SUPS Coding and Billing Position Statement on ancillary / adjunct penile prosthesis surgical procedures: part I.

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Running Head: Society position statement on coding for adjunct penile prosthesis procedures / "Billing and Coding in prosthetic urology: a baseline understanding."

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ABSTRACT:

Introduction: While the Medicare Current Procedural Terminology (CPT®) code book lists descriptions of procedures, it is very brief and lacks detail in the small subspecialty field of prosthetic urology. At educational / research meetings, it was identified that there was a wide variation in how experts in prosthetic urology were coding the same procedures, and there was a recognized desire to have a standardized format in billing common ancillary surgeries. Medicare claims to penalize undercoding as much as over coding. The aim was to create a society position statement on a few common adjunct penile prosthesis (PP) procedures.

Material and Methods: At urological society meetings, we identified the need to have uniform CPT® coding for common adjunct PP surgical procedures, as there were differing opinions on the same surgery performed. A subcommittee within the Society of Prosthetic Urologic Surgeons (SUPS) was created to develop a survey which assessed coding options for several common adjunct penile prosthesis procedures and was distributed in the fall of 2022. The results of the survey were used to develop consensus statements on coding adjunct penile prosthesis procedures which were brought to the society membership and meetings for approval.

Results: The survey was sent to society members for expert opinions on coding & billing for adjunct PP surgical procedures. 30 members replied, and demographics were obtained as follows: 22 / 30 have done a fellowship, 15 identified as in university/academics and 15 in community/private practice, and 19 / 30 respondents do more than 50 implants a year. Demonstrating the severity of the issue, only 1 of the 30 respondents answered that they were confident in their coding of these ancillary procedures. Differences in how to code curvature correction procedures were seen among the respondents throughout the survey results.

Conclusions: Only 1 / 30 prosthetic urologists felt confident in their coding & billing of adjunct PP procedures, further confirming the need to have a society position statement. Therefore, we generated a consensus society position statement on some common adjunct surgeries with penile prosthesis.

Keywords: surgery, coding, penile prosthesis, CPT® codes, Billing, Peyronie's

INTRODUCTION

While the Medicare CPT® code book lists descriptions of procedures, it is very brief and lacks detail in the small subspecialty field of prosthetic urology. At educational / research meetings, it was identified that there was a wide variation in how experts in the field of prosthetic urology were coding the same procedures, and it was recognized that there was a demand to have a united front on billing ancillary surgeries. For example, a redacted operative report was reviewed, and some surgeons would only use one CPT® code while other surgeons would use code 4 CPT® codes. Medicare rules state that undercoding is equally as problematic as overcoding.

Currently, there is no detailed description of coding for adjunct procedures with penile prosthesis (PP) placement, leading to inconsistency in coding and, subsequently, in the reimbursement process. This lack of detail is problematic for providers and patients alike in that it can produce unexpected out-of-pocket costs for patients and reduced appropriate reimbursement for providers and institutions. The authors hope that by making coding more uniform, the issues above will be mitigated by providing clear and consistent coding for adjunct procedures associated with prosthetic procedures. Additionally, by having a standardized coding process, tracking and analysis of prosthetic urologic cases will be more uniform and accurate. This standardization, in turn, will provide valuable data and outcomes that can be used to improve best practices and guidelines for optimal care of penile prosthesis patients. Many members of the Society of Urologic Prosthetic Surgeons (SUPS) wanted clarification and to make a unified position statement after carefully reviewing of the CPT® codes book with expert opinion.

We evaluated the CPT® coding book by creating a volunteer subcommittee of SUPS members at educational meetings, produced a questionnaire survey that was sent to the membership, produced statements using expert opinion, sent those statements out to the membership for review / approval, in order to make a society position statement on a few common adjunct PP procedures. While equally as important, adjunct procedures with other prosthetic devices (i.e., artificial urinary sphincters) were

purposefully excluded from this paper and will be addressed in future manuscripts. Furthermore, the goal of this manuscript is to focus on adjunct correction procedures and, as such, other adjunct procedures (circumcision, hydrocelectomy, vasectomy, etc.) and cash / cosmetic versus Medicare-covered CPT® procedures will also not be addressed here.

MATERIALS AND METHODS

At society meetings, we identified the need to have uniform CPT® coding for common adjunct penile prosthesis surgical procedures, as there were differing opinions on the same surgery performed. An operative note was reviewed, and experts at SUPS coded anywhere from 1 to 4 procedures. Due to the variability in coding among prosthetic experts, a subcommittee was created, approved, and volunteers were obtained to meet and generate ideas. A literature review was performed on PUBMED using CPT® coding accuracy, and Medicare Coding was also performed to help guide our process. There have been other medical field sub-specialties with similar coding issues and concerns[13-15]. Therefore, after a review of the literature we decided to use a similar systematic approach for prosthetic urology.

Common CPT® codes (Table 1) for adjunct and penile prosthesis procedures were incorporated into a survey which assessed several common coding scenarios (Table 2) was generated, approved, and sent out to the SUPS society in fall 2022. After reviewing the survey results, several key procedures were identified for a position statement. We sought to focus on residual curvature correction for Peyronie's disease after penile prosthesis implantation. The results of the survey were used as a basis for what to evaluate further within the subcommittee. Then, recommendations were generated, discussed at meetings, and sent out to the whole society for approval. The final approved statements were discussed at our annual SUPS educational summit meeting, and only unanimous approved recommendations were made as SUPS positional statements.

RESULTS

The survey was sent to society members for expert opinions on coding & billing for adjunct penile prosthesis surgeries. 30 / 99 members replied. Demographics were obtained as follows: 22 / 30 are fellowship-trained, 15 (50%) identified as in academics and 15 (50%) private practices, and 19 / 30 respondents reported doing more than 50 implants a year (Table 3). The most represented section of the AUA was the Southeastern (40%), followed by the North Central (17%). (See Table 3)

The most concerning result, and a significant indication of a need for a coding consensus paper, was that only 1 of the 30 (3%) respondents answered that they were confident in their coding of these ancillary procedures. Furthermore, only 1 (out of a total of 8) clinical scenarios was answered unanimously (Question 6), which assessed coding for insertion of 3 -piece inflatable penile prosthesis with 8 dot plication for dorsal curvature. This included 2 clear procedures (in that each has its own CPT® code) being performed. All respondents chose to code both procedures. There was a marked variation in coding for curvature correction procedures after penile prosthesis placement seen throughout the entirety of the survey. Despite doing a separate/adjunct curvature correction procedure along with a penile implant, 26% (8/30) of surgeons only code one CPT® code due to fear of improperly coding (Table 1). 70% (21/30) would code for manual modeling for residual curve of more than 30 degrees after penile prosthesis placement.

DISCUSSION:

Society position papers should help their members feel comfortable and confident in the care they provide to their patients. Development and implementation of standardized coding for penile prosthesis surgery are necessary for accurate coding and reimbursement, data tracking, and, most importantly, to improve patient care and outcomes. As noted in the introduction, during society meetings, most of the discussion and confusion pertains to the billing & coding of specific procedures. Our aim was to help bring a firm

basis for proper coding for prosthetic urologic procedures. For this position statement, we concentrated on adjunctive procedures with concurrent implantation of a penile prosthesis.

Perhaps the main issue is the need for billing & coding training during medical residency and fellowship. Wiley et al.[2] distributed surveys regarding billing and coding practices to 129 orthopedic residents and fellows. 37.98% reported receiving formal training in billing and coding during residency training. Despite formal training, 0% of residents and fellows reported feeling comfortable with CPT billing practices. Certainly, residency should be and is focused on clinical knowledge, but the integration of billing & coding education has shown benefits in coding accuracy among residents taking these courses[3,4].

Billing and coding discrepancies are also seen on an institutional level. One study distributed 9 fictitious patient charts to 11 institutions evaluating agreements in coding. Interestingly, there was only a 13.7% agreement in the ICD-9 codes and a 16.3% agreement for CPT® codes[1]. In our SUPS questionnaire, only 1/8 of the coding questions were agreed upon unanimously. These discrepancies may highlight the need for ongoing education regarding billing and coding practices for all, including surgeons, residents, and coders.

The most powerful statement our survey demonstrated was a lack of confidence in coding & billing ancillary procedures, with only 1 / 30 (3%) respondents confident in the current CPT® coding. Clearly, in our small subspecialty of prosthetic urology, both in open meeting discussions and a survey of our membership, a vast majority would like more confidence and guidance on billing & coding adjunct penile prosthesis surgical procedures. The Medicare CPT® code book for some of these procedures is vague and short in its descriptions, while others have no concrete representation in the coding book. After discussion and results of the survey, one of the authors' focuses was on curvature correction adjunct procedures as these are most widely performed and have very differing opinions of how to best code for each. In

addition, several procedures were identified as appropriate for a society position statement to help guide and inform our members.

Our survey questionnaire demonstrated an equal demographic spread of academic and private practice (50/50) in respondents. Moreover, and more importantly, respondents include most of the high-volume implanters in the United States (US), some of whom have written many of the peer-reviewed publications on prosthetic urology in the US. A review of annualized case logs for certifying and recertifying urologists found that only 14 urologists performed >50 implants annually[6]. The respondents were from across the US, and the Southeast represented the largest percent as the Southeastern Section of the AUA has the most members in the AUA, showing that the survey was well-representative of the geographic proportions of the AUA. We only included doctors in the US as CPT® coding is the designated coding set used by the US Department of Health and Human Services.

Society guidelines provide explicit algorithms for treating residual curvature > 30 degrees after prosthesis placement[7,8]. Intraoperative curvature correction procedures after penile prosthesis implantation are used in 39-96% of procedures[9,10]. The most used techniques for residual curvature after penile prosthesis placement include modeling, tunical plication, tunical incision/excision, and grafting procedures. Residual Curvature Correction after penile prosthesis implantation can be broken down into several adjunctive procedures for residual curvature greater than 30 degrees of angulation after placement and inflation of the penile prosthesis. 30 degrees and greater was chosen as guidelines have stated that curves less than 30 degree typically improves after time with implantation of an PP[7]. Statement for Code 54360: Plastic operation of the penis to correct angulation, which is the same code as an independent penile plication surgery, “when done as an adjunctive procedure with PP implantation, that code covers both when the operating surgeon places plication suture or significant manual modeling” was the most discussed statement. Survey results found that 70% of respondents indicated using this code for manual modeling in conjunction with the placement of PP. A follow-up question was submitted to 3 co-authors

Commented [MMJ1]: 26. Chung E, Ralph D, Kagioglu A, et al. Evidence-Based Man- agement Guidelines on Peyronie's Disease. J Sex Med 2016; 13:905-923.
27. Salonia A, BCCJ, Corona G, et al. (EAU Sexual and Repro- ductive Health Guidelines Panel). European Association of Urology Sexual and Reporductive Health Guidelines; EAU Guidelines Edn presented at the EAU Annual Congress Amsterdam 2020; 2020; ISBN 978-94-92671-07-3.

who did not use that code for manual modeling. All 3 noted they felt that using the code was warranted given the scenario of manual modeling but didn't include it due to fear of overbilling. Significant manual modeling after IPP implantation has its own set of complications, most notably, distal tip perforation into the urethra, as well as rupture of the coporotomy[11], indicating significant risk and a known learning curve. Therefore, when manual modeling is performed for a residual curve of >30º as previously described, we agree CPT® 54360 should be utilized[16].

CPT® 54110, Excision of Penile Plaque/treatment of a penile lesion, describes when the surgeon makes an incision(s) without grafting to improve residual curvature. Typically, this procedure is known as tunical incisions, usually done with a knife or electrocautery on cutting current with low energy. Moreover, usually, there is more than one incision made into the tunica albuginea at the point of maximum curvature. With defects <2cm in length, grafting over the PP is generally not necessary[12]. With defects >2cm in length, device herniation is a concern, and grafting is recommended. CPT® 54111 describes an excision of penile plaque requiring grafting <5 cm, while CPT® 54112 describes graft size > 5cm. In this procedure, the surgeon excises a tunical plaque and then places a graft over the defect with measurements of less than (54111) or more than (54112) 5 cm. The graft utilized and placement technique are not critical for code usage, just the graft size as described, with more than or less than 5 cm being the critical description.

Ventral phalloplasty, CPT® 55175 (simple scrotoplasty), is commonly done and accepted as an indicated adjunct to PP placement and a stand-alone procedure. Ventral phalloplasty describes the reduction/excision of the penoscrotal webbing that can form due to penile shortening after radical prostatectomy[5,17]. Patient satisfaction rates and perception of increased penile length were 98% and 84%, respectively, when ventral phalloplasty was performed as an adjunct PP procedure[5,17]. When a ventral phalloplasty is performed as previously described for a penoscrotal web, we agree that CPT® 55175 should be utilized[5].

Injection of vasoactive substance, CPT® code 54235, is another commonly done adjunct procedure when performing penile implant surgery. After reviewing the CPT® coding book, we feel that the vasoactive injection must go into the corpora (i.e., artificial erection) to help evaluate for any penile deformities and possibly assist with dilating the corpora for cylinder placement. The medication used needs to be classified as a vasoactive agent, such as papaverine, alprostadil, lidocaine, bupivacaine, etc. We do not recommend using this code for the use of lidocaine or bupivacaine as a local dorsal penile or ring nerve block. Furthermore, some prosthetic surgeons consider the placement of a hemostatic agent within the corporal body justification for the use of this code as well; however, this consideration does not meet the CPT® code description, and we recommend against it.

The limitations of this study are that it only surveyed SUPS members and that these members were predominantly high-volume implanters. In addition, our survey only contained eight coding questions focused on residual curvature correction for Peyronie's disease after penile prosthesis implantation, meaning it does not encompass other significant issues that need to be addressed. For example, an issue not addressed here but that was widely discussed is cash-pay versus Medicare-covered CPT® procedures. One such procedure is glanspexy which currently has no CPT® code. Without accurate CPT® code representation for this procedure, variability in both billing and coding will persist. This issue was seen in both the survey and open society discussion at meetings and is currently being evaluated for future projects.

CONCLUSIONS

Only 1 / 30 prosthetic urologists felt confident in their coding & billing of adjunct penile prosthesis procedures. With the goal of providing a solid foundation to better accurately and more uniformly code

these most common adjunct procedures we used a method similar to those used by other fields. By using this process, the authors produce a society position statement on some common adjunctive surgeries during implantation of a penile prosthesis.

SUPS position statement on CPT codes for use in conjunction with penile prosthesis procedures.

1. **CPT 54235—**Injection of corpus cavernosum with pharmacologic agent(s): we feel that the vasoactive injection must go into the corpora (artificial erection) to help evaluate for any penile deformities and possibility assist with dilating the corpora for cylinder placement.
2. **CPT 54360—** Plastic operation of the penis to correct angulation: we feel this code should be used when the surgeon places either plication sutures or performs significant manual modeling or corporoplasty, when there is residual curvature after implantation of an IPP.
3. **CPT 54110—**Excision of penile plaque / treatment of penile lesion: we feel this code should be used when there is either incision or excision of a penile plaque without placement of a grafting material, when there is residual curve greater than 30 degrees angulation.
    a. **CPT 54111—**Excision of penile plaque with grafting less than 5cm
    b. **CPT 54112—**Excision of penile plaque with grafting greater than 5cm
4. **CPT 55175—**Simple Scrotoplasty (ventral phalloplasty): we feel this code should be used when there is reduction/excision of penoscrotal webbing

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LEGENDS:

Table 1. Billing Scenarios and Participant Reponses--questionnaire

Question		Responses # (%)
1. Insertion of primary IPP with modeling, intra-cavernosal injection of local anesthetic prior to incision.		
	54405 only	6 (20)
	54405 + 54360	5 (17)
	54405 + 53460 + 54235	16 (53)
	Other	3 (10)
2. Removal and replacement of all components of a 3-piece IPP; right-sided extracapsular tunneling needed due to impending cylinder erosion.		
	54410 only	15 (50)
	54410 + 14040	5 (17)
	54410 + 53460	4 (13)
	Other	6 (20)
3. Insertion of 3-piece IPP, incision of a dorsal plaque resulting in only 1.5 cm defect not needing a graft.		
	54405 only	1 (3)
	54405 + 54110	14 (47)
	54405 + 54360	9 (30)
	54405 + 54111	5 (17)
	Other	1 (3)
4. Insertion of 3-piece IPP, excision and grafting of a dorsal plaque, > 5cm		
	54405 only	0 (0)
	54405 + 54111	3 (10)
	54405 + 54112	23 (77)
	54405 + 54360	1 (3)
	54405 + 15275	0 (0)
	Other	3 (10)
5. Insertion of 3-piece IPP with ventral phalloplasty; total amount of redundant skin excised >10 sq cm		
	54405 only	0 (0)
	54405 + 55175	10 (33)
	54405 + 55180	18 (60)
	54405 + self pay	0 (0)

	Other	2 (7)
6. Insertion of 3-piece IPP with 8 dot plication for dorsal curvature		
	54405 only	0 (0)
	54405 + 54360	30 (100)
	Other	0 (0)
7. Insertion of 3-piece inflatable penile prosthesis with glanspexy performed.		
	54405	4 (13)
	54405 + 54260	21 (70)
	54405 + self pay	2 (7)
	Other	3 (10)
8. In the clinic setting, penile doppler ultrasound is performed by an ultrasound tech with the physician		
	93980	2 (7)
	93980 + 54235 + J code for medication	22 (73)
	54235	1 (3)
	93980 + 54231	1 (3)
	Other	4 (13)
9. Would a position statement from SUPS help define these procedure codes / billing?		
	Yes, would be more confident	18 (60)
	Yes, wondering what others are coding	11 (37)
	No, totally confident with coding	1 (3)
	No, self pay business	0 (0)
10. If you are only coding one CPT per procedure (despite doing multiple procedures (i.e., insert IPP and perform plication/modeling/glanspexy etc) do you only code one procedure because:		
	I do not know how to properly code for more than one procedure	4 (13)
	I fear coding improperly	9 (30)
	I believe that only 1 code can be used	1 (3)
	I don't code, someone reads my operative report and codes for me	8 (27)
	Other	8 (27)

Table 2. Current Procedural Terminology® (CPT®) Codes

Procedure Type	Current Procedural Terminology (CPT) Code	Description of CPT Code
Penile Implant	54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders and reservoir
	54410	Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session
Peyronie's Disease	54360	Plastic operation on penis to correct angulation
	54110	Excision of penile plaque/treatment of penile lesion
	54111	Excision of penile plaque requiring grafting, <5cm in length
	54112	Excision of penile plaque requiring grafting, >5cm in length
Penis	54235	Injection of corpora cavernosa with pharmacologic agent(s)
	93980	Duplex scan of arterial inflow and venous outflow of penile vessels; complete study
	54235	Dynamic cavernosometry, including intracavernosal injection of vasoactive drugs (eg, papaverine, phentolamine)
Scrotum	55175	Scrotoplasty, simple
	55180	Scrotoplasty, complicated
Skin	14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
	15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits

Table 3: Survey Respondent Information.

Question		Responses # (%)
1. Fellowship vs No Fellowship		
	Fellowship	22 (73)
	No Fellowship	8 (27)
2. Academic Practice vs Private Practice		
	54410 only	15 (50)
	54410 + 14040	15 (50)
3. Which is more important in at your practice?		
	RVU	17 (57)
	Collections	13 (43)
4. Section of the AUA membership		
	Northeastern	0 (0)
	New England	2 (7)
	New York	2 (7)
	Mid-Atlantic	4 (13)
	North Central	5 (17)
	Southeastern	12 (40)
	South Central	3 (10)
	Western	2 (6)
	I am not a member of the AUA	0 (0)
5. Number of implants per year		
	<10	0 (0)
	11-25	3 (10)
	26-50	8 (27)
	50-100	12 (40)
	100+	7 (23)

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