Hernia & Surgical

Reimbursement & Coding Guide

ACell®
Healing Through Regenerative Medicine

Hernia and General Surgery

Reimbursement and Coding Guide

Gentrix® devices facilitate the remodeling of functional, site-appropriate tissue. Compromised of ACell's proprietary MatriStem UBM™ (Urinary Bladder Matrix) technology, these biologically-derived devices maintain an intact epithelial basement membrane, which facilitates cellular infiltration and capillary ingrowth. 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

General Surgery

Gentrix® Incisonal Matrix (1-layer) is intended for the reinforcement of soft tissue.

General Surgery and Hernia Repair

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 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* Thick 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.

*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

			Hospital Outpatient		ASC	
CPT CODE	Description	Physician: 2018 Medicare National Payment In-Facility	Status Indicator (S1)	2018 Medicare National Avg. Payment	Status Indicator (S1)	2018 Medicare National Avg. Payment
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible	$428.76	J1	$2,910.96	A2	$1,332.80
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	$630.35	J1	$2,910.96	A2	$1,332.80
49505	Repair initial inguinal hernia, age 5 years or older; reducible	$541.07	J1	$2,910.96	A2	$1,332.80
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	$609.83	J1	$2,910.96	A2	$1,332.80
49520	Repair recurrent inguinal hernia, any age; reducible	$657.35	J1	$2,910.96	A2	$1,332.80
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	$745.55	J1	$2,910.96	A2	$1,332.80
49525	Repair inguinal hernia, sliding, any age	$595.43	J1	$2,910.96	A2	$1,332.80
49560	Repair initial incisional or ventral hernia; reducible	$767.87	J1	$2,910.96	A2	$1,332.80
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	$968.03	J1	$2,910.96	A2	$1,332.80
49565	Repair recurrent incisional or ventral hernia; reducible	$799.19	J1	$4,488.37	A2	$2,097.42

Hernia Repair (continued)

CPT CODE	Description	Physician: 2018 Medicare National Payment In-Facility	Hospital Outpatient		ASC	
			Status Indicator (S1)	2018 Medicare National Avg. Payment	Status Indicator (S1)	2018 Medicare National Avg. Payment
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	$976.67	J1	$4,488.37	A2	$2,097.42
+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)	$279.36	N	Packaged	N1	Packaged
49580	Repair umbilical hernia, younger than age 5 years; reducible	$345.96	J1	$2,910.96	A2	$1,332.80
49582	Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated	$502.19	J1	$2,910.96	A2	$1,332.80
49585	Repair umbilical hernia, age 5 years or older; reducible	$462.95	J1	$2,910.96	A2	$1,332.80
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	$494.63	J1	$2,910.96	A2	$1,332.80
49650	Laparoscopy, surgical; repair initial inguinal hernia	$446.04	J1	$4,488.37	A2	$2,097.42
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	$578.15	J1	$4,488.37	A2	$2,097.42
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	$774.35	J1	$4,488.37	G2	$2,097.42

*Report the implantation of mesh or other prosthesis (CPT 49568) with only incisional or ventral hernia repair. The use of mesh or other prostheses with other types of hernia repair is not reported separately.

2018 CPT Professional Edition

Hiatal Hernia Repair

			Hospital Outpatient		ASC	
CPT CODE	Description	Physician: 2018 Medicare National Payment In-Facility	Status Indicator (S1)	2018 Medicare National Avg. Payment	Status Indicator (S1)	2018 Medicare National Avg. Payment
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	$903.59	C	N/A	N/A	
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	$975.59	C	N/A	N/A	
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures	$1,127.15	J1	$7,594.89	N/A	
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	$1,609.90	J1	$7,594.89	N/A	
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	$1,810.42	J1	$7,594.89	N/A	
+43283	Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	$165.60	C	N/A	N/A	
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	$1,209.59	C	N/A	N/A	
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	$1,317.95	C	N/A	N/A	
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	$1,302.83	C	N/A	N/A	
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	$1,397.86	C	N/A	N/A	
43336	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	$1,568.86	C	N/A	N/A	
43337	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis	$1,615.66	C	N/A	N/A	

Parastomal Hernia Repair

CPT CODE	Description	Physician: 2018 Medicare National Payment In-Facility	Hospital Outpatient		ASC	
			Status Indicator (S1)	2018 Medicare National Avg. Payment	Status Indicator (S1)	2018 Medicare National Avg. Payment
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	$1,234.79	C	N/A	N/A	

General Surgery

CPT CODE	Description	Physician: 2018 Medicare National Payment In-Facility	Hospital Outpatient		ASC	
			Status Indicator (S1)	2018 Medicare National Avg. Payment	Status Indicator (S1)	2018 Medicare National Avg. Payment
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	(C)	Q1	$168.93	N/A	

- If implants for soft tissue reinforcement are used in other anatomical areas, and the implant reinforcement is not inherent to the procedure performed, then it may be separately reported with unlisted code 17999, unlisted procedure, skin, mucous membrane and subcutaneous tissue.
- If the soft tissue reinforcement placed is an inherent part of the procedure performed, it is not appropriate to separately report unlisted code 17999.
- Definition of Primary Closure: Actively closing a wound immediately after completing the procedure with sutures, Steri-Strips®, or another active binding mechanism. Any typical procedure required to close the surgical wound is bundled with the primary procedure.

2018 CPT Professional Edition and CPT Assistant October 2013, Volume 23, Issue 10, p 15-17

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

Q1: STV-packaged Codes Paid under OPPS; Addendum B displays APC assignments when services are seperately payable.

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 code list has examples of potential ICD-10 procedure codes that are available for hospitals when reporting inpatient hernia procedures.

Hernia Procedures Except Inguinal and Femoral	Operating Room Procedures
0DQU0ZZ	Repair Omentum, Open Approach
0DQU3ZZ	Repair Omentum, Percutaneous Approach
0DQU4ZZ	Repair Omentum, Percutaneous Approach
0WMF0ZZ	Repair Omentum, Percutaneous Endoscopic Approach
0WQF0ZZ	Reattachment of Abdominal Wall, Open Approach
0WQF3ZZ	Repair Abdominal Wall, Percutaneous Approach
0WQF4ZZ	Repair Abdominal Wall, Percutaneous Endoscopic Approach
0WQFXZZ	Repair Abdominal Wall, External Approach
0WUF07Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Open Approach
0WUF0JZ	Supplement Abdominal Wall with Synthetic Substitute, Open Approach
0WUF0KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Open Approach
0WUF47Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
0WUF4JZ	Supplement Abdominal Wall with Synthetic Substitute, Percutaneous Endoscopic Approach
0WUF4KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach

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 2018 Medicare National Unadjusted Payment
	Hernia Repair	
350	Inguinal and femoral hernia procedures with mcc	$14,829
351	Inguinal and femoral hernia procedures with cc	$8,975
352	Inguinal and femoral hernia procedures without cc/mcc	$6,252
353	Hernia procedures except inguinal and femoral with mcc	$18,139
354	Hernia procedures except inguinal and femoral with cc	$10,388
355	Hernia procedures except inguinal and femoral without cc/mcc	$7,959
	Parastomal Repair	
347	Anal and stomal procedures with mcc	$15,847
348	Anal and stomal procedures with cc	$8,511
349	Anal and stomal procedures without cc/mcc	$6,116
	Hiatal Repair	
326	Stomach, esophageal and duodenal procedures with mcc	$27,407
327	Stomach, esophageal and duodenal procedures with cc	$12,753
328	Stomach, esophageal and duodenal procedures without cc/mcc	$9,066

Sources

- CPT Professional. (2018). American Medical Association.
- CPT Assistant through 2017
- CPT Changes through 2017
- Medicare - National Correct Coding Policy Manual, Physician Version 23.3 Effective October 1, 2017
- 2018 Medicare Hospital Outpatient Prospective Payment System (CMS-1678-FC) Addendum B
- 2018 Ambulatory Surgery Center Prospective Payment System (CMS-1678-FC) Addendum AA
- CMS-1676-F Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018/Downloads
- FY 2018 Hospital Impatient Prospective Payment Systems for Acute Care Hospitals (CMS 1677-CN), Effective October 1, 2017
- 2018 Physician Fee Schedule RVU File

The ACell Reimbursement Support Center

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

800-826-2926, x 7 | reimbursement@acell.com

ACell's Reimbursement Support Center 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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