Billing Rezūm to Medicare age Patients: It's not all the same….

There are several kinds of policies/products that impact Medicare payment rules and rates. They all have different subsets, parts, plans, administrators and are often called a lot of different things. Billing for Rezūm can vary based on the type of Medicare a patient has chosen. Payment and coverage will also vary. Below are a list of the primary Medicare products/policies and the considerations for each when considering Rezūm, its coverage and required reporting.

1. **Traditional Medicare/Standard Medicare /Original Medicare/Straight Medicare** (all names for the same thing)
   - Traditional Medicare plans do not require prior authorization for services and instead rely on coverage policies, published rules and MAC local coverage policies to communicate which services are paid for and how they are to be reported. Medicare also reserves the right to review claims submitted to see if documentation supports the medical necessity of any service and to determine if the documentation supports the services reported. With Traditional Medicare and for any plan accurate documentation, coding and knowledge of local payer rules is essential to payment for any service.
   - For Rezūm, some of the Medicare Administrative Contractors (MACs) have issued specific coding instructions for the service. If you are reporting Rezūm to a MAC with no policy or coding Article in place, we recommend you report the service with CPT code 53899 – unlisted urology code. FCSO, Noridian, and Novitas all have coding articles requiring this code. The term "Rezūm" should also be listed in Box 19 on the CMS-1500 form. This will allow for less delay in claims processing. Palmetto and WPS currently consider Rezūm investigational and will not cover the service pending further evaluation of the published studies. Any updates will be available through the Medicare bulletins or the individual MAC list-serves.

2. **Medicare Part C/Medicare Advantage/MA plans/Medicare Replacement Plans**. (All names for the same thing).
   - These plans are **run by private insurance companies** (i.e., Aetna, Humana United Health Care, etc.). These plans are paid for with Medicare dollars and regulated by the government, and must offer coverage that's comparable to Original Medicare parts A and B. Most also include prescription drug coverage (Part D Medicare).
   - If a patient has a Medicare Advantage Plan, **they are covered by a private plan.** This can be confusing as the patient is Medicare age and may have been covered in the past under Traditional Medicare. Patients will carry cards with plans that may not obviously state they are Medicare advantage plans.

Most of these plans have contracted provider networks and as such you will need to make sure you understand whether or not the practice is in network or out of network as payment for services will vary. Medicare Care Advantage plan rules for reporting of services and coverage of services may vary from Medicare policy and will often vary based on plan type and company.

- For Rezūm, PRS recommends that physicians should continue to report Rezūm using the CPT 53852 code, regardless of where the procedure is performed, as most payers will currently follow the prior AUA coding recommendations for proper reporting of services. If the private payer has issued a coding update via written policy than the claim should report the required code.

3. **Medicare Supplement plans/Private "Medigap" insurance/80 – 20 plans** (All names for the same thing)
   - These are supplemental plans offered by private insurance companies that cover or help cover certain deductibles, coinsurance and out-of-pocket costs of Traditional Medicare (#1 on this list.) As mentioned above, Traditional Medicare only covers 80% of the cost of most services, and the patient is responsible for 20% of the costs and the yearly deductible. These “supplemental plans” usually fill in some or all of the remaining 20% that a patient would normally be responsible for. Some plans may also pay for services not covered by Medicare but this is rare.
   - While there are ten different Medigap policies, each one is very specifically defined by the government, and are standardized: No matter what private company offers it, every Medigap policy must follow these federal and state laws, and it must be clearly identified as "Medicare Supplement Insurance."
   - These policy benefits are based on Medicare payment and coverage for the most part. Typically, these plans are billed through a crossover process and require a Medicare EOB prior to payment. Therefore, these plans will likely pay for the balance of service covered for and billed to traditional Medicare.
   - For Rezūm, follow your MAC rules to bill Medicare primary.