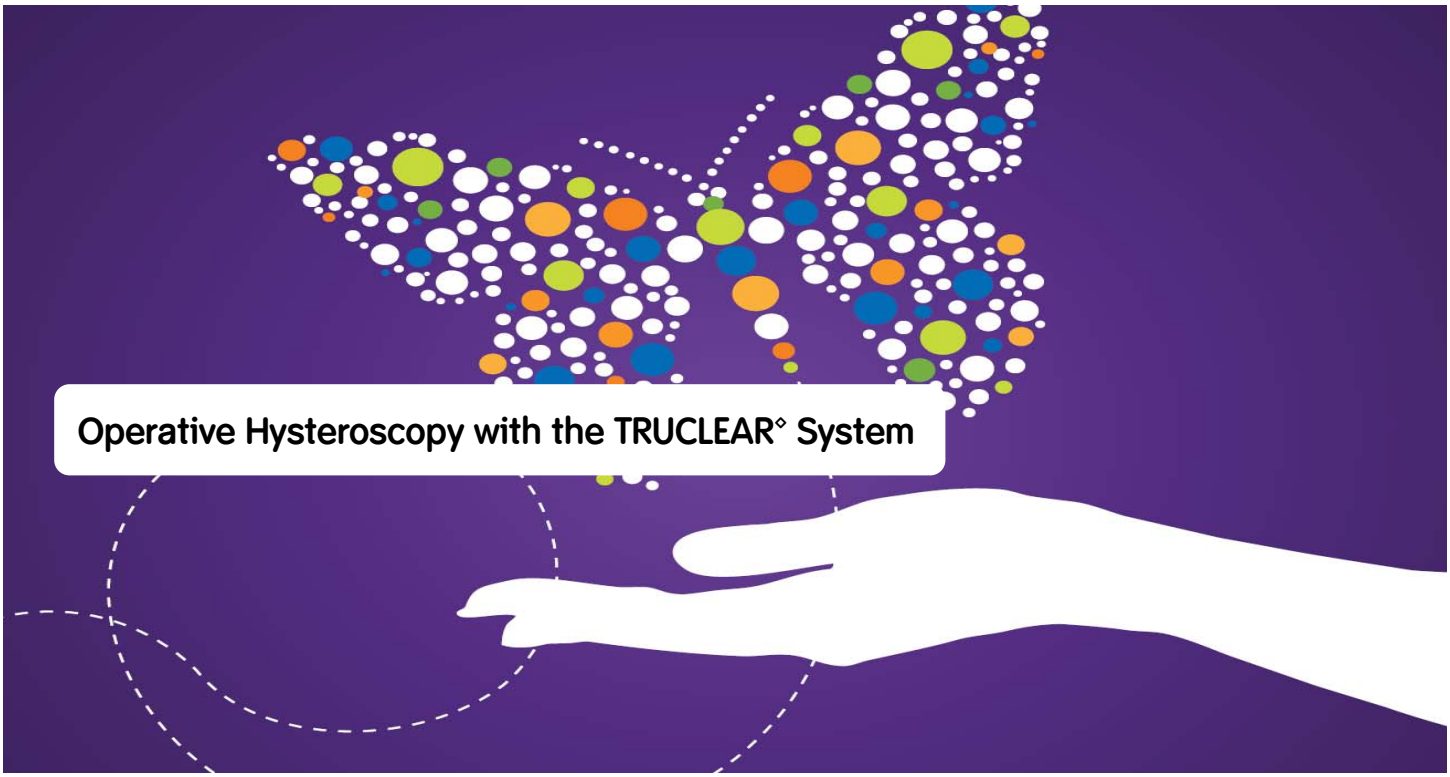

2016 Medicare Coding and Payment Reference Sheet

Visit the site at www.smith-nephew.com/reimbursement to obtain specific geographic payment information.

HYSTEROSCOPIC PROCEDURES

Note: *Private payer coverage and payment policies will vary. Payers should be consulted in regard to their specific policies. Most payers closely monitor Medicare fee schedules*

Common Physician Coding

CPT codes are used by hospital outpatient departments, ambulatory surgery centers, and physicians to describe professional services and procedures.

Based on CY2016 Medicare Physician Fee Schedule national payment rates are as follows:

CPT Code	Description	Non-Facility	Facility
58555	Hysteroscopy, diagnostic, separate procedure	$315.08	$192.27
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C (Removal of polyps)	$409.60	$270.68
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	**N/A	$346.58
58561	Hysteroscopy, surgical; with removal of leiomyomata (Removal of fibroids)	**N/A	$554.24

**Non-Facility Indicator N/A - An "NA" in this field indicates that this procedure is rarely or never performed in the non-facility setting

ICD-9-CM and ICD10 Cross walk

ICD9	Description	ICD10	Description
218.0	Submucous leiomyoma of uterus	D25.0	Submucous leiomyoma of uterus
218.1	Intramural leiomyoma of uterus	D25.1	Intramural leiomyoma of uterus
218.2	Subserous leiomyoma of uterus	D25.2	Subserosal leiomyoma of uterus
218.9	Leiomyoma of uterus, unspecified	D25.9	Leiomyoma of uterus, unspecified
621.0	Polyp of corpus uteri	N84.0	Polyp of corpus uteri
621.5	Intrauterine synechiae	N85.6	Intrauterine synechiae
626.2	Excessive or frequent menstruation	N92.0	Excessive and frequent menstruation with regular cycle
627.1	Postmenopausal bleeding	N95.0	Postmenopausal bleeding

Common Outpatient Coding

CPT codes are used by hospital outpatient departments, ambulatory surgery centers, and physicians to describe professional services and procedures.

Based on CY2016 Medicare Hospital Outpatient Prospective Payment System (OPPS) national payment rates are as follows:

APC/ Status*	Description	Cross Reference CPT Code	Payment
5414/T	Level IV Gynecologic Procedures	58555, 58558	$1,861.18
5415/T	Level V Gynecologic Procedures	58559, 58561	$3660.20

Revenue Codes -

These codes are a billing code used to categorize charges based on the type of service, supply, or procedure provided

0272 Sterile Supply (disposable supplies, TRUCLEAR® System)

Note: *Each hospital will need to determine appropriate Revenue Codes used within their facility based on their accounting practices*

Medicare provides coverage in the ASC setting based on the CPT codes indicated below.
CY2016 National ASC payment levels are based on hospital outpatient prospective payment system (OPPS)

CPT Code	Description	Payment Indicator	Payment
58555	Hysteroscopy, diagnostic, separate procedure	A2	$1040.74
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or w/o D & C (Removal of polyps)	A2	$1040.74
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)	A2	$1809.89
58561	Hysteroscopy, surgical; with removal of leiomyomata (Removal of fibroids)	A2	$1809.89

*A2-Payment based on OPPS relative payment weight.

Note: Private payers should be contacted for their specific ASC coverage and payment guidelines

Common Modifiers

In addition to selecting appropriate CPT codes, providers should pay attention to the use of modifiers. A modifier indicates that a service or procedure was altered by specific circumstances, but not changed in its definition or code.

Modifier	Descriptor
-22	Unusual Services *(physician only)*
-51	Multiple Procedures *(physician only)*
-52	Reduced Services *(physician and facility)*
-73	Discon OUT-PT/ASC procedure before Anesthesia Administered *(facility only)*
-74	Discon OUT-PT/ASC procedure after Anesthesia Administered *(facility only)*

This coding list is not all-inclusive and is not intended to represent all coding options. Coding of diagnosis/procedure code(s) is dependent on documentation in the patient's medical record. The information in this document is provided as a guide for coding procedures and services involving the TRUCLEAR® System. It is not intended to increase or maximize reimbursement by any payer. Providers assume full responsibility for all reimbursement decisions or actions. We strongly suggest that you consult your payer organizations with regard to local coverage and reimbursement policies.

Hysteroscopy

2016 Medicare Coding and Payment Reference Sheet

For assistance with outpatient reimbursement questions, email Reimbursement@smith-nephew.com or call 1.888.711.9903.
For office reimbursement questions, email Office.Reimbursement@smith-nephew.com or call 1.888.711.9903 and specify that you would like to speak with an office reimbursement specialist.

FREQUENTLY ASKED QUESTIONS

1. Q. Does the TRUCLEAR System have FDA clearance?

A. Yes. The TRUCLEAR® System originally received FDA clearance December 2, 2003, and received clearance to expand its indications for use on December 13, 2013.

2. Q. Should hospitals use a C-code when billing for the TRUCLEAR System?

A. No. There is no C-code applicable to the TRUCLEAR® System.

3. Q. Is 58558 the appropriate code to use when the TRUCLEAR System is used to remove a polyp?

A. Yes. The AMA was informally queried via a telephone call by an independent reimbursement consultant regarding CPT coding for "*a surgical hysteroscopy with removal of polyp using a tissue removal device placed through the operating lumen of a hysteroscope. The polyp was resected and aspirated through the hysteroscope.*" Based on the procedure description, the AMA CPT Information Services indicated that CPT 58558 was appropriate.

4. Q. Is 58561 the appropriate CPT code to use when the TRUCLEAR System is used to remove a submucous fibroid?

A. Yes. The AMA was informally queried via a telephone call by an independent reimbursement consultant regarding CPT coding for "*a surgical hysteroscopy with removal of fibroid using a tissue removal device placed through the operating lumen of a hysteroscope. The fibroid was resected and aspirated through the hysteroscope.*" Based on the procedure description, the AMA CPT Information Services indicated that CPT 58561 was appropriate.

5. Q: Is 58558 the appropriate code to use when the TRUCLEAR System is used to remove retained products of conception?

A: Yes, the physician performs a cervical dilation and uterine curettage through the working channel of a hysteroscope.

6. Q. If more than one fibroid/polyp is removed, can the procedure be coded more than once?

A. No. However, if removal of the additional fibroid/polyp requires substantial time and is more complex, the physician may add modifier -22 (*unusual services*). A SPECIAL REPORT (op report/procedure description) should be included with the claim detailing the number of polyps/fibroids removed total weight of tissue removed and time required.

7. Q. Can a D&C subsequent to removal of fibroids/polyps be coded?

A. If a *polypectomy* and a D&C are performed, only the polypectomy can be coded since the code descriptor for polypectomy includes a D&C. If removal of fibroids and D&C are performed *both* procedures can be coded and billed using modifier -51 *(Multiple procedures)*.

8. Q. What does the term "global period" mean?

A. Global period refers to a predetermined time frame whereby all typical follow up care related to the procedure is included in the payment for the procedure and cannot be coded and billed separately. The predetermined timeframe varies by CPT code. The global period for 58558, 58559 and 58561 is 0 days. Therefore, if the patient returns to the physician's office for follow up care, the physician can bill for the follow up service.

9. Q. Do payers provide coverage for the TRUCLEAR System?

A. This is difficult to answer as private payer policies vary. We recommend preauthorization in advance of services utilizing the TRUCLEAR® System. Preauthorization clarifies benefits and coverage criteria in advance of care.

Note: *Traditional Medicare does not preauthorize medical procedures, however most questions can be answered by reviewing the contractor's web site or contacting the Medicare Medical Director.*

10. Q. What is the payment rate for non-Medicare payers?

A. Private payer policies and payment rates vary and usually depend on the physician's contracted or negotiated rate. Coverage payment policies should be confirmed with the patient's payer prior to scheduling surgery.

This coding list is not all-inclusive and is not intended to represent all coding options. Coding of diagnosis/procedure code(s) is dependent on documentation in the patient's medical record. The information in this document is provided as a guide for coding procedures and services involving the TRUCLEAR® System. It is not intended to increase or maximize reimbursement by any payer. Providers assume full responsibility for all reimbursement decisions or actions. We strongly suggest that you consult your payer organizations with regard to local coverage and reimbursement policies.