2022 Urinary Incontinence Reimbursement Guide

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

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

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

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

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

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

Surgeon CPT, APC & DRG Codes

SURGEON CPT CODE[2]	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT[3]
	Sling Operation	
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	$ 764

OUTPATIENT FACILITY
Hospital Outpatient Department

APC	APC DESCRIPTION	STATUS INDICATOR	MEDICARE PAYMENT[4]
5415	Level 5 Gynecologic Procedures (CPT Code: 57288)	J1	$ 4,503

Ambulatory Surgery Center

CPT CODE	PROCEDURE	NATIONAL AVERAGE MEDICARE PAYMENT[5]
57288	Sling operation for stress incontinence (eg, fascia or synthetic)	$ 2,586

DRG	DESCRIPTION*	AVERAGE LENGTH OF STAY (DAYS)[6]	NATIONAL AVERAGE DRG PAYMENT[7]
662	Minor Bladder Procedures with MCC	6.9	$ 19,369
663	Minor Bladder Procedures with CC	3.7	$ 10,548
664	Minor Bladder Procedures without CC/MCC	1.9	$ 7,806
748	Female Reproductive System Reconstructive Procedures	1.6	$ 8,886

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

1. ICD-10 Procedural Coding System (ICD-10-PCS) is developed and maintained by the Centers for Medicare and Medicaid Services. 2. All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines and other material are copyright 2021 American Medical Association. 3. CY 2022 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (CMS-1751-F, Vol 86, No. 221; November 19, 2021); Addendum B. All MPFS Fee Schedules calculated using CF of $34.6062 effective January 2022. 4. Medicare Hospital Outpatient National Hospital Average APC Payment. 5. CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-F, Vol. 86, No. 218; November 16, 2021); Addendum B and Final ASC Addenda AA. 6. All Healthcare Common Procedure Coding System (HCPCS) Level II alpha-numeric codes, descriptions, instructions, guidelines and other material are copyright 2021 Centers for Medicare & Medicaid Services (CMS). All Rights Reserved. 7. Medicare Inpatient Prospective Payment System Final Rule [CMS-1752-F], Federal Register (Vol. 86, Issue 154), Friday, August 13, 2021; Final: National Average DRG Payment.

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