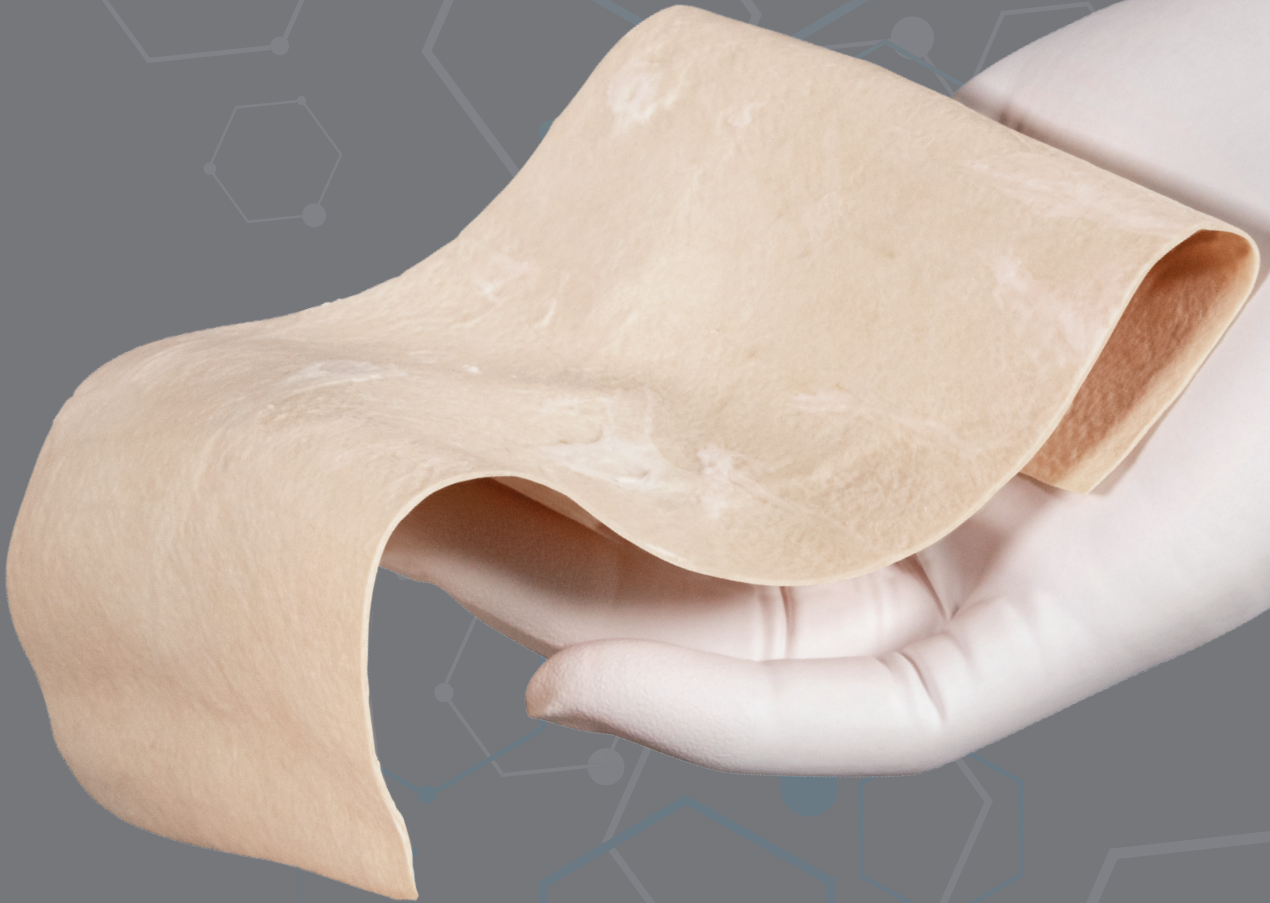


MiroFlex[®]

Biologic Matrix

2022 Coding and Billing Guide



Disclaimer: This information is for educational/informational purposes only and should not be construed as authoritative. The information presented here is current as of January 2022 and is based upon publicly available source information. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third party payors is solely responsible for the accuracy of the codes assigned to the services or items in the medical record. When making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS your local Medicare Administrative Contractor and other health plans to which you submit claims. Items and services that are billed to payors must be medically necessary and supported by appropriate documentation. It is important to remember that while a code may exist describing certain procedures and/or technologies, it does not guarantee payment by payors.

HCPCS and CPT coding is universal, however, coverage and payment of medical and surgical services can vary among government (Medicare, Medicaid, TRICARE) and private health insurance companies. The procedures described in this reimbursement guide are widely covered by government and commercial insurers when MiroFlex Biologic Matrix is applied in hospitals (both in and outpatient), ambulatory surgery centers (ASCs) and clinic-based practices. Accurate coding is important to guide how MiroFlex and the surgical procedures it is used with are covered and paid appropriately. Commercial insurer payment methodologies and payment levels will vary from Medicare and other government payers. It is not possible to capture all insurers' payment methodologies in this guide. Providers should contact their patients' insurers directly to obtain information on unique billing, coverage and payment requirements.

Reprise[∞]
Biomedical™

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Customer Service:
952-377-8238

customerservice@reprisebio.com



MiroFlex® Biologic Matrix is intended to be implanted to reinforce soft tissue, and is also intended for implantation to reinforce soft tissue where weakness exists in patients requiring soft tissue repair or reinforcement in plastic and reconstructive surgery. See Instructions For Use (IFU) for full prescribing information, including indications, contraindications, precautions, and potential complications.

MiroFlex is a biological matrix for soft tissue reinforcement used by surgeons in hernia repair. MiroFlex is manufactured using Reprise Biomedical’s proprietary technology, a method to decellularize whole or partial organs and tissues. The technology is based on removing cells while maintaining an extracellular matrix or scaffold with its original architecture and an extensive natural vascular network. MiroFlex was originally cleared for marketing by FDA under the 510(k) program (K134033).

MiroFlex Ordering Information

Model	SIZE (cm)	TOTAL CM ²
BLM-100-01-0608	6cm x 8cm	48
BLM-100-01-0808	8cm x 8cm	64
BLM-100-01-1010	10cm x 10cm	100
BLM-100-01-0816	8cm x 16cm	128
BLM-100-01-1016	10cm x 16cm	160
BLM-100-01-1020	10cm x 20cm	200

PLACING AN ORDER

Email: customerservice@reprisebio.com

Phone: 952-377-8238 or Fax: 952-856-5085

Winter Shipping (October 1st – April 30th):

- All orders (Monday – Friday) ship FedEx2Day (The customer can elect to have product shipped FedEx Priority Overnight and pay the shipping difference)
- Thursday shipments will be delivered on Monday
- Friday shipments will be delivered on Tuesday

Summer Shipping (May 1st – September 30th):

- All orders ship FedEx Priority Overnight, at no extra charge to the customer.
- No Friday shipments unless Saturday delivery is requested, available, and paid for by the customer.

Billing questions: ap@reprisebio.com or Phone: 763-284-6771

Product Coding

MiroFlex Biologic Matrix does not hold a product-specific HCPCS code. The following codes are options for providers to specifically identify MiroFlex Biologic Matrix.

HCPCS CODE	
HCPCS	DESCRIPTION
A4649	Surgical Supply, Miscellaneous

REVENUE CODE	
Revenue codes are 4-digit numbers used on a hospital bill to provide detail on where a patient received treatment or type of item received.	
REVENUE CODE	DESCRIPTION
278	Other implant

Recommendations only. Providers are encouraged to check internal Coding and Charge Master guidance and SOPs for appropriate billing of all procedures and products provided.

Place-of-Service Codes¹

Place-of-service codes are 2-digit numbers included on health care professional claims to indicate the setting in which a service was provided. The Centers for Medicare and Medicaid Services (CMS) maintain place-of-service codes used throughout the health care industry. Listed below are place-of-service and descriptions that typically apply to our products. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payors for reimbursement policies regarding these codes.

PLACE-OF-SERVICE CODE	PLACE-OF-SERVICE NAME	PLACE-OF-SERVICE DESCRIPTION
11	Office	Location other than hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or Local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location other than a hospital or other facility, where the patient receives care in a private residence.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. Description change effective January 1, 2016.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

1. https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

ICD-10-CM Diagnosis Codes¹

The ICD-10[®]-CM codes listed below represent some of the etiology diagnosis codes commonly associated with causes of hernia repair. This is not meant to be an exhaustive list.

ICD-10-CM	DESCRIPTION
K40.00	Bilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent
K40.01	Bilateral inguinal hernia, with obstruction, without gangrene, recurrent
K40.10	Bilateral inguinal hernia, with gangrene, not specified as recurrent
K40.11	Bilateral inguinal hernia, with gangrene, recurrent
K40.20	Bilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
K40.21	Bilateral inguinal hernia, without obstruction or gangrene, recurrent
K40.30	Unilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent
K40.31	Unilateral inguinal hernia, with obstruction, without gangrene, recurrent
K40.40	Unilateral inguinal hernia, with gangrene, not specified as recurrent
K40.41	Unilateral inguinal hernia, with gangrene, recurrent
K40.90	Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
K40.91	Unilateral inguinal hernia, without obstruction or gangrene, recurrent
K41.00	Bilateral femoral hernia, with obstruction, without gangrene, not specified as recurrent
K41.01	Bilateral femoral hernia, with obstruction, without gangrene, recurrent
K41.10	Bilateral femoral hernia, with gangrene, not specified as recurrent
K41.11	Bilateral femoral hernia, with gangrene, recurrent
K41.20	Bilateral femoral hernia, without obstruction or gangrene, not specified as recurrent
K41.21	Bilateral femoral hernia, without obstruction or gangrene, recurrent
K41.30	Unilateral femoral hernia, with obstruction, without gangrene, not specified as recurrent
K41.31	Unilateral femoral hernia, with obstruction, without gangrene, recurrent
K41.40	Unilateral femoral hernia, with gangrene, not specified as recurrent
K41.41	Unilateral femoral hernia, with gangrene, recurrent
K41.90	Unilateral femoral hernia, without obstruction or gangrene, not specified as recurrent
K41.91	Unilateral femoral hernia, without obstruction or gangrene, recurrent
K42.0	Umbilical hernia with obstruction, without gangrene
K42.1	Umbilical hernia with gangrene
K42.9	Umbilical hernia without obstruction or gangrene
K43.0	Incisional hernia with obstruction, without gangrene
K43.1	Incisional hernia with gangrene
K43.2	Incisional hernia without obstruction or gangrene
K43.3	Parastomal hernia with obstruction, without gangrene
K43.4	Parastomal hernia with gangrene
K43.5	Parastomal hernia without obstruction or gangrene
K43.6	Other and unspecified ventral hernia with obstruction, without gangrene
K43.7	Other and unspecified ventral hernia with gangrene
K43.9	Ventral hernia without obstruction or gangrene
K44.0	Diaphragmatic hernia with obstruction, without gangrene
K44.1	Diaphragmatic hernia with gangrene
K44.9	Diaphragmatic hernia without obstruction or gangrene
K45.0	Other specified abdominal hernia with obstruction, without gangrene
K45.1	Other specified abdominal hernia with gangrene
K45.8	Other specified abdominal hernia without obstruction or gangrene
K46.0	Unspecified abdominal hernia with obstruction, without gangrene
K46.1	Unspecified abdominal hernia with gangrene
K46.9	Unspecified abdominal hernia without obstruction or gangrene
Q40.1	Congenital hi atus hernia
Q79.0	Congenital diaphragmatic hernia
Q79.51	Congenital hernia of bladder

1. The International Classification of Diseases Clinical Modification Edition 9 is developed by the National Center for Health Statistics (NCHS). ICD-9 CM and ICD-10 CM are copyrighted by the World Health Organization. WHO is the copyright holder of ICD-10, and can grant licenses for the use of ICD-10 worldwide for commercial and non-commercial uses.

ICD-10-CM Procedure Coding¹

Hospital inpatient procedures are billed with ICD-10 CM Procedure Codes. These procedure codes are mapped to specific Diagnosis Related Groups (DRGs) for payment. Private payor claims processing protocol can vary, but often use the same DRG Grouper as Medicare resulting in assignment to the same DRGs.

NOTE: This list is not all inclusive. These procedure codes, when combined with appropriate ICD-10 CM diagnosis codes are typically mapped to DRGs for payment. The ICD-10 PCS system provides greater granularity in the reporting of procedures. See DRG Coding and Payment section of this guide for additional details.

ICD-10 PCS PROCEDURE CODES	
INCISIONAL HERNIA REPAIR	
OWQF0ZZ	Repair Abdominal Wall, Open Approach
OWQF3ZZ	Repair Abdominal Wall, Percutaneous Approach
OWQF4ZZ	Repair Abdominal Wall, Percutaneous Endoscopic Approach
REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL	
OWQF0ZZ	Repair Abdominal Wall, Open Approach
OWQF3ZZ	Repair Abdominal Wall, Percutaneous Approach
OWQF4ZZ	Repair Abdominal Wall, Percutaneous Endoscopic Approach
OTHER OPEN INCISIONAL HERNIA REPAIR WITH GRAFT OF PROSTHESIS	
OWUF07Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Open Approach
OWUF0JZ	Supplement Abdominal Wall with Synthetic Substitute, Open Approach
OWUF0KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Open Approach
LAPAROSCOPIC INCISIONAL HERNIA REPAIR WITH GRAFT OR PROSTHESIS	
OWUF47Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
OWUF4JZ	Supplement Abdominal Wall with Synthetic Substitute, Percutaneous Endoscopic Approach
OWUF4KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
OTHER LAPAROSCOPIC REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL WITH GRAFT OR PROSTHESIS	
OWUF47Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
OWUF4JZ	Supplement Abdominal Wall with Synthetic Substitute, Percutaneous Endoscopic Approach
OWUF4KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
OTHER AND OPEN REPAIR OF OTHER HERNIA OF ANTERIOR ABDOMINAL WALL WITH GRAFT OR PROSTHESIS	
OWUF07Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Open Approach
OWUF0JZ	Supplement Abdominal Wall with Synthetic Substitute, Open Approach
OWUF0KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Open Approach
OWUF47Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
OWUF4JZ	Supplement Abdominal Wall with Synthetic Substitute, Percutaneous Endoscopic Approach
OWUF4KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
LAPAROSCOPIC REPAIR OF DIAPHRAGMATIC HERNIA, ABDOMINAL APPROACH	
OBQR4ZZ	Repair Right Diaphragm, Percutaneous Endoscopic Approach
OBQS4ZZ	Repair Left Diaphragm, Percutaneous Endoscopic Approach
REPAIR OF DIAPHRAGMATIC HERNIA, ABDOMINAL APPROACH, NOT OTHERWISE SPECIFIED	
OBQR0ZZ	Repair Right Diaphragm, Open Approach
OBQR3ZZ	Repair Right Diaphragm, Percutaneous Approach
OBQR4ZZ	Repair Right Diaphragm, Percutaneous Endoscopic Approach
OBQS0ZZ	Repair Left Diaphragm, Open Approach
OBQS3ZZ	Repair Left Diaphragm, Percutaneous Approach
OBQR4ZZ	Repair Left Diaphragm, Percutaneous Endoscopic Approach

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ICD-10-CM Procedure Coding¹ (continued)

ICD-10 PCS PROCEDURE CODES	
REPAIR OF DIAPHRAGMATIC HERNIA, THORACIC APPROACH, NOT OTHERWISE SPECIFIED	
OBQR0ZZ	Repair Right Diaphragm, Open Approach
OBQR3ZZ	Repair Right Diaphragm, Percutaneous Approach
OBQR4ZZ	Repair Right Diaphragm, Percutaneous Endoscopic Approach
OBQS0ZZ	Repair Left Diaphragm, Open Approach
OBQS3ZZ	Repair Left Diaphragm, Percutaneous Approach
OBQR4ZZ	Repair Left Diaphragm, Percutaneous Endoscopic Approach
APPLICATION OF THE DIAPHRAGM	
OBQR0ZZ	Repair Right Diaphragm, Open Approach
OBQR3ZZ	Repair Right Diaphragm, Percutaneous Approach
OBQR4ZZ	Repair Right Diaphragm, Percutaneous Endoscopic Approach
OBQS0ZZ	Repair Left Diaphragm, Open Approach
OBQS3ZZ	Repair Left Diaphragm, Percutaneous Approach
OBQR4ZZ	Repair Left Diaphragm, Percutaneous Endoscopic Approach
REPAIR OF PARASTERNAL HERNIA	
OBQR0ZZ	Repair Right Diaphragm, Open Approach
OBQR3ZZ	Repair Right Diaphragm, Percutaneous Approach
OBQR4ZZ	Repair Right Diaphragm, Percutaneous Endoscopic Approach
OBQS0ZZ	Repair Left Diaphragm, Open Approach
OBQS3ZZ	Repair Left Diaphragm, Percutaneous Approach
OBQR4ZZ	Repair Left Diaphragm, Percutaneous Endoscopic Approach
LAPAROSCOPIC REPAIR OF DIAPHRAGMATIC HERNIA, THORACIC APPROACH	
OBQR4ZZ	Repair Right Diaphragm, Percutaneous Endoscopic Approach
OBQS4ZZ	Repair Left Diaphragm, Percutaneous Endoscopic Approach
OTHER AND OPEN REPAIR OF DIAPHRAGMATIC HERNIA, WITH THORACIC APPROACH	
OBQR0ZZ	Repair Right Diaphragm, Open Approach
OBQR3ZZ	Repair Right Diaphragm, Percutaneous Approach
OBQS0ZZ	Repair Left Diaphragm, Open Approach
OBQS3ZZ	Repair Left Diaphragm, Percutaneous Approach

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ICD-10-CM Procedure Coding¹ (continued)

ICD-10 PCS PROCEDURE CODES	
OTHER HERNIA REPAIR	
ODQS0ZZ	Repair Greater Omentum, Open Approach
ODQS3ZZ	Repair Greater Omentum, Percutaneous Approach
ODQS4ZZ	Repair Greater Omentum, Percutaneous Endoscopic Approach
ODQT0ZZ	Repair Lesser Omentum, Open Approach
ODQT3ZZ	Repair Lesser Omentum, Percutaneous Approach
ODQT4ZZ	Repair Lesser Omentum, Percutaneous Endoscopic Approach
ODQS0ZZ	Repair Back Subcutaneous Tissue and Fascia, Open Approach
OJQ73ZZ	Repair Back Subcutaneous Tissue and Fascia, Percutaneous Approach
OJQC0ZZ	Repair Pelvic Region Subcutaneous Tissue and Fascia, Open Approach
OJQC3ZZ	Repair Pelvic Region Subcutaneous Tissue and Fascia, Percutaneous
OJQM0ZZ	Repair Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach
OJQM3ZZ	Repair Left Upper Leg Subcutaneous Tissue and Fascia, Open Approach
OJQN0ZZ	Repair Right Lower Leg Subcutaneous Tissue and Fascia, Open Approach
OJQN3ZZ	Repair Right Lower Leg Subcutaneous Tissue and Fascia, Percutaneous Approach
OWQF0ZZ	Repair Abdominal Wall, Open Approach
OWQF3ZZ	Repair Abdominal Wall, Percutaneous Approach
OWQF4ZZ	Repair Abdominal Wall, Percutaneous Endoscopic Approach
OWUF07Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Open Approach
OWUF47Z	Supplement Abdominal Wall with Synthetic Substitute, Open Approach
OWUF0KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Open Approach
OWUF47Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Percutaneous Endoscopic Approach
OWUF4JZ	Supplement Abdominal Wall with Synthetic Substitute, Percutaneous Endoscopic Approach
OWUF4KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach
OTHER REPAIR OF ABDOMINAL WALL	
OWMF0ZZ	Reattachment of Abdominal Wall, Open Approach
OWQF0ZZ	Repair Abdominal Wall, Open Approach
OWQF3ZZ	Repair Abdominal Wall, Percutaneous Approach
OWQF4ZZ	Repair Abdominal Wall, Percutaneous Endoscopic Approach
OWQFXZZ	Repair Abdominal Wall, External Approach
OWUF07Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Open Approach
OWUF0JZ	Supplement Abdominal Wall with Synthetic Substitute, Open Approach
OWUF0KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Open Approach
OWUF47Z	Supplement Abdominal Wall with Autologous Tissue Substitute, Percutaneous Endoscopic Approach 0WUF4JZ
OWUF4JZ	Supplement Abdominal Wall with Synthetic Substitute, Percutaneous Endoscopic Approach
OWUF4KZ	Supplement Abdominal Wall with Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach

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2022 Inpatient Hospital Coding/Payment - Medicare

Hospital inpatient procedures are billed with ICD-10-CM procedure codes. These procedure codes are mapped to specific Medicare Diagnosis Related Groups (DRGs) for payment. Private payer claims processing protocol can vary, but often use the same DRG Grouper as Medicare. Payment for private payers will differ per contract, payer and patient benefits.

The table below provides potential MS-DRGs assignments for hospitals when applying MiroFlex Biologic Matrix. These are 2022 Medicare average rates and are provided as a benchmark. Rates nationwide can vary widely.

DRG ^{1,2}	Description	DRG WEIGHT	MEDICARE PAYMENT ^{3,4}
326	Stomach, esophageal & duodenal procedures with MCC	5.3163	\$32,544
327	Stomach, esophageal & duodenal procedures with CC	2.5647	\$15,700
328	Stomach, esophageal & duodenal procedures without CC/MCC	1.6669	\$10,204
347	Anal & stomal procedures with MCC	2.4647	\$15,088
348	Anal & stomal procedures with CC	1.3481	\$8,253
349	Anal & stomal procedures without CC/MCC	0.9793	\$5,995
350	Inguinal & femoral hernia procedures with MCC	2.4548	\$15,028
351	Inguinal & femoral hernia procedures with CC	1.4927	\$9,138
352	Inguinal & femoral hernia procedures without CC/MCC	1.1044	\$6,761
353	Hernia procedures except inguinal & femoral with MCC	3.0249	\$18,518
354	Hernia procedures except inguinal & femoral with CC	1.7848	\$10,926
355	Hernia procedures except inguinal & femoral without CC/MCC	1.3602	\$8,327

2022 Medicare payments are based on a factor of \$6,121.71 weight of one. They do not include adjustments for Disproportionate Share or Direct or Indirect Medical Education. These allowances are effective as of October 1, 2021.

Hernia repair will routinely fall into one of the these 12 DRGs. The exact assignment is dependent upon the presence or absence of Complications and Comorbidities (CC) or Major Complications or Comorbidities (MCC). These payment assignments also assume the hernia repair is the primary procedure.

Hospital inpatient procedures are billed with ICD-10 CM Procedure Codes. These procedure codes are mapped to specific Diagnosis Related Groups (DRGs) for payment. Private payor claims processing protocol can vary, but often use the same DRG Grouper as Medicare resulting in assignment to the same DRGs.

NOTE: This list is not all inclusive. These procedure codes, when combined with appropriate ICD-10 CM diagnosis codes get mapped to DRGs for payment. The ICD-10 PCS system provides greater granularity in the reporting of procedures.

1. The International Classification of Diseases Clinical Modification Edition 9 is developed by the National Center for Health Statistics (NCHS). ICD-9 CM and ICD-10 CM are copyrighted by the World Health Organization. WHO is the copyright holder of ICD-10, and can grant licenses for the use of ICD-10 worldwide for commercial and non-commercial uses.
2. 2022 MS-DRG relative weight multiplied by 2022 rate of \$6,121.71 per IPPS Final Rule as calculated by MCRA, payment rates will vary by facility. Calculation includes labor related, non-labor related and capital rates. EX-20-032.
3. Medicare reimburses hospital inpatient stays based on the Medicare Severity Diagnosis Related Group (MS-DRG) system. MS-DRGs represent a consolidated prospective payment for all services provided by the hospital during hospitalization, based on submitted claims data. With limited exceptions, the MS-DRG payment is inclusive of all services, products, and resources, regardless of the final cost to the hospital. Medicare and many private payors use the MS-DRG based system to reimburse facilities for inpatient services.
4. Reference: <https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ippa-final-rule-home-page>

2022 Hospital Outpatient/ASC - Medicare

Hospital outpatient departments and Ambulatory Surgery Centers (ASCs) submit CPT codes to government and private payers. These CPT codes are then mapped to specific comprehensive Ambulatory Payment Classification (APCs) (hospitals) or a fee schedule (ASC) for Medicare payment.

Under Medicare, non-hospitalized hernia repair procedures are categorized into one of the following 3 payments levels for hospitals/ASCs as described below.

See CPT Coding Section of this guide for CPT coding details.

DESCRIPTION*	HOSPITAL OUTPATIENT NATIONAL AVG	ASC NATIONAL AVG
APC: 5341 - Abdominal/Peritoneal/Biliary and Related Procedures	\$3,265	\$3,249
APC: 5361 - Level 1 Laparoscopy and Related Services	\$5,193	\$5,167
APC: 5362 - Level 2 Laparoscopy and Related Services	\$9,139	\$9,096

*These surgeries may be performed via laparoscopy or open procedure.

Coinsurance/Deductibles: As with all products and services paid for under Medicare Parts A & B, Medicare will reimburse 80 percent of the allowable amount. The patient, or secondary/supplemental plan, is responsible for the remaining, 20 percent coinsurance amount. The appropriate annual deductions also apply.

Sequestration¹: Since April 1, 2013, all Medicare claims with date-of-service on or after April 1 2013 are subjected to a 2 percent sequestration amount, which remains in effect in the U.S. budget until 2022. Please note, the 2 percent is deducted from the 80 percent allowable amount paid by Medicare and not the coinsurance amount.

Geographic Practice Cost Index (GPCI)²: The Medicare physician fee schedule amounts are adjusted to reflect the variation in practice costs from area to area. A GPCI has been established for every Medicare payment locality based on the RVUs for work, practice expense, and malpractice. The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

1. Sequestration applies to all providers. On December 10, 2021, President Biden signed into law: s.610, the "Protecting Medicare and American Farmers from Sequester Cuts Act," which delays the Medicare sequester and makes other changes to Medicare payments. The moratorium on sequestration is extended through March 31, 2022 and the sequestration cut is reduced to 1% from April to June 30, 2022. In effect, providers won't see any Medicare payment reductions until April 1, 2022, with the full sequestration cut in effect beginning July 1, 2022. The updated Medicare Physician Fee Schedule Conversion Factor for CY 2022 is \$34.6062.

2. Reference: <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/cms-1753-fc>

CPT is a registered trademark of the American Medical Association.

2022 Outpatient/ASC Coding and Payment - Medicare

The Current Procedural Terminology (CPT) code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payors for administrative, financial, and analytical purposes.

The following CPT codes map to specific APCs and represent the most commonly performed hernia repair procedures. “IP Only” means the procedure is only performed in a hospital inpatient - refer to the section on inpatient hospital coding and payment and physician CPT coding and payment for additional information.

CPT ^{1,2}	Description	APC	HOPPS Nat Avg	ASC Nat Avg
HERNIA PROCEDURES				
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	5051	\$18,431	\$17,955
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy, reducible	5341	\$3,265	\$3,249
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	5341	\$3,265	\$3,249
49505	Repair initial inguinal hernia, age 5 years or older; reducible	5341	\$3,265	\$3,249
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	5341	\$3,265	\$3,249
49520	Repair recurrent inguinal hernia, any age; reducible	5341	\$3,265	\$3,249
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	5341	\$3,265	\$3,249
49525	Repair inguinal hernia, sliding, any age	5341	\$3,265	\$3,249
49550	Repair initial femoral hernia, any age; reducible	5341	\$3,265	\$3,249
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	5341	\$3,265	\$3,249
49555	Repair recurrent femoral hernia; reducible	5341	\$3,265	\$3,249
49557	Repair recurrent femoral hernia; incarcerated or strangulated	5341	\$3,265	\$3,249
49560	Repair initial incisional or ventral hernia; reducible	5341	\$3,265	\$3,249
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	5341	\$3,265	\$3,249
49565	Repair recurrent incisional or ventral hernia; reducible	5361	\$5,193	\$5,168
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	5361	\$5,193	\$5,168
49580	Repair umbilical hernia, younger than age 5 years; reducible	5341	\$3,265	\$3,249
49582	Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated	5341	\$3,265	\$3,249
49585	Repair umbilical hernia, age 5 years or older; reducible	5341	\$3,265	\$3,249
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	5341	\$3,265	\$3,249
LAPAROSCOPY PROCEDURES				
44238	Unlisted laparoscopy procedure, intestine (except rectum)	5361	\$5,193	\$5,168
49650	Laparoscopy, surgical; repair initial inguinal hernia	5361	\$5,193	\$5,168
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	5361	\$5,193	\$5,168
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible or 5362 with complexity adjustment \$7,741 (ASC payment would be the same)	5361	\$5,193	\$5,168
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated or 5363 with complexity adjustment	5361	\$5,193	\$5,168
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	5362	\$9,139	\$9,096
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	5362	\$9,139	\$9,096
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	5362	\$9,139	\$9,096
49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	5362	\$9,139	\$9,096
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	5361	\$5,193	\$5,168
44346	Revision of colostomy; simple (release of superficial scar) (separate procedure) with repair of paracolostomy hernia (separate procedure)	5341	\$3,265	\$3,249

1. Providers are encouraged to reference CMS Global Surgery Booklet for Coding and Billing Guidance: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalSurgery-ICN907166Printfriendly.pdf>

2. Reference: <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/cms-1753-fc>

2022 Outpatient/ASC Coding and Payment - Medicare (continued)

CPT ^{1,2}	Description	APC	HOPPS Nat Avg	ASC Nat Avg
LAPAROSCOPIC FUNDOPLASTY				
43280	Laparoscopy, surgical, esophagogastric fundoplasty (e.g., Nissen, Toupet procedures)	5362	\$9,139	\$9,096
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	5362	\$9,139	\$9,096
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	5362	\$9,139	\$9,096
43289	Unlisted laparoscopy procedure, esophagus	5361	\$5,193	\$5,168
LAPAROSCOPY PROCEDURES (IP ONLY CODES)				
44187	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube		IP Only	
44188	Laparoscopy, surgical, colostomy or skin level cecostomy			
44202	Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis			
44203	Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)			
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis			
44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy			
44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)			
44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)			
44208	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy			
44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy			
44211	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed			
44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy			
44213	Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)			
44227	Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis			
LAPAROSCOPIC REPAIR (IP ONLY CODES)				
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis		IP Only	
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis			
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis			
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis			
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis			
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis			
43338	Esophageal lengthening procedure (e.g., Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)			
OTHER (IP ONLY CODES)				
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute		IP Only	
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic			
44346	Revision of colostomy; simple (release of superficial scar) (separate procedure) with repair of paracolostomy hernia (separate procedure)			

1. Providers are encouraged to reference CMS Global Surgery Booklet for Coding and Billing Guidance: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalSurgery-ICN907166Printfriendly.pdf>

2. Reference: <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/cms-1753-fc>

2022 Physician Services - Medicare

HERNIA PROCEDURES		
CPT Code ^{1,2}	Description	Medicare National Avg
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	YYY*
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy, reducible	\$430.84
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated	\$629.14
49505	Repair initial inguinal hernia, age 5 years or older; reducible	\$541.93
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated	\$608.38
49520	Repair recurrent inguinal hernia, any age; reducible	\$656.48
49521	Repair recurrent inguinal hernia, any age; incarcerated or strangulated	\$741.61
49525	Repair inguinal hernia, sliding, any age	\$594.53
49550	Repair initial femoral hernia, any age; reducible	\$597.30
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	\$655.79
49555	Repair recurrent femoral hernia; reducible	\$627.41
49557	Repair recurrent femoral hernia; incarcerated or strangulated	\$750.26
49560	Repair initial incisional or ventral hernia; reducible	\$763.06
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated	\$959.98
49565	Repair recurrent incisional or ventral hernia; reducible	\$794.21
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated	\$968.28
49580	Repair umbilical hernia, younger than age 5 years; reducible	\$349.87
49582	Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated	\$504.21
49585	Repair umbilical hernia, age 5 years or older; reducible	\$464.06
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated	\$495.56
44187	Laparoscopy, surgical; ileostomy or jejunostomy, non-tube	\$1121.58
44188	Laparoscopy, surgical, colostomy or skin level cecostomy	\$1250.32
44202	Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis	\$1427.51
44203	Laparoscopy, surgical; each additional small intestine resection and anastomosis (List separately in addition to code for primary procedure)	\$246.05
44204	Laparoscopy, surgical; colectomy, partial, with anastomosis	\$1576.31
44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy	\$1368.68
44206	Laparoscopy, surgical; colectomy, partial, with end colostomy and closure of distal segment (Hartmann type procedure)	\$1787.41
44207	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)	\$1853.16
44208	Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis) with colostomy	\$2016.85
44210	Laparoscopy, surgical; colectomy, total, abdominal, without proctectomy, with ileostomy or ileoproctostomy	\$1807.48
44211	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileoanal anastomosis, creation of ileal reservoir (S or J), with loop ileostomy, includes rectal mucosectomy, when performed	\$2146.62
44212	Laparoscopy, surgical; colectomy, total, abdominal, with proctectomy, with ileostomy	\$2068.06
44213	Laparoscopy, surgical, mobilization (take-down) of splenic flexure performed in conjunction with partial colectomy (List separately in addition to primary procedure)	\$191.03
44227	Laparoscopy, surgical, closure of enterostomy, large or small intestine, with resection and anastomosis	\$1703.66

1. Providers are encouraged to reference CMS Global Surgery Booklet for Coding and Billing Guidance: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalSurgery-ICN907166Printfriendly.pdf>

2. Reference: <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/cms-1753-fc>

*YYY = Codes with YYY are contractor priced codes for which Medicare Administrative Contractors determine the global period and payment.

2022 Physician Services - Medicare (continued)

LAPAROSCOPY PROCEDURES		
CPT Code ^{1,2}	Description	Medicare National Avg
44238	Unlisted laparoscopy procedure, intestine (except rectum)	YYY*
49650	Laparoscopy, surgical; repair initial inguinal hernia	\$448.15
49651	Laparoscopy, surgical; repair recurrent inguinal hernia	\$585.19
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible or 5362 with complexity adjustment \$7,741 (ASC payment would be the same)	\$769.64
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated or 5363 with complexity adjustment	\$964.13
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	\$873.11
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	\$1070.02
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible	\$948.56
49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	\$1361.75
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	YYY*
44346	Revision of colostomy; simple (release of superficial scar) (separate procedure) with repair of paracolostomy hernia (separate procedure)	1214.33

LAPAROSCOPIC FUNDOPLASTY PROCEDURES		
CPT Code ¹	Description	Medicare National Avg
43280	Laparoscopy, surgical, esophagogastric fundoplasty (e.g., Nissen, Toupet procedures)	\$1112.59
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	\$1585.66
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	\$1782.57
43283	Laparoscopy, surgical, esophageal lengthening procedure (e.g., Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	\$161.96
43289	Unlisted laparoscopy procedure, esophagus	YYY*

LAPAROSCOPIC REPAIR PROCEDURES		
CPT Code ¹	Description	Medicare National Avg
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	\$1184.57
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis	\$1293.58
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	\$1270.39
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis	\$1359.33
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	\$1477.34
43337	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal;with implantation of mesh or other prosthesis	\$1574.24
43338	Esophageal lengthening procedure (e.g., Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	\$116.97

1. Providers are encouraged to reference CMS Global Surgery Booklet for Coding and Billing Guidance: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalSurgery-ICN907166Printfriendly.pdf>

2. Reference: <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/cms-1753-fc>

*YYY = Codes with YYY are contractor priced codes for which Medicare Administrative Contractors determine the global period and payment.

2022 Physician Services - Medicare (continued)

INPATIENT PROCEDURES		
CPT Code ^{1,2}	Description	Medicare National Avg
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	\$886.96
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic	\$966.20
44346	Revision of colostomy; simple (release of superficial scar) (separate procedure) with repair of paracolostomy hernia (separate procedure)	\$1214.33

Coinsurance/Deductibles: As with all products and services paid for under Medicare Parts A & B, Medicare will reimburse 80 percent of the allowable amount. The patient, or secondary/supplemental plan, is responsible for the remaining, 20 percent coinsurance amount. The appropriate annual deductions also apply.

Sequestration³: Since April 1, 2013, all Medicare claims with date-of-service on or after April 1 2013 are subjected to a 2 percent sequestration amount, which remains in effect in the U.S. budget until 2022. Please note, the 2 percent is deducted from the 80 percent allowable amount paid by Medicare and not the coinsurance amount.

Geographic Practice Cost Index (GPCI)⁴: The Medicare physician fee schedule amounts are adjusted to reflect the variation in practice costs from area to area. A GPCI has been established for every Medicare payment locality based on the RVUs for work, practice expense, and malpractice. The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

CMS Global Surgery Guidelines:

Physicians are encouraged to reference Global Surgery Booklet for Coding and Billing Guidance:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalSurgery-ICN907166Printfriendly.pdf>

1. Providers are encouraged to reference CMS Global Surgery Booklet for Coding and Billing Guidance: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GlobalSurgery-ICN907166Printfriendly.pdf>

2. Reference: <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/cms-1753-fc>

3. Sequestration applies to all providers. On December 10, 2021, President Biden signed into law: s.610, the "Protecting Medicare and American Farmers from Sequester Cuts Act," which delays the Medicare sequester and makes other changes to Medicare payments. The moratorium on sequestration is extended through March 31, 2022 and the sequestration cut is reduced to 1% from April to June 30, 2022. In effect, providers won't see any Medicare payment reductions until April 1, 2022, with the full sequestration cut in effect beginning July 1, 2022. The updated Medicare Physician Fee Schedule Conversion Factor for CY 2022 is \$34.6062.

4. 2022 AMA CPT® Professional. Procedure coding should be based upon medical necessity, procedures and supplies provided to the patient. Coding and reimbursement information is provided for educational purposes and does not assure coverage of the specific item or service in a given case. Reprise Biomedical makes no guarantee of coverage or reimbursement of fees. These payment rates are nationally unadjusted average amounts and do not account for differences in payment due to geographic variation. Contact your Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments. CPT five-digit numeric codes, descriptions, and numeric modifiers only are Copyright AMA. (Updated January 2022).

Sample Letter of Medical Necessity

Date
Insurer Name
Insurer Address
City, State, Zip Code

RE: Medical Necessity for MiroFlex Biologic Matrix

Patient's Name:
Policy Number:
Group Number:
Date of Birth:

Dear [Insurance Contact Name]:

I am writing to notify you of my intent to treat Mr./Ms. [Patient's Name] with MiroFlex Biologic Matrix, which is used to reinforce soft tissue and is also intended for implantation to reinforce soft tissue where weakness exists in patients requiring soft tissue repair or reinforcement in plastic and reconstructive surgery.

The patient's medical history is as follows: [include relevant medical history]

MiroFlex Biologic Matrix is an acellular matrix that is derived from the highly vascularized porcine liver and was cleared by the FDA under 510(k) K134033. Reprise Biomedical manufactures MiroFlex Biologic Matrix and is a medical device company focused on the development of clinically relevant biologic medical devices for the surgical and wound care space.

My patient has not responded to conservative care for [time frame] and has not responded to more advanced therapy including [product name(s) & type(s) of products]. More aggressive treatment is medically necessary to prevent further damage and [list risk(s) of non-closure]. I believe my patient will benefit from treatment with MiroFlex Biologic Matrix.

I have enclosed information regarding the clinical utility of MiroFlex.

Please feel free to contact me if additional information is required to process my request for coverage.

Sincerely,
[Name]
[Contact info]

CAUTION: Federal (USA) law restricts this device to sale by or on the order of a physician.

Refer to the Instructions for Use for a complete listing of the indications, contraindications, warnings and precautions. Information in this material is not a substitute for the product Instructions for Use.

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