2022 REIMBURSEMENT GUIDE

PHYSICIAN AND FACILITY

PDS™ Flexible Plate

©Mentor Worldwide LLC 2022 063849-211208

PDS™ FLEXIBLE PLATE

2022 Physician, Hospital Outpatient and ASC Medicare National Average Payments

		PHYSICIAN SERVICES	HOSPITAL OUTPATIENT			AMBULATORY SURGERY CENTER	
CPT®	Description	Medicare Reimbursement[1]	SI	APC	Medicare Reimbursement[2]	PI	Medicare Reimbursement[2]
21335	Open treatment of nasal fracture; with concomitant open treatment of fractured septum	$737	J1	5164	$2,794	A2	$1,109
21336	Open treatment of nasal septal fracture, with or without stabilization	$665	J1	5113	$2,892	A2	$1,362
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip	$1,479	J1	5165	$5,194	A2	$2,445
30420	Rhinoplasty, primary; including major septal repair	$1,515	J1	5165	$5,194	A2	$2,445
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	$1,128	J1	5165	$5,194	A2	$2,445
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)	$1,402	J1	5165	$5,194	A2	$2,445
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)	$1,825	J1	5165	$5,194	A2	$2,445
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	$860	J1	5165	$5,194	A2	$2,445
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies	$1,658	J1	5165	$5,194	A2	$2,445
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)	$1,070	J1	5165	$5,194	A2	$2,445
30520	Septoplasty or submucous resection; with/without cartilage scoring, contouring or replacement with graft	$703	J1	5164	$2,794	A2	$1,109
30630	Repair nasal septal perforations	$699	J1	5164	$2,794	A2	$1,109

2022 Hospital Inpatient Medicare National Average Payments

		HOSPITAL INPATIENT
MS-DRG	Description	Medicare Reimbursement[3]
143	Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC	$19,650
144	Other Ear, Nose, Mouth and Throat O.R. Procedures with CC	$11,616
145	Other Ear, Nose, Mouth and Throat O.R. Procedures without MCC	$8,075
515	Other Musculoskeletal System and Connective Tissue O.R. Procedure with MCC	$20,710
516	Other Musculoskeletal System and Connective Tissue O.R. Procedure with CC	$12,943
517	Other Musculoskeletal System and Connective Tissue O.R. Procedure without CC/MCC	$9,220

		HOSPITAL INPATIENT
MS-DRG	**Description**	**Medicare Reimbursement[3]**
579	Other Skin, Subcutaneous Tissue and Breast Procedures with MCC	$20,738
580	Other Skin, Subcutaneous Tissue and Breast Procedures with CC	$11,400
581	Other Skin, Subcutaneous Tissue and Breast Procedures without CC/MCC	$9,079
907	Other Operating Room Procedures for Injuries with MCC	$26,036
908	Other Operating Room Procedures for Injuries with CC	$13,521
909	Other Operating Room Procedures for Injuries without CC/MCC	$9,041
957	Other Operating Room Procedures for Multiple Significant Trauma with MCC	$48,936
958	Other Operating Room Procedures for Multiple Significant Trauma without MCC	$27,734
959	Other Operating Room Procedures for Multiple Significant Trauma without CC/MCC	$18,043

CC: Complications and/or comorbidity **MCC:** Major Complications and/or comorbidity

Supply Codes

PDS FLEXIBLE PLATE		HOSPITAL OUTPATIENT			AMBULATORY SURGERY CENTER	
CPT®/ HCPCS	**Description**	**SI**	**APC**	**Medicare Reimbursement[2]**	**PI**	**Medicare Reimbursement[2]**
A4649	Surgical supply, miscellaneous	N	N/A	Packaged	N/A	N/A
99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered	B	N/A	N/A	N/A	N/A

Notes:
- Medicare reimbursement for the PDS Flexible Plate is packaged with the primary code
- Medicare: report A4649
- Non-Medicare: report 99070
- There is no specific HCPCS code / C-code for the PDS Flexible Plate

Hospital Outpatient Status Indicators (SI):
B: Not paid under OPPS. J1: Hospital Part B services paid through a Comprehensive APC. Paid under OPPS; all covered Part B services on the same claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products) that are authorized or approved to treat or prevent COVID-19. **N:** Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.

Ambulatory Surgery Center (ASC) Payment Indicators (PI): A2: Surgical procedure on ASC list in CY 2007, payment based on OPPS relative payment weight.

Sources:
[1] CY 2022 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1751-F); Addendum B. All MPFS Fee Schedules calculated using CF of $33.5983 effective January 2022.
[2] CY 2022 Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs (CMS-1753-FC); Addendum B and Final ASC Addenda.
[3] DRG values calculated using a base rate of $6,121.65 and Capital Standard Payment of $472.59. The national average hospital Medicare base rate is the sum of the full update labor-related and non-labor-related amount published in the Federal Register, FY 2022 IPPS Final Rule (CMS-1752-F2 and CMS-1762-F2) Table 5; Tables 1A, 1D.

FOR ADDITIONAL QUESTIONS OR INFORMATION PLEASE CONTACT MENTOR REIMBURSEMENT SUPPORT SERVICES AT: MENTORREIMBURSEMENTSUPPORT@ITS.JNJ.COM OR 1 (877) 260-0102

The information is provided to assist you in understanding the reimbursement process. It is intended to assist providers in accurately obtaining reimbursement for health care services. It is not intended to increase or maximize reimbursement by any payer. We strongly suggest that you consult your payer organization with regard to local reimbursement policies. The information contained in this document is provided for information purposes only and represents no statement, promise or guarantee by Mentor Worldwide LLC concerning levels of reimbursement, payment or charge. Similarly, all CPT® & HCPCS codes are supplied for information purposes only and represent no statement, promise or guarantee by Mentor Worldwide LLC that these codes will be appropriate or that reimbursement will be made.
CPT® codes and descriptors copyright ©2021 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Third party trademarks used herein are trademarks of their respective owners.

MENTOR®
PART OF THE Johnson&Johnson FAMILY OF COMPANIES

©Mentor Worldwide LLC 2022 063849-211208