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Outpatient Facility Coding Alert

Case Studies: Break Down Robotic Pelvis Exploration Coding Mechanics

Look to this specific category III code.

Robotic procedures are cutting edge from a medical, technological, and coding perspective. Today, you're going to have a look at a coding scenario involving a robotic pelvis exploration.

With some helpful instruction from **Michael A. Ferragamo, MD,** clinical assistant professor of urology, State University of New York Stony Brook, you'll stay ahead of the technological curve by tackling a real-world example.

Situation: A patient is taken to the operating room for robotic exploration and excision of a left perirectal mass. The urologist located the mass below the left ureter and lateral to the rectum; it was quite close to the rectum and bladder. It was a continuous mass around titanium clips that were placed by another surgeon during an open prostatectomy two years ago. The area of concern extended in the plane between the rectum and bladder in the area of Denonvillier's fascia. The rectum, bladder, and left ureter all were still intact at the end of the procedure.

Consider the Coding Options

At first glance, a coder of the urology specialty might look to 38571 (Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy).

Dig in: In a procedure represented by 38571, the provider enters the abdomen and, once he establishes good visualization of the cavity, removes any adhesions that are present. Then the provider explores the abdomen and excises all of the lymph nodes in the pelvis. Cases involving extensive metastatic cancer might also necessitate the removal of other lymph nodes in the area of the disease. For cancer in the lower abdomen, this might involve removing the pelvic lymph nodes and other tissues in the patient's pelvis and abdomen.

Because the case in question involves exploring and excising a mass below the left ureter and lateral to the rectum instead of in the definitive pelvic area, Ferragamo says that CPT® code 38571 would not be the appropriate code to bill.

Option 1: CPT® 2019 includes a temporary procedure code in which the provider uses the transanal endoscopic microsurgical approach for identification and removal of a rectal tumor: 0184T (Excision of rectal tumor, transanal endoscopic microsurgical approach (ie, TEMS), including muscularis propria (ie, full thickness)).

When using this approach, the urologist inserts the proctoscope to identify the tumor. He then insufflates the lumen of the rectum with high flow carbon dioxide. The provider dissects the tumor from its lower edge by keeping a macroscopic margin of 5 mm from the tumor. He continues full-thickness resection circumferentially and safeguards the normal surrounding mucosa. The provider then irrigates the rectum with antimicrobial agents like iodopovidone solution and sutures the rectal wall. Finally, he examines the rectum through the proctoscope for appropriate closure.

The procedure described by 0184T is a transanal procedure and not a laparoscopic /robotic procedure; this means reporting 0184T in this situation is improper coding. In addition, Ferragamo points out that 0184T is a Category III code. It is primarily used for tracking and has no fee schedule value. "Thus, code 0184T is [generally] not payable," he says.

Plus: Coding guidelines include several procedures that you cannot bill in conjunction with 0184T. These include codes ranging from 45300-45320.

Option 2: If you aren't able to report 0184T, where does that leave you? Because the current edition of the CPT® manual does not include a specific code for the robotic exploration and excision of a left perirectal mass, your best option, especially if the procedure is performed by a urologist, could be to bill the unlisted code from the urinary system

section: 51999 (Unlisted laparoscopy procedure, bladder).

When reporting a procedure with an unlisted code, submit a cover letter explaining the reason for choosing the unlisted code instead of a defined active code. Also, include the operative notes or other relevant documentation to strengthen the claim and to avoid a possible denial. Your payers will consider claims with unlisted procedure codes on a case-by-case basis, and they will determine payment based on the documentation you provide**.** Also provide the payer with a specific benchmark CPT® code, usually an open procedure code, similar to the unlisted laparoscopic/robotic procedure your urologist performed. The payer will use this code to determine the payment for the unlisted code.