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FREQUENTLY ASKED QUESTIONS

For Providers

Health Insurance Coverage and Payment
for the Prostatic Urethral Lift Procedure using the UroLift™ System

Q: Which insurers cover the Prostatic Urethral Lift (PUL) procedure using UroLift™ System?

A: The PUL procedure is covered by Medicare, national and commercial plans, including all independent licensees of Blue Cross Blue Shields (BCBS) Association when medical necessity criteria are met. For information regarding a specific health plan, please contact the UroLift™ System Reimbursement Support Hotline at 844.516.5966 or visit www.urolift.com/physicians/the-urolift-system/reimbursement-details.

Q: What do I need to know about prior authorization for the UroLift System procedure?

A: a. The PUL procedure has unique CPT and HCPCS codes assigned. Physicians will always bill the CPT codes regardless of site care. The procedural HCPCS codes are used primarily for facility billing.

b. The number of implants used in a procedure is determined by the treating physician and will vary by patient. It is up to the physician to determine the number of implants to be used in a procedure and the number of implants for which prior authorization may be sought; however, only the number of medically-necessary implants actually used should be billed. There are two CPT codes available depending on the number of implants used. Current Medicare guidelines allow 1 unit of CPT code 52441 and up to 6 units of CPT code 52442.

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Q: How is the UroLift System procedure coded?

A: Code sets vary based on provider type, site of care and sometimes insurer preference.

a. Physicians bill CPT codes for services provided in all sites of care. CPT code 52441 and add-on CPT code 52442, describe the PUL procedure.

b. Medicare requires PUL procedures performed in an ambulatory surgery center (ASC) or hospital outpatient setting be reported using either HCPCS code C9739 (1-3 implants) or C9740 (4 or more implants). Medicare also requires hospitals to report a separate device HCPCS code to account for the exact number of implants delivered during each procedure. Currently, Medicare requires HCPCS code L8699 to report implants. Commercial insurers may prefer CPT vs. HCPCS codes for reporting PUL procedures in the facility setting. Verify facility coding requirements with commercial insurers. The UroLift™ System Commonly Billed Codes can be found at www.urolift.com/physicians/the-urolift-system/reimbursement-details.

Q: Is add-on CPT code 52442 typically billed in units or as separate line items?

A: Medicare requires CPT code 52442 to be billed in multiple units on a single line. Most commercial insurers also recognize this coding methodology, but it is recommended to verify coding requirements with your commercial insurers. CPT code 52442 is designated as an add-on code and is therefore not subject to the multiple procedure discounting rule.

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For Providers *cont.*

Q: How does a surgery center bill Medicare for a PUL procedure?

A: Medicare requires PUL procedures performed in an ambulatory surgery center (ASC) be reported using either HCPCS code C9739 (1-3 implants) or C9740 (4 or more implants). Although C codes are not typically billed by ASCs to Medicare, the two C codes required by Medicare to bill for PUL are considered procedure codes, not device codes. Commercial insurers may prefer CPT vs. HCPCS codes for reporting PUL in the ASC setting. Verify facility coding requirements with commercial insurers. The UroLift System Commonly Billed Codes can be found at www.urolift.com/physicians/the-urolift-system/reimbursement-details.

Q: Can L8699 be billed in the ASC?

A: Medicare does not require nor recognize the use of a separate device code such as L8699 in the ASC site of care when filing claims for the UroLift™ System procedure. Some commercial insurer contracts may recognize, require and/or reimburse, a separate device code when billing for the UroLift™ System procedure. Verify ASC coding requirements with commercial insurers.

Q: What should I do if I get a prior authorization or claim denial?

A: a. Where appropriate, denials can be appealed by following the insurer's appeal process as outlined in the denial received

b. Sample appeal letters can be found at www.urolift.com/physicians/the-urolift-system/reimbursement-details

c. The UroLift System Reimbursement Team is available to answer additional questions and can be reached at 844-516-5966 or by email at uroliftreimbursement@teleflex.com

Q: Where can I find information about insurer medical necessity requirements for UroLift™ System procedure?

A: Medical necessity requirements will vary by insurer and can often be found on the insurer's website. A summary of medical necessity criteria can also be provided in the UroLift System State Coverage Profile and/or at the following link: https://UroLift.policyacumen.health/. State Coverage Profiles can be provided by your Sales Representative or the Teleflex Interventional Urology Reimbursement Team by calling 844-516-5966 or emailing UroLiftreimbursement@teleflex.com.

Q: How would I bill the removal of a PUL implant?

A: Should an implant removal be necessary on the day of the procedure, it is considered incidental to the index procedure and not separately billable. If a removal is necessary on a day other than the day of the index procedure, CPT 52310 would be used to report the removal.

We encourage you to check with the health plan regarding any additional questions you may have regarding coding for the UroLift System procedure.

FREQUENTLY ASKED QUESTIONS

For Providers *cont.*

UroLift™ System Reimbursement Support

Teleflex Incorporated has developed this Billing Guide to help support your efforts throughout the reimbursement process for the prostatic urethral lift procedure using the UroLift™ System. Additional resources can be found at www.urolift.com/physicians/the-urolift-system/reimbursement-details or through the Teleflex Interventional Urology Reimbursement Team at 844-516-5966 or by email at uroliftreimbursement@teleflex.com.