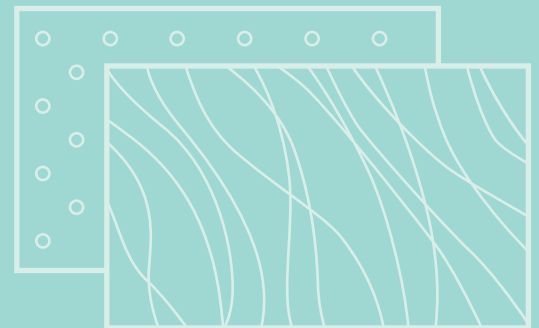
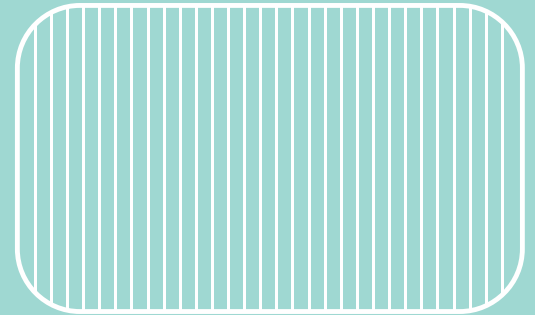
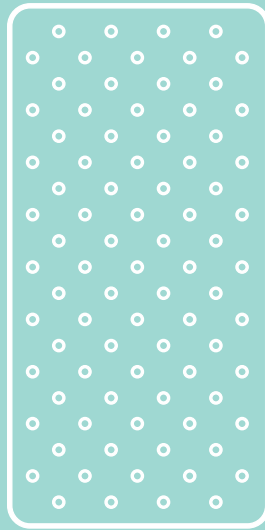
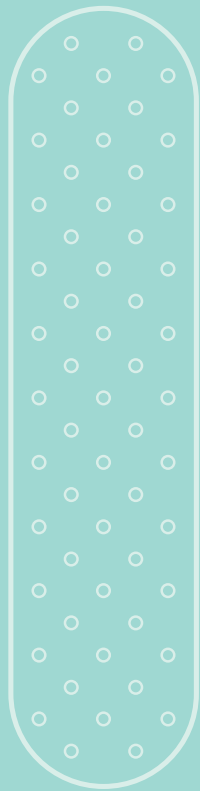




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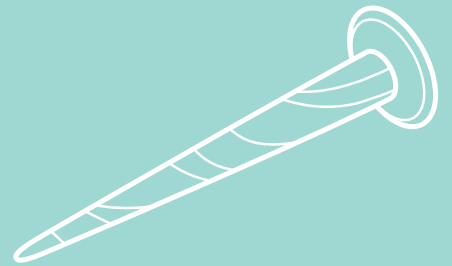
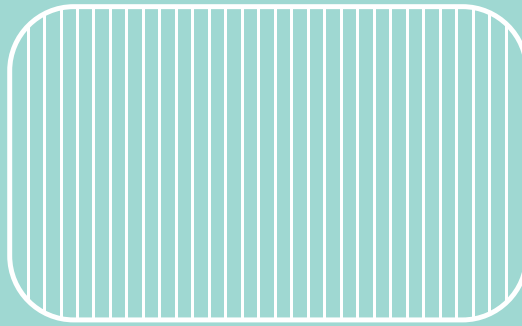
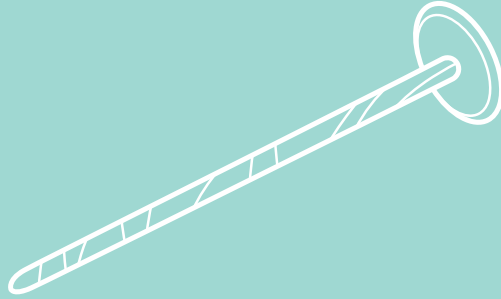


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MEDICAL

Ventral/Incisional Hernia Repair

2008 Coding and Reimbursement Guide





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This guide was developed to assist with Medicare reporting and reimbursement when utilizing Surgisis Biodesign during ventral/incisional hernia repair.

Coverage

Medicare carriers may issue Local Coverage Decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (<http://www.cms.hhs.gov/mcd/search.asp?>) and contact their carrier's medical director (www.cms.hhs.gov/contacts/) or commercial insurers to determine if a procedure is covered.

Coding

Utilizing Surgisis Biodesign during ventral/incisional hernia repair typically involves coding for the repair and the appropriate C-code (when care is provided to Medicare patients in the hospital outpatient setting) to describe the device.

Ventral/incisional hernia repair is typically reported by one of the following CPT codes. It is the physician's responsibility to choose a CPT code that accurately describes the procedure performed.

Open Repair Codes

- 49560 Repair initial incisional or ventral hernia; reducible
- 49561 Repair initial incisional or ventral hernia; incarcerated or strangulated
- 49565 Repair recurrent incisional or ventral hernia; reducible
- 49566 Repair recurrent incisional or ventral hernia; incarcerated or strangulated
- +49568 Implantation of mesh or other prosthesis for incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue (List separately in addition to code for the incisional or ventral hernia repair)

(+) in front of a procedure code denotes an add-on code. Add-on codes allow reporting of additional work associated with a primary procedure(s) and must never be reported alone. In addition, physician add-on codes are exempt from multiple procedure reduction.

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Laparoscopic Repair Code

49659 Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy

It would not be appropriate to report code 49568 in addition to laparoscopic code 49659¹

HCPCS Code

Some commercial payers (not Medicare) may recognize the following temporary HCPCS Level II codes:

- S2075 Laparoscopy, surgical; repair incisional or ventral hernia
- S2077 Laparoscopy, surgical; implantation of mesh or other prosthesis for incisional or ventral hernia repair (list separately in addition to code for the hernia repair)

C - Codes

Medicare requires hospitals to report, if applicable, device(s) by using Level II HCPCS codes or "C-codes." When reporting use of Surgisis Biodesign in a hospital outpatient setting, we recommend the following C-code:

- C1763 Connective tissue, nonhuman

Hospitals use ICD-9-PCS procedure codes to describe procedures performed during inpatient hospital admissions. A number of procedure codes exist to describe ventral and hernia repairs. Following are two examples of procedure codes that may be pertinent for a given hospital admission.

Facilities coding for ventral/incisional hernia repair utilizing Surgisis Biodesign should consider:

- 53.61 Incisional hernia repair with graft or prosthesis
- 53.69 Repair of other hernia of anterior abdominal wall with graft or prosthesis

¹AMA CPT Assistant: 2001, Sept. 11.

Primary Diagnosis Codes (ICD-9-CM)

Submitting a claim using one of the following primary diagnoses will typically be grouped to one of the following inpatient DRGs:

551.20 551.21 552.20 552.21 553.20 553.21

DRG	Description	Medicare (National Average Payment)*
353	Hernia procedures except inguinal and femoral with major comorbidity or complication	\$9,903.92
354	Hernia procedures except inguinal and femoral with comorbidity or complication	\$6,895.22
355	Hernia procedures except inguinal and femoral without comorbidity or complication or major comorbidity or complication	\$4,964.93

*2007 Ingenix - Appendix D - National Average Payment Table

The actual procedure code(s) along with the actual diagnosis code(s) selected and submitted may vary from case-to-case, therefore varying the eventual DRG grouping and payment of each hospital stay.

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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which may include, but are not limited to, the CPT, ICD-9, and MS-DRG coding systems; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, AHA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.



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Payment

Medicare Reimbursement for Services Performed in an Outpatient Hospital or Ambulatory Surgery Center

CPT Code	Description	Ambulatory Surgery Center*	Outpatient Hospital (National Medicare Avg) [†]		Physician Services (National Medicare Avg) [‡]
		Facility Payment	APC	Facility Payment	Fee When Service Provided in the Hospital or in ASC
49560	Repair initial incisional or ventral hernia; reducible	\$790.03	0154	\$1,954.06	\$645.96
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	\$1,321.78	0154	\$1,954.06	\$810.87
49565	Repair recurrent incisional or ventral hernia; reducible	\$790.03	0154	\$1,954.06	\$666.14
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	\$1,321.78	0154	\$1,954.06	\$819.25
+49568	Implantation of mesh or other prosthesis for incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)	\$531.89 <i>Multiple procedure reduction applied</i>	0154	\$977.03	\$243.38
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	<i>Unlisted codes are not included on Medicare's approved list of procedures</i>	0130	\$2,190.81	<i>Carrier priced procedure</i>

*2008 Medicare Ambulatory Surgery Center Fee Schedule

†2008 Medicare Outpatient Prospective Payment System Fee Schedule

‡2008 Medicare Physician Fee Schedule

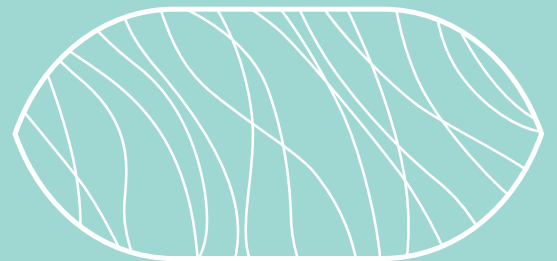
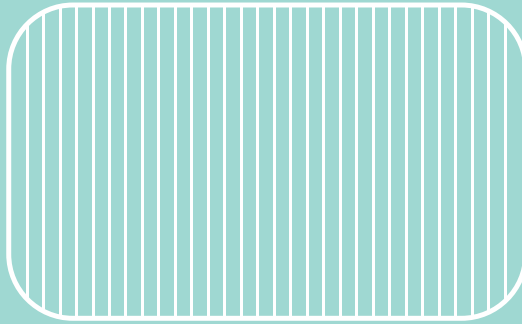
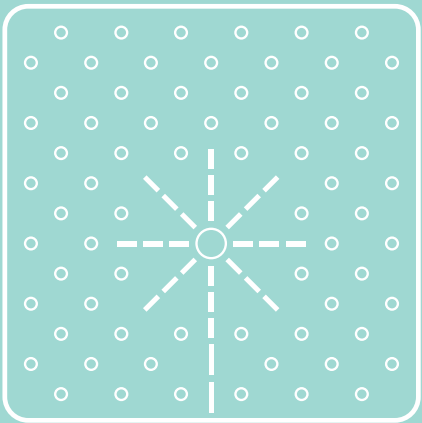
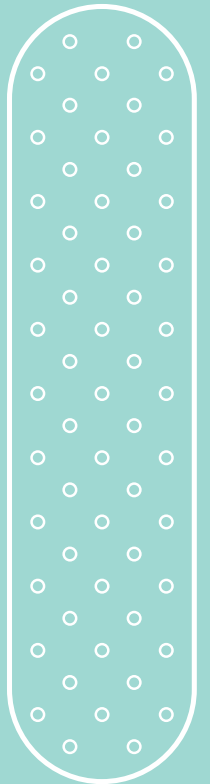
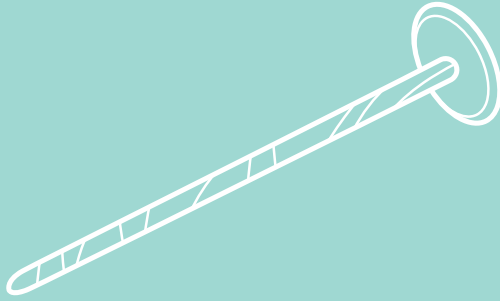
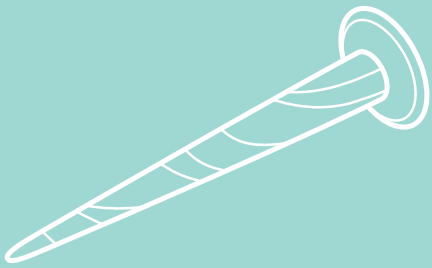
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2008 physician fees for your local area can be found at the following CMS links:

http://www.cms.hhs.gov/apps/pfslookup/02_PFSsearch.asp

or

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/list.asp#TopOfPage>





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