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GUIDEPOINT
Reimbursement Resources

Percutaneous Nephrostolithotomy (PCNL)

2016 Coding & Payment Quick Reference

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options

As the primary PCNL procedures, CPT® Codes 50080 and 50081 are mutually exclusive and can never be billed together.

The following codes are thought to be relevant to PCNL procedures and are referenced throughout this guide.

CPT® Code[1]	Description
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
50395	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access
50561	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureterospyelography, exclusive or radiologic service
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)
74420	Urography, retrograde, with our without KUB

See important notes on the uses and limitations of this information on page 4.

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Physician Relative Value Units (RVUs)

Physician Relative Value Units (RVUs) are based on the Medicare 2016 Physician Fee Schedule effective January 1, 2016.

	Office-Based[1]				Facility-Based[1]			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
50080	**See Note**				15.74	7.47	1.78	**24.99**
50081	**See Note**				23.50	10.55	2.65	**36.70**
50561	7.58	5.18	0.86	**13.62**	7.58	2.94	0.86	**11.38**
50395	**See Note**				3.37	1.47	0.32	**5.16**
50430	3.15	11.35	0.28	**14.78**	3.15	1.40	0.28	**4.83**
50431	1.10	3.39	0.10	**4.59**	1.10	0.72	0.10	**1.92**
50432	4.25	19.33	0.37	**23.95**	4.25	1.76	0.37	**6.38**
50433	5.30	26.47	0.47	**32.24**	5.30	2.11	0.47	**7.88**
52005	2.37	4.88	0.27	**7.52**	2.37	1.19	0.27	**3.83**
52332	2.82	10.66	0.32	**13.80**	2.82	1.34	0.32	**4.48**
74420-26	**See Note**				0.36	0.13	0.01	**0.50**

Note: There are no current Medicare valuations for CPT Codes 50080, 50081, 50395, 74420-26 and when performed in the physician office setting.

Payment – Medicare

Outpatient payments for secondary procedures (excluding 74420) will be reduced by 50%.

All rates shown are 2016 Medicare national averages; actual rates will vary geographically and/or by individual facility.

	Physician[1]			Facility	
CPT® Code	MD In-Office Medicare Allowed Amount[2,5]	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
50080	N/A	$895	5376	$7,428	$5,926
50081	N/A	$1,315	5376	$7,428	$5,926
50561*	$488	$408	5375	$3,394	$1,744
50395*	N/A	$185	5374	$2,243	$1,255
50430	$530	$173	5372	$524	N/A
50431	$164	$69	5372	$524	N/A
50432	$858	$229	5373	$1,506	$842
50433	$1,155	$282	5373	$1,506	$842
52005*	$269	$137	5373	$1,506	$842
52332*	$494	$161	5374	$2,243	$1,255
74420 -26[6]	N/A	$18	5524	$352	N/A

* See reference #5

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Hospital Inpatient Allowed Amounts – Medicare

ICD-10-PCS Procedure Code	Description
0T9030Z	Drainage of right kidney with drainage device, perc approach
0T9040Z	Drainage of right kidney with drain dev, perc endo approach
0T9130Z	Drainage of left kidney with drainage device, perc approach
0T9140Z	Drainage of left kidney with drain dev, perc endo approach
0TC03ZZ	Extirpation of matter from right kidney, perc approach
0TC04ZZ	Extirpation of matter from right kidney, perc endo approach
0TC13ZZ	Extirpation of matter from left kidney, perc approach
0TC14ZZ	Extirpation of matter from left kidney, perc endo approach
0TC43ZZ	Extirpation of matter from left kidney pelvis, percutaneous approach
0TC44ZZ	Extirpation of matter from left kidney pelvis, percutaneous endoscopic approach
0TF33ZZ	Fragmentation in right kidney pelvis, percutaneous approach
0TF43ZZ	Fragmentation in left kidney pelvis, percutaneous approach
0TF44ZZ	Fragmentation in left kidney pelvis, perc endo approach
0TF34ZZ	Fragmentation in right kidney pelvis, percutaneous endoscopic approach

ICD-10-CM Diagnosis Code	Description
N20.0	Calculus of kidney
N20.9	Urinary calculus, unspecified

Possible MS-DRG Assignment[7]	Description	Reimbursement[8]
659	Kidney & ureter procedures for non-neoplasm with major complication or comorbidity (MCC)	$20,577
660	Kidney & ureter procedures for non-neoplasm with complication or comorbidity (CC)	$11,237
661	Kidney & ureter procedures for non-neoplasm without CC/MCC	$8,255

See important notes on the uses and limitations of this information on page 4.

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved.

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1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2016 release, RVU16A file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending The 2016 National Average Medicare physician payment rates have been calculated using a 2016 conversion factor of $35.8279. Rates subject to change.
2. "Allowed Amount" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance, etc.
3. Hospital outpatient payment rates are 2016 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2016 release, CMS-1633-FC https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
4. ASC payments rates are 2016 Medicare ASC national averages. ASC rates are from the 2016 Ambulatory Surgical Center Covered Procedures List - Addendum AA. Source: January 2016 release, CMS-1633-FC; CMS-1607-F2 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
5. "NA" in the 2016 "MD-In-Office Medicare Allowed Amount" column means that there is no in-office differential.
6. Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight Source: November 11, 2015 Federal Register. CMS-1613-FC.
7. The patient's medical record must support the existence and treatment of the complication or comorbidity.
8. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,904.74). Source: August 17, 2015 Federal Register; CMS-1632-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2015 Rates.

Sequestration Disclaimer
Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2016.

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