GUIDEPOINT Reimbursement Resources

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# Sling Procedure for Female Stress Urinary Incontinence

## 2016 Coding & Quick Reference Guide

This guide contains coding and reimbursement information relevant to physicians and facilities (e.g., hospital outpatient facilities & hospital inpatient facilities).

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.

# PHYSICIAN Coding & Reimbursement (PFS)

## Physician Relative Value Units (RVUs)

The following codes are thought to be relevant to common transvaginal pelvic floor procedures and are referenced throughout this guide.

| | | Medicare Rates (National Average) | **Medicare RVUs (Facily Based)[1] | | | |
|---|---|---|---|---|---|---|
| CPT® Code | Description | 2016 Physician[1,2] Allowed Amount | Work RVU | Practice RVU | Malpractice RVU | Total RVUs |
| 57287 | Removal or revision of sling for stress incontinence (e.g., fascia or synthetic) | **$694** | 11.15 | 6.91 | 1.30 | **19.36** |
| 57288 | Sling operation for stress incontinence (e.g., fascia or synthetic) | **$728** | 12.13 | 6.79 | 1.41 | **20.33** |

*There are no current Medicare valuations for CPT Codes 57287 or 57288 for the physician office setting.

NOTE: Additional coding/reimbursement guides, including Uphold™ LITE Vaginal Support System and Pelvic Floor Repair Procedures-Transvaginal are available on the Boston Scientific reimbursement webpage.

# FACILITY Coding & Reimbursement Hospital Outpatient-OPPS

## 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 will be unconditionally packaged into the OPPS payment of the primary service.

| | | Medicare Rates (National Average) | Medicare OPPS Relative Weight | |
|---|---|---|---|---|
| CPT® Code | Description | APC Code | 2016 Hospital Outpatient[2,3] Allowed Amount | APC Relative Weight[3] |
| 57287 | Removal or revision of sling for stress incontinence (e.g., fascia or synthetic) | **5414** | **$1.861** | 25.2449 |
| 57288 | Sling operation for stress incontinence (e.g., fascia or synthetic) | **5415** | **$3,660** | 49.6467 |

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 APCs & Complexity Adjustment Coding Scenarios-Hospital Outpatient Facilities for relevant procedure exceptions.

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


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## 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.

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

| C-Code | Description | Device Impacted |
|---|---|---|
| C1771 | Repair device, urinary, incontinence, with sling graft | Advantage™ System (Transvaginal)<br>Advantage Fit™ System (Transvaginal)<br>Lynx™ System (Suprapubic)<br>Obtryx™ System Halo or Curved (Transobturator)<br>Obtryx II System Halo or Curved (Transobturator)<br>Solyx™ SIS System (Single Incision) |

*Note: There is no C-code for the Colpassist™ Vaginal Positioning 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 the Boston Scientific reimbursement webpage.

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# FACILITY Coding & Reimbursement Hospital Inpatient-IPPS

## Coding & Medicare Reimbursement

| ICD-10-CM Procedure Code | Description |
|---|---|
| 0TSC0ZZ | Reposition bladder neck, open approach |
| 0TUC07Z | Supplement bladder neck with autologous tissue substitute, open approach |
| 0TUC0KZ | Supplement bladder neck with nonautologous tissue substitute, open approach |
| 0TUC47Z | Supplement bladder neck with autologous tissue substitute, percutaneous endoscopic approach |
| 0TUC4KZ | Supplement bladder neck with nonautologous tissue substitute, percutaneous endoscopic approach |
| 0TPD07Z | Removal of autologous tissue substitute from urethra, open approach |
| 0TPD0JZ | Removal of synthetic substitute from urethra, open approach |
| 0TPD0KZ | Removal of nonautologous tissue substitute from urethra, open approach |
| 0TWD07Z | Revision of autologous tissue substitute in urethra, open approach |
| 0TWD0JZ | Revision of synthetic substitute in urethra, open approach |
| 0TWD0KZ | Revision of nonautologous tissue substitute in urethra, open approach |

| ICD-10-CM Diagnosis Code | Description |
|---|---|
| N39.3 | Stress incontinence, female |
| N36.41 | Hypermobility of urethra |
| N36.42 | Intrinsic sphincter deficiency (ISD) |
| N36.43 | Combined hypermobility of urethra and intrinsic sphincter deficiency |

| Possible MS-DRG Assignment[6] | Description | Reimbursement[5] |
|---|---|---|
| 748 | Female reproductive system reconstructive procedures | $6,638 |
| 662 | Minor bladder procedures with major complication or comorbidity (MCC) | $17,063 |
| 663 | Minor bladder procedures with complication or comorbidity (CC) | $9,833 |
| 664 | Minor bladder procedures without CC/MCC | $7,668 |

# FACILITY Coding & Reimbursement Ambulatory Surgery Center

## Ambulatory Surgery Center Allowed Amounts (Medicare National Average)

| | | Medicare Rates (National Average) | Medicare ASC Relative Weight | |
|---|---|---|---|---|
| CPT® Code | Description | APC Code | 2016 ASC[2,4] Allowed Amount | APC Relative Weight[4] |
| 57287 | Removal or revision of sling for stress incontinence (e.g., fascia or synthetic) | **5415** | **$1,041** | 23.5585 |
| 57288 | Sling operation for stress incontinence (e.g., fascia or synthetic) | **5415** | **$1,810** | 40.9690 |

*CMS's C-APC policy does not apply to services provided by ASC facilities.

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

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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.

Repliform Tissue Regeneration Matrix complies with U.S. Regulations in 21 CFR part 1271 Human Tissue Intended for Transplantation.

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

**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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