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GUIDEPOINT
Reimbursement Resources

Pelvic Floor Repair Procedures – Transvaginal

2016 Coding & Quick Reference Guide

This guide contains coding and reimbursement information relevant to physicians and facilities (e.g., ambulatory surgery centers, hospital outpatient facilities & hospital inpatient facilities).

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.

Reimbursement amounts provided in this guide are based on 2016 Medicare national average allowed amounts and will vary geographically and/or by individual facility.

PHYSICIAN Coding & Reimbursement (PFS)

Physician Relative Value Units (RVUs)

Proper medical record documentation is critical to ensure appropriate reimbursement from all payers. The medical record must specifically support all procedures and diagnoses billed.

The following codes are thought to be relevant to common transvaginal pelvic floor procedures and are referenced throughout this guide.

		Medicare Rates (National Average)	**Medicare RVUs (Facily Based)[1]			
CPT® Code	Description	2016 Physician[1,2] Allowed Amount	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	**$684**	11.5	6.21	1.37	**19.08**
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	**$688**	11.5	6.31	1.39	**19.20**
57260	Combined anteroposterior colporrhaphy;	**$847**	14.44	7.46	1.73	**23.63**
57265	Combined anteroposterior colporrhaphy; with enterocele repair	**$928**	15.94	8.04	1.91	**25.89**
*57267	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site (anterior, posterior compartment), vaginal approach (List separately in addition to code for primary procedure)	**$262**	4.88	1.85	0.57	**7.30**
57268	Repair of enterocele, vaginal approach (separate procedure)	**$493**	7.57	5.21	0.97	**13.75**
57282	Colpopexy, vaginal; extra-peritoneal approach	**$510**	7.97	5.30	0.98	**14.23**
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	**$684**	11.6	6.12	1.37	**19.09**
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	**$486**	7.82	4.82	0.93	**13.57**

*According to AMA-CPT instruction, use CPT Code 57267 in conjunction with CPT Codes 45560, 57240-57265, 57285

**There are no current Medicare valuations for the above CPT Codes for the physician office setting.

NOTE: Additional coding/reimbursement guides, including Uphold™ LITE Vaginal Support System and Sling Procedures are available on the Boston Scientific reimbursement webpage.

See important notes on the uses and limitations of this information on page 5.

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FACILITY Coding & Reimbursement Hospital Outpatient-OPPS

Coding, APC Relative Weights & Medicare Reimbursements

Comprehensive APCs (C-APCs), originally implemented by CMS in 2014, were created with the goal of identifying certain high-cost device-related hospital outpatient procedures. CMS has fully implemented this policy and has identified these high-cost, device-related procedures as the primary service on a claim. All other services reported on the same claim will be considered "adjunct services" provided to support the delivery of the primary service and will be unconditionally packaged into the OPPS payment of the primary service.

			Medicare Rates (National Average)	Medicare OPPS Relative Weight
CPT® Code	Description	APC Code	2016 Hospital Outpatient[2,3] Allowed Amount	APC Relative Weight[3]
57240	Anterior repair, cystocele	**5415**	**$3,660**	49.6467
57250	Posterior repair, rectocele	**5415**	**$3,660**	49.6467
57260	Combined A&P repair	**5415**	**$3,660**	49.6467
57265	Combined A&P repair w/enterocele repair	**5415**	**$3,660**	49.6467
57267	Insertion of mesh (ADD-ON CODE)	*No Separate Reimbursement (See *Note Below)*		
57268	Repair of enterocele, vaginal approach	**5414**	**$1,861**	25.2449
57282	Colpopexy, vaginal; extra-peritoneal approach	**5416**	**$5,699**	77.3001
57285	Paravaginal defect repair (including cystocele if performed); vaginal approach	**5416**	**$5,699**	77.3001
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	**5414**	**$1,861**	25.2449

*NOTE: As of January 2014, Medicare expanded their Packaging Policy (bundling), for hospital outpatient facilities and ambulatory surgical centers, to include most Add-on codes Reimbursement for these services is now included in the facility's reimbursement for the primary procedure. CPT 57267 (mesh insertion) is one of the "Add-on" codes affected by this policy change and is no longer separately reimbursed under the Medicare OPPS/ASC payment system. See note below for additional reimbursement opportunities under CMS' C-APC Complexity Adjustment Criteria.

This change does NOT apply to physician coding/reimbursement of mesh insertion under Medicare. Private payer reimbursement policies may differ.

NOTE: Exceptions to CMS's C-APC reimbursement policy apply, based on CMS's "complexity adjustment" criteria (applicable to hospital facilities ONLY). Visit the Boston Scientific reimbursement webpage to reference our online guide titled CMS Comprehensive APC & Complexity Adjustment Coding Scenarios-Hospital Outpatient Facilities for relevant procedure exceptions.

Medicare Pass-Through Codes (C-Codes) for Select Pelvic Floor Repair Devices

- C-codes are ONLY for use by hospital outpatient facilities, under the Medicare program. Medicare requires hospitals to use "C-codes" to report devices on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS in order to improve the claims data used annually to update the OPPS payment rates. The codes below, while no longer paid separately, are still important to report on outpatient hospital claims. Hospitals will continue to be paid for outpatient care using ambulatory payment classification (APC) rates based on procedures performed, and not on C-codes.
- It is important to charge appropriately for device-related procedures because hospital's charging practices will determine adequacy of future Medicare hospital outpatient rates. Medicare sets new hospital outpatient rates using hospital claims data from prior years. When hospitals fail to include appropriate device charges on the claim, this reduces future payment rates because the device-related costs are not captured for that service. As a result, it is important for hospitals to accurately reflect all procedure costs in insurance claims charges, including device cost, using the appropriate C-code, where applicable in conjunction with revenue code 278 Medical/Surgical Supplies and Devices - Other Implant.

See important notes on the uses and limitations of this information on page 5.

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Medicare Pass-Through Codes (C-Codes) for Select Pelvic Floor Repair Devices

C-Code	Description	Device Impacted
C1762	Connective tissue, human (includes fascia lata)	Repliform™ Tissue Regeneration Matrix
C1763	Connective Tissue, nonhuman (includes synthetic)	Uphold™ LITE Vaginal Support System Xenform™ Tissue Repair Matrix
C2631	Repair device, urinary, incontinence, without sling graft	Capio™ and Capio CL Suture Capturing Device Capio™ SLIM Suture Capturing Device

For additional online information related to CMS Pass-Through Codes (aka, HCPCS or C-codes) as well as a comprehensive list of Boston Scientific Urology and Pelvic Health products with C-Codes, see our online tool available on the Boston Scientific reimbursement webpage.

FACILITY Coding & Reimbursement Hospital Inpatient-IPPS

Coding & Medicare Reimbursement

ICD-10-PCS Procedure Code	Description
0JUC07Z	Supplement of pelvic region subcutaneous tissue and fascia with autologous tissue substitute, open approach
0JUC0JZ	Supplement of pelvic region subcutaneous tissue and fascia with synthetic substitute, open approach
0JUC0KZ	Supplement of pelvic region subcutaneous tissue and fascia with nonautologous tissue substitute, open approach
0JQC0ZZ	Repair pelvic region subcutaneous tissue and fascia, open approach
0USG0ZZ	Reposition vagina, open approach
0UUG07Z	Supplement vagina with autologous tissue substitute, open approach
0UUG0JZ	Supplement vagina with synthetic substitute, open approach
0UUG0KZ	Supplement vagina with nonautologous tissue substitute, open approach
0UQF0ZZ	Repair cul-de-sac, open approach
0UUF07Z	Supplement cul-de-sac with autologous tissue substitute, open approach
0UUF0JZ	Supplement cul-de-sac with synthetic substitute, open approach
0UUF0KZ	Supplement cul-de-sac with nonautologous tissue substitute, open approach
0UPH07Z	Removal of autologous tissue substitute from vagina and cul-de-sac, open approach
0UPH0JZ	Removal of synthetic substitute from vagina and cul-de-sac, open approach
0UPH0KZ	Removal of nonautologous tissue substitute from vagina and cul-de-sac, open approach
0UWH07Z	Revision of autologous tissue substitute in vagina and cul-de-sac, open approach
0UWH0JZ	Revision of synthetic substitute in vagina and cul-de-sac, open approach
0UWH0KZ	Revision of nonautologous tissue substitute in vagina and cul-de-sac, open approach

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ICD-10-CM Diagnosis Code	Description
N81.0	Urethrocele
N81.10	Cystocele, unspecified
N81.11	Cystocele, midline
N81.12	Cystocele, lateral
N81.2	Incomplete uterovaginal prolapse
N81.3	Complete uterovaginal prolapse
N81.4	Uterovaginal prolapse, unspecified
N81.5	Vaginal enterocele
N81.6	Rectocele

Possible MS-DRG Assignment[6]	Description	Reimbursement[5]
748	Female reproductive system reconstructive procedures	$6,638
662	Minor bladder procedures with major complication or comorbidity (MCC)	$17,063
663	Minor bladder procedures with complication or comorbidity (CC)	$9,833
664	Minor bladder procedures without CC/MCC	$7,668

FACILITY Coding & Reimbursement

Ambulatory Surgery Center

Ambulatory Surgery Center Allowed Amounts

		Medicare Rates (National Average)	Medicare ASC Relative Weight	
CPT® Code	Description	APC Code	2016 ASC[2,4] Allowed Amount	APC Relative Weight[4]
57240	Anterior repair, cystocele	**5415**	**$1,810**	40.9690
57250	Posterior repair, rectocele	**5415**	**$1,810**	40.9690
57260	Combined A&P repair	**5415**	**$1,810**	40.9690
57265	Combined A&P repair w/enterocele repair	**5415**	**$1,810**	40.9690
57267	Insertion of mesh (ADD-ON CODE)	*No Separate Reimbursement (See *Note Below)*		
57268	Repair of enterocele, vaginal approach	**5414**	**$1,041**	23.5585
57282	Colpopexy, vaginal; extra-peritoneal approach	**Not eligible for reimbursement in an ASC setting**		
57285	Paravaginal defect repair (including cystocele if performed); vaginal approach	*(based on Medicare's "2016 List of Approved ASC Procedures")*		
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach	**5414**	**$1,041**	23.5585

NOTE: As of January 2014, Medicare expanded their Packaging Policy (bundling), for hospital outpatient facilities and ambulatory surgical centers, to include most Add-on codes Reimbursement for these services is now included in the reimbursement for the primary procedure. CPT code 57267 (mesh insertion) is one of the "Add-on" codes affected by this policy change and is no longer separately reimbursed under the Medicare OPPS/ASC payment system. Private payer reimbursement policies may differ.

This change does NOT apply to physician coding/reimbursement of mesh insertion under Medicare.

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Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved.

Health economics 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 provided 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.

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.

Please refer to package insert provided with the products for complete Indications for Use, Contraindications, Warnings, Precautions, Adverse Events, and Instructions prior to use.

Products are labeled for individual use and concomitant repairs are at the discretion of the physician.

Accordingly for medical devices:
CAUTION: Federal Law (USA) restricts these devices to sale by or on the order of a physician.

Accordingly for mesh for transvaginal repair of pelvic organ prolapse:
CAUTION: Federal Law (USA) restricts this device to sale by or on the order of a physician trained in use of surgical mesh for transvaginal repair of pelvic organ prolapse.

Accordingly for stress urinary incontinence mesh products:
CAUTION: Federal Law (USA) restricts this device to sale by or on the order of a physician trained in use of surgical mesh for repair of stress urinary incontinence.

Repliform Tissue Regeneration Matrix complies with U.S. Regulations in 21 CFR part 1271 Human Tissue Intended for Transplantation.

1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2016 release, RVU16A file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending The 2016 National Average Medicare physician payment rates have been calculated using a 2016 conversion factor of $35.8279. 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. Hospital outpatient payment rates are 2016 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2016 release, CMS-1633-FC https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
4. ASC payments rates are 2016 Medicare ASC national averages. ASC rates are from the 2016 Ambulatory Surgical Center Covered Procedures List - Addendum AA. Source: January 2016 release, CMS-1633-FC; CMS-1607-F2 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
5. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,904.74). Source: August 17, 2015 Federal Register; CMS-1632-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.
6. The patient's medical record must support the existence and treatment of the complication or comorbidity.

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, 2016.

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