Dilapan-S® CERVICAL DILATOR

REIMBURSEMENT GUIDE

The following provides 2022 Medicare Physician Fee Schedule (MPFS) and facility national payment rates for the CPT® code(s) that may be reported for the induction of labor procedure. Payers may have specific coding, reimbursement requirements and policies. Prior to filing claims, it is recommended that healthcare professionals verify current reimbursement and policies with their local payer. **Payment will vary by region.**

Device Description

Dilapan-S® is an FDA-cleared, osmotic, hygroscopic, cervical dilator rod composed of Aquacryl®, a synthetic patented hydrogel. Each Dilapan-S rod absorbs fluid from the surrounding cervical tissue and expands to several times its original diameter, gradually softening and dilating the cervix.[1,2] Dilapan-S contains no pharmacologically active substance.[1]

Indications for Use

Dilapan-S® is for use by healthcare professionals trained in OB/GYN whenever cervical softening and dilation are desired, such as for cervical ripening during term labor induction or gynecological procedures that require cervical preparation.[1]

Physician Payment

Medicare reimburses physicians according to the Medicare Physician Fee Schedule (MPFS), which is based on Relative Value Units (RVUs), and payments vary by geographic region. Physicians bill Medicare and other payers for services performed regardless of whether the service takes place in the physician's office, a hospital, or an outpatient facility.

CY 2022 Final Physician Payment

CPT® Code[3]	Description	Non-Facility (In-Office)		Facility (Inpatient; Outpatient)	
		RVUs	Medicare National Payment[4]	RVUs	Medicare National Payment[4]
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)	3.20	$107.51	1.31	$44.01

Modifier

- If this service was performed one day or more prior to a delivery, it can be reported separately. Use modifier 59 or other appropriate X[EPSU] sub-modifier per payer policy.[5]
- Modifier 59: Distinct Procedural Service[3]
- If this service was performed on the same day as a delivery, it is considered part of the global obstetric package and not reported separately.[5]

Outpatient Facility Reimbursement

Hospital outpatient services are reimbursed under the Medicare Outpatient Prospective Payment System (OPPS) based on the associated Ambulatory Payment Classification (APC). Procedures requiring similar resources are grouped into APCs and facilities are paid a lump sum payment for the services provided.

CY 2022 Final Hospital Outpatient Payment

CPT® Code[3]	Description	Hospital Outpatient		
		APC	Status Indicator[6]	Medicare National Payment[7]
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)	5412	T	$288.04
G0463	Hospital outpatient clinic visit	5012	J2	$121.35

Status Indicator
Each CPT code in the OPPS is assigned a status indicator to signify whether a discount (payment reduction) applies to the respective APC payment. The following status indicators are represented in this procedure:

- "T" Procedure or service, multiple procedure reduction applies. Paid under OPPS; separate APC payment.
- "J2" Hospital Part B services that may be paid through a Comprehensive APC. Paid under OPPS; Addendum B displays APC assignments when services are separately payable.

Inpatient Facility Reimbursement

ICD-10-PCS (Procedure Classification System) for Inpatient Procedure

ICD-10-PCS is used for inpatient hospital settings in the United States. ICD-10-PCS is the official system of assigning codes to procedures associated with hospital utilization. These codes support data collection, payment, and electronic health records. ICD-10-PCS is intended for use by healthcare professionals, health care organizations, and insurance programs.

ICD-10-PCS[8]	Description
0U7C7ZZ	Dilation of Cervix, Via Natural or Artificial Opening

Medicare Severity-Diagnosis Related Groups (MS-DRGs)

Hospital payment for inpatient services or procedures are usually based on Medicare Severity Diagnosis Related Group (MS-DRGs aka DRGs), case rates, per diem rates, or a line-item payment methodology. Medicare assigns a hospital inpatient stay to a DRG based on the reported diagnoses, condition of the patient, and reason for the procedure. Hospitals generally receive a fixed, predetermined payment for each DRG, which includes all costs associated with the patient's hospital stay.

FY 2021 Final Hospital Inpatient Potential MS-DRG Assignment

MS-DRG	Description	Relative Weight	Medicare National Payment[9]
783	C-section with sterilization w/MCC	1.8749	$12,437.79
784	C-section with sterilization w/CC	1.0959	$7,270.03
785	C-section with sterilization w/o CC/MCC	0.9168	$6,081.90
786	C-section without sterilization w/MCC	1.5944	$10,576.99
787	C-section without sterilization w/CC	1.0644	$7,061.06
788	C-section without sterilization w/o CC/MCC	0.8871	$5,886.87
796	Vaginal delivery with sterilization/D&C w/MCC	1.0708	$7,103.52
797	Vaginal delivery with sterilization/D&C w/CC	0.9194	$6,099.15
798	Vaginal delivery with sterilization/D&C w/o CC/MCC	0.8275	$5,489.50
805	Vaginal delivery w/o sterilization/D&C w/MCC	1.0299	$6,832.19
806	Vaginal delivery w/o sterilization/D&C w/CC	0.7346	$4,873.22
807	Vaginal delivery w/o sterilization/D&C w/o CC/MCC	0.6423	$4,260.92

CC – Complications or Comorbidities; MCC – Major Complications or Comorbidities

Documentation

Medical record documentation is key to communicating essential information for making a decision as to whether a procedure was medically necessary for a particular patient.

Medical record documentation should convey information about a patient's medical condition, the rationale for the induction of labor procedure, and the outcome of the procedure.

See payer policy for specific documentation and medical coverage criteria.

Important Safety Information[1]

Indication for Use:
Dilapan-S® is for use by healthcare professionals trained in OB/GYN whenever cervical softening and dilation are desired, such as for cervical ripening during term labor induction or gynecological procedures that require cervical preparation.

Contraindication:
Dilapan-S® is contraindicated in the presence of clinically apparent genital tract infection.

Warnings & Precautions:

- Dilapan-S® is intended for single use only. **Do not** reuse, resterilize, reprocess, or use if primary packaging has been opened or damaged. Discard after use.
- Careful placement of the device is essential to avoid traumatic injury to the cervix or uterus (see Instructions for Use—Insertion). The device should not be left in place more than 24 hours. **Instruct patients to:** Report any excessive bleeding, pain, or temperature elevation, and to avoid bathing, douching, and intercourse. Patients should return to the healthcare provider for removal of Dilapan-S® at the indicated time and should be instructed not to attempt self-removal under any circumstances.
- Potential Complications/Risks: Twisting of device during removal may cause the device to break (see Instructions for Use—Removal). Complications may include: device entrapment and/or fragmentation, expulsion, or retraction; patient discomfort or bleeding; spontaneous rupture of membranes; spontaneous onset of labor; cervical laceration.

Storage & Handling: Store between +15°C and +30°C and keep away from direct sunlight and high humidity.

Please click here to download the Instructions for Use.

You are encouraged to report adverse events related to Dilapan-S® by calling 1 (888) 257-9676. If you prefer, you may contact the U.S. Food and Drug Administration (FDA) directly. Visit http://www.fda.gov/MedWatch or call 1-800-FDA-1088.

References

1. Dilapan-S Instructions for Use. DSPlenus-Rev019/2021-04.
2. U.S. Food and Drug Administration. Dilapan-S. 510(k) – K143447. April 17, 2015.
3. Current Procedural Terminology 2022. CPT® copyright 2021 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS apply.
4. Calendar Year 2022 Medicare Physician Fee Schedule. Final Rule [CMS-1751-F]. Federal Register, November 19, 2021. Medicare physician national payment rates listed in this document are based on the 2022 PFS conversion factor of $33.5983. No geographic adjustments have been made to the reported payments.
5. ACOG 2020 OB/GYN Coding Manual: Components of Correct Procedural Coding. CPT® copyright 2019. American Medical Association. All rights reserved.
6. Calendar Year 2022 Medicare Outpatient Prospective Payment and Ambulatory Surgical Center Payment System. Final Rule [CMS-1753-FC]. Addendum D1. Federal Register, November 16, 2021.
7. Calendar Year 2022 Medicare Outpatient Prospective Payment and Ambulatory Surgical Center Payment System. Final Rule [CMS-1753-FC]. Addendum B. Federal Register, November 16, 2021.
8. Centers for Medicare & Medicaid Services ICD-10. 2021 ICD-10-PCS. https://www.cms.gov/medicare/icd-10/2022-icd-10-pcs Accessed: December 21, 2021.
9. Fiscal Year 2021 Medicare Inpatient Prospective Payment System. Final Rule [CMS-1752-F and CMS-1762-F]. CN Table 5, and CN Table 1A – 1E. Federal Register, August 13, 2021.

