BARD

ADVANCING LIVES AND THE DELIVERY OF HEALTH CARE™

DAVOL INC.

2017 Medicare Final Rule

National Average Payments Procedural Payment Guide

Physician Payment

Outpatient Hospital

Ambulatory Surgery Center

Inpatient

Table of Contents

Hernia Repair.......... 2

Component Separation 5

Parastomal Hernia Repair.......... 6

Hiatal Hernia Repair 7

Laparoscopic Procedures.......... 9

Wound Irrigation..........12

Breast Reconstruction 13

HERNIA REPAIR

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment						Outpatient Hospital			Ambulatory Surgery Center			Inpatient				
		In-office (Free Standing Center)			In Hospital (Professional Fee)			APC Payment			ASC Payment			ICD-9 Procedure Code	MS-DRG Description	Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
49500	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; reducible				$373	$408	9.4%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%					
49501	Repair initial inguinal hernia, age 6 months to younger than 5 years, with or without hydrocelectomy; incarcerated or strangulated				$605	$628	3.8%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%	53.0-53.17	350 - Inguinal and Femoral Hernia Procedures with MCC	$13,575	$13,208	-2.7%
49505	Repair initial inguinal hernia, age 5 years or older; reducible				$540	$540	0.0%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%	53.9	351 - Inguinal and Femoral Hernia Procedures with CC	$7,667	$7,622	-0.6%
49507	Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated				$608	$607	-0.2%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%		352 - Inguinal and Femoral Hernia Procedures without CC/MCC	$5,306	$5,452	2.8%
49520	Repair recurrent inguinal hernia, any age; reducible				$656	$656	0.0%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%					

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

HERNIA REPAIR *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment – In-office (Free Standing Center) 2016	2017	% Change	Physician Payment – In Hospital (Professional Fee) 2016	2017	% Change	Outpatient Hospital – APC Payment 2016	2017	% Change	Ambulatory Surgery Center – ASC Payment 2016	2017	% Change	Inpatient – ICD-9 Procedure Code	Inpatient – MS-DRG Description	Inpatient – Nat'l Avg Payment 2016	2017	% Change
49560	Repair initial incisional or ventral hernia; reducible				$765	$766	0.1%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%	53.41, 53.49	353 - Hernia Procedures Except Inguinal and Femoral with MCC	$15,835	$15,647	-1.2%
49561	Repair initial incisional or ventral hernia; incarcerated or strangulated				$966	$966	0.0%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%	53.51, 53.61	354 - Hernia Procedures Except Inguinal and Femoral with CC	$9,042	$9,118	0.8%
49565	Repair recurrent incisional or ventral hernia; reducible				$797	$797	0.0%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%		355 - Hernia Procedures Except Inguinal and Femoral without CC/ MCC	$6,719	$6,912	2.9%
49566	Repair recurrent incisional or ventral hernia; incarcerated or strangulated				$975	$974	-0.1%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%		N/A			
49568	Implantation of mesh or other prosthesis for incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)				$278	$278	0.0%	pack-aged	pack-aged		pack-aged			N/A	Inclusive to main procedure DRG			

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

HERNIA REPAIR *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center)			Physician Payment: In Hospital (Professional Fee)			Outpatient Hospital: APC Payment			Ambulatory Surgery Center: ASC Payment			Inpatient: ICD-9 Procedure Code	Inpatient: MS-DRG Description	Inpatient: Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
49580	Repair umbilical hernia, younger than age 5 years; reducible				$345	$340	-1.4%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%					
49582	Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated				$502	$479	-4.6%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%	53.41, 53.49	353 - Hernia Procedures Except Inguinal and Femoral with MCC	$15,835	$15,647	-1.2%
49585	Repair umbilical hernia, age 5 years or older; reducible				$461	$461	0.0%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%	53.51, 53.61	354 - Hernia Procedures Except Inguinal and Femoral with CC	$9,042	$9,118	0.8%
49587	Repair umbilical hernia, age 5 years or older; incarcerated or strangulated				$493	$492	-0.2%	$2,613	$2,862	9.5%	$1,461	$1,453	-0.5%		355 - Hernia Procedures Except Inguinal and Femoral without CC/ MCC	$6,719	$6,912	2.9%
11008	Removal of mesh in abdominal wall for infection				$287	$286	-0.3%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		N/A				

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

COMPONENT SEPARATION

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment						Outpatient Hospital			Ambulatory Surgery Center			Inpatient				
		In-office (Free Standing Center)			In Hospital (Professional Fee)			APC Payment			ASC Payment			ICD-9 Procedure Code	MS-DRG Description	Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk (Note: Report 15734 twice if procedure is bilateral)	$1,552	$1,541	-0.7%	$1,370	$1,362	-0.6%	$2,137	$2,504	17.2%	$1,195	$1,352	13.1%	83.82	Secondary to primary hernia DRG			

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

PARASTOMAL HERNIA REPAIR

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center) 2016	2017	% Change	Physician Payment: In Hospital (Professional Fee) 2016	2017	% Change	Outpatient Hospital: APC Payment 2016	2017	% Change	Ambulatory Surgery Center: ASC Payment 2016	2017	% Change	Inpatient: ICD-9 Procedure Code	Inpatient: MS-DRG Description	Inpatient: Nat'l Avg Payment 2016	2017	% Change
44346	Revision of colostomy; with repair of paracolostomy hernia (separate procedure)				$1,231	$1,231	0.0%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		46.42	347 - Anal and Stomal Procedures with MCC	$13,290	$13,509	1.6%
															348 - Anal and Stomal Procedures with CC	$7,871	$7,878	0.1%
															349 - Anal and Stomal Procedures without CC/MCC	$5,034	$5,204	3.4%

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

HIATAL HERNIA REPAIR
2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment						Outpatient Hospital			Ambulatory Surgery Center			Inpatient				
		In-office (Free Standing Center)			In Hospital (Professional Fee)			APC Payment			ASC Payment			ICD-9 Procedure Code	MS-DRG Description	Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis				$1,209	$1,208	-0.1%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		53.80				
43333	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; with implantation of mesh or other prosthesis				$1,319	$1,319	0.0%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		53.80	326 - Stomach, Esophageal and Duodenal Procedures with MCC	$29,588	$29,215	-1.3%
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis				$1,312	$1,303	-0.7%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		53.80	327 - Stomach, Esophageal and Duodenal Procedures with CC	$14,345	$14,098	-1.7%
43335	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; with implantation of mesh or other prosthesis				$1,408	$1,398	-0.7%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		53.80	328 - Stomach, Esophageal and Duodenal Procedures without CC/MCC	$8,234	$8,359	1.5%
43336	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis				$1,578	$1,570	-0.5%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		53.80				
43337	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracoabdominal incision, except neonatal; with implantation of mesh or other prosthesis				$1,702	$1,693	-0.5%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		53.80				

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

HIATAL HERNIA REPAIR *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center) 2016	2017	% Change	Physician Payment: In Hospital (Professional Fee) 2016	2017	% Change	Outpatient Hospital: APC Payment 2016	2017	% Change	Ambulatory Surgery Center: ASC Payment 2016	2017	% Change	Inpatient: ICD-9 Procedure Code	MS-DRG Description	Nat'l Avg Payment 2016	2017	% Change
39541	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic				$982	$981	-0.1%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		53.71, 53.72, 53.75, 53.83, 53.84	326 - Stomach, Esophageal and Duodenal Procedures with MCC	$29,588	$29,215	-1.3%
															327 - Stomach, Esophageal and Duodenal Procedures with CC	$14,345	$14,098	-1.7%
															328 - Stomach, Esophageal and Duodenal Procedures without CC/MCC	$8,234	$8,359	1.5%
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; chronic				$900	$981	9.0%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		53.71, 53.72, 53.75, 53.83, 53.84	326 - Stomach, Esophageal and Duodenal Procedures with MCC	$29,588	$29,215	-1.3%
															327 - Stomach, Esophageal and Duodenal Procedures with CC	$14,345	$14,098	-1.7%
															328 - Stomach, Esophageal and Duodenal Procedures without CC/MCC	$8,234	$8,359	1.5%

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

LAPAROSCOPIC PROCEDURES
2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment – In-office (Free Standing Center)			Physician Payment – In Hospital (Professional Fee)			Outpatient Hospital – APC Payment			Ambulatory Surgery Center – ASC Payment			Inpatient – ICD-9 Procedure Code	Inpatient – MS-DRG Description	Inpatient – Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
43280	Laparoscopy, surgical, esophagogastric fundoplasty (eg, Nissen, Toupet procedures)				$1,125	$1,124	-0.1%	$6,861	$6,967	1.5%	N/A	N/A		44.67	326 - Stomach, Esophageal and Duodenal Procedures with MCC	$29,588	$29,215	-1.3%
															327 - Stomach, Esophageal and Duodenal Procedures with CC	$14,345	$14,098	-1.7%
															328 - Stomach, Esophageal and Duodenal Procedures without CC/ MCC	$8,234	$8,359	1.5%
49650	Laparoscopy, surgical; repair initial inguinal hernia				$444	$444	0.0%	$4,001	$4,197	4.9%	$2,011	$2,037	1.3%	17.11, 17.12, 17.13, 17.21, 17.23, 17.24	350 - Inguinal and Femoral Hernia Procedures with MCC	$13,575	$13,208	-2.7%
															351 - Inguinal and Femoral Hernia Procedures with CC	$7,667	$7,623	-0.6%
															352 - Inguinal and Femoral Hernia Procedures without CC/ MCC	$5,306	$5,452	2.8%

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

LAPAROSCOPIC PROCEDURES *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment						Outpatient Hospital			Ambulatory Surgery Center			Inpatient				
		In-office (Free Standing Center)			In Hospital (Professional Fee)			APC Payment			ASC Payment			ICD-9 Procedure Code	MS-DRG Description	Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
49651	Laparoscopy, surgical; repair recurrent inguinal hernia				$576	$577	0.2%	$4,001	$4,197	4.9%	$2,011	$2,037	1.3%	17.11, 17.12, 17.13, 17.21, 17.23, 17.24	350 - Inguinal and Femoral Hernia Procedures with MCC	$13,575	$13,208	-2.7%
															351 - Inguinal and Femoral Hernia Procedures with CC	$7,667	$7,623	-0.6%
															352 - Inguinal and Femoral Hernia Procedures without CC/ MCC	$5,306	$5,452	2.8%

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

LAPAROSCOPIC PROCEDURES *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center)			Physician Payment: In Hospital (Professional Fee)			Outpatient Hospital: APC Payment			Ambulatory Surgery Center: ASC Payment			Inpatient: ICD-9 Procedure Code	Inpatient: MS-DRG Description	Inpatient: Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible				$772	$772	0.0%	$4,001	$4,197	4.9%	$2,011	$2,037	1.3%	53.42, 53.43, 53.63				
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated				$963	$963	0.0%	$4,001	$4,197	4.9%	$2,011	$2,037	1.3%	53.42, 53.43, 53.63				
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible				$877	$878	0.1%	$6,861	$6,967	1.5%	$3,278	$3,273	-0.2%	53.42, 53.43, 53.63	353 - Hernia Procedures Except Inguinal and Femoral with MCC	$15,835	$15,647	-1.2%
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated				$1,071	$1,072	0.1%	$6,861	$6,967	1.5%	$3,278	$3,273	-0.2%	53.62	354 - Hernia Procedures Except Inguinal and Femoral with CC	$9,042	$9,118	0.8%
49656	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible				$954	$953	-0.1%	$6,861	$6,967	1.5%	$3,278	$3,273	-0.2%	53.62	355 - Hernia Procedures Except Inguinal and Femoral without CC/MCC	$6,719	$6,912	2.9%
49657	Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated				$1,371	$1,372	0.1%	$6,861	$6,967	1.5%	$3,278	$3,273	-0.2%	53.62				

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

WOUND IRRIGATION

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center) 2016	2017	% Change	Physician Payment: In Hospital (Professional Fee) 2016	2017	% Change	Outpatient Hospital: APC Payment 2016	2017	% Change	Ambulatory Surgery Center: ASC Payment 2016	2017	% Change	Inpatient: ICD-9 Procedure Code	Inpatient: MS-DRG Description	Inpatient: Nat'l Avg Payment 2016	2017	% Change
97597	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure water-jet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters	$76	$76	0.0%	$24	$24	0.0%	$226	$153	-32.3%	N/A	N/A		86.22	901 - Wound Debridements for Injuries with MCC	$21,393	$23,550	10.1%
97598	Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (eg, high pressure water-jet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area greater than 20 square centimeters	$25	$25	0.0%	$11	$11	0.0%	pack-aged	pack-aged		N/A	N/A		86.28	902 - Wound Debridements for Injuries with CC	$9,925	$10,297	3.7%
															903 - Wound Debridements for Injuries without CC/MCC	$6,370	$6,050	-5.0%

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

BREAST RECONSTRUCTION

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment						Outpatient Hospital			Ambulatory Surgery Center			Inpatient				
		In-office (Free Standing Center)			In Hospital (Professional Fee)			APC Payment			ASC Payment			ICD-9 Procedure Code	MS-DRG Description	Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
+15777	Implantation of biologic implant (eg, a cellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure)				$223	$224	0.4%	pack-aged	pack-aged		pack-aged	pack-aged						
19324	Mammaplasty, augmentation, without prosthetic implant				$505	$510	1.0%	$3,647	$6,484	77.8%	$2,039	$2,274	11.5%	85.50, 85.53, 85.54				
															584- Breast biopsy, local excision and other breast procedures with CC/MCC	$9,126	$9,772	7.1%
															585- Breast biopsy, local excision and other breast procedures without CC/ MCC	$8,251	$8,641	4.7%
19325	Mammaplasty, augmentation, with prosthetic implant				$665	$662	-0.5%	$7,558	$6,484	-14.2%	$3,137	$2,274	-27.5%	85.53, 85.54	907- Other OR procedures for injuries with MCC	$20,688	$21,055	1.8%
															908- Other OR procedures for injuries with CC	$10,816	$11,205	3.6%
															909- Other OR procedures for injuries with CC/MCC	$7,060	$7,136	1.1%

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

BREAST RECONSTRUCTION *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment						Outpatient Hospital			Ambulatory Surgery Center			Inpatient				
		In-office (Free Standing Center)			In Hospital (Professional Fee)			APC Payment			ASC Payment			ICD-9 Procedure Code	MS-DRG Description	Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction				$1,044	$1,036	-0.8%	$3,647	$4,418	21.1%	$2,039	$1,934	-5.1%	85.33, 85.34	582- Mastectomy for malignancy with CC/MCC	$7,265	$8,163	12.4%
															583- Mastectomy for malignancy without CC/MCC	$6,442	$7,164	11.2%
															584- Breast biopsy, local excision and other breast procedures with CC/MCC	$9,126	$9,772	7.1%
															585- Breast biopsy, local excision and other breast procedures without CC/MCC	$8,251	$8,641	4.7%
															907- Other OR procedures for injuries with MCC	$20,688	$21,055	1.8%
															908- Other OR procedures for injuries with CC	$10,816	$11,205	3.6%
															909- Other OR procedures for injuries with CC/MCC	$7,060	$7,136	1.1%
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction				$959	$952	-0.7%	$7,558	$6,484	-14.2%	$3,137	$2,274	-27.5%	85.33, 85.34				

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

BREAST RECONSTRUCTION *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center) 2016	2017	% Change	Physician Payment: In Hospital (Professional Fee) 2016	2017	% Change	Outpatient Hospital: APC Payment 2016	2017	% Change	Ambulatory Surgery Center: ASC Payment 2016	2017	% Change	Inpatient: ICD-9 Procedure Code	Inpatient: MS-DRG Description	Inpatient: Nat'l Avg Payment 2016	2017	% Change
19350	Nipple/areola reconstruction	$852	$844	-0.9%	$700	$695	-0.7%	$2,188	$2,498	14.2%	$1,223	$1,006	-17.7%	85.87	584- Breast biopsy, local excision and other breast procedures with CC/MCC	$9,126	$9,772	7.1%
															585- Breast biopsy, local excision and other breast procedures without CC/MCC	$8,251	$8,641	4.7%
															907- Other OR procedures for injuries with MCC	$20,688	$21,055	1.8%
															908- Other OR procedures for injuries with CC	$10,816	$11,205	3.6%
															909- Other OR procedures for injuries with CC/MCC	$7,060	$7,136	1.1%
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion				$1,565	$1,553	-0.8%	$7,558	$10,033	32.7%	$3,137	$2,815	-10.3%	85.95				

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

BREAST RECONSTRUCTION *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center) 2016	2017	% Change	Physician Payment: In Hospital (Professional Fee) 2016	2017	% Change	Outpatient Hospital: APC Payment 2016	2017	% Change	Ambulatory Surgery Center: ASC Payment 2016	2017	% Change	Inpatient: ICD-9 Procedure Code	Inpatient: MS-DRG Description	Inpatient: Nat'l Avg Payment 2016	2017	% Change
19361	Breast reconstruction with latissimus dorsi flap, without prosthetic implant				$1,637	$1,629	-0.5%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		85.42, 85.71	582- Mastectomy for malignancy with CC/MCC	$7,265	$8,163	12.4%
19364	Breast reconstruction with free flap				$2,871	$2,852	-0.7%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		85.73, 85.74, 85.75, 85.76	583- Mastectomy for malignancy without CC/ MCC	$6,442	$7,164	11.2%
19366	Breast reconstruction with other technique				$1,459	$1,459	0.0%	$3,647	$4,418	21.1%	$2,039	$1,934	-5.1%	85.55, 85.70, 85.79, 85.85	584- Breast biopsy, local excision and other breast procedures with CC/MCC	$9,126	$9,772	7.1%
19367	Breast reconstruction with transverse rectus abdominus myocutaneous flap [TRAM], single pedicle, including closure of donor site				$1,861	$1,849	-0.6%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		85.72	585- Breast biopsy, local excision and other breast procedures without CC/ MCC	$8,251	$8,641	4.7%
19368	Breast reconstruction with TRAM, single pedicle, including of closure of donor site; with microvascular anastomosis (supercharged)				$2,295	$2,279	-0.7%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		85.72	907- Other OR procedures for injuries with MCC	$20,688	$21,055	1.8%
19369	Breast reconstruction with TRAM, double pedicle, including closure of donor site				$2,124	$2,097	-1.3%	Inpatient Only	Inpatient Only		Inpatient Only	Inpatient Only		85.72	908- Other OR procedures for injuries with CC	$10,816	$11,205	3.6%
															909- Other OR procedures for injuries with CC/MCC	$7,060	$7,136	1.1%

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

BREAST RECONSTRUCTION *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center)			Physician Payment: In Hospital (Professional Fee)			Outpatient Hospital: APC Payment			Ambulatory Surgery Center: ASC Payment			Inpatient: ICD-9 Procedure Code	Inpatient: MS-DRG Description	Inpatient: Nat'l Avg Payment		
		2016	2017	% Change	2016	2017	% Change	2016	2017	% Change	2016	2017	% Change			2016	2017	% Change
19370	Open periprosthetic capsulectomy, breast				$714	$708	-0.8%	$3,647	$2,498	-31.5%	$2,039	$1,006	-50.7%	85.00, 85.21	584- Breast biopsy, local excision and other breast procedures with CC/MCC	$9,126	$9,772	7.1%
															585- Breast biopsy, local excision and other breast procedures without CC/ MCC	$8,251	$8,641	4.7%
19371	Periprosthetic capsulectomy, breast				$815	$809	-0.7%	$2,188	$2,498	14.2%	$1,223	$1,006	-17.7%	85.00, 85.21	907- Other OR procedures for injuries with MCC	$20,688	$21,055	1.8%
19380	Revision of reconstructed breast				$804	$798	-0.7%	$3,647	$4,418	21.1%	$2,039	$1,934	-5.1%	85.93	908- Other OR procedures for injuries with CC	$10,816	$11,205	3.6%
															909- Other OR procedures for injuries with CC/MCC	$7,060	$7,136	1.1%
19396	Preparation of moulage for custom breast implant	$286	$299	4.5%	$146	$151	3.4%	$2,188	$2,498	14.2%	$1,223	$1,006	-17.7%	99.99	Secondary to primary DRG			

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

BREAST RECONSTRUCTION *cont.*

2017 Procedural Payment Guide

Definitions:
CC = Complications and/or Comorbidy
MCC = Major Complications and/or Comorbidy
Double Digit or Greater Increase
Double Digit or Greater Decrease

NOTE: ICD-9 listings are for reference only. ICD-10PCS coding requires clinical interpretation in order to determine the most appropriate code(s) for your specific coding situation.

CPT Code	Description	Physician Payment: In-office (Free Standing Center) 2016	2017	% Change	Physician Payment: In Hospital (Professional Fee) 2016	2017	% Change	Outpatient Hospital: APC Payment 2016	2017	% Change	Ambulatory Surgery Center: ASC Payment 2016	2017	% Change	Inpatient: ICD-9 Procedure Code	MS-DRG Description	Nat'l Avg Payment 2016	2017	% Change
11970	Replacement of tissue expander with permanent prosthesis				$633	$628	-0.8%	$4,969	$5,219	5.0%	$2,486	$2,647	6.5%	85.53, 85.54, 85.96, 86.05	584- Breast biopsy, local excision and other breast procedures with CC/MCC	$9,126	$9,772	7.1%
															585- Breast biopsy, local excision and other breast procedures without CC/MCC	$8,251	$8,641	4.7%
															907- Other OR procedures for injuries with MCC	$20,688	$21,055	1.8%
															908- Other OR procedures for injuries with CC	$10,816	$11,205	3.6%
															909- Other OR procedures for injuries with CC/MCC	$7,060	$7,136	1.1%

Effective October 1, 2015, the ICD-10 CM diagnosis and ICD-10 PCS procedure code sets replaced ICD-9 coding. Access ICD-9 to ICD-10 code cross reference for diagnosis and procedure codes at: http://www.icd10data.com/Convert

See page 19 for important information about the uses and limitations of this document.

DAVOL INC.

100 Crossings Boulevard
Warwick, RI 02886 USA

Phone: (800) 556-6756
Customer Service: (800) 556-6275
CustServ.Davol@crbard.com

www.davol.com

DEPARTMENT OF HEALTH AND HUMAN SERVICES, Centers for Medicare & Medicaid Services, 42 CFR Parts 414, 416, 419, 482, 486, 488, and 495, [CMS-1656-FC and IFC], RIN 0938-AS82; Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Non-excepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital

DEPARTMENT OF HEALTH AND HUMAN SERVICES, Centers for Medicare & Medicaid Services, 42 CFR Parts 405, 410, 411, 414, 417, 422, 423, 424, 425, and 460, [CMS-1654-F], RIN 0938-AS81; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements

Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 405, 412, 413, et al., Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2017 Rates; Quality Reporting Requirements for Specific Providers; Graduate Medical Education; Hospital Notification Procedures Applicable to Beneficiaries Receiving Observation Services; Technical Changes Relating to Costs to Organizations and Medicare Cost Reports; Finalization of Interim Final Rules With Comment Period on LTCH PPS Payments for Severe Wounds, Modifications of Limitations on Redesignation by the Medicare Geographic Classification Review Board, and Extensions of Payments to MDHs and Low-Volume Hospitals; Final Rule

American Medical Association's "Physician's Current Procedural Terminology CPT 2015", www.ama-assn.org

World Health Organization. International Classification of Diseases, 9th revision. Geneva: WHO, 2015. All Rights Reserved.

C. R. Bard, Inc. does not guarantee that use of any of the codes provided will ensure coverage or payment at any particular level. Medicare may implement policies differently in various sections of the country. Physicians and hospitals should confirm with a particular payor or coding authority, such as the American Medical Association or medical specialty society, which codes or combinations of codes are appropriate for a particular procedure or combination of procedures. Reimbursement for a product or procedure can be different depending upon the setting in which the product is used. Coverage and payment policies also change over time, so that information provided here may at some point need to be revised.