Hernia

Reimbursement & Coding Guide

ACell®
Healing Through Regenerative Medicine

Hernia

Reimbursement and Coding Guide

Gentrix™ products are medical devices that maintain and support a healing environment through constructive remodeling. Comprised of naturally-occurring urinary bladder matrix (UBM), Gentrix maintains an intact epithelial basement membrane. Gentrix surgical devices are appropriate for a range of surgical procedures.

Reimbursement and eligibility for coverage for the use of these products and associated procedures varies by Medicare and payers. Coverage policies, prior authorizations, contract terms, billing edits, and site of service influence reimbursement. It is recommended that providers verify coverage and billing policies.

The following information is shared for educational purposes only to help answer common coding and reimbursement questions. While ACell believes this information to be correct, information is subject to change without notice.

For assistance with reimbursement questions, contact the Reimbursement Hotline at **reimbursement@acell.com** or call **800-826-2926 x7**.

PLEASE NOTE: The payments specified in this document reflect Medicare national, unadjusted published payments from the Centers for Medicare & Medicaid Services (CMS). Actual payment rates will vary based on geographical adjustments. As such, all codes and payments provided herein are for illustrative purposes and shall not be construed as a warranty, statement, promise or guarantee that these codes are accurate or that the product will be covered in all instances, and if covered, that reimbursement in the amounts specified will be received.

The decision of how to complete a reimbursement claim form, including codes and amounts to bill, is exclusively the responsibility of the QHPs and other providers. Coding requirements are subject to change at any time; please check with your local payer regularly for updates.

Indications for Use

Refer to Product Label for Full Instructions for Use

Gentrix™ Surgical Matrix* Thin (3-layer) are intended for implantation to reinforce soft tissue where weakness exists in patients requiring urological, gastroenterological, or plastic & reconstructive surgery. Reinforcement of soft tissue within urological, gastroenterological, and plastic & reconstructive surgery includes, but is not limited to, the following procedures: hernia and body wall repair, colon and rectal prolapse repair, tissue repair, and esophageal repair.

Gentrix™ Surgical Matrix* (6-layer) is intended for implantation to reinforce soft tissue where weakness exists in patients requiring gastroenterological or plastic & reconstructive surgery. Reinforcement of soft tissue within gastroenterological and plastic & reconstructive surgery includes, but is not limited to, the following procedures: hernia and body wall repair, colon and rectal prolapse repair, tissue repair, and esophageal repair.

Gentrix™ Surgical Matrix* Plus (8-layer) is intended for implantation to reinforce soft tissue where weakness exists in urological and gastroenterological anatomy including, but not limited to the following procedures: hernia and body wall repair, colon and rectal prolapse repair, tissue repair, and esophageal repair.

*Also marketed as MatriStem® Surgical Matrix.

Procedures: CPT Codes and Medicare Payments

Physician and Outpatient Facility

The following tables are examples of potential CPT codes that may be utilized when reporting surgical procedures.

Hernia Repair

CPT Code	Descriptor	2017 Physician: Medicare National Payment In-Facility	2017 Medicare Hospital Outpatient Payment and Status Indicator		2017 ASC: Medicare National Payment and (Status Indicator)	
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible	$408.41	$2,861.53	(J1)	$1,452.70	(A2)
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	$628.41	$2,861.53	(J1)	$1,452.70	(A2)
49505	Repair initial inguinal hernia, age 5 years or older; reducible	$539.77	$2,861.53	(J1)	$1,452.70	(A2)
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	$606.88	$2,861.53	(J1)	$1,452.70	(A2)
49520	Repair recurrent inguinal hernia, any age; reducible	$655.69	$2,861.53	(J1)	$1,452.70	(A2)
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	$743.61	$2,861.53	(J1)	$1,452.70	(A2)
49525	Repair inguinal hernia, sliding, any age	$594.32	$2,861.53	(J1)	$1,452.70	(A2)
49560	Repair initial incisional or ventral hernia; reducible	$765.86	$2,861.53	(J1)	$1,452.70	(A2)
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	$965.76	$2,861.53	(J1)	$1,452.70	(A2)
49565	Repair recurrent incisional or ventral hernia; reducible	$797.45	$4,197.36	(J1)	$1,452.70	(A2)
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	$974.38	$4,197.36	(J1)	$1,452.70	(A2)
+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) Per CPT: Use 49568 in conjunction with 11004-11006, 49560-495660; implantation of mesh is not separately reported for other hernia procedures	$278.50	Packaged	(N)	Packaged	(N1)
49580	Repair umbilical hernia, younger than age 5 years; reducible	$339.51	$2,861.53	(J1)	$1,452.70	(A2)
49582	Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated	$478.76	$2,861.53	(J1)	$1,452.70	(A2)
49585	Repair umbilical hernia, age 5 years or older; reducible	$461.17	$2,861.53	(J1)	$1,452.70	(A2)
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	$492.39	$2,861.53	(J1)	$1,452.70	(A2)

Hernia Repair (continued)

CPT Code	Descriptor	2017 Physician: Medicare National Payment In-Facility	2017 Medicare Hospital Outpatient Payment and Status Indicator		2017 ASC: Medicare National Payment and (Status Indicator)	
49650	Laparoscopy, surgical; repair initial inguinal hernia	$443.96	$4,197.36	(J1)	$2,037.05	(A2)
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	$577.11	$4,197.36	(J1)	$2,037.05	(A2)
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	$771.99	$4,197.36	(J1)	$2,037.05	(G2)
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	$963.29	$4,197.36	(J1)	$2,037.05	(G2)
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	$878.23	$6,966.89	(J1)	$3,272.69	(G2)
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	$1,071.68	$6,966.89	(J1)	$3,272.69	(G2)
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	$952.88	$6,966.89	(J1)	$3,272.69	(G2)
49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	$1,372.43	$6,966.89	(J1)	$3,272.69	(G2)
49659	Unlisted lap procedure, hernioplasty, herniorrhaphy, herniotomy	Carrier priced	$4,197.36	(J1)	N/A	

Hiatal Hernia Repair

CPT Code	Descriptor	2017 Physician: Medicare National Payment In-Facility	2017 Medicare Hospital Outpatient Payment and Status Indicator		2017 ASC: Medicare National Payment and (Status Indicator)
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	$902.60	(C)		N/A
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	$980.84	(C)		N/A
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	$1,124.39	$6,966.89	(J1)	N/A
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	$1607.10	$6,966.89	(J1)	N/A
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	$1,807.71	(C)		N/A
43283+	Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	$165.45	(C)		N/A

Hiatal Hernia Repair (continued)

CPT Code	Descriptor	2017 Physician: Medicare National Payment In-Facility	2017 Medicare Hospital Outpatient Payment and Status Indicator	2017 ASC: Medicare National Payment and (Status Indicator)
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	$1,208.06	(C)	N/A
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	$1,318.60	(C)	N/A
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	$1,303.17	(C)	N/A
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	$1,397.92	(C)	N/A
43336	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	$1,570.19	(C)	N/A
43337	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	$1,692.57	(C)	N/A

Parastomal Hernia Repair

CPT Code	Descriptor	2017 Physician: Medicare National Payment In-Facility	2017 Medicare Hospital Outpatient Payment and Status Indicator	2017 ASC: Medicare National Payment and (Status Indicator)
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	$1,230.67	(C)	N/A

C: Not paid under outpatient; inpatient procedure only

N: Items and services are packaged into payment for other services

A2 Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight

G2 Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight

J1 Paid under OPPS. Hospital Part B services paid through a Comprehensive APC; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI = F, G, H, L, and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services

HCPCS "C" Codes:

Product, Hospital Outpatient

"C" codes are only reported by hospitals. When devices are used in combination with associated procedures provided in the outpatient setting, hospitals report these codes for Medicare patient procedures. While the following codes are not paid separately from the procedure, reporting these codes and assignment of charges identify device-related costs. This is important for future rate-setting by Medicare. Private payers' policies vary if they require the use of these "C" codes.

The following table includes examples of potential HCPCS procedure codes that are available to hospitals when reporting surgical procedures.

HCPCS Code	Definition	Medicare Payment
C1781 Mesh (implantable)	A mesh implant or synthetic patch composed of absorbable or non-absorbable material that is used to repair hernias, support weakened or attenuated tissue, cover tissue defects, etc.	Payment Indicator N1: Packaged service/item; no separate payment made
C1763 Connective tissue, non-human (includes synthetic)	Connective tissue, non-human (includes synthetic) - These tissues include a natural, acellular collagen matrix typically obtained from porcine or bovine small intestinal submucosa, or pericardium. This bio-material is intended to repair or support damaged or inadequate soft tissue. They are used to treat urinary incontinence resulting from hypermobility or Intrinsic Sphincter Deficiency (ISD), pelvic floor repair, or for implantation to reinforce soft tissues where weakness exists in the urological or musculoskeletal anatomy.	

Hospital Inpatient Codes and Payments:

Medicare uses a prospective payment system to reimburse hospitals for inpatient services based on Medicare Severity Diagnosis Related Groups (MS-DRGs). Services are classified into clinically cohesive groups that exhibit similar use of hospital resources. Hospitals receive a single payment for all services provided during an inpatient admission based on the MS-DRG assigned, regardless of the actual length of stay or costs of services. Only one MS-DRG may be assigned per patient stay. The MS-DRG assignment to the categories of Complications or Comorbidities (CCs) and/or Major Complications or Comorbidities (MCCs) is influenced by the medical record documentation describing the clinical circumstances. Diagnoses and procedures are reported with ICD-10 codes.

The following tables are examples of potential ICD-10 procedure codes that are available for hospitals when reporting inpatient pelvic procedures.

Hernia Procedures Except Inguinal and Femoral ICD-10-PCS Codes

0DQ - Medical and Surgical Gastrointestinal Systems, Repair

Section:	**0** - Medical and Surgical
Body System:	**D** - Gastrointestinal System
Operation:	**Q** - Repair: Restoring, to the extent possible, a body part to its normal anatomic structure and function

Body Part	Approach	Device	Qualifier
1 - Esophagus, Upper **2** - Esophagus, Middle **3** - Esophagus, Lower **4** - Esophagogastric Junction **5** - Esophagus **6** - Stomach **7** - Stomach, Pylorus **8** - Small Intestine **9** - Duodenum **A** - Jejunum **B** - Ileum **C** - Ileocecal Valve **E** - Large Intestine **F** - Large Intestine, Right **G** - Large Intestine, Left **H** - Cecum **J** - Appendix **K** - Ascending Colon **L** - Transverse Colon **M** - Descending Colon **N** - Sigmoid Colon **P** - Rectum	**0** - Open **3** - Percutaneous **4** - Percutaneous Endoscopic **7** - Via Natural or Artificial Opening **7** - Via Natural or Artificial Opening Endoscopic	**Z** - No Device	**Z** - No Qualifier
Body Part	**Approach**	**Device**	**Qualifier**
Q - Anus	**0** - Open **3** - Percutaneous **4** - Percutaneous Endoscopic **7** - Via Natural or Artificial Opening **7** - Via Natural or Artificial Opening Endoscopic **X** - External	**Z** - No Device	**Z** - No Qualifier

Hernia Procedures Except Inguinal and Femoral ICD-10-PCS Codes (continued)

0DQ - Medical and Surgical Gastrointestinal Systems, Repair

Section:	**0** - Medical and Surgical
Body System:	**D** - Gastrointestinal System
Operation:	**Q** - Repair: Restoring, to the extent possible, a body part to its normal anatomic structure and function

Body Part	Approach	Device	Qualifier
R - Anal Sphincter **S** - Greater Omentum **T** - Lesser Omentum **V** - Mesentery **W** - Peritoneum	**0** - Open **3** - Percutaneous **4** - Percutaneous Endoscopic	**Z** - No Device	**Z** - No Qualifier

0WM - Medical and Surgical Anatomical Regions, Reattachment

Section:	**0** - Medical and Surgical
Body System:	**W** - Anatomical Regions, General
Operation:	**M** - Reattachment: Putting back in or on all or a portion of a separated body part to its normal location or other suitable location

Body Part	Approach	Device	Qualifier
2 - Face **4** - Upper Jaw **5** - Lower Jaw **6** - Neck **8** - Chest Wall **F** - Abdominal Wall **K** - Upper Back **L** - Lower Back **M** - Perineum, Male **N** - Perineum, Female	**0** - Open	**Z** - No Device	**Z** - No Qualifier

Hernia Procedures Except Inguinal and Femoral ICD-10-PCS Codes

0WQ - Medical and Surgical Anatomical Regions, Repair

Section:	**0** - Medical and Surgical
Body System:	**W** - Anatomical Regions, General
Operation:	**Q** - Repair: Restoring, to the extent possible, a body part to its normal anatomic structure and function

Body Part	Approach	Device	Qualifier
2 - Face **4** - Upper Jaw **5** - Lower Jaw **6** - Neck **8** - Chest Wall **F** - Abdominal Wall **K** - Upper Back **L** - Lower Back **M** - Perineum, Male **N** - Perineum, Female	**0** - Open **3** - Percutaneous **4** - Percutaneous Endoscopic **X** - External	**Z** - No Device	**Z** - No Qualifier

Body Part	Approach	Device	Qualifier
6 - Neck **F** - Abdominal Wall	**0** - Open **3** - Percutaneous **4** - Percutaneous Endoscopic	**Z** - No Device	**Z** - No Qualifier

Body Part	Approach	Device	Qualifier
6 - Neck **F** - Abdominal Wall	**0** - Open **3** - Percutaneous **4** - Percutaneous Endoscopic	**Z** - No Device	**2** - Stoma **Z** - No Qualifier

Body Part	Approach	Device	Qualifier
C - Mediastinum	**0** - Open **3** - Percutaneous **4** - Percutaneous Endoscopic	**Z** - No Device	**Z** - No Qualifier

Hernia Procedures Except Inguinal and FemoralICD-10-PCS Codes

0WU - Medical and Surgical Anatomical Regions, General-Supplement

Section:	**0** - Medical and Surgical
Body System:	**W** - Anatomical Regions, General
Operation:	**U** - Supplement: Putting in or on biological or synthetic material that physically reinforces and/or augments the function of a portion of a body part

Body Part	Approach	Device	Qualifier
0 - Head **2** - Face **4** - Upper Jaw **5** - Lower Jaw **6** - Neck **8** - Chest Wall **F** - Abdominal Wall **K** - Upper Back **L** - Lower Back **M** - Perineum, Male **N** - Perineum, Female	**0** - Open **4** - Percutaneous Endoscopic	**7** - Autologous Tissue Substitute **J** - Synthetic Substitute **K** - Nonautologous Tissue Substitute	**Z** - No Qualifier

MS-DRGs - Hospital Inpatients

Gentrix product payment is included in the DRG payment; may be identified on the hospital claim using the HCPCS and/or revenue code; captured as a surgical supply for hospital cost accounting.

MS-DRG	Description	FY 2017 Medicare National Payment
	Hernia Repair	
350	Inguinal and femoral hernia procedures with mcc	$14,331.00
351	Inguinal and femoral hernia procedures with cc	$8,271.15
352	Inguinal and femoral hernia procedures without cc/mcc	$5,915.14
353	Hernia procedures except inguinal and femoral with mcc	$16,978.19
354	Hernia procedures except inguinal and femoral with cc	$9,893.61
355	Hernia procedures except inguinal and femoral without cc/mcc	$7,499.79
	Parastomal Repair	
347	Anal and stomal procedures with mcc	$14,658.21
348	Anal and stomal procedures with cc	$8,548.16
349	Anal and stomal procedures without cc/mcc	$5,646.99
	Hiatal Repair	
326	Stomach, esophageal and duodenal procedures with mcc	$31,699.00
327	Stomach, esophageal and duodenal procedures with cc	$15,296.67
328	Stomach, esophageal and duodenal procedures without cc/mcc	$9,070.27

Sources

- CPT® 2017 Professional Codebook
- CPT® Assistant through 2017
- CPT® Changes through 2017
- Medicare - National Correct Coding Policy Manual, Physician Version 22.3 Effective October 1, 2016
- 2017 Medicare Hospital Outpatient Prospective Payment System (CMS-1656-F) Addendum B
- 2017 Ambulatory Surgery Center Prospective Payment System (CMS-1656-F) Addendum A
- CMS-1654-F Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017/Downloads Physician Fee Schedule RVU File

The ACell Reimbursement Hotline

Monday - Friday: 9:00 am - 5:00 pm, Eastern

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ACell's Reimbursement Hotline is dedicated to providing answers to all of your reimbursement questions. It also serves as a resource for obtaining accurate billing information and reimbursement support for ACell's surgical products.

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