Medtronic

2022 Billing and Coding Guide

Urology Surgery

Rates listed in this guide are based on their respective site of care- physician office, ambulatory surgical center, or hospital outpatient department. All rates provided are for the Medicare unadjusted national average rounded to the nearest whole number for 2022 and do not represent adjustment specific to the provider's location or facility. Commercial rates are based on individual contracts. Providers are encouraged to review contracts to verify their specific contracted allowables.

Medtronic products used associated with wound closure procedures addressed within this guide do not have dedicated HCPCS[1] level II coding assignment. Providers may choose to report *A4649 Surgical supply; miscellaneous* for purposes of cost tracking. Medicare considers the use of surgical supplies to be included in the payment for the associated CPT and no additional payment is allowed.

CPT® Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Cystectomy				
51550	Cystectomy, partial; simple	Facility Only:$976	Inpatient only, not reimbursed for hospital outpatient or ASC	
51555	Cystectomy, partial; complicated (eg, postradiation, previous surgery, difficult location)	Facility Only: $1277	Inpatient only, not reimbursed for hospital outpatient or ASC	
51565	Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)	Facility Only:$1,302	Inpatient only, not reimbursed for hospital outpatient or ASC	
51570	Cystectomy, complete (separate procedure)	Facility Only:$1,485	Inpatient only, not reimbursed for hospital outpatient or ASC	
51575	Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	Facility Only:$1,838	Inpatient only, not reimbursed for hospital outpatient or ASC	
51580	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations	Facility Only:$1,913	Inpatient only, not reimbursed for hospital outpatient or ASC	
51585	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations, with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	Facility Only:$2,129	Inpatient only, not reimbursed for hospital outpatient or ASC	
51590	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis	Facility Only:$1,949	Inpatient only, not reimbursed for hospital outpatient or ASC	
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	Facility Only:$2,204	Inpatient only, not reimbursed for hospital outpatient or ASC	
51596	Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder	Facility Only:$2,375	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT® Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
Nephrectomy				
50220	Nephrectomy, including partial ureterectomy, any open approach including rib resection	Facility Only:$1,070	Inpatient only, not reimbursed for hospital outpatient or ASC	
50225	Nephrectomy, including partial ureterectomy, any open approach including rib resection; complicated because of previous surgery on same kidney	Facility Only:$1,218	Inpatient only, not reimbursed for hospital outpatient or ASC	
50230	Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy	Facility Only:$1,294	Inpatient only, not reimbursed for hospital outpatient or ASC	
50234	Nephrectomy with total ureterectomy and bladder cuff; through same incision	Facility Only:$1,320	Inpatient only, not reimbursed for hospital outpatient or ASC	
50236	Nephrectomy with total ureterectomy and bladder cuff; through separate incision	Facility Only:$1,480	Inpatient only, not reimbursed for hospital outpatient or ASC	
50240	Nephrectomy, partial	Facility Only:$1,341	Inpatient only, not reimbursed for hospital outpatient or ASC	
50543	Laparoscopy, surgical; partial nephrectomy	Facility Only:$1,505		
50545	Laparoscopy, surgical; radical nephrectomy (includes removal of Gerota's fascia and surrounding fatty tissue, removal of regional lymph nodes, and adrenalectomy)	Facility Only:$1,348	Inpatient only, not reimbursed for hospital outpatient or ASC	
50546	Laparoscopy, surgical; nephrectomy, including partial ureterectomy	Facility Only:$1,217	Inpatient only, not reimbursed for hospital outpatient or ASC	
50548	Laparoscopy, surgical; nephrectomy with total ureterectomy	Facility Only:$1,355	Inpatient only, not reimbursed for hospital outpatient or ASC	
Prostatectomy				
55801	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy)	Facility Only:$1,107	Inpatient only, not reimbursed for hospital outpatient or ASC	
55810	Prostatectomy, perineal radical	Facility Only:$1,321	Inpatient only, not reimbursed for hospital outpatient or ASC	
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	Facility Only:$1,623	Inpatient only, not reimbursed for hospital outpatient or ASC	
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes	Facility Only:$1,777	Inpatient only, not reimbursed for hospital outpatient or ASC	
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages	Facility Only:$883	Inpatient only, not reimbursed for hospital outpatient or ASC	

CPT® Code[2]	Description	Physician[3]	Ambulatory Surgical Center[4]	Hospital Outpatient[4]
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal	Facility Only:$957	Inpatient only, not reimbursed for hospital outpatient or ASC	
55840	Prostatectomy, retropubic radical, with or without nerve sparing	Facility Only:$1,181	Inpatient only, not reimbursed for hospital outpatient or ASC	
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)	Facility Only:$1,182	Inpatient only, not reimbursed for hospital outpatient or ASC	
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes	Facility Only:$1,374	Inpatient only, not reimbursed for hospital outpatient or ASC	
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Facility Only:$1,455	NA	$9,096
Robotic Assistance				
S2900	Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)	HCPCS II S-Codes cannot be reported to Medicare. They are used only by non-Medicare payers, which may cover and price them according to their own requirements		

Hospital Inpatient Procedure Coding for Urology Surgery

ICD-10-PCS procedure codes[5] are used by hospitals to report surgeries and procedures performed in the inpatient setting.

All ICD-10-PCS codes have seven digits, each digit representing a specific character associated with procedures. Code assignment in ICD-10-PCS is a process of "constructing" the code by selecting values from a code table for each of the seven standard characters. Key characters are discussed below.

Character	Description
3: Root Operation	The two main root operations for removal of tissue are B-Excision and T-Resection. By definition, B-Excision involves removing a portion of the body part and T-Resection involves removing the entire body part.[2] For example, partial cystectomy uses B-Excision and complete cystectomy uses T-Resection. Note that physicians may use these terms more broadly. It's the coder's responsibility to determine what the physician's documentation equates to in terms of ICD-10-PCS definitions. The physician is not expected to document using ICD-10-PCS code descriptions, and the coder is not required to query the physician in these circumstances.[2]
5: Approach	Different codes are constructed depending on the approach: **0-**Open involves an open incision to directly expose the surgical site **4-**Percutaneous Endoscopic is used for procedures performed via laparoscopy.

ICD-10-PCS Code	Code Description
Cystectomy	
Partial cystectomy	
0TBB0ZZ	Excision of bladder, open approach
0TBB4ZZ	Excision of bladder, percutaneous endoscopic approach
Total cystectomy	
0TTB0ZZ	Resection of bladder, open approach
0TTB4ZZ	Resection of bladder, percutaneous endoscopic approach
Radical cystectomy	
Radical cystectomy involves complete removal of the bladder with diversion of the ureters, sometimes with extensive lymphadenectomy. Removal of the bladder is coded to total cystectomy, as above. Additional codes are then assigned to capture the ureteral diversion and lymphadenectomy as performed.	
Nephrectomy	
Partial nephrectomy	
0TB00ZZ	Excision of right kidney, open approach
0TB04ZZ	Excision of right kidney, percutaneous endoscopic approach
0TB10ZZ	Excision of left kidney, open approach
0TB14ZZ	Excision of left kidney, percutaneous endoscopic approach
Total nephrectomy	
0TT00ZZ	Resection of right kidney, open approach
0TT04ZZ	Resection of right kidney, percutaneous endoscopic approach
0TT10ZZ	Resection of left kidney, open approach
0TT14ZZ	Resection of left kidney, percutaneous endoscopic approach
Nephroureterectomy	
Nephroureterectomy involves complete removal of the kidney with complete removal of the ureter. Removal of the kidney is coded to total nephrectomy as above. One or more of the codes below are then assigned additionally to capture the total urethrectomy.	
0TT60ZZ	Resection of right ureter, open approach
0TT64ZZ	Resection of right ureter, percutaneous endoscopic approach
0TT70ZZ	Resection of left ureter, open approach
0TT74ZZ	Resection of left ureter, percutaneous endoscopic approach
Radical nephrectomy	
Radical nephrectomy involves complete removal of the kidney, typically with extensive lymphadenectomy and/or removal of the adrenal gland. Removal of the kidney is coded to total nephrectomy, as above. Additional codes are then assigned additionally to capture the lymphadenectomy and adrenalectomy as performed.	
Prostatectomy	
Excision of prostate lesion, subtotal or partial prostatectomy (suprapubic, retropubic, perineal)	
0VB00ZZ	Excision of prostate, open approach
0VB04ZZ	Excision of prostate, percutaneous endoscopic approach
0VB07ZZ	Excision of prostate, via natural or artificial opening
0VB08ZZ	Excision of prostate, via natural or artificial opening endoscopic approach
Total prostatectomy (suprapubic, retropubic, perineal)	
0VT00ZZ	Resection of prostate, open approach
0VT04ZZ	Resection of prostate, percutaneous endoscopic approach
0VT07ZZ	Resection of prostate, via natural or artificial opening
0VT08ZZ	Resection of prostate, via natural or artificial opening endoscopic approach

ICD-10-PCS Code	Code Description
Radical prostatectomy	
Radical nephrectomy involves complete removal of the prostate, typically with complete removal of the seminal vesicles, partial removal of the vas deferens, and/or extensive lymphadenectomy. Removal of the prostate is coded to total prostatectomy, as above. Additional codes are then assigned to capture removal of the seminal vesicles and vas deferens and the lymphadenectomy as performed.	
Robotic Assistance[6]	
8E0W0CZ	Robotic assisted procedure of trunk region, open approach
8E0W4CZ	Robotic assisted procedure of trunk region, percutaneous endoscopic approach

Hospital Inpatient DRG's of Urology Surgery

Under Medicare's MS-DRG[7] methodology for hospital inpatient payment, each inpatient stay is assigned to one of about 750 diagnosis-related groups, based on the ICD-10 codes assigned to the diagnoses and procedures. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. MS- DRGs shown are those typically assigned to the following scenarios when the patient is admitted specifically for the procedure.

MS-DRG	Description	FY2022 Payment
Cystectomy: The DRG clusters vary depending on whether the principal diagnosis is related to the urinary tract (DRGs 653-655, 665-667), the male reproductive system (DRGs 707-708), or the female reproductive system (DRGs 749-750).		
653	Major Bladder Procedures W MCC	$35,999
654	Major Bladder Procedures W CC	$19,142
655	Major Bladder Procedures W/O CC/MCC	$13,718
707	Major Male Pelvic Procedures W CC/MCC	$12,675
708	Major Male Pelvic Procedures W/O CC/MCC	$9,833
749	Other Female Reproductive System O.R. Procedures W CC/ MCC	$17,895
750	Other Female Reproductive System O.R. Procedures W/O CC/MCC	$9,653
Nephrectomy		
656	Kidney and Ureter Procedures for Neoplasm W MCC	$21,662
657	Kidney and Ureter Procedures for Neoplasm W CC	$12,758
658	Kidney and Ureter Procedures for Neoplasm W/O CC/MCC	$10,405
659	Kidney and Ureter Procedures for Non-Neoplasm W MCC	$17,583
660	Kidney and Ureter Procedures for Non-Neoplasm W CC	$9,516
661	Kidney and Ureter Procedures for Non-Neoplasm W/O CC/ MCC	$7,014
Prostatectomy Codes 0VB00ZZ, 0VB4ZZ for excision of prostate lesion or subtotal prostatectomy group to DRGs 715-718 when they are the only procedure performed.		
665	Prostatectomy W MCC	$20,058
666	Prostatectomy W CC	$11,472
667	Prostatectomy W/O CC/MCC	$6,578
707	Major Male Pelvic Procedures W CC/MCC	$12,675
708	Major Male Pelvic Procedures W/O CC/MCC	$9,833

[1]Centers for Medicare & Medicaid Services. Alpha-numeric HCPCS. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

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[3]Centers for Medicare and Medicaid Services. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Federal Register (86 Fed. Reg. No. 221 64996-66031) https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf Published November 19, 2021. Physician Fee Schedule – January 2022 Release. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-valuefiles/rvu22a

[4]Centers for Medicare and Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Final Rule, Federal Register (86 Fed. Reg. No.218 63458-63477), https://www.govinfo.gov/content/pkg/FR-2021-11-16/pdf/2021-24011.pdf Published November 16, 2021. ASC Payment Rates – Addenda January 2022 ASC Approved HCPCS Code and Payment Rates-Updated January 4, 2022. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates

[5]ICD-10-PCS: Department of Health and Human Services, Centers for Medicare & Medicaid Services. International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs

[6]Codes for robotic assistance are assigned separately in addition to the primary procedure code.

[7]Centers for Medicare and Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the LongTerm Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Final Rule, Federal Register (86 Fed. Reg. No. 154 44774-45615), https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf Published August 13, 2021.

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