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GUIDEPOINT
Reimbursement Resources

AdVance™ Male Sling System

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.

The following codes are thought to be relevant to AdVance™ Male Sling System procedures and are referenced throughout this guide.

CPT® Code[1]	Code Description
53440	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)
53442	Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)

Physician Relative Value Units (RVUs)

Physician Relative Value Units (RVUs) are based on the Medicare 2016 Physician Fee Schedule effective January 1, 2016.

	Office-Based[1]				Facility-Based			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
53440	**See Note**				13.36	6.76	1.50	**21.62**
53442					13.49	7.46	1.52	**22.47**

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

Payment – Medicare

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis. All rates shown are 2016 Medicare national averages; actual rates will vary geographically and/or by individual facility.

	Physician[1]			Facility	
CPT® Code	MD In-Office Medicare Allowed Amount	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
53440	-	$775	5376	$7,428	$5,926
53442	-	$805	5375	$3,394	$1,744

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Hospital Inpatient Allowed Amounts – Medicare

Possible MS-DRG Assignment[7,8]		Reimbursement
662	Minor Bladder Procedures w/MCC	$17,063
663	Minor Bladder Procedures w/CC	$9,833
664	Minor Bladder Procedures w/o CC/MCC	$7,668

ICD-10 Diagnostic Code	
R32	Unspecified urinary incontinence
N39.3	Stress incontinence (female) (male)
788.37	Continuous leakage
788.39	Other urinary incontinence
T83.090A	Other mechanical complication of cystostomy catheter, initial encounter
T83.198A	Other mechanical complication of other urinary devices and implants, initial encounter
T83.29XA	Other mechanical complication of graft of urinary organ, initial encounter
T83.498A	Other mechanical complication of other prosthetic devices, implants and grafts of genital tract, initial encounter
T83.81XA	Embolism of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.82XA	Fibrosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.83XA	Hemorrhage of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.84XA	Pain from genitourinary prosthetic devices, implants and grafts, initial encounter
T83.85XA	Stenosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.86XA	Thrombosis of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.89XA	Other specified complication of genitourinary prosthetic devices, implants and grafts, initial encounter
T83.9XXA	Unspecified complication of genitourinary prosthetic device, implant and graft, initial encounter

ICD-10 Procedure Code	
0TQB0ZZ	Repair Bladder, Open Approach
0TQB3ZZ	Repair Bladder, Percutaneous Approach
0TQB4ZZ	Repair Bladder, Percutaneous Endoscopic Approach
0TQB7ZZ	Repair Bladder, Via Natural or Artificial Opening
0TQB8ZZ	Repair Bladder, Via Natural or Artificial Opening Endoscopic

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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
5. 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
6. The patient's medical record must support the existence and treatment of the complication or comorbidity.
7. 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.

Disclaimer
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.

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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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Boston Scientific Corporation
300 Boston Scientific Way
Marlborough, MA 01752
www.bostonscientific.com/reimbursement

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