2020 Urinary Incontinence Reimbursement Fact Sheet

Finding the appropriate ICD-10-PCS Code[1]

STEP 1: Using the table below, select the appropriate codes from each column in the respective order.

Procedure Code	Body Part	Approach	Device	Qualifier
0TU: Supplement/Urinary System	C Bladder Neck	0 Open 4 Percutaneous Endoscopic 7 Via natural or artificial opening 8 Via Natural or Artificial Opening Endoscopic	7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous tissue substitute	Z No Qualifier
0TU: Supplement/Urinary System	D Urethra	0 Open 4 Percutaneous Endoscopic 7 Via natural or artificial opening 8 Via Natural or Artificial Opening Endoscopic X External	7 Autologous Tissue Substitute J Synthetic Substitute K Nonautologous tissue substitute	Z No Qualifier

STEP 2: Combine the code in the respective order from left to right. This is your ICD-10-PCS Code.

For example, the code for **Reposition Urethra, Open Approach (0TSD0ZZ)** would be created in the steps below:

Example: STEP 1: Procedure Code 0TS + Body Part D + Approach 0 + Device Z + Qualifier Z = **STEP 2: 0TSD0ZZ**

Surgeon CPT, APC & DRG Codes

SURGEON CPT CODE[2]	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT[3]
	Sling Operation	
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	$ 765
51990	Laparoscopy, surgical; urethral suspension for stress incontinence	$ 779
51992	Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)	$ 877

OUTPATIENT FACILITY
Hospital Outpatient Department

APC	APC DESCRIPTION	STATUS INDICATOR	MEDICARE PAYMENT[4]
5415	Level 5 Gynecologic Procedures (CPT Code: 57288)	J1	$ 4,271
5361	Level I Laparoscopy & Related Services (CPT Codes: 51990, 51992)	J1	$ 4,833

Ambulatory Surgery Center

CPT CODE	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT[5]
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	$ 2,452
51990	Laparoscopy, surgical; urethral suspension for stress incontinence	N/A
51992	Laparoscopy, surgical; sling operation for stress incontinence (eg, fascia or synthetic)	$ 2,924

NOTE: CPT code 51990 is not approved for ASC by Medicare.

INPATIENT FACILITY

DRG	DESCRIPTION*	AVERAGE LENGTH OF STAY (DAYS)[6]	NATIONAL AVERAGE DRG PAYMENT[7]
662	Minor Bladder Procedures with MCC	10.2	$ 19,823
663	Minor Bladder Procedures with CC	4.9	$ 9,542
664	Minor Bladder Procedures without CC/MCC	2.3	$ 6,931
748	Female Reproductive System Reconstructive Procedures	2.0	$ 8,279

*CC stands for Complications and Comorbidities while MCC refers to Major Complications and Comorbidities. These are a measure of the severity of an illness indicating additional diagnoses present on a case that MAY increase the expected resource consumption beyond that of the same case without a CC or MCC under the current Medicare definition. Whether a complication or comorbidity is classified as a CC or MCC is defined by Medicare.

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Ethicon Reimbursement Support Services – (888) 750-1242

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