

Outpatient Facility Coding Alert

Case Studies: Refine Your Prostatectomy Coding Skillset with these Scenarios

Know when to rely on a specific set of modifiers to help your cause.

Prostatectomy procedures are commonly performed in outpatient facilities such as ambulatory surgical centers (ASCs). Despite their frequent occurrence, outpatient facility coders are often vocal in voicing their concerns in coding these complicated surgeries.

Whether simple or radical, laparoscopic or open approach, you've got to have a firm handle on how to handle any prostatectomy coding scenario that arises. Refresh your knowledge of coding tactics based on three scenarios from Outpatient Facility Coding Alert subscribers.

Scenario 1: Simple Laparoscopic Prostatectomy = 55899

Question: I need some help coding a laparoscopic simple prostatectomy. Would CPT® code 55866 with modifier 52 be correct?

Answer: Start by remembering the purpose behind the modifier. A claim with modifier 52 (Reduced services) shows the payer that your physician did less than the full procedure represented by a code's descriptor. Appending the modifier 52, however, should not change the original code descriptor.

Correct coding: Since there is no specific CPT® code for a simple robotic prostatectomy, you should report the most appropriate unlisted code. In this situation, that would be 55899 (Unlisted procedure, male genital system). Because 55866 (Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed) is for a radical robotic prostatectomy, this code would not be the proper code for the procedure you describe even if you add modifier 52. "Benchmark code 55899 to the similar code for the open procedure 55821 (Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal...) or 55831 (...retropubic, subtotal), based on the laparoscopic robotic technique used," suggests **Michael A. Ferragamo, MD, FACS**, clinical assistant professor of urology at the State University of New York in Stony Brook.

Caveat: Also remember that unlisted codes do not accept modifiers. That means modifier 52 should not be applied to the unlisted code 55899. You can, however, use the above reminder about not using 52 to alter descriptors with other claims.

Scenario 2: Radical Prostatectomy + Cystectomy = Multiple Codes

Question: The urologist completed a radical prostatectomy and cystectomy during the same operative session. Can I code for both procedures?

Answer: You should report the radical prostatectomy separately from the cystectomy because it is not included in the work of 51595 (Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes).

"A number of years ago, the American Urological Association (AUA) had indicated that you should bill for the radical prostatectomy when the urologist includes this procedure with the total cystectomy," Ferragamo explains. "Most urologists surgically remove the prostate when they perform a radical cystectomy because anatomically, the prostate is so closely associated with the bladder that performing a complete cystectomy in the male mandates that you also

remove the prostate.”

Use 55840 (Prostatectomy, retropubic radical, with or without nerve sparing) to report the radical prostatectomy. Append modifier 51 (Multiple procedures) to 55840 to show your payer that the urologist performed the cystectomy and the prostatectomy during the same surgical session.

Payer check: Attaching modifier 51 to 55840 may not work with all insurers. “Many payers, including Medicare, no longer require modifier 51 as CMS’s claims processing system will append the modifier to the correct procedure code as appropriate,” says **Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS**, president and CEO of SLG, Inc. Consulting in Raleigh, North Carolina.

Also, remember that you can expect half the global reimbursement for codes with modifier 51 attached. Most insurance companies have adopted Medicare’s policy of paying 50 percent for codes with modifier 51 attached, but not all. Verify the payer’s stance on modifier 51 claims before you file.

“Note also that modifier 51 applies to professional claims only; it is not applicable in the facility setting,” advises Goodman.

Tip: You should not bill 51595 and 55845 (Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes) together. The Correct Coding Initiative (CCI) edits bundle 55845 into 51595. As both code descriptors include a lymphadenectomy; this edit cannot be unbundled with any modifier.

Scenario 3: Completed Some of a Planned Procedures = Modifier 53

Question: One of our patients was scheduled for an open radical prostatectomy because of prostate cancer. The surgeon completed a laparotomy. During an initial difficult dissection, the prostate was found to be attached to the rectum and inseparable from it. The patient also had a right inguinal hernia, which the surgeon repaired. After repairing the hernia, the operation was aborted due to the surgeon’s inability to separate the prostate from the rectum although a considerable amount of time was spent in this dissection. How should I code this case? I see three possible options for the encounter:

1. Radical prostatectomy with modifier 52
2. Radical prostatectomy with modifier 53
3. Exploratory laparotomy.

Answer: Your best option is to submit CPT® code 55840, as it appears that the surgeon did perform part of the radical procedure before terminating the surgery due to possible extension of the tumor into the rectum (which could be classified as extenuating circumstances or discontinuing the procedure for the well-being of the patient). Add modifier 53 (Discontinued procedure) to the professional services claim or modifier 74 (Discontinued Out-patient Hospital/Ambulatory Surgery Center (ASC) procedure after administration of anesthesia) in the facility setting to indicate the termination of the surgical procedure. Modifier 52 (Reduced services) does not really apply.

However, the surgeon did complete a procedure (the inguinal hernia repair). Therefore, also include 49505 (Repair initial inguinal hernia, age 5 years or older; reducible) on the claim.

If you are billing a commercial insurer, include a copy of the operative note. For a Medicare claim, make a note of “Additional information available upon request” in Box 19 and send the operative note when Medicare requests it.