CODING
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.

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

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>57240</td>
<td>Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele</td>
</tr>
<tr>
<td>57250</td>
<td>Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy</td>
</tr>
<tr>
<td>57260</td>
<td>Combined anteroposterior colporrhaphy</td>
</tr>
<tr>
<td>57265</td>
<td>Combined anteroposterior colporrhaphy; with enterocele repair</td>
</tr>
<tr>
<td>*57267</td>
<td>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)</td>
</tr>
<tr>
<td>57268</td>
<td>Repair of enterocele, vaginal approach (separate procedure)</td>
</tr>
<tr>
<td>57282</td>
<td>Colpopexy, vaginal; extra-peritoneal approach</td>
</tr>
<tr>
<td>57285</td>
<td>Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach</td>
</tr>
<tr>
<td>57295</td>
<td>Revision (including removal) of prosthetic vaginal graft; vaginal approach</td>
</tr>
</tbody>
</table>

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

NOTE: Additional coding/reimbursement guides, including Uphold™ LITE Vaginal Support System, are available on the Boston Scientific reimbursement webpage ([www.bostonscientific.com/reimbursement](http://www.bostonscientific.com/reimbursement)).

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See last page for important information about the uses and limitations of this document.
PHYSICIAN RELATIVE VALUE UNITS (RVUs)

- Physician Relative Value Units (RVUs) are based on the Medicare 2014 Physician Fee Schedule effective January 1, 2014.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>2014 Physician RVUs</th>
<th>Work Practice RVU</th>
<th>Malpractice RVU</th>
<th>Total RVUs</th>
<th>2014 Hospital Outpatient RVUs</th>
<th>Work Practice RVU</th>
<th>Malpractice RVU</th>
<th>Total RVUs</th>
<th>2014 Ambulatory Surgery Center RVUs</th>
<th>Work Practice RVU</th>
<th>Malpractice RVU</th>
<th>Total RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>57240</td>
<td>Anterior repair, cystocele</td>
<td>19.26</td>
<td>11.50</td>
<td>6.20</td>
<td>1.56</td>
<td>24.15</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>26.45</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>57250</td>
<td>Posterior repair, rectocele</td>
<td>19.59</td>
<td>11.50</td>
<td>6.31</td>
<td>1.78</td>
<td>22.44</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>22.44</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>57260</td>
<td>Combined A&amp;P repair</td>
<td>24.15</td>
<td>14.44</td>
<td>7.47</td>
<td>2.24</td>
<td>24.15</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>24.15</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>57265</td>
<td>Combined A&amp;P repair w/enterocele</td>
<td>26.45</td>
<td>15.94</td>
<td>8.05</td>
<td>2.46</td>
<td>26.45</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>26.45</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>57267</td>
<td>Insertion of mesh (ADD-ON CODE)</td>
<td>7.42</td>
<td>4.88</td>
<td>1.85</td>
<td>0.69</td>
<td>7.42</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>7.42</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>57268</td>
<td>Repair of enterocele, vaginal approach</td>
<td>19.45</td>
<td>11.60</td>
<td>6.13</td>
<td>1.72</td>
<td>19.45</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>19.45</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>57295</td>
<td>13.78</td>
<td>7.82</td>
<td>4.81</td>
<td>1.15</td>
<td>13.78</td>
<td>13.78</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>13.78</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

MEDICARE PAYMENT

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.

- All rates shown are 2014 Medicare national averages; Actual rates will vary geographically.
- When multiple procedures are performed during the same operative session, Medicare’s Multiple Procedure Payment Reduction policy applies. This policy allows 100% reimbursement for the primary procedure and 50% reimbursement for all other procedures (except Add-on codes). Private payer reimbursement policies may differ.

PHYSICIAN, HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER ALLOWED AMOUNTS

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>2014 Physician Allowed Amount</th>
<th>2014 Hospital Outpatient Allowed Amount</th>
<th>2014 Ambulatory Surgery Center Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>57240</td>
<td>Anterior repair, cystocele</td>
<td>$655 0195 $2,523 $1,394</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57250</td>
<td>Posterior repair, rectocele</td>
<td>$667 0195 $2,523 $1,394</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57260</td>
<td>Combined A&amp;P repair</td>
<td>$822 0195 $2,523 $1,394</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57265</td>
<td>Combined A&amp;P repair w/enterocele</td>
<td>$900 0202 $3,569 $1,972</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57267</td>
<td>Insertion of mesh (ADD-ON CODE)</td>
<td>$252 See *Note Below</td>
<td>See *Note Below</td>
<td>See *Note Below</td>
</tr>
<tr>
<td>57268</td>
<td>Repair of enterocele, vaginal approach</td>
<td>$474 0195 $2,523</td>
<td></td>
<td>$1,394</td>
</tr>
<tr>
<td>57282</td>
<td>Colpopexy, vaginal; extra-rectoanal approach</td>
<td>$491 0202 $3,569</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57285</td>
<td>Paravaginal defect repair (including cystocele if performed); vaginal approach</td>
<td>$662 0202 $3,569</td>
<td></td>
<td></td>
</tr>
<tr>
<td>57295</td>
<td>Revision (including removal) of prosthetic vaginal graft; vaginal approach</td>
<td>$469 0195 $2,523</td>
<td></td>
<td>$1,394</td>
</tr>
</tbody>
</table>

*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 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.

Important to note, this change does not affect physician coding/reimbursement. Private payer reimbursement policies may differ.
MEDICARE PAYMENT (continued)

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.

- All rates shown are 2014 Medicare national averages; Actual rates will vary geographically.

HOSPITAL INPATIENT ALLOWED AMOUNTS

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Code</th>
<th>Procedure Code</th>
<th>Possible MS-DRG Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>618.00 – Unspecified prolapse of vaginal walls</td>
<td>70.51 – Repair of cystocele</td>
<td>748 – Female reproductive system reconstructive procedures</td>
</tr>
<tr>
<td>618.01 – Cystocele, midline</td>
<td>70.54 – Repair of cystocele with graft or prosthesis (Anterior colporrhaphy)</td>
<td>$5,855</td>
</tr>
<tr>
<td>618.02 – Cystocele, lateral</td>
<td>70.77 – Vaginal suspension and fixation</td>
<td>662 – Minor bladder procedures with major complication or comorbidity (MCC)</td>
</tr>
<tr>
<td>618.03 – Urethrocele</td>
<td>70.78 – Vaginal suspension and fixation with graft or prosthesis</td>
<td>$17,283</td>
</tr>
<tr>
<td>618.09 – Other prolapse of vaginal walls without mention of uterine prolapse</td>
<td>70.95 – Insertion of synthetic graft or prosthesis</td>
<td>663 – Minor bladder procedures with complication or comorbidity (CC)</td>
</tr>
<tr>
<td>618.90 – Other prolapse of vaginal walls with mention of uterine prolapse</td>
<td>70.96 – Insertion of synthetic graft or prosthesis</td>
<td>664 – Minor bladder procedures without CC/MCC</td>
</tr>
</tbody>
</table>

Some examples of complications or comorbidities may include congestive heart failure (CHF), cardiomyopathy, decubitus ulcer, malnutrition and urinary tract infection. The presence or absence of major complications and comorbidities (MCC) and/or presence or absence of complications and comorbidities (CC) may affect diagnosis-related group (DRG) assignment. Physicians should refer to package insert provided with the product for complete Indications for Use, Contraindications, Warnings, Precautions, Adverse Events, and Instructions prior to device use.

RELEVANT 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 conclude 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.

<table>
<thead>
<tr>
<th>C-code</th>
<th>Code Description</th>
<th>Device Impacted</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1762</td>
<td>Connective tissue, human (includes fascia lata)</td>
<td>Repilorm™ Tissue Regeneration Matrix</td>
</tr>
<tr>
<td>C1763</td>
<td>Connective Tissue, nonhuman (includes synthetic)</td>
<td>Uphold™ LITE Vaginal Support System Xenform™ Tissue Repair Matrix</td>
</tr>
<tr>
<td>C2631</td>
<td>Repair device, urinary, incontinence, without sling graft</td>
<td>Capio™ and Capio CL Suture Capturing Device Capio™ SLIM Suture Capturing Device Precision SpeedTac™ Transvaginal Anchor System Precision Twist™ Transvaginal Anchor System</td>
</tr>
</tbody>
</table>

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ENDNOTES:

http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/FFS-Relative-Value-Files-Items/RVU14A.html?DLPage=1&DLSort=0&DLSortDir=descending. The 2014 National Average Medicare physician payment rates have been calculated using a 2014 conversion factor of $35.8228 which reflects the 0.5 percent update for January 1, 2014 through March 31, 2014, as adopted by section 101 of the Pathway for SGR Reform Act of 2013. Rates subject to change.

2 Allotted 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 hospital outpatient payment rates are 2014 Medicare national averages. Source: November 27, 2013 Federal Register, CMS-1601-FC.

4 The ASC payments rates are 2014 Medicare national averages. ASC rates are from the 2014 Ambulatory Surgical Center Covered Procedures List – Addendum AA. Source: November 27, 2013 Federal Register, CMS-1601-FC.

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 ($5,799.59). Source: August 19, 2013 Federal Register; CMS-1599-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2014 Rates.

6 The patient’s medical record must support the existence and treatment of the complication or comorbidity.

Sequestration
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, 2014.

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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.


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