Uphold™ LITE Vaginal Support System
2014 Coding and Quick Reference Guide

Boston Scientific

GuidePoint
Simplifying Reimbursement

Women's Health

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 Uphold LITE Vaginal Support System and are referenced throughout this guide.*

CPT® Code	Code Description
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele
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)
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)
57288	Sling operation for stress incontinence (eg, fascia or synthetic)*

**Products are labeled for individual use and concomitant repair are at the discretion of the physician*

PHYSICIAN RELATIVE VALUE UNITS (RVUs)

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

Facility-Based					Office-Based			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	**Total RVUs**	Work RVU	Practice RVU	Malpractice RVU	**Total RVUs**
57240	11.50	6.20	1.56	**19.26**	**N/A** *There are no current Medicare valuations for these procedures performed in the physician office setting.*			
57267	4.88	1.85	0.69	**7.42**				
57282	7.97	5.27	1.19	**14.43**				
57288	12.13	6.79	20.44	**35.82**				

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.

Please refer to package insert provided with the product for complete Indications for Use, Contraindications, Warnings, Precautions, Adverse Events, and Instructions prior to using these products.

See last page for important information about the uses and limitations of this document.

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HOSPITAL OUTPATIENT SETTING:

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.

- Identified below are two (2) common coding/reimbursement scenarios relating to the use of *Uphold LITE Vaginal Support System* when performed in a hospital outpatient setting.
- *CPT Code 57282 is not eligible for reimbursement in an ASC setting according to CMS' "**List of Approved ASC Procedures**". Therefore, ASC reimbursements are not reflected in this guide.*
- 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 Physician facility-based relative value units (RVU). Physician allowances for secondary procedures, when applicable, have been reduced by 50% based on Medicare's *Multiple Procedure Payment Reductions* policy. The mesh insertion code (CPT Code 57267) will be paid at 100% as an "add-on" code under Medicare's Physician Fee Schedule payment system. Private payer reimbursement policies may differ.

SCENARIO 1:

"Repair of Apical Prolapse with Cystocele, with Sling Procedure and Mesh Insertion"*

CPT® Code	Code Description	Related ICD-9-CM Diagnosis Codes	2014 Physician Medicare Allowed Amount[1,2]	APC	2014 Hospital Outpatient Medicare Allowed Amount[2,3]
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	**625.6 **or** 788.33	$732	0202	$3,569
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	618.01 **or** 618.2 **or** 618.3	$345	0195	$1,262
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	618.09 **or** 618.2 **or** 618.3	$259	0202	$1,785
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	$266	0195	***See *Note Below***
		TOTAL:	**$1,602**		**$6,616**

***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 Code 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.

**Products are labeled for individual use and concomitant repair are at the discretion of the physician*

HOSPITAL OUTPATIENT SETTING (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.

SCENARIO 2:

"Repair of Apical Prolapse with Cystocele and Mesh Insertion (No Sling Procedure)"

CPT® Code	Code Description	Related ICD-9-CM Diagnosis Codes	2014 Physician Medicare Allowed Amount[1,2]	APC	2014 Hospital Outpatient Medicare Allowed Amount[2,3]
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	618.01 **or** 618.2 **or** 618.3	$690	0195	$1,262
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)	618.09 **or** 618.1 **or** 618.2 **or** 618.3	$259	0202	$3,569
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	$266	0195	***See *Note Below***
		TOTAL:	**$1,215**		**$4,831**

***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 Code 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.

HOSPITAL INPATIENT ALLOWED AMOUNTS:

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Possible MS-DRG Assignment[4,5,6]
59.79 – Other repair of urinary stress incontinence	**625.6** – Stress incontinence, female	**748** – Female reproductive system reconstructive procedures $5,855
70.51 – Repair of cystocele **70.54 –** Repair of cystocele with graft or prosthesis (Anterior colporrhaphy) **70.77 –** Vaginal suspension and fixation **70.78 –** Vaginal suspension and fixation with graft or prosthesis **70.95 –** Insertion of synthetic graft or prosthesis	**599.81** – Urethral hypermobility **599.82** – Intrinsic (urethral) sphincter deficiency (ISD) **618.00** – Unspecified prolapse of vaginal walls **618.01** – Cystocele, midline **618.02** – Cystocele, lateral **618.03** – Urethrocele **618.09** – Other prolapse of vaginal walls without mention of uterine prolapse	**662** – Minor bladder procedures with major complication or comorbidity (MCC) $17,283 **663** – Minor bladder procedures with complication or comorbidity (CC) $9,086 **664** – Minor bladder procedures without CC/MCC $7,080

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RELEVANT MEDICARE PASS-THROUGH CODES ("C-CODES"):

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-codes are only for use by hospital outpatient facilities, under the Medicare program.
- Medicare requires hospitals to use C-codes to report devices on outpatient claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPPS in order to improve the outpatient claims data used annually to update the OPPS payment rates. The codes below, while not eligible for separate reimbursement, 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 *278 Medical/Surgical Supplies and Devices - Other Implant*.

C-code	Code Description	*Device Impacted
C1763	Connective tissue, nonhuman (includes synthetic)	*Uphold LITE Vaginal Support System*
C2631	Repair device, urinary, incontinence, without sling graft	*Capio™ SLIM Suture Capturing Device*

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.

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 stress urinary incontinence:
CAUTION: Federal Law (USA) restricts this device to sale by or on the order of a physician trained in use of mesh for the repair of stress urinary incontinence.

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.

ENDNOTES

[1] Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – December 27, 2013 revised release, RVU14A file. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-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] "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] The hospital outpatient payment rates are 2014 Medicare national averages. Source: November 27, 2013 Federal Register, CMS-1601-FC.
[4] 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.
[5] The patient's medical record must support the existence and treatment of the complication or comorbidity.
[6] The principle diagnosis of ISD must be documented and supported in the patient's medical record.

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