Anorectal Fistula Repair

Coverage, Coding and Reimbursement Overview — Physician/Hospital/ASC

2013 Edition[†] — All Reimbursement Amounts are Listed at National Medicare Rates

PHYSICIAN OVERVIEW

Physician rates effective January 1, 2014 through December 31, 2014.

COVERAGE APPLICABLE FOR PHYSICIAN, HOSPITAL, ASC	
NOTE: Existence of a CPT® procedure code for a service does NOT guarantee payment. Pre-authorization for any operative intervention is highly recommended and may be a payer requirement.	
Medicare	A/B MAC/Carrier Local Coverage Determination
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

PROCEDURE[A]	CODING	REIMBURSEMENT[B]
	CPT® Code	Professional
Repair of anorectal fistula with plug	46707	$472

HOSPITAL (FACILITY) OVERVIEW

Hospital Inpatient rates effective October 1, 2013 through September 30, 2014.
Hospital Outpatient rates effective January 1, 2014 through December 31, 2014.

	CODING		REIMBURSEMENT				
			Inpatient (IPPS)		Outpatient (OPPS)		
	ICD-9 Procedure Code	HCPCS / CPT® Code	MS-DRG[C]	Rate[D]	APC	SI[E]	Rate[F]
Device Code*					Required for Medicare Outpatient Claims		
Mesh (implantable)		C1781			—	N	—
Procedure							
Closure of anal fistula	49.73		347	$14,605	0150	T	$2,366
	49.73		348	$7,879			
	49.73		349	$5,173			

MS-DRG Descriptions

347 - Anal fistula with MCC
348 - Anal fistula with CC
349 - Anal fistula without CC/MCC

APC Description

0150 - Level IV Anal/Rectal Procedures

AMBULATORY SURGERY CENTER (ASC) OVERVIEW

ASC rates effective January 1, 2013 through December 31, 2013.

	CODING	REIMBURSEMENT
	CPT® Code	Rate[F]
Procedure[G]		
Repair of anorectal fistula with plug	46707	$1,382

A. Abbreviated CPT® code descriptions. See CPT® codebook for complete descriptions.
B. Conversion factor used for this overview is $35.8228, as published in CMS Change Request 8533.
C. MS-DRG assignment is determined by the patient ICD-9 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.
D. Rates per CMS-1599-FC.
E. Status Indicators: C—Inpatient Procedures; N—Items & Services Packaged into APC Rates; Q1—STVX-Packaged Codes; Q2—T-Packaged Codes; S—Significant Procedure, Not Discounted When Multiple;
T—Significant Procedure, Multiple Reduction Applies
F. Rates per CMS-1601-FC.
G. Refer to Addenda AA and BB of CMS-1601-FC for covered ASC procedures: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1501-FC.html
* Medicare OPPS billing instructions require the reporting of device C codes for certain APCs–refer to Table 3 of CMS-1501-FC.