

2011 Pelvic Floor Reconstruction Reimbursement Information OVERVIEW PAGE

Medicare MD, Outpatient, and ASC Payment Changes

Overall payments for pelvic floor reconstruction and payments for paravaginal defect repair had only slight changes for 2011.

- 57288 MD Allowance for slings procedure increased by \$10 (\$721)
- 57284 MD Allowance for paravaginal defect repair increased by \$18 (\$831)

MD Allowance payments for the following CPT Codes increased by an average of 2.1% for 2011:

<u>Code</u>	<u>Description</u>	<u>MD Increase</u>	<u>MD Decrease</u>
- (51845)	Abdominal-vaginal vesical neck suspension	\$ 6	
- (53500)	Urethrolisis, transvaginal, secondary, open including cystocele	\$ 6	
- (57230)	Plastic repair of urethrocele	\$ 13	
- (57240)	Anterior colporrhaphy, repair of Cystocele	\$ 17	
- (57250)	Posterior colporrhaphy, repair of Rectocele	\$ 24	
- (57260)	Combined anteroposterior colporrhaphy	\$ 27	
- (57265)	Combined anteroposterior colporrhaphy; w/enterocele repair	\$ 28	
- (57267)	Insertion of mesh or other prosthesis for repair of pelvic floor defect	\$ 5	
- (57268)	Repair of enterocele, vaginal approach (separate procedure)	\$ 17	
- (57280)	Colpopexy, abdominal approach	\$ 24	
- (57282)	Colpopexy, vaginal; extra-peritoneal approach	\$ 16	
- (57283)	Colpopexy, vaginal; intra-peritoneal approach	\$ 21	
- (57289)	Pereyra procedure, including anterior colporrhaphy	\$ 5	

2011 Summary of Most Commonly Billed Codes & Allowances: MD, Outpatient, ASC

CPT Code	Code Description	2011 Average Payment		
		MD	Hospital Outpatient	ASC
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	\$672	\$2,457	\$1,382*
57250	Posterior colporrhaphy, repair of rectocele w/w-o perineorrhaphy	\$675	\$2,457	\$1,382*
57260	Combined anteroposterior colporrhaphy	\$834	\$2,457	\$1,382*
57265	Combined anteroposterior colporrhaphy; with enterocele repair	\$919	\$3,127	\$1,759*
57267**	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site	\$263	\$2,457	\$1,382*
57268	Repair of enterocele, vaginal approach (separate procedure)	\$486	\$2,457	\$1,382*
57280	Colpopexy, abdominal approach	\$967	Inpatient	NA
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliooccygeus)	\$507	\$3,127	NA
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)	\$698	\$3,127	NA
57284	Paravaginal defect repair (including repair of cystocele if done) – Abdominal approach	\$831	\$3,127	NA
57285	Paravaginal defect repair (including repair of cystocele if done) – Vaginal approach (New 2009)	\$685	\$3,127	NA
57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach	\$488	\$1,424	\$801

* Payment for device included in global ASC payment

** Add-on code 57267 is only to be used with CPT 45560, 57240-57265, 57285 and is exempt from multiple procedure discount.

Please refer to the following page for detailed information on CPT codes, descriptions and payments.

2011 Pelvic Floor Reconstruction General Reimbursement Information

Medicare Physician Payment Outpatient and ASC

- The add on code CPT® Code 57267 – Insertion of mesh for the pelvic floor repair
 - Can be billed with CPT codes 45560 and 57240-57265
 - Is for each site. This code can be billed more than once.
- Sling (57288) or paravaginal defect repair (57284) will be the main procedure for most pelvic floor repairs.
- Secondary procedures: actual payments would be reduced by 50% per Medicare’s multiple procedure discounting policy.
- All rates shown (except 57267) are 2011 Medicare national averages; actual rates will vary by geography.

CPT Code	Code Description)	MD	ASC	Outpatient
57288	Sling operation for stress incontinence. Can be billed with defect repair	\$721	\$1,759	\$3,127
57284	Paravaginal defect repair (including repair of cystocele, SUI and/or complete vaginal prolapse)	\$831	NA	\$3,127
57285	Paravaginal defect repair (including repair of Cystocele, if performed); vaginal approach	\$685	NA	\$3,127

Secondary procedures that can be billed in conjunction with 57288 or 57284 or 57285

CPT Code	Code Description	Can be Billed With	MD In-Facility
51845	Abdominal-vaginal vesical neck suspension, with or w/out endoscopic control	57284, 57285, 57288	\$608
53500	Urethrolisis, transvaginal, secondary, open, including cysto	57288, 57284, 57285	\$773
57230	Plastic repair of urethrocele	57288, 57284, 57285	\$404
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	57288, 57285	\$672
57250	Posterior colporrhaphy, repair of rectocele w/w-o perineorrhaphy	57288, 57284, 57285	\$675
57260	Combined anteroposterior colporrhaphy	57288, 57284, 57285	\$834
57265	Combined anteroposterior colporrhaphy; with enterocele repair	57288, 57284, 57285	\$919
57267	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site	57288, 57284	\$263
57268	Repair of enterocele, vaginal approach (separate procedure)	57267	\$486
57280	Colpopexy, abdominal approach	57288, 57284, 57285	\$967
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, illococcygeus)	57288, 57284, 57285	\$507
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)	57288, 57284, 57285	\$698
57289	Pereyra procedure, including anterior colporrhaphy	57288, 57284, 57285	\$738
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	*Unclear at this time	\$953

*Currently don't have the information to determine if this procedure can be billed with 57288 or 57284

Graft Revision/ Removal

CPT Code	Code Description	MD In-Facility Amount Allowed	Hospital Outpatient Amount Allowed
57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach	\$488	\$1,424

HCPCS Code:

- L8699 – Prosthetic implant, not otherwise specified

2011 Pelvic Floor Reconstruction General Reimbursement Information

Medicare C Codes for Hospital Outpatient Claims:

These codes should be added to the hospital's chargemaster to report device costs. No additional reimbursement will be given to the facility. These C codes are used to gather information on the cost of devices for future APC rate setting.

- C1762 – Connective tissue, human (includes fascia lata)
- C1763 – Connective tissue, non-human (includes synthetic)
- C1771 – Repair device, urinary, incontinence, with sling graft
- C2631 – Repair device, urinary, incontinence, without sling graft

Applying the Add On Mesh CPT Code 57267

2011 Medicare Physician (MD) Payment

Below you will find a chart showing you how to apply CPT Code 57267, the add-on mesh CPT code, allowing your surgeon to maximize their billing during their procedures.

Procedure	Primary CPT Code		Secondary CPT Code (50%)		Add-on Mesh CPT Code		Total MD Allowance
Sling	57288	\$721	-	-	-	-	\$721
Anterior Repair w/o Graft	57240	\$672	-	-	-	-	\$672
Anterior Repair w/Graft	57240	\$672	-	-	57267	\$263	\$935
Posterior Repair w/o Graft	57250	\$675	-	-	-	-	\$675
Posterior Repair w/Graft	57250	\$675	-	-	57267	\$263	\$938
A&P Repair w/o Graft	57260	\$834	-	-	-	-	\$834
A&P Repair w/Graft	57260	\$834	-	-	57267 x 2	\$526	\$1,360
Paravaginal Repair w/Posterior Graft	57284	\$831	57250	\$337.50	57267	\$263	\$1,431.50
Anterior Repair w/Graft & Sling	57288	\$721	57240	\$336	57267	\$263	\$1,320
Posterior Repair w/Graft & Sling	57288	\$721	57250	\$337.50	57267	\$263	\$1,321.50
A&P Repair w/Graft & Sling	27260	\$834	57260	\$360	57267 x 2	\$526	\$1,720

- The -59 modifier should be used when the add-on mesh code is billed more than once.
- For secondary procedures; actual payments would be reduced by 50% per Medicare's multiple procedure discounting policy.
- The add-on mesh code (57267) will be paid 100% as an inpatient secondary procedure.
- For the hospital outpatient payments, both secondary and add on mesh procedures (57267) are reduced by 50%.

Medicare Hospital Outpatient (OP) Payment

Procedure	Primary CPT Code		Secondary CPT Code (50%)		Add-on Mesh CPT Code (50%)		Total OP Allowance
Sling	57288	\$3,127	-	-	-	-	\$3,127
Anterior Repair w/o Graft	57240	\$2,457	-	-	-	-	\$2,457
Anterior Repair w/Graft	57240	\$2,457	-	-	57267	\$1,228.50	\$3,685.5
Posterior Repair w/o Graft	57250	\$2,457	-	-	-	-	\$2,457
Posterior Repair w/Graft	57250	\$2,457	-	-	57267	\$1,228.50	\$3,685.5
A&P Repair w/o Graft	57260	\$2,457	-	-	-	-	\$2,457
A&P Repair w/Graft	57260	\$2,457	-	-	57267 x 2	\$2,457	\$4,914
Paravaginal Repair w/Posterior Graft	57284	\$3,127	57250	\$1,228.50	57267	\$1,228.50	\$5,584
Anterior Repair w/Graft & Sling	57288	\$3,127	57240	\$1,228.50	57267	\$1,228.50	\$5,584
Posterior Repair w/Graft & Sling	57288	\$3,127	57250	\$1,228.50	57267	\$1,228.50	\$5,584
A&P Repair w/Graft & Sling	57288	\$3,127	57260	\$1,228.50	57267 x 2	\$2,457	\$6,812.5

2011 Pelvic Floor Reconstruction General Reimbursement Information

Medicare Hospital Outpatient (OP) Payment

CPT Code	Code Description	Hospital Outpatient Payment
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	\$2,457
57250	Posterior colporrhaphy, repair of rectocele w/w-o perineorrhaphy	\$2,457
57260	Combined anteroposterior colporrhaphy	\$2,457
57265	Combined anteroposterior colporrhaphy; with enterocele repair	\$3,127
57267*	Insertion of mesh or other prosthesis for repair of pelvic floor defect, each site	\$2,457
57268	Repair of enterocele, vaginal approach (separate procedure)	\$2,457
57280	Colpopexy, abdominal approach	Inpatient Only
57282	Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, ilioococcygeus)	\$3,127
57283	Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)	\$3,127
57284	Paravaginal defect repair (including repair of cystocele, SUI and/or incomplete vaginal prolapse)	\$3,127
57295	Revision (including removal) of prosthetic vaginal graft, vaginal approach	\$1,424

* Add-on code 57267 is only to be used with CPT 45560,57240-57265, 57285 and is exempt from multiple procedure discount

ICD-9 Billing Codes

As of October 1, 2008, the Center for Medicare and Medicaid Services (CMS) is replacing the Diagnosis Related Groups (DRG) System with the Medicare Severity DRG (MS-DRG) classification system to recognize the severity of illness among patients. The new system, which will be phased in over a two year period, expands the current list of 538 DRG's to a new list of 745 "severity-adjusted" DRG's.

1. Use diagnosis codes 618.01-618.09 when no uterine prolapse is present.
2. If uterine prolapse is present, document and use diagnosis codes 618.02 – 618.04
3. If incontinence is present and due to prolapse, code the prolapse as the primary diagnosis.

ICD-9-CM Diagnosis Codes	ICD-9-CM Procedure Code
599.81 – Urethral Hypermobility 599.82 – Intrinsic Sphincter Deficiency (ISD) 618.00 – Unspecified prolapse of vaginal walls 618.01 – Cystocele, midline 618.02 – Cystocele, lateral 618.03 – Urethrocele 618.04 – Rectocele 618.05 – Perineocele 618.06 – Vaginal enterocele, congenital or aquired 618.09 – Other prolapse of vaginal walls without mention of uterine prolapse 625.6 – Stress Urinary Incontinence (SUI)	59.79 – Urinary Incontinence repairs NEC 70.50 - 70.55 - Repair of cystocele and/or rectocele with or without graft prosthesis 70.77 – Vaginal suspension and fixation 70.78 – Vaginal suspension and fixation with graft or prosthesis 70.79 – Other repair of vagina 70.94 – Insertion of biological graft 70.95 – Insertion of synthetic graft or prosthesis

Medicare Hospital Inpatient Payment

Possible MS-DRG Assignment

MS-DRG Code	Description	Hospital Inpatient Payment
662	Minor bladder procedures with major complication or comorbidity (MCC)	\$16,841
663	Minor bladder procedures with complication or comorbidity (CC)	\$8,219
664	Minor bladder procedures without CC/MCC	\$6,184
748	Female Reproductive System Reconstructive Procedures	\$5,120

Important – Please Note: Reimbursement information provided by Caldera Medical, Inc. is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice, and Caldera Medical makes no representation or warranty regarding this information or its completeness, accuracy or timeliness. Laws, regulations and payer policies concerning reimbursement are complex and change frequently, and service providers are responsible for all decisions relating to coding and reimbursement submissions. Accordingly, Caldera Medical strongly recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.