

### 1) What is the appropriate code to report when performing endometrial cryoablation utilizing the Her Option® therapy system?

**CPT 58356** (Endometrial cryoablation with ultrasonic guidance, including endometrial curettage, when performed) is the appropriate CPT code to report when utilizing the Her Option system.

### 2) Is prior authorization or pre-certification necessary for the endometrial cryoablation procedure?

As a rule, Medicare does not require prior authorization for any procedure. Commercial or private insurance carriers (e.g., Aetna, Blue Cross, etc.) and some Medicare supplemental plans may require a prior authorization or pre-certification for surgical procedures. Therefore, it is recommended that you check with insurers (primary and secondary) to verify coverage and pre-certification requirements prior to performing any procedure.

### 3) What modifier is used to report CPT® 58356 in the office setting to receive the global reimbursement rate?

CPT 58356 does not require the use of a modifier. The site of service entered on the claim showing that the procedure was performed in the office should trigger the global rate.

### 4) What HCPCS codes for drugs might be used in conjunction with CPT 58356?

Some common pre- or post-procedure injectables and their associated HCPCS codes are as follows:

- J2001 — Injection, lidocaine HCl for intravenous infusion, 10 mg (use this for Xylocaine)
- S0020 — Injection, bupivacaine HCl 30 ml (use this code for Marcaine, Sensorcaine)
- J1885 — Injection, ketorolac tromethamine, per 15mg (use this for Toradol)
- J9218 — Leuprolide acetate, per 1 mg (use this code for Lupron, Eligard)

### 5) What procedures are included in CPT 58356 and not separately billable?

Below are some of the more commonly performed procedures which are not separately billable according to National Correct Coding Initiative (NCCI) edits. (Not all commercial payers follow NCCI edit guidelines.)

- 58100 — Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)
- 58120 — Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)
- 58340 — Catheterization and introduction of saline or contrast material for infusion sonohysterography (SOS) or hysterosalpingography
- 64435 — Injection, anesthetic agent; paracervical (uterine) nerve

### 6) Is the endometrial cryoablation procedure (CPT® code 58356) payable in an Ambulatory Surgery Center (ASC)?

Yes. Beginning January 2008, Medicare will pay for surgery-related facility services provided in ASCs using a payment system based on the hospital outpatient prospective payment system (OPPS). The ASC system uses the same payment groups (APCs) as the OPPS but uses a conversion factor that is equal to 65% of the OPPS conversion factor (\$41.40).

There are however, certain procedures that are not paid at the same 65% of the OPPS rates. Office based procedures previously not covered in the ASC that are performed in physician offices at least 50% of the time will be paid the lower of the ASC rate (based on the methodology described above) or the practice expense portion of the physician fee schedule payment rate that applies when the service is furnished in a physician's office.

MedPac Ambulatory Surgical Centers Payment System. Revised: October 2007.  
[www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_07\\_ASC.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_07_ASC.pdf)

## 7) Is it appropriate for a physician to bill for a diagnostic hysteroscopy when performed prior to an ablation procedure?

When both procedures are done in the same surgical setting but as distinct procedures, it is appropriate to submit a diagnostic hysteroscopy code, CPT 58555, with a 59 modifier in addition to an ablation procedure code (e.g., 58353 or 58356). The 59 modifier indicates that the diagnostic portion of the case is a distinct procedure from the ablation because they use two methods.

When reporting a surgical code with a 59 modifier, many payers may require documentation to review the case in order to determine whether or not the modifier is justified. In these cases, it is important for the provider to know and understand each payer's specific requirements around the use of the modifier. If documentation is needed, any electronically submitted claim may be line-item denied until the payer receives the physician's notes. In this case, it is better for the physician to send a paper claim with documentation instead of submitting an electronic claim.

## 8) How much do Medicare and commercial payers pay for endometrial cryoablation procedures?

The Centers for Medicare and Medicaid Services (CMS) publishes the Medicare payment rates for physicians, hospitals and ambulatory surgery centers. Payment information may be accessed via the CMS website — <http://www.hhs.gov> and navigating to the appropriate provider center.

Fee schedules for commercial payers are contract driven and considered proprietary information. Fee schedules may be based on a percentage of Medicare, discounted charges, capitation or some other method. If a provider has not contracted with a particular payer, reimbursement is typically made at U & C (usual and customary) or billed amount. Before performing any new procedures, contact the individual payer to obtain the fee schedule amounts and any requirements pertaining to prior authorization or referrals.

**Disclaimer:** While reasonable efforts have been made to ensure the accuracy of the information set forth, AMS, Inc. can not guarantee reimbursement for any product or procedure. Providers should report the codes that accurately describe the products and procedures furnished and the patient's medical condition. Providers should contact their payers if they have questions or need specific co-payment, coverage and billing/coding policies as well as to update the information described herein. © January 2008 American Medical Systems, Inc.

### Coding Resources:

1. CPT 2008. Current Procedural Terminology, Professional Edition. American Medical Association, Chicago, IL
2. Expert 2008: HCPCS Level II. Healthcare Common Procedure Coding System. American Medical Association. Ingenix, Salt Lake City, UT
3. EncoderPro.com. Ingenix, Inc. 2008, Salt Lake City, UT