Coding and reimbursement guide

Biodesign Rectopexy Graft

2024

The Biodesign Rectopexy Graft is intended to reinforce soft tissue where weakness exists in the gastroenterological anatomy including transabdominal repair of colon and rectal prolapse.

Introduction

This guide was developed to assist with Medicare reporting and reimbursement when using the Biodesign Rectopexy Graft during colorectal surgery.

Coverage

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies and contact their carrier's medical director or commercial insurers to determine if a procedure is covered. You will find QR codes for these links on the last page of this document.

Coding

Surgical repair is typically reported by one of the following Current Procedural Terminology (CPT®) codes. It is the physician's responsibility to choose a CPT code that accurately describes the procedure performed. Listed reimbursement rates do not represent adjustments specific to the provider's location or facility. Actual payment rates vary with geographic adjustment and are updated quarterly.

C-codes

If applicable, Medicare requires hospitals to report device(s) by using the Level II Healthcare Common Procedure Coding System, or "C-codes." When reporting use of Biodesign grafts in a hospital outpatient setting, we recommend the following C-code:

C1763	**Connective tissue, nonhuman (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. [This excludes those items that are used to replace skin.]**
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.**

Physician coding and reimbursement

		Ambulatory surgery center	Outpatient hospital		Physician's services
CPT Code	Description	Facility payment (national Medicare avg)[1]	APC	Facility payment (national Medicare avg)[2]	Fee when procedure is performed in hospital or ASC (national Medicare avg)[3]
45110	Proctectomy; complete, combined abdominoperineal, with colostomy	This service is not included on Medicare's list of approved procedures.	Inpatient procedure (not paid under OPPS)		$1,771.13
45111	Proctectomy; partial resection of rectum, transabdominal approach	This service is not included on Medicare's list of approved procedures.			$1,065.82
45114	Proctectomy, partial, with anastomosis; abdominal and transsacral approach	This service is not included on Medicare's list of approved procedures.			$1,781.28
45116	Proctectomy, partial, with anastomosis; transsacral approach only (Kraske type)	This service is not included on Medicare's list of approved procedures.			$1,503.29
45123	Proctectomy, partial, without anastomosis, perineal approach	This service is not included on Medicare's list of approved procedures.			$1,087.76
45130	Excision of rectal procidentia, with anastomosis; perineal approach	This service is not included on Medicare's list of approved procedures.			$1,059.60

45171	Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)	$1,349.09	5313	$2,678.02	$609.04
45172	Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)	$1,349.09	5313	$2,678.02	$810.42
45190	Destruction of rectal tumor (eg, electrodesiccation, electrosurgery, laser ablation, laser resection, cryosurgery) transanal approach	$1,349.09	5313	$2,678.02	$686.65
45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy	This service is not included on Medicare's list of approved procedures.	Inpatient procedure (not paid under OPPS)		$1,905.71
45397	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed				$2,061.90
45400	Laparoscopy, surgical; proctopexy (for prolapse)				$1,105.77
45402	Laparoscopy, surgical; proctopexy (for prolapse), with sigmoid resection				$1,478.40
45540	Proctopexy (eg, for prolapse); abdominal approach				$1,025.88
45541	Proctopexy (eg, for prolapse); perineal approach	$1,349.09	5313	$2,678.02	$920.44

45550	**Proctopexy (eg, for prolapse); with sigmoid resection, abdominal approach**	**This service is not included on Medicare's list of approved procedures.**	**Inpatient procedure (not paid under OPPS)**		**$1,417.50**
45990	**Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic**	**$1,349.09**	**5313**	**$2,678.02**	**$103.47**
46700	**Anoplasty, plastic operation for stricture; adult**	**$1,349.09**	**5313**	**$2,678.02**	**$643.75**
46705	**Anoplasty, plastic operation for stricture; infant**	**This service is not included on Medicare's list of approved procedures.**	**Inpatient procedure (not paid under OPPS)**		**$566.15**
46710	**Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; transperineal approach**				**$1,093.00**
46712	**Repair of ileoanal pouch fistula/sinus (eg, perineal or vaginal), pouch advancement; combined transperineal and transabdominal approach**				**$2,171.60**

Note: Alternative payment policies may apply when multiple services are performed at the same encounter, including but not limited to multiple procedure payment reductions and comprehensive ambulatory payment classifications (C-APC).

CMS search (LCDs)

Contact your medical director

Medicare fee schedules

Physician fee schedule look-up tool

Contact the reimbursement team
reimbursement@cookbiotech.com

Biodesign®
BIOLOGIC GRAFT PORTFOLIO

Disclaimer: The information provided herein reflects Cook Biotech's understanding of the procedure(s) and/or devices(s) from sources that may include, but are not limited to, the CPT® coding system, Medicare payment systems, commercially available coding guides, professional societies, and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third-party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. We encourage you, when making coding decisions, to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor, and other health plans to which you may submit claims. Cook Biotech does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. Cook Biotech does not promote the off-label use of its devices.

The reimbursement rates provided are national Medicare averages published by CMS at the time this guide was created. Reimbursement rates may change due to addendum updates Medicare publishes throughout the year and may not be reflected on the guide.

1. 2024 Medicare Ambulatory Surgery Center Fee Schedule
2. 2024 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule
3. 2024 Medicare Physician Fee Schedule