

# 2012 Prolapse Hemorrhoidopexy Reimbursement Fact Sheet

SURGEON CPT CODE <sup>1</sup>	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT FACILITY <sup>2</sup>	NATIONAL AVERAGE MEDICARE PAYMENT NON-FACILITY <sup>2</sup>
45130	Excision of rectal procidentia, with anastomosis; perineal approach	\$1,085	NA
45135	Excision of rectal procidentia, with anastomosis; abdominal and perineal approach	1,354	NA
45500	Proctoplasty, for stenosis	521	NA
45505	Proctoplasty, for prolapse of mucous membrane	584	NA
45520	Perirectal injection of sclerosing solution for prolapse	40	\$151
45540	Proctopexy for prolapse, abdominal approach	1,054	NA
45541	Proctopexy for prolapse, perineal approach	922	NA
45550	Proctopexy combined with sigmoid resection, abdominal approach	1,458	NA
45900	Reduction of procidentia (separate procedure) under anesthesia	201	NA
45990	Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic	107	NA
45999*	Unlisted procedure, rectum	Carrier Priced	Carrier Priced
46947	Hemorrhoidopexy, by stapling	379	NA
46999*	Unlisted procedure, anus	Carrier Priced	Carrier Priced

\* Surgeon must submit operative report when using xx999 procedure codes.

## OUTPATIENT FACILITY

### Hospital Outpatient Department

APC	APC DESCRIPTION	MEDICARE PAYMENT <sup>3</sup>
0015	Level III Debridement & Destruction (For CPT code: 45520)	\$105
0148	Level I Anal/Rectal Procedure (For CPT codes: 45900, 45999, 46999)	389
0149	Level III Anal/Rectal Procedure (For CPT code: 45500, 45990)	1,707
0150	Level IV Anal/Rectal Procedure (For CPT codes: 45505, 45541, 46947)	2,307

### Freestanding Ambulatory Surgery Center

CPT CODE <sup>1</sup>	DESCRIPTION	MEDICARE PAYMENT <sup>4</sup>
45500	Repair of Rectum	\$985
45505	Repair of Rectum	1,331
45520	Treatment of rectal prolapse	61
45541	Correct rectal prolapse	1,331
45900	Reduction of rectal prolapse	224
45990	Surgery diagnosis exam, anorectal	985
46947	Hemorrhoidopexy, by stapling	1,331

## INPATIENT FACILITY

ICD-9 CODE <sup>5</sup>	DESCRIPTION		
17.36	Laparoscopic sigmoidectomy	48.69	Other resection of rectum
45.76	Open and other sigmoidectomy	48.75	Abdominal proctopexy
48.40	Pull-through resection of rectum, not otherwise specified	48.76	Other proctopexy
48.42	Laparoscopic pull-through resection of rectum	48.79	Other repair of rectum
48.43	Open pull-through resection of rectum	49.39	Other local excision or destruction of lesion or tissue of anus
48.50	Abdominoperineal resection of the rectum, not otherwise specified	49.49	Other procedures on hemorrhoids
48.51	Laparoscopic abdominoperineal resection of the rectum	49.79	Other repair of anal sphincter
48.52	Open abdominoperineal resection of the rectum	96.26	Manual reduction of rectal prolapse
48.59	Other abdominoperineal resection of the rectum		

NOTE: ICD-9 codes are grouped into Diagnoses Related Groups (DRGs) for Medicare reimbursement using a patient's diagnoses, procedures performed, age, sex and discharge status. One DRG is assigned to each inpatient stay.

INPATIENT FACILITY			
DRG	DESCRIPTION	AVERAGE LENGTH OF STAY (DAYS) <sup>4</sup>	NATIONAL AVERAGE DRG PAYMENT <sup>6</sup>
264	Other circulatory system O.R. procedures	8.0	\$14,405
332	Rectal resection with MCC	13.7	27,419
333	Rectal resection with CC	7.9	13,942
334	Rectal resection without CC/MCC	4.8	9,031
329	Major small & large bowel procedures with MCC	15.1	29,966
330	Major small & large bowel procedures with CC	8.9	14,591
331	Major small & large bowel procedures without CC/MCC	5.1	9,153
347	Anal & stomal procedures with MCC	8.8	14,264
348	Anal & stomal procedures with CC	5.4	7,901
349	Anal & stomal procedures without CC/MCC	2.8	4,547
579	Other skin, subcutaneous tissue & breast procedures with MCC	9.7	15,168
580	Other skin, subcutaneous tissue & breast procedures with CC	5.1	8,335
581	Other skin, subcutaneous tissue & breast procedures without CC/MCC	2.4	5,348
707	Major male pelvic procedures with CC/MCC	4.3	10,276
708	Major male pelvic procedures without CC/MCC	1.8	7,184

<sup>1</sup> All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2011 American Medical Association. All Rights Reserved.

<sup>2</sup> Federal Register, Vol. 76, No. 228, Monday, November 28, 2011/ Rules and Regulations. The 2012 Final Rule Physician Reimbursement Conversion Factor = \$34.0376.

<sup>3</sup> Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final Rule - Hospital Outpatient Payment.

<sup>4</sup> Federal Register, Vol. 76, No. 230, Wednesday, November 30, 2011/ Rules and Regulations; Final Rule - ASC Reimbursement.

<sup>5</sup> Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2011 Saunders, an imprint of Elsevier, Inc.

<sup>6</sup> Federal Register, Vol. 76, No. 160, Thursday, August 18, 2011/ Rules and Regulations; Final Rule - National Average DRG Payment.

Physicians should refer to their provider Carrier Manual for their geographic payments.

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