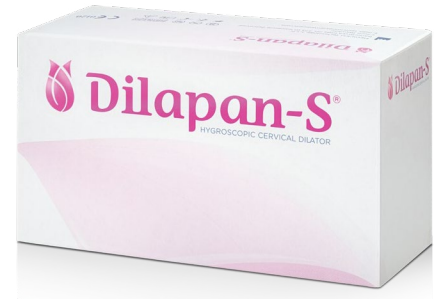


The following provides 2025 Medicare Physician Fee Schedule (MPFS) and facility national payment rates for the CPT® code(s) that may be reported for the induction of labor procedure. Payers may have specific coding, reimbursement requirements and policies. Prior to filing claims, it is recommended that 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.<sup>1,2</sup> Dilapan-S contains no pharmacologically active substance.<sup>1</sup>

## 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.<sup>1</sup>

## Provider Reimbursement

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.

In CY 2023, Medcem brought a concern that CPT 59200 was potentially misvalued to The Center for Medicare and Medicaid (CMS). In CY 2024, the American Medical Association (AMA) RVS Update Committee (RUC) reviewed the work RVU and the Practice expense (PE) inputs for this CPT code. Subsequently, the updated RUC recommendations for the work RVU and PE inputs were proposed and finalized by CMS for VY 2025. The total RVUs in the table below reflect these changes.

### CY 2025 Physician Payment

Effective January 1, 2025

CPT® Code <sup>3</sup>	Description	Non-Facility (In-Office)		Facility (Inpatient; Outpatient)	
		Total RVUs	Medicare National Payment <sup>4</sup>	Total RVUs	Medicare National Payment <sup>4</sup>
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)	3.98	\$128.74	2.02	\$65.34

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#### 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.<sup>5</sup>
- Modifier 59: Distinct Procedural Service<sup>3</sup>
- 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.<sup>5</sup>

**Provider Reimbursement In-Office**

Billing MS-1500-Form5

Identifying Dilapan-S®

**1 Box 19 – Additional Claim Information:** Allows for “text” to include more information about the claim to the payer (e.g., identify Dilapan-S for cervical ripening).

**2 Box 21 – Diagnosis or Nature of Illness or Injury:** Apply appropriate diagnosis codes as required for reimbursement of CPT 59200.

Examples used but not limited to: N88.2 – Stricture and stenosis of cervix uteri; Z3A.40 – 40 Weeks gestation of pregnancy.

**3 Box 24 B. – Place of Service:** 11 Office

**4 Box 24 D. Procedures, Services, or Supplies – CPT/HCPCS:** Bill for the insertion of a cervical dilator using CPT code 59200 – Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure. *Note: There is no CPT code and no separate payment for removal of Dilapan-S.*)

**5 Box 24 D. Procedures, Services, or Supplies – Modifier:** When insertion of cervical dilator is performed one or more days prior to a delivery, append Modifier 59 to describe the insertion as a Distinct & Separate Procedure.

**Payers may require Medical documentation**

(e.g., medical dictation notes) supporting medical necessity for CPT 59200.

For illustrative purposes only. Example of billing claim form does not contain an exhaustive list of services which may be offered to a patient during the insertion service encounter. Place of service code depends on the site of care where procedure is performed. Diagnosis codes are based on the patient’s condition. Use modifier 59 or X{EPSU} subset per patient policy. The physician is responsible for appropriate selection of procedure/service/ treatment CPT/HCPCS codes and ICD-10-CM diagnosis codes. Selection of CPT/HCPCS, ICD-10-CM and ICD-10-PCS codes is based on the documentation in the medical record supporting medical necessity.

**If insertion occurs more than 24 hours prior to delivery, with appropriate modifier and documentation of medical necessity, CPT 59200 is reported separately (outside the Maternity Global Bundle).**

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.

CPT® Code <sup>3</sup>	Description	Hospital Outpatient		
		APC	Status Indicator <sup>6</sup>	Medicare National Payment <sup>7</sup>
59200	Insertion of cervical dilator (e.g., laminaria, prostaglandin) (separate procedure)	5412	T	\$304.19
G0463	Hospital outpatient clinic visit	5012	J2	\$128.87

**Status Indicator**

Each CPT code in the OPSS 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 OPSS; separate APC payment.
- “J2” Hospital Part B services that may be paid through a Comprehensive APC. Paid under OPSS; Addendum B displays APC assignments when services are separately payable.

**Revenue Code<sup>8</sup>**

Generally, CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPSS since hospital assignment of cost vary. Where explicit instructions are not provided, hospitals are to report charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

**Note:** The “X” below serves as a placeholder for the fourth numerical digit (possible range 0-9), please consider the appropriate digit assignment.

**Examples used but not limited to:**

- 027X – Medical/Surgical Supplies and Devices (Also see 062X, an extension of 027X): Code indicates charges for supply items required for patient care. Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third-party payer requirements.
- 036X – Operating Room Services: Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery as well the operating room (heat, lights) and equipment. Rationale: Permits identification of particular services.
- 050X – Outpatient Services: Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. This revenue code is no longer used for Medicare.
- 072X – Labor Room/Delivery: Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

# Inpatient Facility Reimbursement

## ICD-10-Diagnosis Codes

ICD-10-CM diagnosis codes are used by physicians and facilities to report patient conditions. Physicians are responsible for selecting the most appropriate code with the highest level of detail to describe the service(s) rendered to the patient. List all diagnoses on the claim form and code to the highest available level of specificity based on the documentation in the patient’s medical record.

ICD-10-CM diagnosis codes referenced in this Reimbursement Guide are used for illustrative purposes only. For a complete list of codes and descriptions, consult the current ICD-10-CM code manual.

## 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 <sup>9</sup>	Description
0U7C7D	Dilation of Cervix, Via Natural or Artificial Opening e rar

## Inpatient Hospital Reimbursement

Medicare hospital payments for inpatient services or procedures are usually based on Medicare Severity Diagnosis Related Group (MS-DRGs aka DRG. 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. Payment by commercial payers for inpatient services or procedures is determined by the contractual arrangement between the payer and provider. Commercial payers may use case rates, per diem rates, or a line-item payment methodology

# Inpatient Facility

## Billing CMS-1450-Form 11 Identifying Dilapan-S®

**Field 42 – Revenue Code:** Hospitals are to report charges under the revenue code that will result in the charges being assigned to the same cost center to which the costs of those services are assigned in the cost report.

For example:

- 027X – Medical/Surgical Supplies and Devices;
- 0272 – Sterile Service

**Field 45 – Service Date:** Enter the date indicated service was provided.

**Field 46 – Diagnosis:** Enter appropriate diagnosis code as indicated.

**Field 47 – Admit Date (Admitting Diagnosis):** Enter a valid ICD-10-CM Diagnosis, code to the highest level of specificity.

Examples used but not limited to: O13.9 Gestational [pregnancy-induced] hypertension without significant proteinuria, unspecified trimester

**Field 74 – Secondary Procedure Date:** Enter the appropriate ICD-10-PCS code identifying the secondary medical or surgical procedure.

Examples used: OU7C7D – Dilatation of Cervix, Via Natural or Artificial Opening

**Field 8 – Remarks:** This field is used to report additional information necessary to receive the claim for the procedure (e.g., identify Dilapan-S for cervical ripening).

The image shows a CMS-1450-Form 11 (Inpatient Facility) with several fields highlighted by numbered circles:

- 1:** Field 42 (Revenue Code) in the procedure list.
- 2:** Field 45 (Service Date) in the procedure list.
- 3:** Field 46 (Diagnosis) in the patient information section.
- 4:** Field 47 (Admit Date) in the patient information section.
- 5:** Field 74 (Secondary Procedure Date) in the procedure list.

If insertion occurs more than 24 hours prior to delivery, with appropriate modifier and documentation of medical necessity, CPT 59200 is reported separately (outside the Maternity Global Bundle).

**Payers may require medical documentation (e.g., medical dictation notes) supporting medical necessity for CPT 59200.**

For illustrative purposes only. Example of billing claim form does not contain an exhaustive list of services which may be offered to a patient during the insertion service encounter. Place of service code depends on the site of care where procedure is performed. Diagnosis codes are based on the patient's condition. The physician is responsible for appropriate selection of procedure/service/treatment CPT/HCPCS codes.



## 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<sup>1</sup>

### 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 emailing [USRegulatory@medicem.com](mailto:USRegulatory@medicem.com).*

## References

Dilapan-S Instructions for Use. DSPlenus-Rev019/202 -05.

U.S. Food and Drug Administration. Dilapan-S. 510(k) – K143447. April 17, 2015.

Current Procedural Terminology 2025. CPT<sup>®</sup> copyright 2024 American Medical Association. All rights reserved. CPT<sup>®</sup> is a registered trademark of the American Medical Association. Applicable FARS/DFARS apply.

- 4 Calendar Year 2025 Medicare Physician Fee Schedule. Final Rule [CMS-1807-F]. Federal Register, December 9, 2024. Medicare physician national payment rates listed in this document are based on the 2025 PFS conversion factor of \$32.3465. No geographic adjustments have been made to the reported payments.
- 5 Centers for Medicare & Medicaid Services, CMS 1500 Claim Form. The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill Medicare carriers and durable medical equipment regional carriers (DMERCs) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. Revenue Code; Chapter 25 Medicare Claims Processing Manual, Publication# 100-04; 75.4 - Form Locator 42 (Rev. 1973, Issued: 05-21-10, Effective:09-01-10, Implementation: 09-01-10)  
  
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- 7 Calendar Year 2025 Medicare Outpatient Prospective Payment and Ambulatory Surgical Center Payment System. Final Rule [CMS-1809-FC]. Addendum A and B OPPTS APC. Federal Register, November 7, 2024. No geographic adjustments have been made to the reported payments.
- 8 Centers for Medicare & Medicaid Services Manual System Pub 100-04 Medicare Claims Processing Manual; Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPTS).  
<https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912> Accessed: January 21, 2025.  
  
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<https://www.cms.gov/medicare/icd-10/2023-icd-10-pcs> Accessed: January 20, 2025.  
  
Centers for Medicare & Medicaid Services, CMS 1450 Claim Form. The CMS-1450 form (aka UB-04 at present) can be used by an institutional provider to bill a Medicare fiscal intermediary (FI) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.

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