

# GUIDEPOINT

Reimbursement Resources

## Radical Prostatectomy

### 2015 Coding & Payment Quick Reference

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

There is no separate and additional Medicare reimbursement for the Capiro™ RP Device used during a radical prostatectomy. Still, hospitals should charge for the Capiro RP Device using revenue center codes 272 or 279 to ensure costs are properly tracked for future rate-setting purposes.

The following codes are thought to be relevant to radical prostatectomy procedures and are referenced throughout this guide.

CPT® Code¹	Code Description
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic subtotal
55840	Prostatectomy, retropubic radical, with or without nerve sparing
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)

### Physician Relative Value Units (RVUs)

Physician Relative Value Units (RVUs) are based on the Medicare 2015 Physician Fee Schedule effective January 1, 2015.

CPT® Code	Office-Based¹				Facility-Based			
	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
55845		<b>See Note</b>			25.18	11.16	2.81	<b>39.15</b>
55831		<b>See Note</b>			17.19	8.03	1.92	<b>27.14</b>
55840		<b>See Note</b>			21.36	9.88	2.39	<b>33.63</b>
55842		<b>See Note</b>			21.36	9.87	2.37	<b>33.60</b>

Note: There are no current Medicare valuations for these procedures performed in the physician office setting.

### Payment – Medicare

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These procedures are identified by Medicare as “Inpatient Only” procedures and are not approved to be performed in an outpatient setting.

All rates shown are 2015 Medicare national averages; actual rates will vary geographically and/or by individual facility.

CPT® Code	Physician <sup>1</sup>		APC	Facility	
	MD In-Office Medicare Allowed Amount	MD In-Facility Medicare Allowed Amount <sup>2</sup>		Hospital Outpatient Medicare Allowed Amount <sup>2,3</sup>	ASC Medicare Allowed Amount <sup>2,4</sup>
55845	N/A	\$1,400	N/A	Inpatient Only	Inpatient Only
55831	N/A	\$970	N/A	Inpatient Only	Inpatient Only
55840	N/A	\$1,202	N/A	Inpatient Only	Inpatient Only
55842	N/A	\$1,201	N/A	Inpatient Only	Inpatient Only

### Hospital Inpatient Allowed Amounts – Medicare

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Possible MS-DRG Assignment <sup>3,4</sup>	Reimbursement
60.5 – Radical prostatectomy; by any approach	185 – Malignant neoplasm of prostate	707 – Major male pelvic procedures with complication or comorbidity (CC) / Major complication or comorbidity (MCC)	\$10,649
60.4 – Retropubic prostatectomy	198.82 – Secondary malignant neoplasm of genital organs		708 – Major male pelvic procedures without CC/MCC
60.3 – Suprapubic prostatectomy; transvesical prostatectomy	233.4 – Carcinoma in situ of prostate		
40.3 – Regional lymph node excision	236.5 – Neoplasm of uncertain behavior, prostate		
40.53 – Radical excision of iliac lymph nodes	239.5 – Neoplasm of unspecified nature; other genitourinary organs		
40.59 – Radical excision of other lymph nodes	600 – Hyperplasia of prostate		
	196.6 – Secondary and unspecified malignant neoplasm of Intrapelvic lymph nodes; hypogastric, iliac, obturator, parametrial		
	198.82 – Secondary malignant neoplasm of genital organs		

See important notes on the uses and limitations of this information on page 3.

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges, and modifiers for services that are rendered. Boston Scientific recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label.

1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 8, 2015 revised release, RVU15A file <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU15A.html?DLPPage=1&DLSort=0&DLSortDir=descending>. The 2015 National Average Medicare physician payment rates have been calculated using a 2015 conversion factor of \$35.7547 which reflects changes for January 1, 2015 through March 31, 2015 as a result of the April 1, 2014 Protecting Access to Medicare Act of 2014 (H.R. 4302). Rates subject to change.
2. "Allowed Amount" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance, etc.
3. The patient's medical record must support the existence and treatment of the complication or comorbidity.
4. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,865.48). Source: August 22, 2014 Federal Register; CMS-1607-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2015 Rates.

**Sequestration Disclaimer**

Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2015.

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