 100 ▼

Search:

Search By: ☒ Description ☐ Code

SEARCH GROUP

CLEAR SEARCH

ICD-10 CODE	DESCRIPTION
E29.1	Testicular hypofunction
E30.0	Delayed puberty

Showing 1 to 2 of 2 entries in Group 1

First Prev 1 Next Last

### ICD-10 Codes that DO NOT Support Medical Necessity

#### Additional ICD-10 Information



## General Information

### Associated Information Documentation Requirements

The medical record must substantiate the medical need for testosterone pellets (Testopel®) with documentation of unsuccessful treatments of standard replacement (IM, buccal, transdermal) on more than one occasion, in men with clinically significant symptoms of androgen deficiency.

The reason(s) for a transition to pellets from other effective replacement (IM, buccal, transdermal) must be specifically addressed in the medical record.

The medical record should reflect two total testosterone levels and free testosterone levels when indicated to determine the medical necessity of testosterone replacement. It is suggested to measure morning testosterone level by a reliable assay on two different days. The results of both tests must fall below the normal laboratory reference range. The medical record should include the Clinical Laboratory Improvement Amendments (CLIA) approved reference normal range for the testosterone assay used.

Medical record documentation must be made available upon request. When the documentation does not meet the criteria for the services rendered, or the documentation does not establish the medical necessity for the service(s), such services will be denied as not reasonable and necessary under Section 1862(a)(1) (A) of the Social Security Act.

### Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

### Sources of Information and Basis for Decision

FCSO reference LCD number(s) – L33002

Bhasin, S., Cunningham, G., Hayes, F., Matsumoto, A., Snyder, P., Swerdloff, R., Montori, V. (2010). Testosterone therapy in adult men with androgen deficiency syndromes: an Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism*. 95(6), 2536-59.

Clinical Pharmacology. (2012). Testosterone (Testopel). Retrieved from <http://www.clinicalpharmacology.com>

Goodman, N., Cobin, R., Ginzburg, S., Katz, I., Woode, D., (2011). American association of clinical endocrinologists medical guidelines for clinical practice for the diagnosis and treatment of menopause. *AACE Guidelines*. Retrieved from <https://www.aace.com/files/menopause.pdf>

U.S. Food and Drug Administration. Department of Health and Human Services. (2012). FDA approved drug products. Retrieved from [http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Search.Label\\_ApprovalHistory#apphist](http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction=Search.Label_ApprovalHistory#apphist)

U.S. National Library of Medicine (NLM). (2011). Testopel® (testosterone) pellet label. Slate Pharma. Retrieved from <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=a1741a0b-3d4c-42dc-880d-a06e96cce9ef>

## Revision History Information

**Please note:** Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2015	R1	06/05/2014 – The language and/or ICD-10-CM diagnoses were updated to be consistent with current LCD language and ICD-9-CM coding.	<ul style="list-style-type: none"><li>Revisions Due To ICD-10-CM Code Changes</li></ul>

## Associated Documents

### Attachments

[Coding guidelines](#) (PDF - 80 KB)

### Related Local Coverage Documents

N/A

### Related National Coverage Documents

N/A

### Public Version(s)

Updated on 07/01/2014 with effective dates 10/01/2015 - N/A  
Updated on 05/28/2014 with effective dates 10/01/2015 - N/A  
Updated on 04/02/2014 with effective dates 10/01/2015 - N/A

## Keywords

N/A

**Contractor Name**

First Coast Service Options, Inc.

**Contractor Number**

09101 – Florida  
09201 – Puerto Rico/Virgin Islands  
09102 – Florida  
09202 – Puerto Rico  
09302 – Virgin Islands

**LCD Title**

Testosterone pellets (Testopel®)

**Coding Guidelines**

Providers are instructed to bill the unlisted HCPCS code J3490 (unclassified drugs) when billing for Testosterone pellets (Testopel®). In addition, CPT code 11980 (subcutaneous hormone pellet implantation) should be billed for the implantation of the testosterone pellets. Providers must bill HCPCS code J3490 and CPT code 11980 on the same claim. If HCPCS code J3490 and CPT code 11980 are not billed on the same claim the claim will be subject to prepayment review.

The Medicare Claims Processing Manual, Chapter 26 Completing and Processing Form CMS-1500 Data Set provides instruction for Item 19 on the CMS-1500 claim form. When HCPCS code J3490 (unclassified drugs) is billed enter the drug's name and dosage on Item-19. For example, block 19 might state: testosterone pellets (Testopel®), 75mg per pellet, implanted 225 mg (3 pellets). If a compounded form of testosterone pellets is used, this must be indicated in block 19 with the name, strength and dosage as described in the above example.

**Comments**

N/A

**Revision History**

Date	Revision
10/01/2015	This "Coding Guideline" replaces all previous "Coding Guidelines" to comply with ICD-10-CM based on Change Request 8112. The effective date of this "Coding Guideline" is based on date of service.

# Traditional Medicare (Part B)

Gold standard for published coding and payment rules

- CCI Edits
- Relative Value Updates
- Confusing Incentive and Payment Adjustments

Commercial Managed Care – rules driven by contract language and accompanying policies

- Policies provided “on demand”
- Black box edits
- Pay for performance tied to costs

- Medicare Advantage (Part C) – fixed revenue, sales driven benefits, contracts misunderstood
- Medicaid – multi-state practices forced to honor different rules
- Worker's Comp – Fixed fee schedules, delayed by disputes
- Patients – varying payment expectations and assumption of no duty to pay
- More frequent migration among all options

# Billing

- Use different Fee Schedules?
- Use different codes
- Use different Modifiers
- Rules Change
  - Try new things not in violation of contract
  - CPT rules are a guide
- Transparency Check web sites
- Never Bill What You Cannot Appeal

# Contract Analysis

## Payment Rate

- Medicare based (what year?)
- Conversion factor and RVUS
- Other Methods
- Request fee schedule
  - Watch the games
- What is not eligible?



# Know Your Insurers

## Yearly Review

- Contract Analysis
- Contract vs. Actual
- Rules Variation
- Payment Delay
- % of practice

Quit Bad Payers

# Eligibility Check

- Web portal
- 270/271 transaction

Payers differ on what is provided

Minimum check benefits for DOS

Can provide deductible, co-pay and co-insurance

Future Full claim adjudication?

# Medicare Appeals Process

**Reopening** – correction of typographical or mathematical errors

Up to one year from original claim

## **Redetermination**

Submitted on Redetermination Notice (CMS 20027)-No minimum

Amount in controversy (AIC)

120 days to request -MAC has 60 days to decide

## **QIC Reconsideration**

Submitted (CMS 20033) and performed by Qualified Independent

Contractor – no minimum AIC

180 days to request -QIC has 60 days to decide

# Medicare Appeals Process

## **Administrative Law Judge (ALJ)**

Appellant must prepare (CMS 20034) and a position paper -  
Minimum \$120 AIC

60 days to request -ALJ has 90 days to decide

Plaintiff's attorney is advisable

## **Medicare Appeals Council (MAC)**

Request for oral argument must be made in writing (DAB 101) -  
No minimum AIC

60 days to request review -MAC has 90 days to decide

# Medicare Appeals Process

## Federal Court

Request must be filled in federal district court - \$1180 AIC

Plaintiff's attorney is required

# Prompt Payment Rule

- 47 states have prompt payment laws - insurance plans must pay within a specified time period – know your rights – Contact your state Insurance Dept.
- Insist that contracts refer to prompt payments rules for your state
- Negotiate liquidated damages from health plan for delayed claims







# Contact Info:

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