

# 2010 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	\$1,049	NA
45135	Excision of rectal procidentia, with anastomosis; abdominal and perineal approach	1,309	NA
45500	Proctoplasty, for stenosis	490	NA
45505	Proctoplasty, for prolapse of mucous membrane	545	NA
45520	Perirectal injection of sclerosing solution for prolapse	37	\$123
45540	Proctopexy for prolapse, abdominal approach	1,025	NA
45541	Proctopexy for prolapse, perineal approach	884	NA
45550	Proctopexy combined with sigmoid resection, abdominal approach	1,414	NA
45900	Reduction of procidentia (separate procedure) under anesthesia	191	NA
45990	Anorectal exam, surgical, requiring anesthesia (general, spinal, or epidural), diagnostic	105	NA
45999*	Unlisted procedure, rectum	Carrier Priced	Carrier Priced
46947	Hemorrhoidopexy, by stapling	358	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>
0013	Treatment of Rectal Prolapse (For CPT code: 45520)	\$59
0148	Level I Anal/Rectal Procedure (For CPT codes: 45900, 46999)	361
0149	Level III Anal/Rectal Procedure (For CPT codes: 45500, 45999)	1,612
0150	Level IV Anal/Rectal Procedure (For CPT codes: 45505, 46947)	2,164

### Freestanding Ambulatory Surgery Center

CPT CODE <sup>1</sup>	DESCRIPTION	MEDICARE PAYMENT <sup>4</sup>
45900	Reduction of rectal prolapse	\$236
45990	Surgery diagnosis exam, anorectal	794
45500	Repair of Rectum	826
45505	Repair of Rectum	1,072
46947	Hemorrhoidopexy, by stapling	1,203

## INPATIENT FACILITY

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

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**

<b>DRG</b>	<b>DESCRIPTION</b>	<b>AVERAGE LENGTH OF STAY (DAYS)<sup>6</sup></b>	<b>NATIONAL AVERAGE DRG PAYMENT<sup>6</sup></b>
264	Other circulatory system O.R. procedures	8.5	\$14,158
332	Rectal resection with MCC	14.5	26,955
333	Rectal resection with CC	8.4	13,629
334	Rectal resection without CC/MCC	5.2	9,147
329	Major small & large bowel procedures with MCC	15.7	29,006
330	Major small & large bowel procedures with CC	9.2	14,098
331	Major small & large bowel procedures without CC/MCC	5.5	9,002
347	Anal & stomal procedures with MCC	8.7	12,787
348	Anal & stomal procedures with CC	5.5	7,470
349	Anal & stomal procedures without CC/MCC	2.9	4,326
579	Other skin, subcutaneous tissue & breast procedures with MCC	10.7	16,116
580	Other skin, subcutaneous tissue & breast procedures with CC	5.3	7,899
581	Other skin, subcutaneous tissue & breast procedures without CC/MCC	2.4	4,847
707	Major male pelvic procedures with CC/MCC	4.2	9,419
708	Major male pelvic procedures without CC/MCC	1.7	6,786

<sup>1</sup> All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2009 American Medical Association. All Rights Reserved.

<sup>2</sup> Federal Register, Vol. 74, No. 226, Wednesday, November 25, 2009/ Rules and Regulations. The 2010 Physician Reimbursement Conversion Factor = \$36.0791; Federal Register.

<sup>3</sup> Federal Register, Vol. 74, No. 223, Friday, November 20, 2009/ Rules and Regulations; Hospital Outpatient Payment.

<sup>4</sup> Federal Register, Vol. 74, No. 223, Friday, November 20, 2009/ Rules and Regulations; ASC Reimbursement.

<sup>5</sup> Hospital ICD-9-CM 2010 Volumes 1, 2 & 3, 9th Revision-Clinical Modification, American Medical Association. Copyright © 2009 Saunders, an imprint of Elsevier, Inc.

<sup>6</sup> Federal Register, Vol. 74, No. 165, Thursday, August 27, 2009/ Rules and Regulations; National Average DRG Payment.

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

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