

Penile Prosthesis

• AMS Ambicor™ Inflatable Penile Prosthesis

• Spectra™ Concealable Penile Prosthesis

• AMS 700™ Inflatable Penile Prosthesis



Frequently Asked Questions

1) What CPT® codes are most commonly billed for penile prosthesis procedures that include the use of the AMS inflatable and non-inflatable penile prosthesis?

CPT 54405 (Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders and reservoir) and **CPT 54400** (Insertion of penile prosthesis, non-inflatable (semi-rigid)) are the most commonly billed codes for penile prosthesis procedures.

2) What C-Code is most commonly billed for an AMS 700™ Inflatable Penile Prosthesis or a Spectra™ Concealable Penile Prosthesis?

AMS 700 Inflatable Penile Prosthesis
C1813 Prosthesis, Penile, Inflatable

Spectra Concealable Penile Prosthesis
C2622 Prosthesis, Penile, Non-Inflatable

C-Codes are required for reporting devices when utilizing device-dependent APCs in the hospital outpatient setting. The American Hospital Association suggests that you “Report one unit of HCPCS code C1813, Prosthesis, penile, inflatable, for the penile implant” (versus line item billing all components). There are multiple components inserted during an inflatable penile implant surgery including the cylinders, reservoir, and pump. All three of these items can be lined itemed as one penile implant on the claim form as it is only one implant. (Benjamin D. Oden, CCS, January 18, 2012)

RIGHT

Cylinders, Reservoir, Pump C1813

WRONG

Cylinders	C1813
Reservoir	C1813
Pump	C1813

3) Are penile prosthesis procedures utilizing these AMS products covered by Medicare, Medicaid and Commercial Payers?

Medicare has a National Coverage Determination for the Diagnosis and Treatment of Impotence which includes surgical treatment with a penile prosthesis. Penile prostheses are covered when medically necessary. This policy is available on the CMS website in the National Coverage Determination (NCD) section under Diagnosis and Treatment of Impotence (230.4).

Medicare Advantage Plans are required to provide equal or better coverage than the traditional Medicare plan. Medicare Advantage Plans may have certain criteria that must be met for purposes of medical necessity. It is recommended that you obtain prior authorization before implanting a penile prosthesis.

Medicaid coverage varies from state to state. It is recommended that you contact the Medicaid department in the appropriate state or county for specifics on their coverage and fee schedules and obtain prior authorization before a procedure is performed.

Commercial Payers may have exclusions or limitations for penile prosthesis coverage. It is recommended that you check for benefits and eligibility and obtain written prior authorization before performing a penile prosthesis procedure.

4) Is prior authorization or pre-certification necessary for penile prosthesis procedures utilizing these AMS products?

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 Advantage Plans may require a prior authorization or pre-certification for surgical procedures. Therefore, it is recommended that a written predetermination outlining proof of medical necessity is submitted to the insurance carrier prior to performing this procedure. For copies of template letters or additional assistance with this process, please contact the AMS Global Market Access department.

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

The patient has the following options:

- Appeal the insurance company's decision. The patient can contact AMS' Global Market Access Department for assistance with their appeal at 888-865-3376. AMS can provide guidance on their appeal process and suggestions on drafting an appeal letter.
- During open enrollment at their work, the patient can review other insurance options available through their employer. They will have to call the other insurance companies to see if the policy offered to them covers penile implants for their medical condition.
- The patient may have coverage through Tricare insurance for military service or a secondary insurance policy under a spouse.
- If their employer self funds health insurance for their company, the employer may be able to make exceptions to their plans. The patient can ask Human Resources or the benefits administrator what is the process to have their case reviewed.
- Consider future Medicare eligibility options. Please review question 3.
- If coverage is not available, the patient may want to consider a cash pay option.

6) Are penile prosthesis procedures utilizing these AMS products payable by Medicare when furnished in an Ambulatory Surgery Center (ASC)?

Yes. Most penile prosthesis procedures are approved in the ASC unless there is a revision procedure through an infected field (CPT 54411), which requires an inpatient stay.

7) CPT 53445 (Insertion of urinary sphincter) and CPT 54405 (Insertion of inflatable penile prosthesis) may be performed during the same operative session. How is Medicare payment calculated for these multiple procedures?

Physician: When CPT 53445 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.

Facility: In the case of the outpatient hospital reimbursement from Medicare, both CPT 53445 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.

8) What CPT Code should be billed for the removal and replacement of only 1 component of an inflatable 3 piece penile prosthesis?

There is no CPT Code that accurately describes the removal and replacement of a single component of a 3 piece inflatable penile prosthesis. In this circumstance, you could consider using CPT 54410 or 54411 and adding a 52 reduced services modifier. Make sure that the dictation accurately states what has been performed.

For hospitals, the 52 reduced services modifier for reduced services is also an approved Level 1 CPT Code modifier for Medicare. It is recommended that you include a copy of the implant invoice and/or operative notes with the submitted claim.

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AMS does not promote the use of its products outside of the uses or indications as described in the applicable labeling.

Coding Resources:

1. CPT 2014. Current Procedural Terminology. Professional Edition. CPT is a trademark of the American Medical Association
2. HCPCS Level II Expert 2014. Ingenix, Inc. Salt Lake City, UT



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