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.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53440</td>
<td>Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)</td>
</tr>
<tr>
<td>53442</td>
<td>Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)</td>
</tr>
</tbody>
</table>

**Physician Relative Value Units (RVUs)**

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

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Office-Based</th>
<th>Facility-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Work RVU</td>
<td>Practice RVU</td>
</tr>
<tr>
<td>53440</td>
<td>13.36</td>
<td>6.76</td>
</tr>
<tr>
<td>53442</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Physician²</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MD In-Office Medicare Allowed Amount</td>
<td>MD In-Facility Medicare Allowed Amount²</td>
</tr>
<tr>
<td>53440</td>
<td>-</td>
<td>$775</td>
</tr>
<tr>
<td>53442</td>
<td>-</td>
<td>$805</td>
</tr>
</tbody>
</table>

See important notes on the uses and limitations of this information on page 3.
## Hospital Inpatient Allowed Amounts – Medicare

<table>
<thead>
<tr>
<th>Possible MS-DRG Assignment</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>662 Minor Bladder Procedures w/MCC</td>
<td>$17,063</td>
</tr>
<tr>
<td>663 Minor Bladder Procedures w/CC</td>
<td>$9,833</td>
</tr>
<tr>
<td>664 Minor Bladder Procedures w/o CC/MCC</td>
<td>$7,668</td>
</tr>
</tbody>
</table>

### 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
- **T83.92XA** 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

**Effective:** 1JAN2016  
**Expires:** 31DEC2016

See important notes on the uses and limitations of this information on page 3.
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.


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


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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