Billing and Reimbursement Summary Relating to the Stream Dx At-Home Uroflowmetry Service

Updated: August 01, 2022

Disclaimer:

Below are potential examples of billing/reimbursement scenarios that may be available when utilizing Stream Dx™ technology. Information provided in this resource is for informational purposes only and does not guarantee that codes will be appropriate or that coverage and/or reimbursement will result. Information is subject to change. Customers should consult with their payers for all relevant coverage, coding, and reimbursement requirements. It is the sole responsibility of the healthcare provider to select proper codes and ensure the accuracy of all claims used in seeking reimbursement. This resource is not intended as legal or professional billing advice or as a substitute for a healthcare provider's independent professional judgment. Please refer to the Stream Dx User Guide for product and safety information.

The following reimbursement strategies are as they relate to using the Stream Dx service. All billing strategies require the appropriate notations and documentation entered into the patient EHR.

Billing Strategies outlined in this document do not include any potential soft cost benefits realized in the use of Stream Dx and its services.

- **No costs for providers related to in-clinic uroflowmetry - uroflowmetry is moved out of the clinic.**
- **No clean up after a patient uses the in-clinic uroflowmeter.**
- **No loss of time or money for void with uninterpretable, low volume.**
- **Time saved can be used for other purposes and procedures.**

All coding and reimbursement information in this Billing and Reimbursement Summary has been reviewed by Physicians Reimbursement Systems (http://www.prsnetwork.com), 800-972-9298.

For additional information and clarification please contact:

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Strategy A: Preferred billing strategy by PRS Network:

CPT Code: Unlisted Procedure, urinary system	**Reimbursement:**
Example:	
CPT code 53899: Unlisted Procedure, urinary system	Carrier Priced *
Service would include:	

Equipment and Staff Time:

- Equipment, if supplied by practice or under arrangement to Practice
- Set-up and patient education on use of equipment
- Staff support of patient

Physician Time:

- Interpretation and treatment management services
  - Multi-day and time of day evaluation of Qmax and Qavg
  - Multi-day and time of day evaluation of voided Volumes
  - Evaluation of Liverpool nomogram
  - Evaluation of IPSS score
  - Evaluation of uroflow profiles
  - Evaluation of voiding durations
  - Evaluation of voiding frequency

Each Physician or clinic will determine the line items to include, and the value of each line item based on evaluations of clinic cost to provide the Service.

***See Addendum B for Examples of Carrier Pricing for CPT code 53899**

Addendum A
Proper Use of Unlisted Codes

According to CPT coding instructions, when procedures or services performed by physicians do not have a valid or descriptive CPT or HCPCS code, the service should be reported using an unlisted code. The unlisted code selected must be from the appropriate anatomic section of codes.

Any procedure/service billed with an unlisted code must be appropriately documented in the medical record. The medical record should include an accurate description of the service provided, the associated results, as applicable, and clear and discernable medical necessity for the service. Clinical documentation must be submitted for reimbursement for virtually all unlisted codes. Payer review of the medical documentation will first determine if the unlisted code is appropriate for the service provided. If there are no other applicable codes available and therefore the unlisted code is the most appropriate code, the payer will next review the medical record for medical necessity and appropriateness of the service. Appropriateness of the service for new services will include analysis of safety (FDA approval if appropriate) and efficacy of the service. You may be required to provide supplemental information supporting the safety and efficacy of the service in the form of peer reviewed documents for some unlisted services.

Because there is no set description for these miscellaneous or unlisted procedure codes there is no set reimbursement. When an office is required to report the unlisted code for the same procedure provided to different patients for new technology, it is equally important to guide the payer to a repetitive processing protocol. While these are interrelated and inherent to the code, they require separate steps.

To provide the payer with a repetitive protocol, it is important to use consistent verbiage in the supplemental information box of the claim form. Labeled box 19 in the CMS 1500 form, the supplemental information box is used routinely in the Urology practice to report drug NDC codes, descriptions for supplies and services and to provide explanations required for unlisted codes.

For reimbursement of an unlisted code, we have recommend one of two fundamental paths. The most common path is referred to as “relational reimbursement” in which the Urology practice provides the payer with a list of one or more services that are comparable to the unlisted service you are reporting. The other path is to build a cost structure to support the amount charged by the practice. In each case the practice will need to consider the current fee schedule or process used to develop the fees they charge. As we all know well Urology practice charges are rarely used by payers to develop reimbursement rates. Therefore, your method of charge development is also a guide to the payer to develop reimbursement rates based on the underlying data they have developed for reimbursement of other services.

In Addendum B we will use Stream Dx as an example for both the processing of claims and the pricing of the services provided. Payers have the option of directing payment instructions that do not follow standard CPT protocols. It is recommended that you check with the payer for appropriate coding guidance if available.

Addendum B
Examples of Possible Carrier Pricing for CPT code 53899

Consistent language in the supplemental information Box 19 on Form 1500 allows payer claim processing to recognize a claim or resubmitted claim. We are recommending the following language for the NOC Box and Item 19, *"Multi-Day in-home comp uroflow study Addtl docs upon request"*[1].

If the office continues to submit the same language for each claim, the payer may build a payment edit allowing semi-automated processing of the claim without full medical review once they develop a payment rate and policy. If more than one practice uses the same language in the supplemental information Box 19 the payer can develop a payment policy to apply to all practices.

Developing an Accurate Charge
For charge development as mentioned above the most common approach is to relate the service to existing CPT codes with assigned reimbursement. For the Stream Dx Home Uroflow Service we can look to several different codes which closely reflect the work and costs associated with providing the service. Below is a list of codes that are similar to the services associated with the Stream Dx Home Uroflow Service along with the associated Medicare national reimbursement.

Code	Description	Medicare 2021 National Fee
51741	Complex uroflowmetry (eg, calibrated electronic equipment)	$14.31
99453	Remote monitoring of physiologic parameter(s) (e.g. weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	$19.19
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	$63.16
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	$50.94
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)	$41.17

[1] Additional NOC box and Item 19 descriptor language can be found in the 1500 Claim Form Samples

Code Comparison Method

The code comparison method provides guidance for developing and documenting to payers the expected reimbursement for providing the Stream Dx service. Each line item will need to be accompanied by supporting explanation of any changes to the comparison fee. For this step we will recreate the table with illustrative comments.

NOTE: The Comments added below are for example only, the practice will need to develop their own Comment fields based on actual costs and practice requirements.

Code	Medicare 2021 National Fee	Comments	Practice Fee Adjustment (Example Only Not intended for Pricing Guidance)
51741	$14.31	Included in other codes listed not included	N/A
99453	$19.19	Training of patient similar to code description adopted with no change	$19.19 No change
99454	$63.16	Cost of Device lease for practice $75 add administrative expense of 35%	$101.25
99457	$50.94	Typical contact with patient over the course of the test by practice personnel requires average of 15 minutes per patient. Physician read of test results average 10 minutes	$50.94 No Change
99458	$41.17	Average patient contact and physician time exceeds 20 minutes. Add one unit for average charge. May be added to fee for cases which exceed average support time during the test period.	$41.17 No change

Total Medicare expected reimbursement fee for the Stream Dx service equals **$212.55** under the above method. The practice may align their charges with their typical billing ratio for other patient services. If, for example, the practice typically charges 2 times current Medicare rates for services, the practice may choose to establish in the unlisted code claim a rate that is twice the charges determined through the code comparison method. The practice may also consider increasing their fees for patients requiring more support and time for use of device and provision of test results. This does not guarantee that Medicare or other payers will reimburse the full amount charged or accept the methodology.

Each practice will need to develop their own comparison method for appropriate fee and pricing strategies. Costs of supply, administrative costs and time per service should be estimated for new technology and adjusted based on actual experience with any new product.

Practice Cost Method

Another method for development of pricing and reimbursement is the practice cost method. Even if the cost method is not chosen to determine the reimbursement, it is recommended that the practice determine cost of any service provided including unlisted service codes. Calculating cost of a procedure or service should be comprehensive using the best available practice cost information for the base line assumption.

The following cost method table includes example costs and categories for a simplified approach to cost calculation. The example numbers are for illustrative purposes, each practice should develop their own practice costs included in their service cost estimates. The cost method would include much broader categories in which the practice would provide estimates of practice cost.

Category or Item	Assumption	Cost/patient
Lease of Stream Dx per patient	Actual cost of device $75 plus 35% administration fee	$101.25
Training time spent by staff	Burdened MA (Nurse Practioner) compensation at $40/hour spends 15 minutes with patient explaining process and use. Additional time estimated for patient support during home use 15 minutes	$20.00
Physician time required for interpretation of test	10 minutes with targeted rate of $300/hour (rate is after overhead)	$50.00
Cost of Office supplies for performance of test in office	N/A, test is performed off site shipping and cleaning of device is included in lease. Storage on site not required. Inventory not required	$0.00
General Overhead	Admin support staff, billing and coding, prior authorization, rent, utilities, etc. 50% of income based on practice collections vs. Cost. Formula = (Cost/.5)-Cost	$32.33

Sum of estimated costs to practice = **$203.58**. As with the code comparison method, if the practice typically charges 2 times current Medicare rates for services, the practice may choose to establish for the unlisted code claim a rate that is twice the charges determined through the cost method. Costs of supply, administrative costs and time per service should be estimated for new technology and adjusted based on actual experience with any new product. Cost comparison methods may require invoices and detail to support requests from the payer for reimbursement. You may wish to develop a cost and fee explanation for presentation to the payer supporting the actual fee charged.