MTF Musculoskeletal Transplant Foundation
the better approach

2017 FlexHD® Abdominal Wall Reconstruction Reimbursement Coding Reference

Most Commonly Reported ICD-10-CM Procedure Codes and Descriptors

ICD-10-CM	Description
0WUF0KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Open Approach

Diagnostic Related Groups (DRGs)*

DRG	Description	*Hospital[1]
353	Hernia Procedures Except Inguinal & Femoral With MCC	$17,142.50
354	Hernia Procedures Except Inguinal & Femoral With CC	$9,989.36
355	Hernia Procedures Except Inguinal & Femoral Without CC/ MCC	$7,572.38
907	Other O.R. Procedures For Injuries With MCC	$23,067.18
908	Other O.R. Procedures For Injuries With CC	$12,275.14
909	Other O.R. Procedures For Injuries Without CC/MCC	$7,818.07
957	Other O.R. Procedures For Multiple Significant Trauma With MCC	$41,098.24
958	Other O.R. Procedures For Multiple Significant Trauma With CC	$23,013.51
959	Other O.R. Procedures For Multiple Significant Trauma Without CC/ MCC	$15,072.59
987	Non Extensive OR Procedures Unrelated to Principal Diagnosis With MCC	$19,840.96
988	Non Extensive OR Procedures Unrelated to Principal Diagnosis With CC	$10,239.82
989	Non Extensive OR Procedures Unrelated to Principal Diagnosis Without CC/MCC	$6,299.78

Tissue

*HCPCS	Description	Status Indicator	APC	HOPPS[2]	ASC[2]
Q4128	FlexHD, AlloPatchHD, or Matrix HD, per sq. cm	N	N/A	Packaged	Packaged

Notes:

- DRG payment rates are based upon Medicare National Average Rates effective October 1, 2016 – September 20, 2017
- Modifier JC (i.e. skin substitute used as a graft) is not required when reporting FlexHD with Q4128 per AMA coding guidelines. However, while CMS did not release requirements for use of the modifier, some Medicare Administrative Contractors (MACs) may establish their own requirement. To prevent inappropriately denied claims, we recommend you check with local payers and your MAC to determine if the modifiers should be used.
- FlexHD should be reported per square centimeter
- N = Items and services are packaged into primary procedure
- FlexHD should be reported by the facility where the procedure is performed
- Packaged – Procedure is reimbursed as part of the primary procedure and not paid separately.

Procedure for Implantation of Tissue

*CPT-4®	Description	*SI	*APC	*HOPPS[2]	*ASC[2]	*Physician[3]
15777	Implantation of biologic implant (e.g. acellular dermal matrix) for soft tissue reinforcement (e.g. breast, trunk). List separately in addition to code for primary procedure. Note: For bilateral breast procedure add -50 modifier	N	N/A	Packaged	Packaged	$223.59
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)	N	N/A	Packaged	Packaged	$278.50
C1781	Mesh (implantable)	N	N/A	Packaged	Packaged	N/A

Notes:

*Verify appropriate CPT code and documentation requirements with payer.

*SI = Status Indicator; N = Items and services are packaged into primary procedure

*Packaged: Procedure is reimbursed as part of the primary procedure and not paid separately.

The American Society of Plastic Surgeons recommends when a biologic implant is used in conjunction with hernia repair, code 49568 is appropriate; Q4128 is considered to be the prosthesis. When a biologic implant is used for abdominal wall reconstruction, but no hernia is present, CPT 15777 should be reported.

Additional Procedure Codes for Abdominal Wall Reconstruction

CPT-4®	Description	SI	APC	HOPPS[2]	ASC[2]	Physician[3]
Ventral						
11008	Removal of prosthetic material or mesh, abdominal wall for infection (e.g. for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	C	N/A	N/A	Non-ASC	$286.03
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk	T	5055	$2,503.63	$1,352.27	$1,361.98
49560	Repair initial incisional or ventral hernia; reducible	J1	5341	$2,861.53	$1,452.70	$765.86
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	J1	5341	$2,861.53	$1,452.70	$965.76
49565	Repair recurrent incisional or ventral hernia; reducible	J1	5361	$4,197.36	$2,037.05	$797.45
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	J1	5361	$4,197.36	$2,037.05	$974.38
49585	Repair umbilical hernia, age 5 years or older; reducible	J1	5341	$2,861.53	$1,452.70	$461.17
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	J1	5341	$2,861.53	$1,452.70	$492.39
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	J1	5361	$4,197.36	Non-ASC	By Report
Inguinal						
49505	Repair initial inguinal hernia, age 5 years or older; reducible	J1	5341	$2,861.53	$1,452.70	$539.77
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	J1	5341	$2,861.53	$1,452.70	$606.88
49520	Repair recurrent inguinal hernia, any age; reducible	J1	5341	$2,861.53	$1,452.70	$655.69
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	J1	5341	$2,861.53	$1,452.70	$743.61
49525	Repair inguinal hernia, sliding, any age	J1	5341	$2,861.53	$1,452.70	$594.32

*Table based upon 2017 Medicare National Average Rates

*C = Inpatient procedure only

*T = Paid separately under Medicare OPPS, multiple procedure reduction applies

*J1 = Paid under Medicare OPPS; all covered Medicare 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

Procedure coding should be based upon medical necessity and procedures and supplies provided to the patient. Coding and reimbursement Information is provided for educational purposes and does not assure coverage of the specific item or service in a given case. MTF and The Pinnacle Health Group make no guarantee of coverage or reimbursement of fees. Contact your local Medicare Administrative Contractor (MAC) or the Centers for Medicare and Medicaid Services (CMS) for specific information as payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments.

CPT-4®	Description	SI	APC	HOPPS[2]	ASC[2]	Physician[3]
Hiatal						
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	C	N/A	N/A	Non-ASC	$902.60
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	C	N/A	N/A	Non-ASC	$980.84
39561	Resection, diaphragm; with complex repair (eg, prosthetic material, local muscle flap)	C	N/A	N/A	Non-ASC	$1,291.28
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)	J1	5362	$6,966.89	Non-ASC	$1,124.39
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed;	C	N/A	N/A	Non-ASC	$1,807.71
43325	Esophagogastric fundoplasty; with fundic patch (Thal-Nissen procedure)	C	N/A	N/A	Non-ASC	$1,389.97
43327	Esophagogastric fundoplasty partial or complete; laparotomy	C	N/A	N/A	Non-ASC	$852.72
43328	Esophagogastric fundoplasty partial or complete; thoracotomy	C	N/A	N/A	Non-ASC	$1,173.92
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal;	C	N/A	N/A	Non-ASC	$1,318.55
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal;	C	N/A	N/A	Non-ASC	$1,397.86
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision,	C	N/A	N/A	Non-ASC	$1,692.51
44141	Colectomy, partial; with skin level cecostomy or colostomy	C	N/A	N/A	Non-ASC	$1,899.95
44143	Colectomy, partial; with end colostomy and closure of distal segment (Hartmann type procedure)	C	N/A	N/A	Non-ASC	$1,732.35
44144	Colectomy, partial; with resection, with colostomy or ileostomy and creation of mucofistula	C	N/A	N/A	Non-ASC	$1,841.09

Table based upon 2016 Medicare National Average Rates

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J1 = Paid under Medicare OPPS; all covered Medicare 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

CPT-4®	Description	SI	APC	HOPPS[2]	ASC[2]	Physician[3]
Stoma						
44187	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	C	N/A	N/A	Non-ASC	$1,149.16
44188	Laparoscopy, surgical, colostomy or skin level colostomy	C	N/A	N/A	Non-ASC	$1,274.05
44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostom	C	N/A	N/A	Non-ASC	$1,392.84
44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)	C	N/A	N/A	Non-ASC	$1,823.15
44208	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy	C	N/A	N/A	Non-ASC	$2,068.98
44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy	C	N/A	N/A	Non-ASC	$1,854.01
44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy	C	N/A	N/A	Non-ASC	$2,131.43
44227	Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis	C	N/A	N/A	Non-ASC	$1,735.22
44312	Revision of ileostomy; simple (release of superficial scar) (separate procedure)	T	5055	$2,503.63	$1,352.27	$613.34
44314	Revision of ileostomy; complicated (reconstruction in-depth) (separate procedure)	C	N/A	N/A	Non-ASC	$1,043.28
44320	Colostomy or skin level cecostomy;	C	N/A	N/A	Non-ASC	$1,249.64
44340	Revision of colostomy; simple (release of superficial scar) (separate procedure)	T	5055	$2,503.63	$1,352.27	$647.43
44345	Revision of colostomy; complicated (reconstruction in-depth) (separate procedure)	C	N/A	N/A	Non-ASC	$1,093.89
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)	C	N/A	N/A	Non-ASC	$1,230.62
44605	Suture of large intestine (colorrhaphy) for perforated ulcer, diverticulum, wound, injury or rupture (single or multiple perforations); with colostomy	C	N/A	N/A	Non-ASC	$1,355.88
45136	Excision of ileoanal reservoir with ileostomy	C	N/A	N/A	Non-ASC	$1,986.80

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REFERENCES:

1. DRG values calculated using a base rate of $5516.63 and Capital Standard Payment of $446.81. The Medicare national average hospital base rate is the sum of the full update labor-related and nonlabor-related amount published in the Federal Register, FY 2017 IPPS Final Rule (Tables 1A, 1D & 5).
2. ICD-10-PCS 2017, ©2016 Optum360, LLC. All rights reserved.
3. Medicare Hospital Outpatient Prospective Payment - Final Rule with Comment and Final CY2017 Payment Rates (CMS-1656-FC); Addendum B and Final ASC Addenda.
4. 2017 AMA CPT Professional
5. ICD-10-CM Expert for Physicians 2017, ©2016 Optum360, LLC. All rights reserved.
6. CY 2017 Revisions to Payment Policies under the Medicare Physician Fee Schedule and Other Revisions to Part B; Addendum B.

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