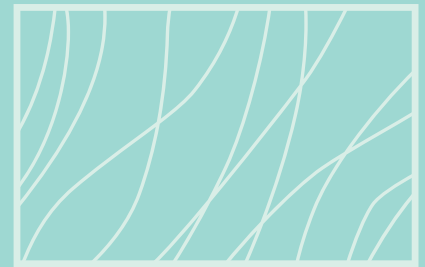
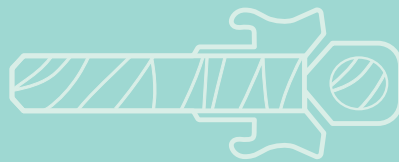
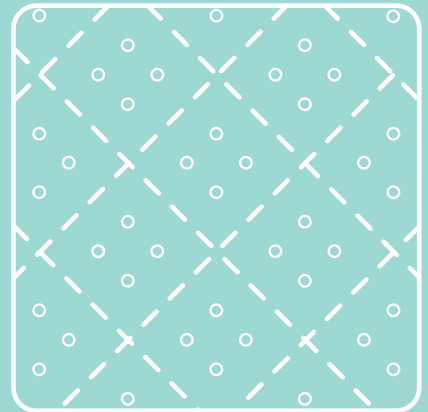
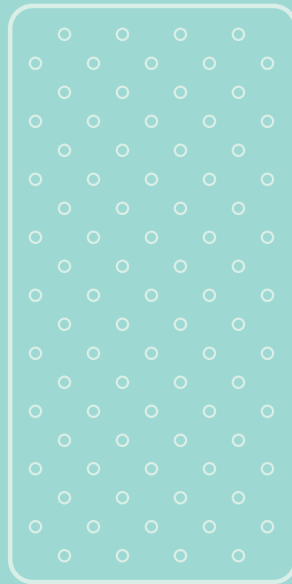
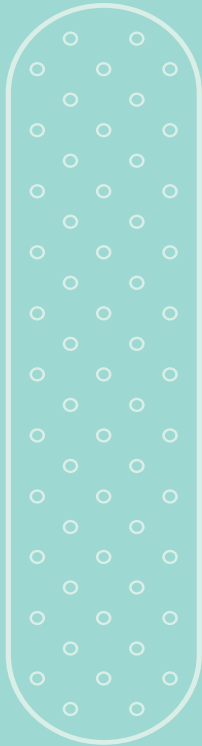




# Biodesign<sup>®</sup>

SURGISIS<sup>®</sup> ADVANCED TISSUE REPAIR PRODUCTS



Ventral/Incisional Hernia Repair

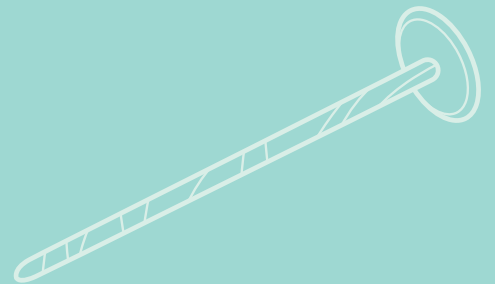
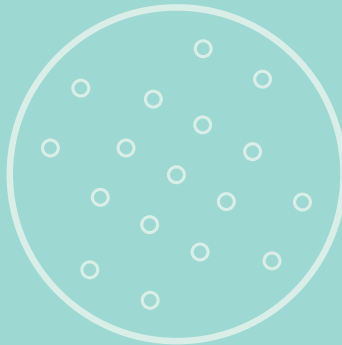
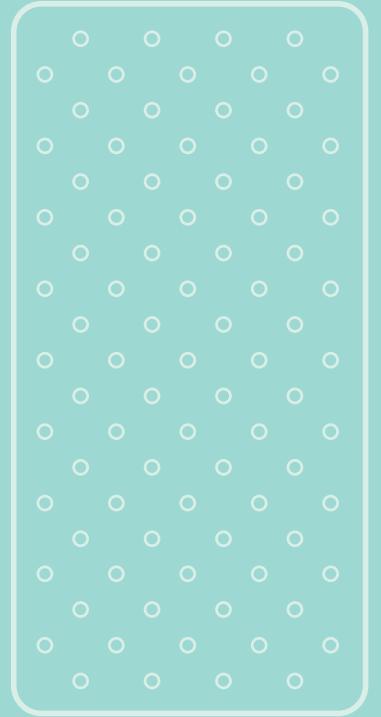
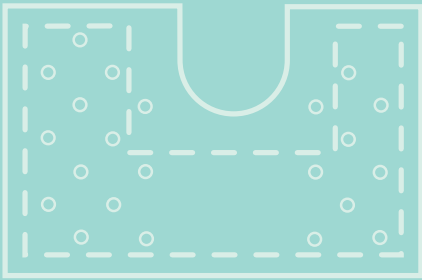
# 2010 Coding and Reimbursement Guide

Effective January 1, 2010 - February 28, 2010

Biodesign<sup>®</sup>

COOK<sup>®</sup>  
MEDICAL

COOK<sup>®</sup>



This guide was developed to assist with Medicare reporting and reimbursement when using Biodesign® grafts during ventral or incisional hernia repairs.

## 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 (<http://www.cms.hhs.gov/apps/contacts/>) or commercial insurers to determine if a procedure is covered.

## Coding

Using Biodesign during ventral or 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 or incisional hernia repair is typically reported by one of the following Current Procedural Terminology (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 open 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)

(+) 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.

CPT copyright 2009 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

*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.*

## Laparoscopic Repair Codes

49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated  <i>It would not be appropriate to report 49652-49657 in addition to 44180 (Laparoscopy, surgical, enterolysis) or 49568 (Implantation of mesh)</i>
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy  <i>It would not be appropriate to report code 49568 in addition to laparoscopic code 49659.<sup>1</sup></i>

## C-Codes

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

C1763	Connective tissue, nonhuman (includes synthetic)
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Hospitals use the ICD-9 Procedure Coding System to describe procedures performed during inpatient hospital admissions. A number of procedure codes exist to describe ventral and incisional hernia repairs using a graft or prosthesis. Following are several examples of procedure codes that may be pertinent for a given hospital admission.

**Facilities coding for ventral or incisional hernia repair using 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
53.62	Laparoscopic incisional hernia repair with graft or prosthesis
53.63	Other laparoscopic repair of other hernia of anterior abdominal wall with graft or prosthesis

Submitting a claim using one of the following primary diagnoses with the above procedure codes will typically group into one of the following inpatient DRGs:

Primary Diagnosis Codes (ICD-9-CM)					
551.20	551.21	552.20	552.21	553.20	553.21

DRG	Description	Medicare (National Avg Payment) <sup>2</sup>
353	Hernia Procedures Except Inguinal and Femoral with Major Comorbidity or Complication	\$13,240.14
354	Hernia Procedures Except Inguinal and Femoral with Comorbidity or Complication	\$7,488.42
355	Hernia Procedures Except Inguinal and Femoral without Comorbidity or Complication or Major Comorbidity or Complication	\$5,159.42

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.

## Payment

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

CPT Code	Description	Ambulatory Surgery Center	Outpatient Hospital		Physician Services
		Facility Payment <sup>3</sup>	APC	Facility Payment (National Medicare Avg) <sup>4</sup>	Fee When Service Provided in the Hospital or ASC (National Medicare Avg) <sup>5</sup>
49560	Repair initial incisional or ventral hernia; reducible	\$1,111.16	0154	\$2,154.85	\$692.46
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	\$1,280.74	0154	\$2,154.85	\$875.41
49565	Repair recurrent incisional or ventral hernia; reducible	\$1,111.16	0154	\$2,154.85	\$720.25
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	\$1,280.74	0154	\$2,154.85	\$884.43
+49568	Implantation of mesh or other prosthesis for open 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)	\$599.23  Multiple procedure reduction applied	0154	\$1,077.43  Multiple procedure reduction applied	\$258.37
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	Unlisted codes are not included on Medicare's approved list of procedures	0130	\$2,565.07	Carrier-priced procedure
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian, or epigastric hernia (includes mesh insertion, when performed); reducible	\$2,922.70	0132	\$4,917.82	\$701.48

Continued on next page

<sup>3</sup>2010 Medicare Ambulatory Surgery Center Fee Schedule

<sup>4</sup>2010 Medicare Outpatient Prospective Payment System Fee Schedule

<sup>5</sup>2010 Medicare Physician Fee Schedule

Continued from previous page

## Payment

CPT Code	Description	Ambulatory Surgery Center	Outpatient Hospital		Physician Services
		Facility Payment <sup>3</sup>	APC	Facility Payment (National Medicare Avg) <sup>4</sup>	Fee When Service Provided in the Hospital or ASC (National Medicare Avg) <sup>5</sup>
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian, or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	\$2,922.70	0132	\$4,917.82	\$877.94
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	\$2,922.70	0132	\$4,917.82	\$806.13
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	\$2,922.70	0132	\$4,917.82	\$970.68
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	\$2,922.70	0132	\$4,917.82	\$808.30
49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	\$2,922.70	0132	\$4,917.82	\$1,165.89

2010 physician fees for your local area can be found at the following CMS links:  
[http://www.cms.hhs.gov/PFSlookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/PFSlookup/02_PFSsearch.asp) or  
<http://www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/list.asp>

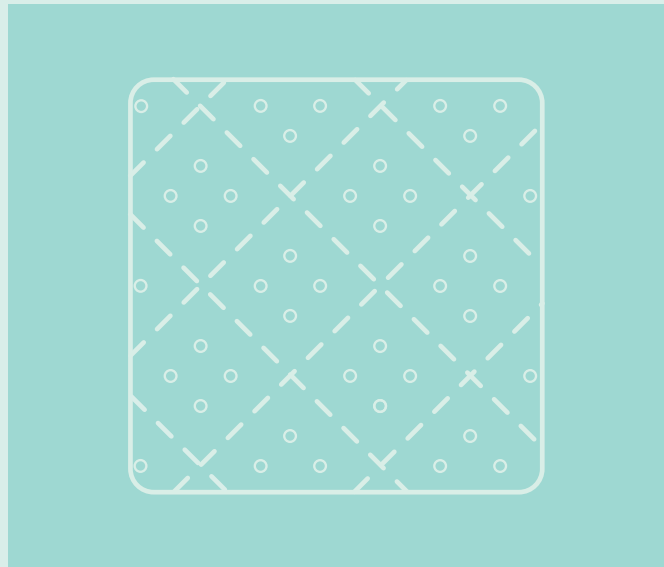
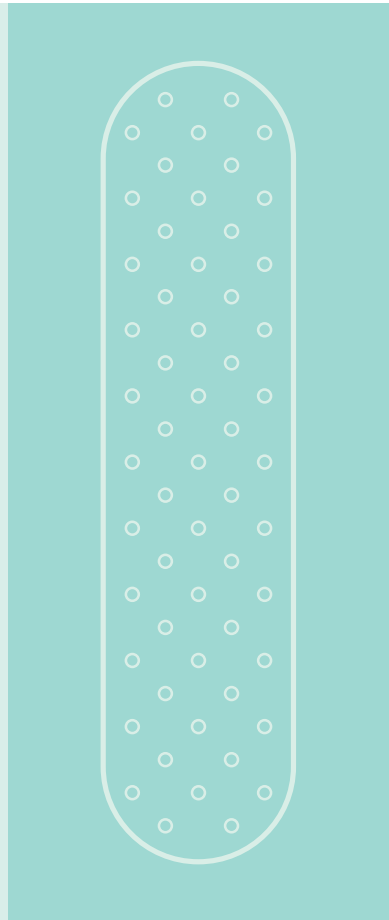
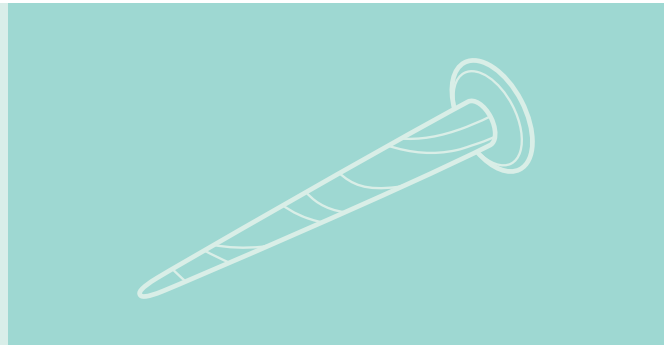
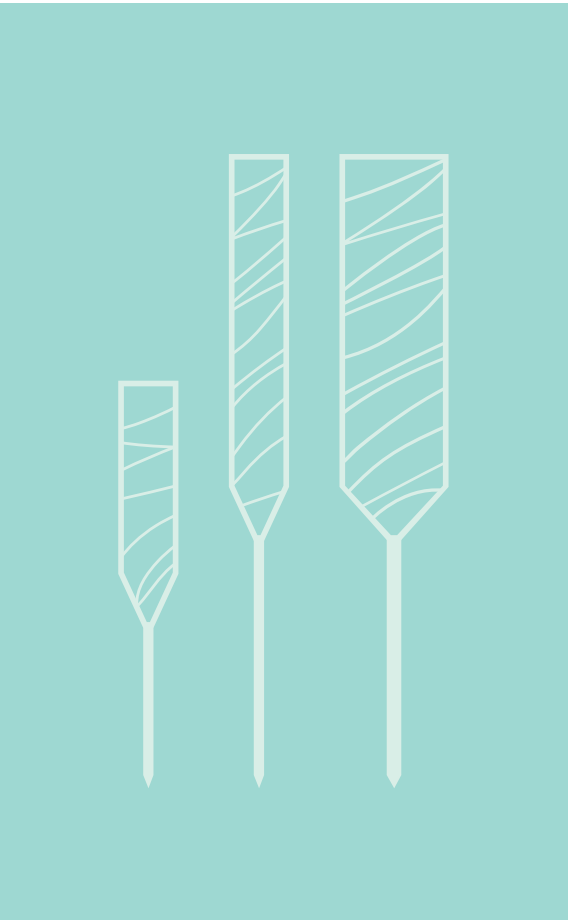
<sup>3</sup>2010 Medicare Ambulatory Surgery Center Fee Schedule

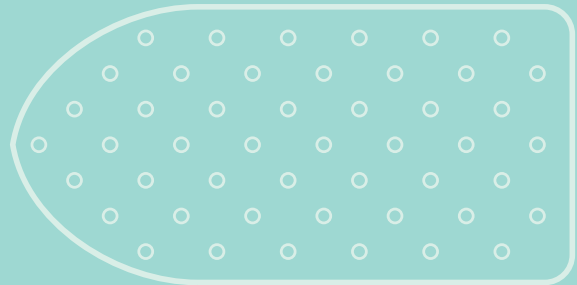
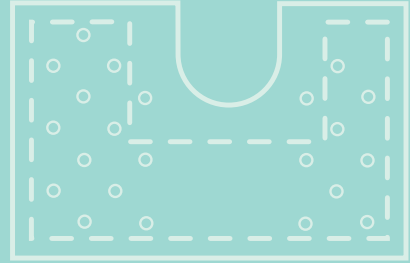
<sup>4</sup>2010 Medicare Outpatient Prospective Payment System Fee Schedule

<sup>5</sup>2010 Medicare Physician Fee Schedule









[www.cookmedical.com](http://www.cookmedical.com)

**COOK MEDICAL INCORPORATED**

P.O. Box 4195, Bloomington, IN 47402-4195 U.S.A.  
Phone: 812.339.2235, Toll Free: 800.457.4500, Toll Free Fax: 800.554.8335

**COOK (CANADA) INC.**

111 Sandiford Drive, Stouffville, Ontario, L4A 7X5 CANADA  
Phone: 905.640.7110, Toll Free: 800.668.0300

**WILLIAM A. COOK AUSTRALIA PTY. LTD.**

95 Brandl Street, Brisbane Technology Park, Eight Mile Plains  
Brisbane, QLD 4113 AUSTRALIA, Phone: +61 7 3841 1188

**COOK IRELAND LTD.**

O'Halloran Road, National Technology Park, Limerick, IRELAND  
Phone: +353 613 34440

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