COOK MEDICAL Biodesign® ADVANCED TISSUE REPAIR

2017 Coding and Reimbursement Guide for Ventral/Incisional Hernia and Complex Abdominal Wall Repair

The information provided herein reflects Cook Medical's understanding of the procedure(s) and/or devices(s) from sources that may include, but are not limited to, the CPT® coding system; 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 Medical does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. We encourage you, when making coding decisions, to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you may submit claims. Cook Medical does not promote the off-label use of its devices.

If you have any questions please contact our reimbursement team at
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or
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Introduction

This guide was developed to assist with Medicare reporting and reimbursement when using Biodesign® grafts during ventral/incisional hernia and complex abdominal wall 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 (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)

Separation of Components

15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk

If both rectus muscles are mobilized report 15734 with modifier -50 to indicate bilateral procedure.[1]

If separation of components is performed through the same incision as the hernia repair, report modifier -51 with 15734 to indicate multiple procedures.[1]

[1]Savarise TM, Senkowski CK, Barney LM. Complex abdominal repairs. *Bull Am Coll Surg*. 2009;94(11):34-35.

Infected Mesh Removal Codes

10180	Incision and drainage, complex, postoperative wound infection
11005	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure
+11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)

(+) 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.

The American Medical Association (AMA) identified several procedures in which code +15777, "implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk)." should and should not be reported. For insertion of mesh or other prosthesis for open incisional or ventral hernia repair, add-on code +49568 should be reported in conjunction with 49560-49566. Therefore, code +15777 should **NOT** be reported for open ventral and incisional hernia repairs.

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 *It would not be appropriate to report 49652-49657 in addition to 44180 (Laparoscopy, surgical, enterolysis) or 49568 (Implantation of mesh)*
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy *It would not be appropriate to report code 49568 in addition to laparoscopic code 49659.*[2]

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)

[2]American Medical Association. *CPT Assistant.* 2005;15(11).

Payment

2017 Medicare Reimbursement for Ventral/Incisional Hernia and Complex Abdominal Wall Repair

		Ambulatory Surgery Center	Outpatient Hospital		Physician Services
CPT Code	Description	Facility Payment (National Medicare Avg)[3]	APC	Facility Payment (National Medicare Avg)[4]	Fee When Service Provided in the Hospital or ASC (National Medicare Avg)[5]
49560	Repair initial incisional or ventral hernia; reducible	$1,452.70	5341	$2,861.53	$765.86
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	$1,452.70	5341	$2,861.53	$965.76
49565	Repair recurrent incisional or ventral hernia; reducible	$2,037.05	5361	$4,197.36	$797.45
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	$2,037.05	5361	$4,197.36	$974.38
+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)	Packaged service/item; no separate payment			$278.50
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	$1,352.27	5055	$2,503.63	$1,361.98
10180	Incision and drainage, complex, postoperative wound infection	$1,030.52	5073	$2,148.00	$183.75
11005	Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; abdominal wall, with or without fascial closure	This service is not included on Medicare's list of approved procedures	Inpatient procedure		$813.60
+11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	This service is not included on Medicare's list of approved procedures	Inpatient procedure		$286.03

Note: Alternative payment policies may apply when multiple services are performed at the same encounter, including but not limited to, multiple procedure payment reductions and comprehensive ambulatory payment classifications (C-APC).

		Ambulatory Surgery Center	Outpatient Hospital		Physician Services
CPT Code	Description	Facility Payment (National Medicare Avg)[3]	APC	Facility Payment (National Medicare Avg)[4]	Fee When Service Provided in the Hospital or ASC (National Medicare Avg)[5]
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	Unlisted codes are not included on Medicare's approved list of procedures	5361	$4,197.36	Carrier-priced procedure
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian, or epigastric hernia (includes mesh insertion, when performed); reducible	$2,037.05	5361	$4,197.36	$771.97
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian, or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	$2,037.05	5361	$4,197.36	$963.25
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	$3,272.69	5362	$6,966.89	$878.20
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	$3,272.69	5362	$6,966.89	$1,071.64
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	$3,272.69	5362	$6,966.89	$952.84
49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	$3,272.69	5362	$6,966.89	$1,372.38

Note: Alternative payment policies may apply when multiple services are performed at the same encounter, including but not limited to, multiple procedure payment reductions and comprehensive ambulatory payment classifications (C-APC).

2017 physician fees for your local area can be found at the following CMS links:

http://www.cms.hhs.gov/PFSlookup/02_PFSSearch.asp

or

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

[3]2017 Medicare Ambulatory Surgery Center Fee Schedule

[4]2017 Medicare Hospital Outpatient Prospective Payment System Fee Schedule

[5]2017 Medicare Physician Fee Schedule

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