Hernia Repair

Coverage, Coding and Reimbursement Overview

2011 Edition[†] — Effective October 1, 2010 through September 30, 2011

HOSPITAL (FACILITY) INPATIENT OVERVIEW

HIGHLIGHTS

MS-DRG: In the MS-DRG, patient severity levels are determined by the presence or absence of Medicare's specified Complication or Comorbid (CC) and / or Major Complication and Comorbid conditions (MCC). It is important that patient conditions are documented and coded to the highest level of specificity in order to ensure appropriate classification. Medicare Tables 6I and 6J provide listings of all CC and MCC conditions (refer to "Resources" section of this document).

"Implanted Device" Cost Center: The 2010 final rule (CMS-1406-F) discussed important updates and revisions to the Medicare cost report, including splitting current cost center "Medical Supplies Charged to Patients" into two lines: **"Medical Supplies Charged to Patients"** and **"Implantable Devices Charged to Patients"**. Cost center "Implantable Devices" is available for cost reporting periods beginning on / after May 1, 2009; hospitals with reporting periods beginning on / after February 1, 2010, should review form CMS-2552-10. Hospitals are urged to review the complete discussion regarding the revised cost report in CMS-1406-F.

COVERAGE FOR HOSPITALS

Medicare	Fiscal Intermediary (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

ANTERIOR ABDOMINAL WALL REPAIR		CODING	REIMBURSEMENT
ABBREVIATED DESCRIPTION	**ICD-9 PROCEDURE**	**2011 MS-DRG[A]**	**2011 MS-DRG RATE[B]**
Primary Procedure with Graft or Prosthesis			
Other open incisional hernia repair with prosthesis	53.61	353, 354, 355	$15,362, $8,668, $5,768
Laparoscopic incisional hernia repair with prosthesis	53.62		
Other and laparoscopic repair, other hernia anterior abdominal wall, with prosthesis	53.63		
Other open repair, other hernia anterior abdominal wall, with prosthesis	53.69		
Secondary Procedure to Adhesiolysis			
Above repair services secondary to Adhesiolysis (e.g., 54.51, 54.59)	Same as above	335, 336, 337	$23,887, $13,098, $8,258

DIAPHRAGMATIC REPAIR[C]		CODING	REIMBURSEMENT
Laparoscopic repair diaphragmatic hernia, abdominal approach	53.71	163, 164, 165, 326, 327, 328	$28,383, $14,651, $9,916, $32,467, $15,206, $7,984
Other and open repair diaphragmatic hernia, abdominal approach	53.72		
Repair diaphragmatic hernia, abdominal approach, not otherwise specified	53.75		
Repair diaphragmatic hernia, thoracic approach, not otherwise specified	53.80		
Plication of the diaphragm, thoracic approach	53.81		
Repair of parasternal hernia, thoracic approach	53.82		
Laparoscopic repair diaphragmatic hernia, thoracic approach	53.83		
Other and open repair diaphragmatic hernia, thoracic approach	53.84		

INGUINAL		CODING	REIMBURSEMENT
Unilateral repair inguinal hernia, not otherwise specified	53.00	350, 351, 352	$13,892, $7,560, $4,818
Other and open repair direct inguinal hernia	53.01		
Other and open repair indirect inguinal hernia	53.02		
Other and open repair direct inguinal hernia with prosthesis	53.03		
Laparoscopic repair direct inguinal hernia with prosthesis	17.11		
Other and open repair indirect inguinal hernia with prosthesis	53.04		
Laparoscopic repair indirect inguinal hernia with prosthesis	17.12		
Repair inguinal hernia with prosthesis, not otherwise specified	53.05		
Laparoscopic repair inguinal hernia with prosthesis, not otherwise specified	17.13		
Bilateral repair inguinal hernia, not otherwise specified	53.10		
Other and open repair bilateral direct inguinal hernia	53.11		
Other and open repair bilateral indirect inguinal hernia	53.12		
Other and open repair bilateral inguinal hernia, one direct and one indirect	53.13		
Other and open repair bilateral direct inguinal hernia with prosthesis	53.14		
Laparoscopic repair bilateral indirect inguinal hernia with prosthesis	17.21		
Other and open repair bilateral indirect inguinal hernia with prosthesis	53.15		
Laparoscopic repair bilateral indirect inguinal hernia with prosthesis	17.22		
Other and open repair bilateral inguinal hernia, one direct one indirect, with prosthesis	53.16		
Laparoscopic repair bilateral inguinal hernia, one direct one indirect, with prosthesis	17.23		
Bilateral repair inguinal hernia with prosthesis, not otherwise specified	53.17		
Laparoscopic repair bilateral inguinal hernia with prosthesis, not otherwise specified	17.24		

OTHER[D]		CODING	REIMBURSEMENT
Repair of paracolostomy hernia (prosthesis not specified)	46.42	347, 348, 349	$13,504, $7,653, $4,457
Repair of gastroschisis (prosthesis not specified)	54.71		
Unilateral repair femoral hernia with prosthesis	53.21	350, 351, 352	$13,892, $7,560, $4,818
Other unilateral femoral herniorrhaphy (prosthesis not specified)	53.29		
Bilateral repair of femoral hernia with prosthesis	53.31		
Other bilateral femoral herriorrhaphy (prosthesis not specified)	53.39		
Other and open repair of umbilical hernia with prosthesis	53.41	353, 354, 355	$15,362, $8,668, $5,768
Laparoscopic repair of umbilical hernia with prosthesis	53.42		
Other laparoscopic umbilical herniorrhaphy (prosthesis not specified)	53.43		
Other umbilical herniorrhaphy (prosthesis not specified)	53.49		
Other hernia repair (prosthesis not specified)	53.9		

[A] CMS-DRG / MS-DRG assignment is determined by the patient ICD-9 diagnoses and procedure codes. Most common assignments provided. Injury and trauma not provided.
[B] Reimbursement rates per CMS-1498-F.
[C] Note use of prosthesis not specified.
[D] With graft / prosthesis, unless noted.

TERMINOLOGY AND ACRONYMS

ABN: Advance Beneficiary Notice. A legal, written notice to a Medicare beneficiary from a physician or hospital informing the patient that the health service or item that the physician has prescribed is not or may not be a covered service under Medicare, and that the patient will be responsible for payment if denied.

Anesthesia Guidelines: The rules for coding and charging are complex. Variable circumstances can include duration, method of anesthesia / sedation, the physician or specialist administering services, and the site of service. Local Medicare Policies, and the AMA CPT® coding book, professional edition, should be consulted for questions regarding the proper coding and billing for anesthesia services.

APC: Ambulatory Payment Classification. These are numeric classifications used by Medicare to reimburse services performed in a hospital outpatient setting. An APC will contain multiple HCPCS Codes that are similar both clinically and in terms of resources used by the hospital. The APC rate is set prospectively by CMS based on historic claims data.

APC Status Indicator: Alpha characters are used to designate the APC payment calculation method. For multiple APCs on a single claim with Status Indicator "T" the first APC will be paid at 100% and all others at 50%. For all APCs with Status Indicator "S" each APC will be paid at 100%, no discounting.

ASC: Ambulatory Surgery Center. When used by Medicare, this designation describes a legal licensing status establishing a site of service distinct from a physician's office or hospital-based facility.

Bundled: Certain supplies / procedures provided by a physician as described by CPT® Codes / HCPCS Codes may be included ("Bundled") with another service for reimbursement purposes.

Carrier: A Medicare contractor responsible for physician and ASC medical policies, adjudication of claims and other administrative functions.

CC: Complications and Comorbidities. Patient conditions utilized as two of several factors in MS-DRG Groupers.

CCI: Correct Coding Initiative. A listing of CPT® Codes that are designated as comprehensive or component codes. If comprehensive and component codes are submitted on the same bill, only the comprehensive code will be paid unless a modifier is submitted. Medicare uses these as NCCI (National Correct Coding Initiative) edits.

CPT® Code: Current Procedural Terminology Code. These 5-digit numeric codes are the property of the American Medical Association and are used to describe physician services. Additionally, Medicare licenses these codes from the AMA and uses them to describe physician, hospital outpatient, ASC services, and other outpatient services.

DRG: Diagnosis Related Group. A numeric classification system used by Medicare and some commercial payers to reimburse for hospital inpatient services. The DRG is assigned by software that considers the ICD-9 procedure and diagnosis codes submitted on a claim.

DME: Durable Medical Equipment. Certified supplies, prosthetics, equipment, etc., provided to patients in other than a hospital inpatient setting.

DMERC: Durable Medical Equipment Regional Contractor. Medicare contractor that adjudicates claims for DME providers.

Facility / Non-Facility: For some physician procedures, the reimbursement is determined by the site of service. If the fee is designated as "Facility," the procedure is performed in a site of service other than a physician office. If the fee is designated as "Non-Facility," the procedure is performed in a physician office.

FI: Fiscal Intermediary. A Medicare contractor responsible for hospital inpatient and outpatient medical policies, adjudication of claims and other administrative functions.

HCPCS: Healthcare Common Procedure Coding System. The name of a coding system established by Medicare to describe services and supplies. The base (Level I) codes are CPT® Codes.

ICD-9: International Classification of Diseases. Numeric codes used by essentially all payers to describe diagnosis and procedures. The combination of procedure and diagnosis codes determines DRG assignment for inpatient reimbursement.

ICD-9 procedure	4-digit codes (e.g., 39.90 Insertion of non-drug-eluting peripheral vessel artery stent(s)) Abbrev: Px.
ICD-9 diagnosis	3, 4 or 5-digit codes (e.g., 586 Renal failure, unspecified) Abbrev: Dx.

Inpatient: The status used to describe a patient who has been admitted to the hospital. Usually involves multi-day stay.

IPPS: Inpatient Prospective Payment System. Medicare (CMS) per case (see "DRG" and "MS-DRG") methodology for hospital inpatient services.

LCD / LMRP: Local Coverage Determination / Local Medical Review Policy. The written policies produced by Medicare contractors applicable to geographic areas. A CMS national policy (see NCD) supersedes a LCD.

MCC: Major Complications and Comorbidities. Patient conditions utilized as two of several factors in MS-DRG Groupers. MCC are typically significant acute manifestations or advanced stages of chronic conditions that would result in higher resource utilization in the course of treatment.

MS-DRG: Medicare Severity Diagnosis Related Group. A numeric classification system effective October 1, 2007 used by Medicare to reimburse for hospital inpatient services. The MS-DRG is assigned by the combination of ICD-9 procedure codes, diagnosis codes and the presence or absence of MCC / CCs as derived from the medical record documentation. The MS-DRG system was designed to more accurately pay hospitals based on patient severity of illness.

Modifier: A 2-digit alphanumeric code that is appended to a CPT® Code for further specificity.

NCD: National Coverage Determination. The written policies from Medicare that have a national jurisdiction (supersede any LCD).

Observation: Hospital outpatient services to monitor and assess a patient for determination of hospital admission or discharge.

OPPS: Outpatient Prospective Payment System. Medicare (CMS) per group (see "APC") methodology for hospital outpatient services.

Outpatient: A patient admitted to a hospital to receive treatment but not admitted as an inpatient (see "Observation").

Packaged: Certain supplies / procedures provided by a facility as described by CPT® Codes / HCPCS Codes may be included ("Packaged") with another service for reimbursement purposes.

Prospective: A predetermined reimbursement rate, regardless of the cost of that service.

Pro / Tech: Professional / Technical. For some diagnostic tests, the physician reimbursement is established in two components. The "Professional" component is for the physician supervision, interpretation and other personal service. The "Technical" component is for the equipment, supplies, staff and other costs related to the test.

S&I: Supervision and Interpretation. This term is sometimes used to differentiate the imaging service (professional reading / interpretation) from other components of the procedure, such as introduction and placement of catheters.

Unadjusted Rate: The prospective reimbursement rate before it is adjusted for local factors such as the wage index, graduate medical education, outlier cases, disproportionate share and other factors. This is sometimes called the "national average" rate. All Medicare reimbursement will have local adjustment factors.

RESOURCES

Suggested Resources: Coding and reimbursement is complex, specific to case documentation and variable by geographic location. Always consult current facility resources.

1. Medicare national (NCD) and local policies (LCD / LMRP): http://www.cms.hhs.gov/mcd/search.asp
2. *CPT® Assistant,* American Medical Association: http://www.ama-assn.org
3. *Current Procedural Terminology CPT®, 2011*, American Medical Association: http://www.ama-assn.org
4. *ICD-9-CM* current edition
5. CC and MCC Tables 6I, 6J: http://www.cms.hhs.gov/acuteinpatientpps

† Disclaimer: The payment amounts listed in this guide are national averages. Actual payment will vary based on several factors including the site of the service, geographic location, patient population mix, and hospital teaching status. References to particular applications and procedures listed in this Coding Overview do not represent the appropriateness or market availability of any GORE Medical Product. The information contained in this Overview is provided for general information purposes only and should NOT be relied on for submission purposes. Consult your professional resources and the patient's insurer for situation-specific information.

Physicians and hospitals are responsible for selecting and reporting the code(s) that most accurately describe the procedure(s) performed, the products used and the patient's condition. The basis for accurate coding is clear and complete documentation in the medical record precisely describing the procedures performed and products used.

Providers should follow coding guidelines from the patient's insurer, and should also review the complete coding authorities (e.g., CPT®, HCPCS, ICD-9-CM) used by the insurer.

The identification of a code in this Coding Overview should not be construed to guarantee coverage for a product or procedure, or payment in any particular amount.

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