

# Uphold™ Vaginal Support System

2010 Coding and Quick Reference Guide

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## BACKGROUND

- Identified are two (2) common coding/reimbursement scenarios relating to the use of the Uphold Vaginal Support System when performed in a hospital outpatient setting.
  - **NOTE:** CPT® Code 57282 - colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus), is not on CMS' List of Approved ASC Procedures and is not included in the scenario's provided.
- Proper medical record documentation is critical to ensure appropriate reimbursement from all payers. The medical record must specifically support all procedures and diagnoses billed.
- All procedures are listed in order of highest to lowest total MD In-Facility relative value units (RVU).
- All rates shown are 2010 Medicare national averages; Actual rates will vary geographically.
- Physician allowances for secondary procedures, when applicable, have been reduced by 50% based on Medicare's *Multiple Surgery Procedure Payment Reductions* policy. The mesh code (57267) will be paid at 100% as an "add-on" code. Private payer reimbursement policies may differ.
- Based on Medicare's Outpatient Prospective Payment System (OPPS), hospital outpatient allowances for secondary procedures and the add-on mesh code have been reduced by 50%. Private payer reimbursement policies may differ.
- 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.

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### OUTPATIENT SCENARIO 1: Repair of Apical Prolapse with Cystocele, with Sling Procedure and Mesh Insertion

CPT® Code	Code Description	Related ICD-9-CM Diagnosis Codes	MD In-Facility Allowed Amount <sup>1,2</sup>	Hospital Outpatient Allowed Amount <sup>2,3</sup>
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	**625.6 or 788.33	\$727	\$3,025
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	618.01 or 618.2 or 618.3	\$335*	\$1,186*
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	618.09 or 618.2 or 618.3 or 618.4 or 618.5	\$251*	\$1,513*
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)	618.81	\$264	\$1,186*
<b>TOTAL:</b>			<b>\$1,577</b>	<b>\$6,910</b>

### OUTPATIENT SCENARIO 2: Repair of Apical Prolapse with Cystocele and Mesh Insertion (No Sling Procedure)

CPT® Code	Code Description	Related ICD-9-CM Diagnosis Codes	MD In-Facility Allowed Amount <sup>1,2</sup>	Hospital Outpatient Allowed Amount <sup>2,3</sup>
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	618.01 or 618.2 or 618.3	\$670	\$1,186*
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	618.09 or 618.1 or 618.2 or 618.3 or 618.4 or 618.5	\$251*	\$3,025
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)	618.81	\$264	\$1,186*
<b>TOTAL:</b>			<b>\$1,185</b>	<b>\$5,397</b>

\*Note: Medicare's Multiple Surgery Procedure Payment Reductions have been applied.

\*\*Note: If the underlying cause of stress urinary incontinence is known and documented, then add additional codes as appropriate (e.g. ISD, hypermobility, or prolapse).

<sup>1</sup>Department of Health and Human Services. Centers for Medicare and Medicaid Services. <http://www.cms.gov/PhysicianFeeSched/>. 2010 National Average Medicare physician payment rates calculated using a 2010 conversion factor \$36.8729 to reflect the June 25, 2010, Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. Rates effective June 1, 2010 through November 30, 2010 and are subject to change and do not reflect a Sustainable Growth Rate reduction.

<sup>2</sup> 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.

<sup>3</sup> Source: Display date July 2, 2010, CMS Correction Notice CMS-1504-N, "Changes to the Hospital OPPS and ASC PS for CY 2010 to Reflect the Affordable Care Act"; Addendum A and Addendum B.

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### HOSPITAL INPATIENT MEDICARE ALLOWED AMOUNTS

ICD-9-CM Diagnosis Code	ICD-9-CM Procedure Code	Possible MS-DRG Assignment
<b>625.6-</b> Stress incontinence, female	<b>59.79-</b> Other repair of urinary stress incontinence	748- Female reproductive system reconstructive procedures \$4,957 <sup>4</sup>
<b>599.82-</b> Intrinsic (urethral) sphincter deficiency (ISD)*	<b>70.50-</b> Repair of cystocele and rectocele	662- Minor bladder procedures with major complication or comorbidity (MCC) \$15,663 <sup>4,5</sup>
<b>599.81-</b> Urethral hypermobility	<b>70.51-</b> Repair of cystocele	663- Minor bladder procedures with complication or comorbidity (CC) \$7,739 <sup>4,5</sup>
<b>618.00-</b> Unspecified prolapse of vaginal walls	<b>70.52-</b> Repair of rectocele	664- Minor bladder procedures without CC/MCC \$5,753 <sup>4</sup>
<b>618.01-</b> Cystocele, midline	<b>70.53-</b> Repair of cystocele and rectocele with graft or prosthesis	
<b>618.02-</b> Cystocele, lateral	<b>70.54-</b> Repair of cystocele with graft or prosthesis (Anterior colporrhaphy)	
<b>618.03-</b> Urethrocele	<b>70.55-</b> Repair of rectocele with graft or prosthesis (Posterior colporrhaphy)	
<b>618.04-</b> Rectocele	<b>70.77-</b> Vaginal suspension and fixation	
<b>618.05-</b> Perineocele	<b>70.78-</b> Vaginal suspension and fixation with graft or prosthesis	
<b>618.09-</b> Other prolapse of vaginal walls without mention of uterine prolapse	<b>70.94-</b> Insertion of biological graft	
	<b>70.95-</b> Insertion of synthetic graft or prosthesis	

<sup>1</sup> Department of Health and Human Services. Centers for Medicare and Medicaid Services. <http://www.cms.gov/PhysicianFeeSched/>. 2010 National Average Medicare physician payment rates calculated using a 2010 conversion factor \$36.8729 to reflect the June 25, 2010, Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. Rates effective June 1, 2010 through November 30, 2010 and are subject to change and do not reflect a Sustainable Growth Rate reduction.

<sup>2</sup> "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.

<sup>3</sup> Source: Display date July 2, 2010, CMS Correction Notice CMS-1504-N, "Changes to the Hospital OPPS and ASC PS for CY 2010 to Reflect the Affordable Care Act"; Addendum A and Addendum B.

<sup>4</sup> National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,643.58). Source: June 2, 2010, Notice 1406-N. Department of Health and Human Services. Centers for Medicare and Medicaid Services.

<sup>5</sup> The patient's medical record must support the existence and treatment of the complication or comorbidity.

\* The principle diagnosis of ISD must be documented and supported in the patient's medical record.

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### **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 OPPTS in order to improve the claims data used annually to update the OPPTS 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 XXX.
- 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

C code	Code Description	Device Impacted
C1762	Connective tissue, human (includes fascia lata)	Repliform® Tissue Regeneration Matr
C1763	Connective tissue, nonhuman (includes synthetic)	<b>Uphold™ Vaginal Support System</b> Pinnacle® Anterior/Apical Pelvic Floor Repair Kit Pinnacle® Posterior Pelvic Floor Repair Kit Pinnacle Duet® Pelvic Floor Repair Kit Xenform® Tissue Repair Matrix Polyform® Synthetic Mesh
C1771	Repair device, urinary, incontinence, with sling graft	Advantage® Transvaginal MUS System Advantage Fit® Transvaginal MUS System Lynx® Suprapubic MUS System Obtryx® Transobturator MUS System Prefyx PPS® Pre-Pubic System Solyx® Single Incision Sling System
C2631	Repair device, urinary, incontinence, without sling graft	Capio® OA and Capio CL Suture Capturing Devices

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