Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Capture Correct MMK Pay With These Quick Tips

Modifier missteps could cost you over $800.

If your urologist documented that he performed a bladder and/or urethral fixation for stress incontinence in conjunction with a gynecologist who performed a transabdominal hysterectomy at the same time, do you know what to report? The answer will depend on the documentation details.

Let our experts walk you through the coding for this sample urogynecology case from reader, **Bhanu Vangara, CPC,** billing specialist for UroPartners LLC in Des Plaines, Ill.

Review the Surgical Case

The patient was undergoing an abdominal hysterectomy by Dr. XXXX.

After he completed the intra-abdominal procedure, the peritoneum was closed. A Pfannenstiel incision had been performed through an old cesarean section scar in the lower abdomen. The recti muscles had been separated in the midline, and I bluntly entered the prevesical space. The bladder had a 16 French Foley catheter in situ, and the bladder had been drained. By careful blunt dissection, the prevesical space was entered. Some small bleeders were coagulated. No severe bleeding was noted during the course of the dissection.

After the anterior aspect of the urethra and bladder neck were carefully identified including the adventitial fat, the bladder neck position was carefully located using the foley balloon, and in this relatively thin patient with a short suprapubic space, the length of the urethra was carefully determined. Using a GU type needle and 0 chromic sutures, stitches were placed in the periurethral tissue on both sides of the midline X2. A second set was placed at the level of the bladder neck. After these 4 sutures had been carefully placed, using the same needle these sutures were then attached to the symphysis pubis through the synchondrosis. The second set of sutures was placed more proximally on the symphysis both elevating and lengthening the urethra and bladder neck. After carefully placing the distal 2 sutures in the synchondrosis, they were all tied. Then the second set of sutures was placed within the synchondrosis in a more proximal fascia and tied.

During the tying of the knots I moved the Foley balloon in and out while an assistant trans-vaginally elevated the anterior vaginal vault so that the knots could be tightened appropriately. The Foley balloon was carefully manipulated proximally and distally to be sure that the catheter had not been sewn into the urethra, which had not been done. After this was completed, the wound was irrigated and a final check for bleeders was carried out. A 7 mm Jackson-Pratt suction drain was placed through a separate stab wound in the right lower quadrant. This was left to bulb drainage.

After a final check of the depths of the wound and careful placement of the Jackson-Pratt drain into the prevesical space through the fascia and the space between the recti muscles, the anterior rectus fascia was closed, and the remainder of the operation was completed by Dr. XXXX. He will dictate this separately, along with the beginning of the case.

Coding dilemma: How would you report this procedure?

Identify What the Urologist Actually Did

Based on the operative note, you can see that the gynecologist and urologist worked together to perform this surgery. The gynecologist performed the hysterectomy, but what did the urologist actually do?

By reviewing the details in the report, you can determine that the urologist performed a Marshall-Marchetti-Krantz (MMK) procedure. "The elevation of the urethra and anterior vaginal wall with sutures to the pubic symphysis constitute a MMK

urethropexy," explains **Michael A. Ferragamo, MD, FACS,** clinical assistant professor of urology at the State University of New York at Stony Brook.

Choose the Right CPT® Code

You may be tempted to report 58267 (Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy [Marshall-Marchetti-Krantz type, Pereyra type] with or without endoscopic control) or 58293 (Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy [Marshall-Marchetti-Krantz type, Pereyra type] with or without endoscopic control) for this procedure since the surgeons performed both the hysterectomy and the MMK. Neither of those is the correct procedure code, however.

Here's why: The gynecologist performed a transabdominal hysterectomy, and codes 58267 and 58293 are for a vaginal hysterectomy with MMK, explains **Melanie Witt, CPC, COBGC, MA,** an independent coding consultant in Guadalupita, N.M.

There is another CPT® procedure code that more accurately reflects the work your surgeons performed and the approach they used: 58152 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s], with or without removal of ovary[s)] with colpo-urethrocystopexy [eg, Marshall-Marchetti-Krantz, Burch]).

Pointer: You should not separately report both a hysterectomy code, such as 58150 (Total abdominal hysterectomy [corpus and cervix], with or without removal of tube[s)], with or without removal of ovary[s]), along with an MMK code (51840, Anterior vesicourethropexy, or urethropexy [e.g., Marshall-Marchetti-Krantz, Burch]; simple or 51841, ... complicated [e.g., secondary repair]), for this clinical scenario. Because there is a combination code that accurately describes the complete procedure (58152), you should use that code and not separate the procedures.

Tap the Proper Modifier

Since your urologist worked with the gynecologist on this procedure, and both surgeons deserve reimbursement, you can't stop at 58152. You'll need to attach modifier 62 (Two surgeons) to 58152, and the gynecologist's coder will have to do the same. "Each surgeon bills the same code: 58152-62," Ferragamo explains.

Check the notes: Keep in mind that each surgeon must document his own part of the surgery, Witt advises.

"Each physician must dictate separately his part of the operative report in detail and indicate what the other physician performed as his part of the operation," Ferragamo agrees. "This information in brief must also be placed in box 19 of the HFCA 1500 form or in the electronic equivalent space of your EMR."

Reap the Payment Benefits

Medicare and most other payers reimburse procedures coded with modifier 62 at 125 percent of the regular fee schedule amount. The payer divides this between the two surgeons reporting the procedure, so each surgeon receives 62.5 percent of the standard fee.

So, for this case, here's the math:

- The normal 100 percent fee for 58152 is $1,276.09 (35.69 national unadjusted relative value units [RVUs] times the conversion factor 35.7547).
- The gynecologist bills 58152-62, and receives 62.5 percent of the global reimbursement, which equals $797.56
- The urologist bills 58152-62, and receives 62.5 percent of the 125 global reimbursement, which equals $797.56.