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GUIDEPOINT
Reimbursement Resources

Uphold™ LITE Vaginal Support System

2016 Coding & Quick Reference Guide

This guide contains specific information for two (2) common coding/reimbursement scenarios related to the use of the Uphold LITE Vaginal Support System when performed in a hospital outpatient setting.

*NOTE: CPT® Code 57282 (Colpopexy, vaginal; extra-peritoneal approach) 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**.*

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.

Reimbursement amounts provided in this guide are based on 2016 Medicare national average allowed amounts and will vary geographically and/or by individual facility.

Proper medical record documentation is critical to ensure appropriate reimbursement from all payers. The medical record must specifically support all procedures and diagnoses billed.

PHYSICIAN Coding & Reimbursement (PFS)

Physician Relative Value Units (RVUs)

All procedures are listed in order of highest to lowest total Physician facility-based relative value units (RVU). Physician allowed amounts for secondary procedures reflect a 50% reduction with the exception of the mesh insertion code (CPT Code 57267) which is paid at 100% as an "Add-On" code based on Medicare's Multiple Procedure Payment Reduction policy. RVUs reflect the full RVU values for each CPT code listed.

		Medicare Rates (National Average)	**Medicare RVUs (Facily Based)[1,2]			
CPT® Code	Description	2016 Physician[1,2] Allowed Amount	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
Scenario #1: "Repair of Apical Prolapse with Cystocele and Mesh Insertion (No Sling Procedure)"						
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	**$684**	11.50	6.21	1.37	**19.08**
57282	Colpopexy, vaginal; extra-peritoneal approach	**$255**	7.97	5.30	0.96	**14.23**
* 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)	**$262**	4.88	1.85	0.57	**7.30**
	TOTALS	**$1,201**	24.35	13.36	2.90	**40.61**
Scenario #2: "Repair of Apical Prolapse with Cystocele and Mesh Insertion, with Sling Procedure"						
57288	Sling operation for stress incontinence (e.g., fascia or synthetic)	**$728**	12.13	6.79	1.41	**20.33**
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	**$342**	11.50	6.21	1.37	**19.08**
57282	Colpopexy, vaginal; extra-peritoneal approach	**$255**	7.97	5.30	0.96	**14.23**
*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)	**$262**	4.88	1.85	0.57	**7.30**
	TOTALS	**$1,587**	36.48	20.15	4.31	**60.94**

*According to AMA-CPT instruction, use CPT Code 57267 in conjunction with CPT Codes 45560, 57240-57265, 57285.

**There are no current Medicare valuations for the above CPT Codes for the physician office setting.

Additional coding/reimbursement guides, including Pelvic Floor Repair Procedures-Transvaginal and Sling Procedures, are available on the Boston Scientific reimbursement webpage.

See important notes on the uses and limitations of this information on page 3.
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FACILITY Coding & Reimbursement (PFS)

Coding, APC Relative Weights & Medicare Reimbursements

Comprehensive APCs (C-APCs), originally implemented by CMS in 2014, were created with the goal of identifying certain high-cost device-related hospital outpatient procedures. CMS has fully implemented this policy and has identified these high-cost, device-related procedures as the primary service on a claim. All other services reported on the same claim will be considered "adjunct services" provided to support the delivery of the primary service and are unconditionally packaged into the OPPS payment of the primary service. Private payer reimbursement policies may differ.

			Medicare Rates (National Average)	Medicare OPPS Relative Weight
CPT® Code	Description	APC Code	2016 Hospital Outpatient[2,3] Allowed Amount	APC Relative Weight[3]
Scenario #1: "Repair of Apical Prolapse with Cystocele and Mesh Insertion (No Sling Procedure)"				
57282	Colpopexy, vaginal; extra-peritoneal approach	**5416**	**$5,699**	77.3001
57240	Anterior repair, cystocele	**5415**	**$0**	C-APC Packaging
57267	Insertion of mesh (ADD-ON CODE)	**N/A**	**See Note**	
		TOTALS	**$5,699**	13.29
Scenario #2: "Repair of Apical Prolapse with Cystocele and Mesh Insertion, with Sling Procedure"				
57282	Colpopexy, vaginal; extra-peritoneal approach	**5416**	**$5,699**	77.3001
57288	Sling operation for stress incontinence (e.g., fascia or synthetic)	**5415**	**$0**	C-APC Packaging
57240	Anterior repair, cystocele	**5415**	**$0**	C-APC Packaging
57267	Insertion of mesh (ADD-ON CODE)	**N/A**	**See Note**	
		TOTALS	**$5,699**	

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 facility's 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. Private payer reimbursement policies may differ.

For Medicare cost reporting purposes, we encourage hospitals to continue to report CPT code 57267 (Mesh insertion) along with the applicable HCPCS/C-code. This change does NOT apply to physician coding/reimbursement of mesh insertion under Medicare.

NOTE: Exceptions to CMS's C-APC reimbursement policy apply, based on CMS's "complexity adjustment" criteria (applicable to hospital facilities ONLY). Visit the Boston Scientific reimbursement webpage to reference our online guide titled CMS Comprehensive APC & Complexity Adjustment Coding Scenarios-Hospital Outpatient Facilities for relevant procedure exceptions.

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 OPPS in order to improve the claims data used annually to update the OPPS 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 278 Medical/Surgical Supplies and Devices - Other Implant.

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Medicare Pass-Through Codes (C-Codes) for Select Pelvic Floor Repair Devices

C-Code	Description	Device Impacted
C1763	Connective Tissue, nonhuman (includes synthetic)	Uphold™ LITE Vaginal Support System
C1771	Repair device, urinary, incontinence, with sling graft	Advantage™ System (Transvaginal) Advantage Fit™ System (Transvaginal) Lynx™ System (Suprapubic) Obtryx™ System Halo or Curved (Transobturator) Obtryx II System Halo or Curved (Transobturator) Prefyx PPS™ System (Pre Pubic) Solyx™ SIS System (Single Incision)
C2631	Repair device, urinary, incontinence, without sling graft	Capio™ and Capio CL Suture Capturing Device Capio SLIM Suture Capturing Device

For additional online information related to CMS Pass-Through Codes (aka, HCPCS or C-codes) as well as a comprehensive list of Boston Scientific Urology and Pelvic Health products with C-Codes, see our Urology and Pelvic Health C-code online tool available on our Boston Scientific reimbursement webpage.

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.

Health economics and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information is provided for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges, and modifiers for services that are rendered. Boston Scientific recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label.

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.

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

Products are labeled for individual use and concomitant repairs are at the discretion of the physician.

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 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.

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

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

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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