

Frequently Asked Questions

1) What CPT® codes are most commonly billed for a male urinary sling procedure that includes the use of the AdVance® or InVance® systems?

CPT 53440 (Sling operation for correction of male urinary incontinence) and **CPT 53442** (Removal or revision of sling for male urinary incontinence) are the appropriate codes to report sling procedures.

2) Is prior authorization or pre-certification necessary for sling procedures?

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 precertification requirements prior to performing any procedure.

3) CPT 53440 (Sling operation for correction of male urinary incontinence) and CPT 54405 (Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders and reservoir) are often performed during the same operative session. How is Medicare payment calculated for these multiple procedures?

When CPT 53440 and CPT 54405 are performed by the same physician during the same operative session, the multiple procedure rule will apply to the physician payment. This means the physician will be paid 100% of the Medicare payment for the first procedure and 50% of the Medicare payment rate for the second procedure.

In the case of the outpatient hospital reimbursement from Medicare, both CPT 53440 and CPT 54405 have an "S" status indicator. This indicator signifies "Significant Procedure, Not Subject to the Multiple Procedure Reduction," which means both procedures will be reimbursed at 100% of the payment rate.

4) Are male urinary sling procedures payable by Medicare in an Ambulatory Surgery Center (ASC)?

Yes, CPT 53440 is reimbursed by Medicare in the ASC setting.

5) What can be done if the patient is denied coverage by his health plan?

Patients should contact their insurance plan and request reconsideration. In addition, providers may appeal the denial and include a letter of medical necessity. Providers may contact the Health Care Affairs Department at 888-865-3373 for information on appeal assistance.

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.

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Coding Resources:

1. CPT 2011. Current Procedural Terminology, Professional Edition. American Medical Association, Chicago, IL
2. Expert 2011: HCPCS Level II. Healthcare Common Procedure Coding System. American Medical Association. Ingenix, Salt Lake City, UT
3. EncoderPro.com. Ingenix, Inc. 2011, Salt Lake City, UT