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GUIDEPOINT
Reimbursement Resources

The Symphion™ System

2016 Coding & Payment Quick Reference

THINGS YOU SHOULD KNOW

- Approximately 93% of myomectomy patients and 88% of polypectomy patients are non-Medicare (private payer, Medicaid, etc.)
- National private payer reimbursements average approximately 200% of Medicare.

NOTE: Private payer reimbursement is highly variable and is based on individual provider contract.

CODING

The following codes are thought to be relevant to hysteroscopic myomectomy or polypectomy procedures and are referenced throughout this guide.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

CPT® Code	Description
58555	Hysteroscopy, diagnostic (separate procedure)
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D & C
58561	Hysteroscopy, surgical; with removal of leiomyomata
58559	Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)
58560	Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)

Possible CPT® Code Modifiers for hysteroscopic myomectomy or polypectomy procedures include:

Modifier	Description
22	Increased Procedural Services
52	Reduced Services
53	Discontinued Services

CPT® modifiers source: AMA's "CPT® 2016 Professional Edition."

Physician Relative Value Units (RVUs)

Physician Relative Value Units (RVUs) are based on the Medicare 2016 Physician Fee Schedule effective January 1, 2016

	Office-Based[1]				Facility-Based[1]			
CPT® Code	Work RVU	Practice RVU	Malpractice RVU	Total RVUs	Work RVU	Practice RVU	Malpractice RVU	Total RVUs
58555	3.33	5.08	0.40	**8.81**	3.33	1.65	0.40	**5.38**
58558	4.74	6.13	0.59	**11.46**	4.74	2.25	0.59	**7.58**
58561	**See Note**				9.99	4.31	1.22	**15.52**
58559	**See Note**				6.16	2.78	0.76	**9.70**
58560	**See Note**				6.99	3.11	0.83	**10.93**

Note: There are no current Medicare valuations for these procedures performed in the physician office setting.
See important notes on the uses and limitations of this information on page 3.
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Payment – Medicare

All rates shown are 2016 Medicare national averages; actual rates will vary geographically and/or by individual facility.

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	Physician[1]			Facility[1]	
CPT® Code	MD In-Office Medicare Allowed Amount[2]	MD In-Facility Medicare Allowed Amount[2]	APC	Hospital Outpatient Medicare Allowed Amount[2,3]	ASC Medicare Allowed Amount[2,4]
58555	$316	$193	5414	$1,861	$1,041
58558	$411	$272	5414	$1,861	$1,041
58561	See Note	$556	5415	$3,660	$1,810
58559	See Note	$348	5415	$3,660	$1,810
58560	See Note	$392	5415	$3,660	$1,810

NOTE: There are no current Medicare valuations for CPT® Codes 58561, 58559, or 58560 performed in the physician office setting.

Hospital Inpatient Allowed Amounts – Medicare

The ICD-10 diagnosis codes shown below are most commonly used when documenting the diagnosis of the patient undergoing a hysteroscopic myomectomy or polypectomy. When complications or comorbidities are present as a secondary diagnosis, it can affect MS-DRG assignment.

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ICD-10-PCS Procedure Code	Description
0UB98ZX	Excision of uterus, via natural or artificial opening endoscopic, diagnostic
0UB98ZZ	Excision of uterus, via natural or artificial opening endoscopic
0UDB8ZX	Extraction of endometrium, via natural or artificial opening endoscopic, diagnostic
0UDB8ZZ	Extraction of endometrium, via natural or artificial opening endoscopic
0UJD8ZZ	Inspection of Uterus and Cervix, Via Natural or Artificial Opening Endoscopic

ICD-10-CM Diagnosis Code	Description
D25.0	Submucous leiomyoma of uterus
D25.1	Intramural leiomyoma of uterus
N84.0	Polyp of corpus uteri
N92.0	Excessive and frequent menstruation with regular cycle
N92.1	Excessive and frequent menstruation with irregular cycle

Possible MS-DRG Assignment[6]	Description	Reimbursement[5]
742	Uterine and adnexa procedures for nonmalignancy with complication or comorbidity (CC) / major complication or comorbidity (MCC	$9,203
743	Uterine and adnexa procedures for nonmalignancy without CC/MCC	$5,958

See important notes on the uses and limitations of this information on page 3.

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The Symphion™ System is intended to distend the uterus by filling it with saline to facilitate viewing with a hysteroscope during diagnostic and operative hysteroscopy and provide fluid management through the closed loop recirculation of filtered distension fluid. It is also intended for resection and coagulation of uterine tissue such as intrauterine polyps and myomas using a bipolar resecting device.

Please note: this coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved.

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Caution: Federal (U.S.) law restricts this device to sale by or on the order of a physician.

1. Department of Health and Human Services. Center for Medicare and Medicaid Services. CMS Physician Fee Schedule – January 2016 release, RVU16A file https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU16A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending The 2016 National Average Medicare physician payment rates have been calculated using a 2016 conversion factor of $35.8279. Rates subject to change.
2. "Allowed Amount" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance, etc.
3. Hospital outpatient payment rates are 2016 Medicare OPPS Addendum B national averages. Source: CMS OPPS - January 2016 release, CMS-1633-FC https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
4. ASC payments rates are 2016 Medicare ASC national averages. ASC rates are from the 2016 Ambulatory Surgical Center Covered Procedures List - Addendum AA. Source: January 2016 release, CMS-1633-FC; CMS-1607-F2 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1633-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
5. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,904.74). Source: August 17, 2015 Federal Register; CMS-1632-F Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2015 Rates.
6. The patient's medical record must support the existence and treatment of the complication or comorbidity.

Sequestration Disclaimer
Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2016.

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