SYNTHASOME INC

2010 Coding and Reimbursement Guide

Introduction

Synthasome, Inc. is pleased to provide this Coding and Reimbursement Guide that has been developed specifically for healthcare providers and professionals responsible for coding and reporting surgical procedures that may utilize X-Repair.

Synthasome received 510(k) clearance on March 27, 2009 for X-Repair, a bioabsorbable, rectangular, double-layered, flexible, woven surgical mesh manufactured from poly-l-lactic acid (PLLA) fiber. The indications for use are:

> X-Repair is intended for use in general surgical procedures for reinforcement of soft tissue where weakness exists.
>
> X-Repair is also intended for reinforcement of soft tissues that are repaired by suture or suture anchors, during tendon repair surgery including reinforcement of rotator cuff, patellar, Achilles, biceps, or quadriceps tendons
>
> X-Repair is not intended to replace normal body structure or provide the full mechanical strength to support the rotator cuff, patellar, Achilles, biceps, or quadriceps tendons. Sutures, used to repair the tear, and sutures or bone anchors, used to attach the tissue to the bone, provide mechanical strength for the tendon repair.

If you have any questions, please contact us at:

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The reimbursement information provided by Synthasome, Inc. is gathered from third-party sources and is presented for illustrative purposes only. It does not guarantee coverage or reimbursement for services performed utilizing X-Repair. Synthasome has made every effort to ensure the completeness and accuracy of the information contained herein; however, no representations or warranties are made regarding the selection of codes for the use of Synthasome's products or the services in which the products may be used, or for compliance with any billing protocols or procedures, requirements, or prerequisites. As with all coverage claims, individual physicians, healthcare providers and facilities are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient's condition and the services

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provided to a patient. Healthcare providers are encouraged to contact the individual Medicare contractor, carrier, fiscal intermediary or other third-party payers, as needed.

CPT Codes and 2010 Medicare Unadjusted National Average Payment Rates for Select Procedures for Physician, Hospital Outpatient and ASC Settings

Included below are select CPT codes and payment rates that may be appropriate to report for surgical tendon repair procedures involving the shoulder (including rotator cuff), knee (including patellar tendon) and the ankle (including Achilles tendon). At this time, there is no CPT code(s) that accurately describes the surgical procedure involving implantation of mesh during surgical repair of tendons, including those involving the shoulder, knee or ankle. Healthcare providers are encouraged to report the appropriate unlisted code for the implantation procedure utilizing X-Repair.

Payment rates indicated below are 2010 Medicare national unadjusted average payment rates.

CPT Code[1]	Descriptor	Physician (in facility) payment[2]	Hospital Outpatient Payment[3]	ASC Payment[3]
Select Tendon Repair Procedures of the Shoulder, Including the Rotator Cuff				
23405	Tenotomy, shoulder area; single tendon	$465	$2,142	$1,061
23406	Tenotomy, shoulder area; multiple tendons through same incision	$580	$2,142	$1,061
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute	$611	$3,140	$1,571
23412	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic	$638	$3,140	$1,637
23415	Coracoacromial ligament release, with or without acromioplasty	$511	$3,140	$1,571
23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	$722	$3,140	$1,637
29826	Arthroscopy, shoulder, decompression of subacromial space with partial acromioplasty, with or without coracoacromial release	$495	$3,291	$1,589
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair	$807	$3,291	$1,638

[1] Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association (AMA). Copyright 2010 AMA. All rights reserved.

[2] Federal Register, Vol. 74:226 dated November 25, 2009. Medicare payment rates effective January 1 through December 31, 2010. Actual payment rates will vary based on geographical adjustments to payments.

[3] Federal Register, Vol. 74:223 dated November 20, 2009. Medicare payment rates effective January 1 through December 31, 2010. Actual payment rates will vary based on geographical adjustments to payments.

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23929	Unlisted procedure, shoulder	-	$112	-
29999	Unlisted procedure, arthroscopy	-	$2,017	-

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CPT Code[1]	Descriptor	Physician (in facility) payment[2]	Hospital Outpatient Payment[3]	ASC Payment[3]
Select Tendon Repair Procedures Involving the Knee, Including Patellar Tendon				
27380	Suture of infrapatellar tendon; primary	$433	$1,484	$741
27381	Suture of infrapatellar tendon; secondary reconstruction, including fascial or tendon graft	$591	$1,484	$783
27385	Suture of quadriceps or hamstring muscle rupture; primary	$464	$1,484	$783
27386	Suture of quadriceps or hamstring muscle rupture; secondary reconstruction, including fascial or tendon graft	$613	$1,484	$783
27599	Unlisted procedure, femur or knee	-	$112	-
Select Tendon Repair Procedures of the Ankle, Including the Achilles Tendon				
27605	Tenotomy, percutaneous, Achilles tendon (separate procedure); local anesthesia	$145	$1,472	$736
27606	Incision of Achilles tendon	$217	$1,484	$741
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon	$497	$3,140	$1,521
27652	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)	$536	$5,976	$2,786
27654	Repair, secondary, Achilles tendon, with or without graft	$533	$3,140	$1,521
27675	Repair, dislocating peroneal tendons; without fibular osteotomy	$373	$1,484	$768
27685	Lengthening or shortening of tendon, leg or ankle; single tendon, (separate procedure)	$350	$2,142	$1,077
27686	Lengthening or shortening of tendon, leg or ankle; multiple tendons (through same incision), each	$414	$2,142	$1,077
27899	Unlisted procedure, leg or ankle	-	$112	-

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HCPCS Coding

Certain HCPCS codes may be appropriate for reporting X-Repair, including:

HCPCS Code	HCPCS Code Descriptor
C1781	Mesh (implantable)
A4649	Surgical supply; miscellaneous

It is important to verify with payers the appropriate HCPCS code for reporting procedures that may utilize X-Repair. For example, C-codes are typically reserved for hospital outpatient procedures for Medicare patients. However, some private payers have begun accepting C-codes for non-Medicare patients in both the hospital outpatient setting and the ASC setting. In the ASC setting, some private payers may reimburse separately for HCPCS A4649, and we encourage ASCs to verify this with their private payers.

In January 2009, CMS published specific instructions regarding reporting HCPCS codes for biologicals. Where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. C1781 no longer has pass-through status, and under the OPPS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals as implantable devices during surgical procedures, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.[1]

Revenue Codes

Hospitals are encouraged to report the appropriate revenue codes for X-Repair. Although there is no additional separate payment by Medicare for X-Repair, third-party payers may provide separate reimbursement.

Revenue Code	Description

[1] *CMS MLN Matters Number: MM6320, January 1, 2009*

0270	Medical/surgical supplies
0272	Sterile supplies
0273	Other implants
0278	Medical/surgical supplies: Other implants

Separate Payment for X-Repair

Separate payment may be available for X-Repair when hospitals and ASCs have negotiated carve-outs in their payer contracts to cover the cost of implantables, such as X-Repair. Hospitals and ASCs may be required to present the manufacturer's invoice along with their charges for the procedure and the implantable. Reimbursement varies by contract and by facility, but often these carve-outs are at invoice or invoice plus a certain percentage.

We encourage facilities to review your contracts to determine the availability of carve-outs. If you are uncertain as to whether your facility may have negotiated carve-outs, we suggest contacting the appropriate administrator at your facility or provider relations at the payer.

Hospital Inpatient Coding and Payment Information

The following ICD-9-CM procedure codes may be appropriate to report for hospital inpatient surgical procedures involving tendon repair of the shoulder (including rotator cuff), knee (including patellar tendon) and the ankle (including Achilles tendon). Payment rates indicated below are Medicare national unadjusted average payment rates for fiscal 2010.

ICD-9-CM Procedure Code	ICD-9-CM Procedure Code Descriptor
81.44	Patellar stabilization
83.13	Other tenotomy
83.61	Suture of tendon sheath
83.62	Delayed suture tendon
83.63	Rotator cuff repair
83.64	Other suture of tendon
83.73	Reattachment of tendon
83.81	Tendon graft

83.88	Other plastic operations on tendon

Listed below are possible MS-DRG assignments along with the associated payment rate for each MS-DRG. MS-DRG assignment is based on the patient's diagnosis and the procedure performed. The payment rates shown are 2010 Medicare national unadjusted average payment rates and are for illustrative purposes only.

MS-DRG	Description	Hospital Inpatient Payment Rate[1]
488	Knee procedures w/o pdx of infection w CC/MCC	$9,481
489	Knee procedures w/o pdx of infection w/o CC/MCC	$6,687
500	Soft tissue procedures w MCC	$17,095
501	Soft tissue procedures w CC	$8,574
502	Soft tissue procedures w/o CC/MCC	$5,559
507	Major shoulder or elbow joint procedures w CC/MCC	$10,281
508	Major shoulder or elbow joint procedures w/o CC/MCC	$7,104
509	Arthroscopy	$6,820
510	Shoulder, elbow or forearm proc, exc major joint proc w MCC	$12,142
511	Shoulder, elbow or forearm proc, exc major joint proc w CC	$7,770
512	Shoulder, elbow or forearm proc, exc major joint proc w/o CC/MCC	$5,671
907	Other O.R. procedures for injuries w MCC	$21,520
908	Other O.R. procedures for injuries w CC	$10,590
909	Other O.R. procedures for injuries w/o CC/MCC	$6,294
984	Prostatic O.R. procedure unrelated to principal diagnosis w MCC	$18,903
985	Prostatic O.R. procedure unrelated to principal diagnosis w CC	$11,011
986	Prostatic O.R. procedure unrelated to principal diagnosis w/o CC/MCC	$6,262

ICD-9-CM Diagnosis Codes

All claim forms must include ICD-9-CM diagnosis codes to report the patient's condition. These codes reflect the physician's assessment of a particular patient's

[1] Federal Register, Vol. 74:165, August 27, 2009, Vol. 74:193 (Correction Notice); and Table 1B, 1D, and 5. Effective October 1, 2009. Actual payment rates will vary based on geographical adjustments to payments. National average (wage index greater than one) MS- DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts ($5,652.40). Hospital inpatient payment rates effective October 1, 2009 through September 30, 2010.

condition, and it is the physician's responsibility to select the code that most appropriately describes the patient's condition.

Documentation Tips

Medical record documentation is critical to the communication of essential information for making a decision as to whether a procedure was reasonable and necessary for a particular patient. Always review the payer's policy for specific documentation and clinical coverage criteria.

The use of the unlisted CPT code for reporting the surgical implantation of X-Repair may require additional supporting documentation to be submitted to the payer, including:

- A description of the procedure and associated work performed
- Operative report
- Clinical benefits and medical necessity
- Physician's charges
- Bibliography of clinical literature