

Summary of Correct Coding Initiative (CCI) Edits for Pelvic Floor Reconstructive Procedures

Reimbursement Information

2009 CODING & PAYMENT QUICK REFERENCE

BACKGROUND

- This billing guide covers Medicare coding and payment scenarios when multiple pelvic floor reconstructive procedures are performed concurrently.
- The table below outlines additional concomitant repairs that may be billed when a sling or paravaginal defect repair is the primary procedure. As of January 1, 2008, if these procedures were billed together, Medicare would now allow separate reimbursement for both the sling and paravaginal defect repair procedures.
- Coding guidelines reflect version 14.3 of the Correct Coding Initiative (CCI) Edits.
- According to coding guidelines, CPT® Code 57267 (Insertion of mesh for pelvic floor repair), can be billed with CPT Codes 45560 and 57240-57265, 57285.**
- All rates shown are 2009 Medicare national averages; Actual rates will vary geographically.

MEDICARE PHYSICIAN PAYMENT

- Sling (57288) or paravaginal defect repair (57284/57285) will be the main procedure for most pelvic floor repairs.
- We have shown the full payment for secondary procedures; actual payments would be reduced by 50% (except 57267) per Medicare's multiple procedure discounting policy.

CPT® Code	Code Description	MD In-Facility Allowed Amount ¹	Can be billed with:	
			Sling	Defect Repair
57288	Sling operation for stress incontinence	\$704		Yes
57284	Paravaginal defect repair (including repair of cystocele, if performed); open abdominal approach	\$799	Yes	
57285	Paravaginal defect repair (including repair of cystocele, if performed); vaginal approach	\$632	Yes	

- Below is a listing of secondary procedures that may be billed in conjunction with either 57288 or 57284/57285.

CPT Code	Code Description	MD In-Facility Allowed Amount ¹	Can be billed with:	
			Sling	Defect Repair Open/Vaginal
57267	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site	\$261	Yes	Yes/No
57230	Plastic repair of urethrocele	\$377	Yes	Yes/Yes
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	\$624	Yes	No/Yes
57250	Posterior colporrhaphy, repair of rectocele w/w-o perineorrhaphy	\$610	Yes	Yes/Yes
57260	Combined anteroposterior colporrhaphy;	\$762	Yes	Yes/Yes
57265	Combined anteroposterior colporrhaphy; with enterocele repair	\$855	Yes	Yes/Yes
57289	Pereyra procedure, including anterior colporrhaphy	\$740	Yes	Yes/Yes
53500	Urethrolisis, transvaginal, secondary, open, including cysto	\$760	Yes	Yes/Yes
51845	Abdomino-vaginal vesical neck suspension, with or without endoscopic control	\$599	Yes	Yes/Yes
57280	Colpopexy, abdominal approach	\$922	Yes	Yes/Yes
57282	Colpopexy, vaginal; extra-peritoneal approach	\$486	Yes	Yes/Yes
57283	Colpopexy, vaginal; intra-peritoneal approach	\$652	Yes	Yes

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2009 CODING AND QUICK REFERENCE GUIDE

MEDICARE HOSPITAL INPATIENT PAYMENT

Effective October 1, 2007, the Center for Medicare and Medicaid Services (CMS) replaced the Diagnosis Related Groups (DRG) System with the Medicare Severity DRG (MS-DRG) classification system to recognize severity of illness among patients.

ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Code	Possible MS-DRG Assignment ²
625.6- Stress Urinary Incontinence (SUI)	59.79- Urinary incontinence repairs NEC	748- Female reproductive system reconstructive procedures- \$4,532
599.82- Intrinsic Sphincter Deficiency (ISD) ³	70.50- 70.55 – Repair of cystocele and/or rectocele with or without graft or prosthesis	662- Minor bladder procedures with major complication or comorbidity (MCC) \$15,052 ⁴
599.81- Urethral Hypermobility	70.77- Vaginal suspension and fixation	663- Minor bladder procedures with complication or comorbidity (CC) \$8,012 ⁴
618.00- Unspecified prolapse of vaginal walls	70.78- Vaginal suspension and fixation with graft or prosthesis	664- Minor bladder procedures without CC/MCC \$5,509
618.01- Cystocele, midline	70.94- Insertion of biological graft	
618.02- Cystocele, lateral	70.95- Insertion of synthetic graft or prosthesis	
618.03- Urethrocele		
618.04- Rectocele		
618.05- Perineocele		
618.09- Other prolapse of vaginal walls without mention of uterine prolapse		

¹ MD rates calculated using the 2009 conversion factor of \$36.0666. Source: November 19, 2008 Federal Register.

“Allowed Amount” is the amount Medicare determines to be the maximum allowance for any Medicare covered service. Actual payment will be based on the maximum allowance less any applicable deductibles, co-insurance, etc.

² National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,552.58). October 3, 2008.

³ The principle diagnosis of ISD must be documented and supported in the patient’s medical record.

⁴ The patient’s medical record must support the existence and treatment of the complication or comorbidity.

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Q- If a urologist performs a sling procedure and a gynecologist performs a concomitant repair on the same patient during the same operative session, may both physicians be entitled to a Medicare fee?

A- Yes, but the payment amounts will depend on the services provided and how the physicians bill the services. Medicare provides full payment for each surgeon provided the procedures are independently performed by different specialists on the same patient on the same day.

If the two specialists were working together as primary surgeons on distinct parts of a single reportable service, each physician would attach the -62 (co-surgeon) modifier onto their bill. Payment for each surgeon would be set at half of 125% of the Medicare fee schedule rate for that procedure. Each would submit a claim for the same CPT® Code, attaching a -62 modifier. Documentation for medical necessity should be submitted in addition to an operative report, which clearly indicates the procedure(s) performed by each surgeon.

If an individual physician performs multiple procedures at the same session, Medicare pays 50% of the fee schedule amount for the second through fifth procedures (certain exceptions apply for endoscopic procedures and add-on codes).

Q- How does Medicare pay physicians when there are two specialists performing a procedure, one acting as the primary surgeon and one as the assistant?

A- In this scenario Medicare would reimburse the primary surgeon 100% of the fee, and the assistant would receive 16% of the procedure fee by billing the surgery with modifier -80. Some private payers may reimburse assistant surgeons more than the Medicare amount of 16%.

Q- If a sling procedure (CPT code 57288) and a paravaginal defect repair-open abdominal approach procedure (CPT code 57284) are performed together, how does Medicare pay the physician?

A- As of January 1, 2008, Medicare no longer bundles the reimbursement of the sling procedure into the paravaginal defect repair (open abdominal approach) procedure. As a result, Medicare would reimburse based on their Multiple Surgery Reduction Policy which would allow 100% reimbursement for the procedure with the highest Medicare allowance and 50% for all subsequent procedures. In this scenario, Medicare would reimburse 100% of the allowed amount for CPT code 57284 and reduce payment for CPT code 57288 by 50%.

Q- If a sling procedure (CPT code 57288) and a paravaginal defect repair-vaginal approach procedure (CPT code 57285) are performed together, how does Medicare pay the physician?

A- Medicare would reimburse based on their Multiple Surgery Reduction Policy which would allow 100% reimbursement for the procedure with the highest Medicare allowance and 50% for all subsequent procedures. In this scenario, Medicare would reimburse 100% of the allowed amount for CPT code 57288 and reduce payment for CPT code 57285 by 50%.

Q- How do Medicare physician fees compare to non-Medicare payers?

A- Reimbursement from Medicare and private payers vary considerably depending on many factors. However, for many private health insurance plans, specialist fees often average about 120% - 140% of the Medicare rate, with some private plans paying considerably more or setting fees using a percentage of physician charges.

Pelvic Floor Reconstructive Procedures

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