2016 OPPS Final Rule

Deborah K. Hale, CCS, CCDS
President - CEO
Resources

*OPPS Update 2016*

- OIG Work Plan 2016
- OIG Judgements
- OPPS Final Rules CY 2016
- IPPS Final Rule FY2016
- Two Midnight Rule Fact Sheet  November, 2016
- Transmittal 3217, March 13, 2015
OIG 2016 Work Plan

Hospital Focus (Partial List)

- Medicare costs associated with defective medical devices

- Medical device credits for replaced medical devices (NEW)

- See also MLN Matters MM9121 Effective 10/1/15 Updates to the List of MS-DRGs Subject to IPPS Replaced Devices...
MS-DRGs Subject to IPPS Replaced Devices Policy

**MLN Matters MM9121 – adds new DRGs to policy**

- MS-DRG 266 (Endovascular Cardiac Valve Replacement w/ Major Complication or Comorbidity (MCC))
- MS DRG 267 (Endovascular Cardiac Valve Replacement w/o MCC)
- MS-DRG 268 (Aortic and Heart Assist Procedures except Pulsation Balloon with MCC)
- MS-DRG 269 (Aortic and Heart Assist Procedures except Pulsation Balloon without MCC)
- MS-DRG 270 (Other Major Cardiovascular Procedures with MCC)
- MS-DRG 271 (Other Major Cardiovascular Procedures with CC)
- MS-DRG 272 (Other Major Cardiovascular Procedures without CC/MCC)
Reminders

Condition Codes on UB

- **49 Product Replacement within Product Lifecycle:** Replacement of a product earlier than the anticipated lifecycle (effective 1/1/15).
- **50 Product Replacement for Known Recall of a Product:** DRG payment will be adjusted to account for the manufacturer’s refund. (when refund is ≥ 50% of the cost of the device)
  - 49 and 50 apply only to specific devices – major joint replacements, defibrillators, pacemakers, cardiac valves, major cardiovascular devices, cochlear implants, peripheral neurostimulators, intracranial devices and heart assist systems.
OIG 2016 Work Plan

Hospital Focus (Partial List)

- Reconciliation of outlier payments

- Use of Outpatient and Inpatient Stays under Medicare’s two-midnight rule

- Medicare oversight of provider-based status

- Selected inpatient and outpatient billing requirements

- Intensity-modulated radiation therapy
OIG 2016 Work Plan

Hospital Focus (Partial List)

- Right heart catheterizations and endomyocardial biopsies during same operative episode
- Mechanical ventilation (> 96 hours)
- Kwashiorkor
- Bone marrow or stem cell transplants
- Medicare payments during MS-DRG payment window (NEW)
The Department of Justice has reached 70 settlements involving 457 hospitals in 43 states for more than $250 million related to cardiac devices that were implanted in Medicare patients in violation of Medicare coverage requirements...

“While recognizing and respecting physician judgment, the department will hold accountable hospitals and health systems for procedures performed by physicians at their facilities that fail to comply with Medicare billing rules,” said Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department’s Civil Division.
US Department of Justice: Cardiac Devices

October 30, 2015

- NCD Violated for Implantable Cardioverter Defibrillators
  - ICDs generally should not be implanted until waiting:
    - 40 days for heart attack
    - 90 days for bypass/angioplasty
  - DOJ alleged that from 2003 to 2010, each of the settling hospitals implanted ICDs during the periods prohibited by the NCD.
New PEPPER

IP vs OP Defibrillators
OIG Kwashiorkor Findings Continue

October 2015

- The Hospital received $8,319,111 in Medicare payments for inpatient hospital claims that included diagnosis code 260 for Kwashiorkor during our audit period (CYs 2010 through 2013) based on CMS’s National Claims History data.

- Kwashiorkor is a form of severe protein malnutrition. It generally affects children living in tropical and subtropical parts of the world during periods of famine or insufficient food supply. Cases in the United States are rare.
ASPEN Excerpts

American Society for Parenteral and Enteral Nutrition

- Undiagnosed Malnutrition in Hospitalized Patients Leads to Slower Healing, Higher Costs

- It is estimated that at least one third of patients in developed countries are malnourished upon admission to the hospital, yet the condition continues to be under-diagnosed across the United States.
OIG Kwashiorkor Findings Continue

October 2015

- For 66 of the inpatient claims, substituting a more appropriate diagnosis code produced no change in the DRG or payment amount.

- However, for the remaining 11 inpatient claims, the errors resulted in overpayments of $62,114. Hospital officials attributed these errors to a former owner of the hospital and to a lack of clarity in the coding guidelines.
ICD-10 Reporting Options

Note all are MCC.

Instances of E40, E41, E42 should be rare.

- **E40** Kwashiorkor
  - Severe malnutrition with nutritional edema with dyspigmentation of skin and hair
  - Excludes1: marasmic kwashiorkor (E42)

- **E41** Nutritional marasmus
  - Severe malnutrition with marasmus
  - Excludes1: marasmic kwashiorkor (E42)

- **E42** Marasmic kwashiorkor
  - Intermediate form severe protein-calorie malnutrition
  - Severe protein-calorie malnutrition with signs of both kwashiorkor and marasmus

- **E43** Unspecified severe protein-calorie malnutrition
  - Starvation edema
Hospital Response to Kwashiorkor Findings

October 2015

- “We have modified our internal coding processes to require a secondary review, inclusive of initiating a physician query process, for every instance that diagnosis code 260 is coded.”

- Do you have processes in place to validate high-risk diagnoses (DRGs) prior to billing?
Hospital Claims at Risk for Incorrect Billing

*Per OIG Reports*

- Inpatient short stays
- Inpatient claims billed with high-severity-level DRGs
- Inpatient claims billed for kyphoplasty services
- Inpatient claims paid in excess of charges
- Inpatient claims with cancelled surgical procedures
Patient Discharge Status & Hospital Transfer Policies

MLN Matters SE1411 Reissued Nov 17, 2015

- Hospitals are responsible for coding the discharge bill based on the discharge plan for the patient, and if the hospital subsequently learns that post-acute care was provided, the hospital should submit an adjustment bill to correct the discharge status code following Medicare’s claim adjustment criteria located in the “Medicare Claims Processing Manual,” Chapter 1, Section 130.1.1 and Chapter 34.
Patient Discharge Status & Hospital Transfer Policies

MLN Matters SE1411 Reissued Nov 17, 2015

- Acute Care Transfer with any MS-DRG:
  - Discharge Status 02 or 82 transfer (or with planned readmit) to acute care
  - Discharge Status 07 AMA but admitted to another PPS hospital same day
  - Discharge Status 66 (or with planned readmit 94) critical access hospital
  - Discharged and readmitted same day to another IPPS hospital – unless readmission is unrelated to initial discharge
Patient Discharge Status & Hospital Transfer Policies

MLN Matters SE1411 Reissued Nov 17, 2015

- Post-Acute Care Transfer affecting select MS-DRGs:
  - To IP Rehab 62 or with planned readmit 90
  - To LTAC 63 or with planned readmit 91
  - Psych 65 or with planned readmit 93
  - Cancer or Children’s hospital 05 or with planned readmit 85
  - SNF 03 or with planned readmit 83
  - Home health for services to occur within 3 days post discharge 06 or with planned readmit 86
Inpatient Only Procedures CY2016
Admission Order Necessity

The Centers for Medicare & Medicaid Services’ (CMS) Transmittal 3217, released on March 13, 2015

- Effective April 1, inpatient-only procedures performed in the outpatient setting can be bundled into billing of the inpatient admission, in accordance with the three-day window policy for outpatient services treated as inpatient services when the reason for admission is related. With this policy change, a hospital now has the opportunity to bundle—and thus obtain additional reimbursement for—any inpatient-only procedures performed in the outpatient setting with the inpatient-related admission.
### 2016 Addendum E Changes - Inpatient Only List

<table>
<thead>
<tr>
<th>Action</th>
<th>Code</th>
<th>Description</th>
<th>2016 SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added - new code 2016</td>
<td>33477</td>
<td>Transcatheter <strong>pulmonary valve</strong> implantation, <strong>percutaneous</strong> approach, including pre-stenting of the valve delivery site, when performed</td>
<td>C</td>
</tr>
<tr>
<td>Added - new code 2016</td>
<td>54438</td>
<td>Replantation, penis, complete amputation including urethral repair</td>
<td>C</td>
</tr>
<tr>
<td>Added - new code 2016</td>
<td>61650</td>
<td>Endovascular <strong>intracranial</strong> prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory</td>
<td>C</td>
</tr>
<tr>
<td>Added - new code 2016</td>
<td>61651</td>
<td>Endovascular <strong>intracranial</strong> prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (List separately in addition to code for primary procedure)</td>
<td>C</td>
</tr>
</tbody>
</table>
## 2016 Addendum E Changes - Inpatient Only List

<table>
<thead>
<tr>
<th>Action</th>
<th>Code</th>
<th>Description</th>
<th>2016 SI</th>
</tr>
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<tbody>
<tr>
<td>Removed - 2016 &quot;N&quot; status</td>
<td>20936</td>
<td>Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)</td>
<td>N</td>
</tr>
<tr>
<td>Removed - 2016 &quot;N&quot; status</td>
<td>20937</td>
<td>Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)</td>
<td>N</td>
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<tr>
<td>Removed - 2016 &quot;N&quot; status</td>
<td>20938</td>
<td>Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)</td>
<td>N</td>
</tr>
<tr>
<td>Action</td>
<td>Code</td>
<td>Description</td>
<td>2016 SI</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Removed - 2016 &quot;N&quot; status</td>
<td>22552</td>
<td>Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)</td>
<td>N</td>
</tr>
<tr>
<td>Removed - 2016 &quot;T&quot; status</td>
<td>27477</td>
<td>Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal</td>
<td>T</td>
</tr>
<tr>
<td>Removed - 2016 &quot;T&quot; status</td>
<td>27485</td>
<td>Arrest, hemiepiphysal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)</td>
<td>T</td>
</tr>
<tr>
<td>Removed - 2016 Deleted Code – Replacement code is 47399 and is “T” status.</td>
<td>47136</td>
<td>Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age</td>
<td>D</td>
</tr>
</tbody>
</table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Removed - 2016 &quot;J1&quot; Status</td>
<td>54411</td>
<td>Removal and replacement of all components of a <strong>multi-component inflatable</strong> penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue</td>
<td>J1</td>
</tr>
<tr>
<td>Removed - 2016 &quot;J1&quot; Status</td>
<td>54417</td>
<td>Removal and replacement of <strong>non-inflatable</strong> (semi-rigid) or <strong>inflatable (self-contained)</strong> penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue</td>
<td>J1</td>
</tr>
<tr>
<td>Removed - 2016 Deleted Code – replacement code is <strong>33477</strong> and is “C” status</td>
<td>0262T</td>
<td>Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach</td>
<td>D</td>
</tr>
<tr>
<td>Removed - 2016 &quot;J1&quot; Status</td>
<td>0312T</td>
<td>Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming</td>
<td>J1</td>
</tr>
</tbody>
</table>
Anterior Cervical Discectomy and Fusion (ACDF)

22551  Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2

+ 22552  cervical below C2, each additional interspace (List separately in addition to code for separate procedure)
Deleted from Addendum E (IP Only List)

- Single level anterior approach c-spine fusion below C2 (22551) was already an OP procedure

- 22551 changed to a J1 Status Indicator in 2015 meaning all other procedures on the same DOS are packaged
Deleted from Addendum E (IP Only List)

- Effective 1/1/16, multi-level ACDF below C2 (22552) are removed from the IP only list

- CPT 22552 is an add-on code, so no additional payment will be made when a second or more levels are fused

- 2016 Medicare Payment for 22551 is $10,537.90
The physician performs spinal fusion (arthrodesis) for indications such as herniated disc; degenerative, traumatic, and/or congenital lesions; or to stabilize fractures or dislocations of the spine.

Skull tong traction is applied. The physician uses an anterior approach to reach the damaged vertebrae. An incision is made through the neck, avoiding the esophagus, trachea, and thyroid. Retractors separate the intervertebral muscles.
The physician cleans out the intervertebral disc space with a rongeur, removing the cartilaginous material above and below the vertebra to be fused. Preparation includes discectomy and osteophytectomy for nerve root or spinal cord decompression.

The physician obtains and packs separately reportable graft material of iliac or other donor bone into the spaces. Traction is gradually decreased to maintain the graft in its bed. The fascia is sutured. A drain is placed and the incision is sutured. Report 22551 for a single cervical interspace below C2. Report 22552 for each additional interspace below C2.
Video of ACDF

Inpatient ICD-10-PCS

- ICD-10-PCS Procedure code - 0RG2070
  - Fusion 2-6 C Jt w Autol Sub, Ant Appr A Col, Open
- MS-DRG 473 w/o CC/MCC – 2.265 - $14,486
- MS-DRG 472 w/CC – 2.9051 - $18,502
- 2016 Medicare Payment for 22551 is $10,537.90
  - J1 Status Indicator
  - Comprehensive APC Payment
  - Packaged payment for UB-04 claim 131
Two (2) Midnight Rule for Cervical Fusion

- Length of stay expectation of 2 or more midnights – no instrumentation
  - Inpatient status should be ordered
- Length of stay expectation of only 1 midnight
  - Outpatient surgery should be ordered
- Posterior or Anterior Instrumentation being used – Inpatient only procedure
  - Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation, dual rods with multiple hooks,
Deleted from Addendum E (IP Only List)

+ **20936** Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)

   (Use 20936 in conjunction with 22319, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812)

+ **20937** morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)

   (Use 20937 in conjunction with 22319, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812)

+ **20938** structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)

   (Use 20938 in conjunction with 22319, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812)

   (For needle aspiration of bone marrow for the purpose of bone grafting, use 38220. Do not report 38220-38230 for bone marrow aspiration for platelet rich stem cell injection. For bone marrow aspiration for platelet rich stem cell injection, use 0232T)
IP Only Procedures that will package into SI=N when reported with a JI like 22551

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>22830</td>
<td>Exploration of spinal fusion</td>
<td>C</td>
</tr>
<tr>
<td>22840</td>
<td>Insert spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22841</td>
<td>Insert spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22842</td>
<td>Insert spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22843</td>
<td>Insert spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22844</td>
<td>Insert spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22845</td>
<td>Insert spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22846</td>
<td>Insert spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22847</td>
<td>Insert spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22849</td>
<td>Reinsert spinal fixation</td>
<td>C</td>
</tr>
<tr>
<td>22850</td>
<td>Remove spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22852</td>
<td>Remove spine fixation device</td>
<td>C</td>
</tr>
<tr>
<td>22855</td>
<td>Remove spine fixation device</td>
<td>C</td>
</tr>
</tbody>
</table>
Update on Two Midnight Rule for Inpatient Admission
Inpatient Admission Decisions

“...Admit as inpatient if and when additional information suggests a longer stay or the passing of the second midnight is anticipated.”

“The decision to admit becomes easier as the time approaches the second midnight, and beneficiaries in medically necessary hospitalizations should not pass a second midnight prior to an admission order being written.”
Inpatient Admission Decisions

- Count preadmission hospital care beginning with the initial assessment and development of the treatment plan. Do not count ED triage time.

Source: Open Door Forum, December 19, 2013
Inpatient Admission Decisions

Define medical necessity for continued stay ...

✓ Clinical judgement of the physician?
✓ Admission screening criteria?
✓ Clinical judgement of the UR nurse
✓ Physician advisor opinion
Decision to Admit Following Observation

- An order to “admit” may be written just prior to discharge, but it can’t be backdated. Admission is warranted if patient is receiving reasonable and necessary services that can only be provided in a hospital setting.

Source: Open Door Forum 12-19-2013
Inpatient Admission Decisions

- CMS is “agnostic” regarding intensity of service at the time of the admission order. Audit will evaluate the medical necessity of the hospital services provided to establish necessity of admission.

Source: CMS Open Door Forum December 19, 2013
Decision to Admit Following Observation

- “This revision should virtually eliminate the use of extended observation.”

- Admission orders can not be backdated to the beginning of the observation care.
“As we considered changes to this rule, CMS sought to balance multiple goals, including:

- respecting the judgment of physicians;
- supporting high quality care for Medicare beneficiaries;
- providing clear guidelines for hospitals and doctors; and
- incentivizing efficient care to protect the Medicare trust funds.”

Source: Fact Sheet - 2016 Principles for Proposing to Update the Two Midnight Rule
Inpatient Admission Decisions
New 2016

“For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient only list or otherwise listed as a national exception), an inpatient admission would be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician.”*

*Decision must be supported by clinical evidence in the medical record.*

*Source: Fact Sheet - 2016 Principles for Proposing to Update the Two Midnight Rule*
Inpatient Admission Decisions
New 2016

- CMS is reiterating the expectation that it would be rare and unusual for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight. CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review.
For hospital stays that are expected to be two midnights or longer, our policy is unchanged;
Inpatient Admission Audits
New 2016

- CMS has decided to use QIOs, rather than Medicare Administrative Contractors (MACs) or Recovery Auditors, to conduct the first line medical reviews of providers who submit claims for inpatient admissions.
Quality Improvement Organizations (QIOs) will oversee the majority of patient status audits, with the Recovery Audit program focusing on only those hospitals with consistently high denial rates.
New Recovery Auditor Review Limits

*Effective January 2016*

- Annual ADR (additional documentation request) limit 0.5% of provider’s total number of paid claims from the previous year.

- ADR letters sent on 45-day cycle; cycle limit = annual limit / 8

- “CMS will adjust a provider’s ADR limit based on the provider’s compliance with Medicare rules. Providers with low denial rates will have ADR limits decreased, while providers with high denial rates will have their ADR limits increase.”
New Recovery Auditor Review Limits

Effective January 2016

- For Example:
  - Provider’s 2014 Medicare claims paid: 22,530
  - Annual ADR limit = 0.5% 112.65
  - 45-Day cycle limit (8) 14 records

- ADR limits diversified across all claim types based on types of bills paid in previous year
Auditor Review Limits

2016

To address hospitals’ concerns that they do not have the opportunity to rebill for medically necessary Medicare Part B services by the time a medical review contractor has denied a Medicare Part A claim, CMS is changing the recovery auditor “look-back period” for patient status reviews to 6 months from the date of service in cases where a hospital submits the claim within 3 months of the date that it provides the service.
Auditor Review Limits

2016

- CMS has also announced a requirement that recovery auditors must complete complex reviews within 30 days and that failure to do so will result in the loss of the recovery auditor’s contingency fee, even if an error is found.
Finally, CMS will require recovery auditors to wait 30 days before sending a claim to the MAC for adjustment. This 30-day period allows the provider to submit a discussion period request before the MAC makes any payment adjustments.
2016 OPPS Final Rule

Kathy Dean, CPMA, CPC, COC, CPC-P, CCS-P
2016 OPPS Final Rule

- OPPS Final Rule: CMS-1633-FC (display)
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html
Medicare Physician Fee Schedule

- Medicare Physician Fee Schedule Rule: CMS01631-FC (display)

References

- Review coding and billing instructions from CMS
  - January 2016 OPPS Update – MM9486

References

HCPCS code updates for 2016

References

- National Correct Coding Initiative Manual
  

- The 2016 manual chapters have been posted to the CMS website
Additional References

- Medically Unlikely Edits (MUEs)
  - https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

- CMS internet only manuals
  - Medicare Claims Processing Manual (Pub. 100-04)
  - Benefit Policy Manual (Pub. 100-02)
Additional References

- FDA information on biosimilars

- CPT codes - Copyright © 2015 by the American Medical Association
2016 OPPS Update

- Overall decrease in payment rates of 0.3%

- Continuing the 2.0 percentage point reduction in payment for facilities failing to meet the hospital OP quality reporting requirements
2016 OPPS Final Rule

- Continuing the rural adjustment of 7.1% to certain rural sole community hospitals (SCHs) including essential access community hospitals (EACHs)

- Excludes:
  - Separately payable drugs and biologicals
  - Devices paid under pass through payment policy
  - Items paid at charges reduced to cost
Outlier Payment

- Designed for high cost, complex procedures that could present significant financial loss to hospitals because the cost greatly exceeds the APC payment amount

- Continues with two threshold model
  - 1.75 times the APC payment amount
  - Fixed-dollar threshold of $3,250
    - Increased from $2,775 for 2015
Outlier Payment

- CMS will continue to pay 50% of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment when both thresholds are met.
APC Changes

- **Skin Procedures**
  - Combined debridement and skin procedures to create more appropriate categories
  - Skin Procedures and related services – Levels 1 - 5
  - SI changed to Q1 for 36 codes in these APCs

- **Negative Pressure Wound Therapy Services**
  - CPT 97605 and 97606 represent the therapy provided with DME
  - SI changed to Q1 for these codes
Payment Packaging

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>SI</th>
<th>APC</th>
<th>2016 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>11042</td>
<td>Deb subq tissue 20 sq cm/&lt;</td>
<td>T</td>
<td>5052</td>
<td>$225.55</td>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>SI</th>
<th>APC</th>
<th>2016 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>97605</td>
<td>Neg press wound tx &lt;=50 cm</td>
<td>Q1</td>
<td>5051</td>
<td>$117.83</td>
</tr>
</tbody>
</table>

If Debridement is done on the same date as negative pressure wound therapy then only the debridement will be paid. This is due to CPT 97605 being changed to Q1 status indicator.
APC Changes

- Orthopedic Procedures
  - We believe that establishing more inclusive categories of the orthopedic-related procedures is more appropriate for future ratesetting under the OPPS because the restructured APCs have more clinically appropriate groupings, while improving resource similarity.

- Musculoskeletal Procedures – Levels 1 – 5
- Strapping and Cast Application – Levels 1 and 2
- Closed Treatment Fracture and Related Services – Levels 1 – 3
Orthopedic APC Change Examples

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>2016 SI</th>
<th>2015 APC</th>
<th>2016 APC</th>
<th>2015 Payment Rate</th>
<th>2016 Payment Rate</th>
<th>Difference +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>23450</td>
<td>Repair shoulder capsule</td>
<td>T</td>
<td>0052</td>
<td>5122</td>
<td>$6,322.79</td>
<td>$2,395.59</td>
<td>-$3,927.20</td>
</tr>
<tr>
<td>29125</td>
<td>Apply forearm splint</td>
<td>Q1</td>
<td>0420</td>
<td>5734</td>
<td>$131.75</td>
<td>$91.18</td>
<td>-$40.57</td>
</tr>
</tbody>
</table>
New Status Indicator J2

- **J2** - Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
2016 OPPS Final Rule

- CMS reminds providers to report all services provided to patients whether they are separately paid or not.

**Bedside Procedure Examples**
- Drug Administration Services (injections and infusions)
- Indwelling Catheter Insertion
- Arterial Puncture, withdrawal of blood for diagnosis
- Central Line Placement
- Intubation
- CPR
- CO2 expired gas determination by infrared analyzer
2016 OPPS Final Rule

- It is more important than ever to report appropriate charges for all services and procedures provided due to the implementation of Comprehensive APC’s.

- CMS uses the charge data to create accurate future Comprehensive APC payments
Composite APCs

- 3 Composite APCs remain intact for CY 2016

  - LDR Prostate Brachytherapy
  - Multiple Imaging Services
    - Families listed in Table 10 of the final rule
  - Mental Health Services

  - EP and Ablation moved to Comprehensive APC in 2015
  - Observation moved to C-APC payment in 2016
Comprehensive APCs

- A C-APC is defined as a classification for the provision of a primary service and all adjunctive services provided to support the delivery of the primary service. CMS established C-APCs as a category broadly for OPPS payment and implemented 25 C-APCs beginning in CY 2015
  - (79 FR 66809 through 66810).
Comprehensive APCs

- Status Indicator J1 implemented in CY 2015
  
  When a primary service is reported on a hospital OP claim, a single payment is made for all items and services reported on the claim; payment for adjunctive services are packaged into the payment for the primary service.
Comprehensive APCs

- Services excluded from C-APC packaged payment
  - Ambulance services
  - Brachytherapy
  - Diagnostic and screening mammograms
  - Physical/Speech-Language/Occupational therapy services reported on a separate facility claim for recurring services
  - Pass-through drugs, biologicals and devices
Comprehensive APCs

- Preventive services defined in 42 CFR 410.2
  - Additional preventive services as defined in section 1861(ddd)(1) of the Act
- Self-administered drugs that do not function as supplies
- Services assigned OPPS status indicators F and L
- Certain Part B Inpatient services
Comprehensive APCs

- Certain Self-administered drugs are packaged into the C-APC payment as they are considered to be supplies

  - Sedatives administered in the preoperative area
  - Mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic drops/ointments, and ocular hypotensives that are administered to a patient immediately before, during, or immediately following an ophthalmic procedure. This does not refer to the patient’s eye drops that the patient uses pre- and postoperatively.
  - Barium or low osmolar contrast media provided integral to a diagnostic imaging procedure.
Comprehensive APCs

- Certain Self-administered drugs are packaged into the C-APC payment as they are considered to be supplies.
  - Topical solution used with photodynamic therapy furnished at the hospital to treat nonhyperkeratotic actinic keratosis lesions of the face or scalp.
  - Antibiotic ointments such as bacitracin, placed on a wound or surgical incision at the completion of a procedure.
  - Medicare Benefit Policy Manual, Chapter 15, section 50.2.M
Comprehensive APCs

- Multiple J1 services on the same claim
  - May trigger a complexity adjustment
  - Additional J1 becomes an “add on” code for complexity adjustment

- No additions for CY 2016
  - Addendum J
Comprehensive APCs

- Impact on recurring claims or series billing
  
  - Claims Processing Manual (Pub 100-4), Chapter 1, section 50.2.2
  - Only recurring services should be billed monthly
  - If recurring service occurs on same day as acute service, report on separate claims
Recurring Services

Service and Revenue Codes

- DME Rental – 290-299
- Radiation Therapy – 333
- Respiratory – 410-419
- PT, OT, ST – 420 – 429, 430 – 439, 440 – 449
- Home Health – 550 – 559
- Kidney Dialysis Treatments – 820 – 859
- Cardiac Rehab Services – 482, 943
- Psychological Services – 900, 901, 911, 919 (in a psychiatric facility)
Comprehensive APCs

- Expansion for CY 2016
  - Finalized 10 new C-APCs
  - Expanded add–on code list to include any J1 add-on code
## Comprehensive APCs

<table>
<thead>
<tr>
<th>CY 2016 C-APC*</th>
<th>CY 2016 APC Group Title</th>
<th>Clinical Family</th>
<th>New C-APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>5123</td>
<td>Level 3 Musculoskeletal Procedures</td>
<td>ORTHO</td>
<td>*</td>
</tr>
<tr>
<td>5125</td>
<td>Level 5 Musculoskeletal Procedures</td>
<td>ORTHO</td>
<td>*</td>
</tr>
<tr>
<td>5165</td>
<td>Level 5 ENT Procedures</td>
<td>ENTXX</td>
<td>*</td>
</tr>
<tr>
<td>5361</td>
<td>Level 1 Laparoscopy</td>
<td>LAPXX</td>
<td>*</td>
</tr>
<tr>
<td>5362</td>
<td>Level 2 Laparoscopy</td>
<td>LAPXX</td>
<td>*</td>
</tr>
<tr>
<td>5375</td>
<td>Level 5 Urology and Related Services</td>
<td>UROXX</td>
<td>*</td>
</tr>
<tr>
<td>5416</td>
<td>Level 6 Gynecologic Procedures</td>
<td>GYNXX</td>
<td>*</td>
</tr>
<tr>
<td>5492</td>
<td>Level 2 Intraocular Procedures</td>
<td>EYEXX</td>
<td>*</td>
</tr>
<tr>
<td>5881</td>
<td>Ancillary Outpatient Services When Patient Expires</td>
<td>N/A</td>
<td>*</td>
</tr>
<tr>
<td>8011</td>
<td>Comprehensive Observation Services</td>
<td>N/A</td>
<td>*</td>
</tr>
</tbody>
</table>
Observation
Patient-Family Perception of Observation

HHS scrutinizes observational care policy

- “A Medicare patients' chances of being admitted to the hospital or kept for observation depend on which hospital they go to -- even when their symptoms are the same.”

Observation
Patient-Family Perception

Some patients pay more in observation

- “For 6 percent of all observation stays, or 83,747 stays, beneficiaries paid more than the inpatient deductible.

- Notably, for 3,439 observation stays, beneficiaries paid more than two times the inpatient deductible.”

Observation
Billing and Reimbursement

- CMS is sharply accelerating its push toward moving outpatient payments from a fee-for-service model to a true prospective payment system with a number of its proposals in the 2016 OPPS proposed rule, including new comprehensive ambulatory payment classifications (C-APC) and extensive APC consolidation and reconfiguration.
Observation
Billing and Reimbursement

Effective January 1, 2016 – new C-APC

- C-APC 8011 – Comprehensive Observation Services
- **Delete** APC 8009 Extended Assessment and Monitoring
- New status indicator – J2
- Proposed payment of **$2,111**

- Based on 1,191,120 claims used for rate setting
Observation
Billing and Reimbursement

- Claim contains one of the following:
  - G0379 – direct referral for observation services
  - 99281–99285, G0384, 99291 – emergency department visit (Type A or B)
  - G0463 – provider-based clinic
  - Same date or one day earlier than the date of service reported with G0378

- Claim does not contain a status indicator “J1” procedure
# Observation

## Billing and Reimbursement

<table>
<thead>
<tr>
<th>Service/Test</th>
<th>CPT/HCPCS</th>
<th>2015 Final</th>
<th>2016 Proposed</th>
<th>$ Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation +8 hr</td>
<td>G0378 x8+</td>
<td>SI N APC 8009</td>
<td>SI N C-APC 8011</td>
<td>-</td>
</tr>
<tr>
<td>ED E&amp;M Level IV</td>
<td>99284-25</td>
<td>SI V $1,234.22</td>
<td>SI J2 $2,111.00</td>
<td>+$876.78</td>
</tr>
<tr>
<td>CBC w/diff</td>
<td>85025</td>
<td>SI N</td>
<td>SI Q4</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>CMP</td>
<td>80053</td>
<td>SI N</td>
<td>SI Q4</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>PT</td>
<td>85610</td>
<td>SI N</td>
<td>SI Q4</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>PTT</td>
<td>85730</td>
<td>SI N</td>
<td>SI Q4</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>Troponin x3</td>
<td>84484 x3</td>
<td>SI N</td>
<td>SI Q4</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>CK-MB x3</td>
<td>82553 x3</td>
<td>SI N</td>
<td>SI Q4</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>Chest X-ray</td>
<td>71010</td>
<td>SI Q3 $59.34</td>
<td>SI Q3 $0</td>
<td>-$59.34</td>
</tr>
<tr>
<td>EKG</td>
<td>93005</td>
<td>SI Q1 $0</td>
<td>SI Q1 $0</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>NM Stress Test</td>
<td>78452</td>
<td>SI S $1,140.10</td>
<td>SI S $0</td>
<td>-$1,140.10</td>
</tr>
<tr>
<td>CV Stress</td>
<td>93017</td>
<td>SI Q1 $0</td>
<td>SI Q1 $0</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>Lexiscan 0.4 mg</td>
<td>J2785 x4</td>
<td>SI N</td>
<td>SI N</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>Cardiolite</td>
<td>A9500 x2</td>
<td>SI N</td>
<td>SI N</td>
<td>$ 0.00</td>
</tr>
<tr>
<td><strong>Total Payment</strong></td>
<td><strong>$2,433.66</strong></td>
<td><strong>$2,111.00</strong></td>
<td></td>
<td><strong>-$322.66</strong></td>
</tr>
</tbody>
</table>

Source: ACS
Observation
Billing and Reimbursement

“... beneficiaries can expect to pay a single copayment for the comprehensive service that would be subject to the copayment liability cap. As a result, we expect that this policy likely reduces the possibility that the overall beneficiary liability exceeds the cap for most of these types of claims.”

Source: OPPS Proposed CY 2016 C-APC+
# Observation versus Inpatient Billing and Reimbursement

<table>
<thead>
<tr>
<th>2016 observation payment</th>
<th>2016 MS-DRG payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAD with unstable angina</strong></td>
<td><strong>CAD with unstable angina</strong></td>
</tr>
</tbody>
</table>
| **$2,111** (includes coinsurance amounts and deductible) | • **MS-DRG 303** GMLOS 2.0 Arteriosclerosis w/o MCC  
• **$4,177** (includes deductible if due) |
Solutions to the Observation Billing and Reimbursement Challenge

- Initial screening at point of entry to avoid overuse of observation services

- Careful monitoring for timely transition from observation to inpatient admission

- To protect future rate setting, post all appropriate charges despite comprehensive APC payment for 2016
President Obama signed the "Notice of Observation Treatment and Implication for Care Eligibility Act," or the NOTICE Act, into law. This law alters both the manner and time frame in which hospitals must notify patients of their observation status.
Comprehensive APCs Specific Policies

- Stereotactic Radiosurgery
  - To collect claims data on the adjunctive services for the SRS “J1” procedures and to ensure appropriate ratesetting for the SRS CAPC in the future, CMS believes it is necessary to unbundle payment for the adjunctive services for CY2016 and CY2017.
Comprehensive APCs Specific Policies

- **Stereotactic Radiosurgery**
  - For CY 2016 and 2017, the codes for planning and preparation services will not be included in the C-APC payment for SRS even if they are furnished on the same date of service.
  - Remind hospitals that procedure codes related to the primary SRS service should either be reported on the same claim, or, if furnished on a different date than the primary service:
    - Must include modifier “CP”
Table 5 - Planning and Preparation Services involved:

<table>
<thead>
<tr>
<th>CPT</th>
<th>St Ind</th>
<th>Long Descriptions</th>
<th>2016 Reimb</th>
</tr>
</thead>
<tbody>
<tr>
<td>70551</td>
<td>Q3</td>
<td>Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material</td>
<td>$273.54</td>
</tr>
<tr>
<td>70552</td>
<td>Q3</td>
<td>Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)</td>
<td>$454.32</td>
</tr>
<tr>
<td>70553</td>
<td>Q3</td>
<td>Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences</td>
<td>$454.32</td>
</tr>
<tr>
<td>77011</td>
<td>N</td>
<td>Computed tomography guidance for stereotactic localization</td>
<td></td>
</tr>
<tr>
<td>77014</td>
<td>N</td>
<td>Computed tomography guidance for placement of radiation therapy fields</td>
<td></td>
</tr>
</tbody>
</table>
Table 5 - Planning and Preparation Services involved:

<table>
<thead>
<tr>
<th>CPT</th>
<th>St Ind</th>
<th>Long Descriptions</th>
<th>2016 Reimb</th>
</tr>
</thead>
<tbody>
<tr>
<td>77280</td>
<td>S</td>
<td>Therapeutic radiology simulation-aided field setting; simple</td>
<td>$166.65</td>
</tr>
<tr>
<td>77285</td>
<td>S</td>
<td>Therapeutic radiology simulation-aided field setting; intermediate</td>
<td>$291.77</td>
</tr>
<tr>
<td>77290</td>
<td>S</td>
<td>Therapeutic radiology simulation-aided field setting; complex</td>
<td>$291.77</td>
</tr>
<tr>
<td>77295</td>
<td>S</td>
<td>3-dimensional radiotherapy plan, including dose-volume histograms</td>
<td>$1,026.81</td>
</tr>
<tr>
<td>77336</td>
<td>S</td>
<td>Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy</td>
<td>$107.40</td>
</tr>
</tbody>
</table>
Comprehensive APCs Specific Policies

- Only applicable to SRS at this time for CY 2016 and 2017 claims

- Hospitals must report modifier “CP” (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure) on TOB 13X claims for any other services (aside from the ten codes in Table 5) that are adjunctive or related to SRS treatment but billed on a different date of service and within 30 days prior or 30 days after the date of service for either CPT codes 77371 (Radiation treatment delivery, stereotactic radiosurgery, complete course of treatment cranial lesion(s) consisting of 1 session; multi-source Cobalt 60-based) or 77372 (Linear accelerator based).
Comprehensive APCs Specific Policies

- The “CP” modifier should be reported under all circumstances in which a service adjunctive or related to SRS treatment is provided within one month of SRS treatment.
- This means that if multiple physicians within the same health system furnish an adjunctive SRS service, then all claims from these physicians would need to report the “CP” modifier with the HCPCS code for the related SRS adjunctive service(s).
Outpatient Visits

- G0463 continues to be utilized for OP Visits
  - Status indicator changed to J2

<table>
<thead>
<tr>
<th></th>
<th>2015 Payment</th>
<th>2016 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$96.25</td>
<td>$102.12</td>
</tr>
</tbody>
</table>
ED Visits

- CPT codes for five (5) levels of Type A ED visits (99281-99285)
  - Status Indicator Changed to J2

<table>
<thead>
<tr>
<th>Code</th>
<th>2015 Payment</th>
<th>2016 Payment</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>$60.49</td>
<td>$59.30</td>
<td>-$1.19</td>
</tr>
<tr>
<td>99282</td>
<td>$112.79</td>
<td>$109.50</td>
<td>-$3.29</td>
</tr>
<tr>
<td>99283</td>
<td>$198.39</td>
<td>$195.98</td>
<td>-$2.41</td>
</tr>
<tr>
<td>99284</td>
<td>$333.80</td>
<td>$326.99</td>
<td>-$6.81</td>
</tr>
<tr>
<td>99285</td>
<td>$492.69</td>
<td>$486.04</td>
<td>-$6.65</td>
</tr>
</tbody>
</table>
# ED Visits

- **HCPCS codes for five (5) levels of Type B ED visits (G0380-G0384)**
  - **Status Indicator Changed to J2**

<table>
<thead>
<tr>
<th>Code</th>
<th>2015 Payment</th>
<th>2016 Payment</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0380</td>
<td>$62.72</td>
<td>$79.22</td>
<td>$16.50</td>
</tr>
<tr>
<td>G0381</td>
<td>$69.51</td>
<td>$76.17</td>
<td>$6.66</td>
</tr>
<tr>
<td>G0382</td>
<td>$112.97</td>
<td>$115.20</td>
<td>$2.23</td>
</tr>
<tr>
<td>G0383</td>
<td>$198.98</td>
<td>$196.25</td>
<td>-$2.73</td>
</tr>
<tr>
<td>G0384</td>
<td>$304.38</td>
<td>$315.88</td>
<td>$11.50</td>
</tr>
</tbody>
</table>
ED Visits

- Critical Care (99291-99292)
  - Status Indicator Change J2

<table>
<thead>
<tr>
<th>Code</th>
<th>2015 Payment</th>
<th>2016 Payment</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291</td>
<td>$656.94</td>
<td>$666.27</td>
<td>$9.33</td>
</tr>
</tbody>
</table>
ED Visits

- CMS noted that additional study is required to determine the best payment structure for Emergency Department Visits
Pass-through Payments for Devices

- Pass-Through status expiring December 31, 2015
  - C1841 - Retinal prosthesis, includes all internal and external components
    - SI becomes N
Pass-through Payments for Devices

- Four Devices continue to have Pass-Through status for CY 2016
  - **C2623** - Catheter, transluminal angioplasty, drug-coated, non-laser
    - The Lutonix® 035 DCB—the first FDA-approved DCB—is an angioplasty balloon coated with a therapeutic dose of the drug paclitaxel, and also utilizes standard mechanical dilatation of the vessel to restore blood flow for patients with peripheral arterial disease (PAD) in the femoropopliteal arteries.
- **C1822** - Generator, neurostimulator (implantable), **high frequency**, with rechargeable battery and charging system
  - Restore Sensor Neurostimulator
## Revised Description

### Table 2 - Revised Short and Long Descriptors for HCPCS Code C1820

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>CY 2016 OPPS SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1820</td>
<td>Gen, neuro, non-HF rechg bat</td>
<td>Generator, neurostimulator (implantable), non-high-frequency with rechargeable battery and charging system</td>
<td>N</td>
</tr>
</tbody>
</table>

Note that HCPCS code C1820 describes an implantable *non high-frequency* neurostimulator generator device with rechargeable battery and charging system, while HCPCS code C1822 describes an implantable *high-frequency* neurostimulator generator device with rechargeable battery and charging system.
- **C2624** - Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components
  - The CardioMEMS HF System is indicated for wirelessly measuring and monitoring pulmonary artery (PA) pressure and heart rate
C2613 - Lung biopsy plug with delivery system

- The BioSentry™ tract sealant system is the first biopsy sealant system of its kind and represents a major advance in the prevention of lung biopsy-related pneumothorax.
- The BioSentry™ system deploys a self-expanding hydrogel plug into the pleural space following biopsy. The plug expands, creating an airtight seal that closes the pleural puncture, reducing the risk of pneumothorax by more than 50%.
Device Intensive Procedures

- Device Intensive APCs
  - 18 APCs for 2016 – Table 42
  - Offset applies if the cost of the device is 40% or greater of the APC payment

- Device to Procedure Edits
  - Any device code on the list will satisfy the edit from a claims processing perspective
Device Intensive Procedures

- CMS expects to see the appropriate/correct device code reported even without device-to-procedure edits.

- CMS expects hospitals to code correctly to report correct device cost.

- **CY 2016** – only procedures that require the implantation of a device assigned to a device intensive APC will require a device code on the claim.
Value Code FD

- Value Code FD (Credit Received from the Manufacturer for a Replaced Medical Device) – effective CY 2014

- Claims data now available with value code and the actual amount of the credit reported when credit was for 50% or more of the cost of the device
Value Code FD

- Policy of reducing the APC payment by full or partial amount based on the credit reported – continues for CY 2016

- Offset applies to all devices reported as part of a device-intensive APC

- No longer limited to a specific list of devices.
Ensure the hospital has a process in place to identify the credit and provide the information to the billing department in order to bill the claim correctly with Value Code FD.
Discontinued Procedures

- Involving Devices
  - Modifier 73 – Discontinued OP procedure prior to the administration of anesthesia

- Payment will be decreased by 100% of the device offset and then the adjustment for the discontinued procedure
Discontinued Procedures

- Modifier 74 – Discontinued OP procedure after administration of anesthesia
  - Offset does not apply
  - CMS believes it is more likely that the device was no longer sterile since the procedure had started
When a procedure assigned to a device-intensive APC is discontinued either prior to administration of anesthesia or for a procedure that does not require anesthesia, we presume that, in the majority of cases, the device was not used and remains sterile such that it could be used for another case. In these circumstances, under current policy, hospitals could be paid twice by Medicare for the same device, once for the initial procedure that was discontinued and again when the device is actually used......
CMS Final Rule Statement

- We note that the commenters did not provide a clinical reason for why an implantable device would need to be opened in advance of a procedure. **Although we acknowledge that some hospitals may choose to open devices prior to the start of the surgery, we do not believe that this practice is necessary.** We continue to believe that, in the majority of cases, supplies for a procedure can be arrayed in advance of the procedure, and that implantable devices that are assigned to a device-intensive APC could be opened when ready for insertion.
Drugs, Biologicals and Radiopharmaceuticals

- **Packaging Threshold**
  - Increases to $100 for CY 2016
    - All drugs with per day cost less than or equal to $100 will be packaged
  - CY 2015 threshold was $95
  - CY 2014 threshold was $90
  - Per day cost greater than $100 - separately payable (ASP +6%)
Drugs, Biologicals and Radiopharmaceuticals

- Packaging determination continues to be on a drug-specific basis, not HCPCS code–specific basis

- Does not apply if the drug or biological is “policy packaged”
Drugs, Biologicals and Radiopharmaceuticals

- Separately payable drugs, biologicals and therapeutic radiopharmaceuticals
  - Reimbursed at ASP plus 6%
  - Same for those with and without pass-through status
    - (SI = G and K)
Radiopharmaceuticals derived from non-highly enriched uranium sources

- HCPCS code Q9969 (*Tc*-99m from non-highly enriched uranium source, full cost recovery add-on, per study dose)
- Hospital certifies that 95% is derived from non-HEU sources
- $10 additional payment
- To be reassessed but not anticipated to extend beyond CY 2017
Drugs, Biologicals and Radiopharmaceuticals

- Pass-through status expires for twelve (12) drugs/biologicals (Table 43)

- Pass-through status continues for thirty-eight (38) drugs/biologicals (Table 44)
Drugs, Biologicals and Radiopharmaceuticals

- Contrast Agent with pass-through status
  - Q9950 - *Injection, sulfur hexafluoride lipid microsphere, per ml*
  - Offset applies if packaged amount is greater than $20
  - Table 46 (page 530 in the display copy) lists procedures to which this applies

- E.g., Echo Contrast (bubble study), Cardiac Catheterizations, CT/CTA with contrast
Drugs, Biologicals and Radiopharmaceuticals

Change request (CR) 9357 provides instructions for Medicare systems to be updated to include influenza virus vaccine code 90630 (Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use) for claims with dates of service on or after August 1, 2015.

Make sure your billing staffs are aware of this code change.

- Status Indicator “L”
Biosimilar Products

Biosimilar

Section 3139 of the Affordable Care Act amended section 1847A of the Act to add the definition of biosimilar biological product and set forth a payment methodology for biosimilar biological products.
Biosimilar Products

Definition
- Biological product approved under an abbreviated application for license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act (PHSA)
- The product has a high degree of similarity in the active component(s)
- No clinically meaningful differences in safety, purity and potency
  - i.e., Produces the same clinical result as the reference product
Biosimilar Products

- First one approved on March 6, 2015
  - Filgrastim (G-CSF), Biosimilar, \textbf{1 mcg} (Q5101)
    Effective 1/1/2016
  - Modifier ZA (Novartis/Sandoz)
  - Status Indicator – G Payment (.97)
Biosimilar Products

- Payment is based on the ASP of all NDCs assigned to the biosimilar biological products including within the same billing and payment code.
  - Single ASP payment limit for products assigned to a specific HCPCS code
  - HCPCS code will represent the products relying on the same common reference product’s biologics license application (BLA)
  - Similar to what is done today under OPPS – packaging and pricing for a HCPCS code is established by cost information for the specific drug and not how the drug is supplied.
Biosimilar Products

- Eligible for pass-through payment
- If non-pass through item, subject to packaging threshold
- Separately payable (ASP+6%)
Biosimilar Products

- Desirable to be able to track biosimilars. Commenters suggested alternative means for tracking this information other than through clinical studies
  - CMS is developing an approach for using manufacturer-specific modifiers on claims to assist in data collection.
    - New modifier ZA = Novartis/Sandoz

- Additional guidance to be provided
Skin Substitutes

- Implantable biologicals are treated as packaged supplies under OPPS

- For CY 2016, removing implantable biological products from the skin substitute cost group
## Implantable Biological Products

<table>
<thead>
<tr>
<th>CY 2016 HCPCS Code</th>
<th>CY 2016 Short Descriptor</th>
<th>CY 2016 Status Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9358</td>
<td>SurgiMend, fetal</td>
<td>N</td>
</tr>
<tr>
<td>C9360</td>
<td>SurgiMend, neonatal</td>
<td>N</td>
</tr>
<tr>
<td>Q4125</td>
<td>Arthrophlex</td>
<td>N</td>
</tr>
<tr>
<td>Q4130</td>
<td>Strattice TM</td>
<td>N</td>
</tr>
<tr>
<td>Q4142</td>
<td>Xcm biologic tiss matrix 1cm</td>
<td>N</td>
</tr>
</tbody>
</table>
Skin Substitutes

- Not removed from the list
  - Q4107 - Graft jacket, per square centimeter
  - Can be used both as an implantable biological and a skin substitute
    - SI = N
Skin Substitutes

- High Cost vs. Low Cost Assignment
  - See Table 50 in the OPPS Final Rule
Blood Products

- No change to payment methodology for Blood Products

- Increase 10 – 60% payment from proposed rule
Blood Products

- New HCPCS codes for Pathogen-reduced products
  - The term “pathogen reduction” describes various techniques (including treatment with Amotosalen and UVA light) used on blood products to eliminate certain pathogens and reduce the risk of transfusion-associated infections
Blood Products

- New HCPCS codes for Pathogen-reduced products
  - P9070 - Plasma, pooled multiple donor, pathogen reduced, frozen, each unit
  - P9071 - Plasma (single donor), pathogen reduced, frozen, each unit
  - P9072 - Platelets, pheresis, pathogen reduced, each unit
Blood Products

- Cross-walked HCPCS codes to similar codes as proxy for payment
  - Interim payments based on proxy and not claims data
  - Interim payments are open for comment until December 29, 2015
  - Will recalculate payments when have claims data for CY 2018 payments
## Blood Products

- Interim Payments and Crosswalks for pathogen reduced blood products (Table 5)

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>P9070</td>
<td>Plasma, pooled multiple donor, pathogen reduced, frozen, each unit</td>
<td>P9059</td>
<td>Fresh frozen plasma between 8-24 hours of collection, each unit</td>
<td>$73.08</td>
</tr>
<tr>
<td>P9071</td>
<td>Plasma (single donor), pathogen reduced, frozen, each unit</td>
<td>P9017</td>
<td>Fresh frozen plasma (single donor), frozen within 8 hours of collection, each unit</td>
<td>$72.56</td>
</tr>
<tr>
<td>P9072</td>
<td>Platelets, pheresis, pathogen reduced, each unit</td>
<td>P9037</td>
<td>Platelets, pheresis, leukocytes reduced, irradiated, each unit</td>
<td>$641.85</td>
</tr>
</tbody>
</table>
Blood Products

- CMS will evaluate remaining P-codes for revision and updates to reflect current product description
Expanded Packaging

- **Pathology Services**
  - Fourteen (14) codes with SI changed to Q1
  - Four APCs - renumbered for 2016 (APC 5671, 5672, 5673, and 5674)
  - Surgical path Levels 3 and 4 will only be packaged when a surgical procedure is reported on the claim
<table>
<thead>
<tr>
<th>Renumbered CY 2016 APC</th>
<th>CY 2016 APC Title</th>
<th>CY 2016 OPPS Status Indicator</th>
<th>CY 2016 Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>5734</td>
<td>Level 4 Minor Procedures</td>
<td>Q1</td>
<td>$119.58</td>
</tr>
<tr>
<td>5673</td>
<td>Level 3 Pathology</td>
<td>Q2</td>
<td>$229.13</td>
</tr>
<tr>
<td>5674</td>
<td>Level 4 Pathology</td>
<td>Q2</td>
<td>$459.96</td>
</tr>
</tbody>
</table>
Expanded Packaging

- Drugs and Biologicals as supplies with surgical procedures
  - Unconditionally packaged without consideration of cost
  - Separately payable drugs (SI = G or K) that will be packaged as a supply for 2016 – based on a clinical review of their function/use

- J0583 - Injection, bivalirudin, 1 mg
- J7315 - Mitomycin, ophthalmic, 0.2 mg
- J0130 - Injection abciximab, 10 mg
Expanded Packaging

- One drug proposed but not packaged due to pass-through status
  - C9447 - *Injection, phenylephrine and ketorolac, 4 ml vial*
  - Will be packaged when pass-through expires Jan 1, 2018
Expanded Packaging

- Clinical Diagnostic Lab Tests
  - New status indicator Q4 - Packaged APC payment if billed on the same claim as a HCPCS code assigned published status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.”
  - Conditional packaging for CY 2016
Expanded Packaging

- Separately payable
  - Only service provided on a given date of service
  - Conducted on same DOS as primary service but ordered for a different diagnosis than the other HOP services and ordered by a different practitioner from the one ordering the primary service
- Molecular pathology service
- Preventive laboratory test

- Medicare Claims Processing Manual, chapter 18, section 1.2)
Expanded Packaging

- Clinical Diagnostic Lab Tests – Common Scenarios
  - Venipuncture (CPT 36415) is assigned SI of Q4

- Venipuncture and lab tests paid if only services on the claim
Expanded Packaging

- CPT 36591 *Collection of blood specimen from a completely implantable venous access device*
- CPT 36592 - *Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified*
  - Both assigned to SI Q1
    - Lab tests will package into these two procedures
**Expanded Packaging**

- **Clinical Diagnostic Lab Tests**
  - Modifier L1 - *Provider Attestation that The Hospital Laboratory Test(s) is not Packaged under the Hospital OPPS*
  - Still applicable on OP claims with a primary service but meets the criteria
  - No longer required on a “lab only” claim (Bill type 131)
Expanded Packaging

- Tests conducted on same DOS as primary service but ordered for a different diagnosis than the other HOP services and ordered by a different practitioner from the one ordering the primary service
Expanded Packaging

- **Clinical Diagnostic Lab Tests**
  - For 2016 – packaging will be done at the claim level and not DOS
  - Lab tests provided during the same OP stay are related to the primary service unless meets the criteria
  - Just because it is provided on a different date of service doesn’t mean that it is not “integral, ancillary, supportive, dependent, or adjunctive “ to the primary service(s) provided in the HOPD
  - Basing this also on infrequency of reporting Modifier L1
Chronic Care Management

- CPT 99490 - *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements*
  - multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - comprehensive care plan established, implemented, revised, or monitored.
Chronic Care Management

- CMS FAQs: http://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/HospitalOutpatientPPS/
Chronic Care Management

- Set of additional requirements published in the MPFS that will be required of OPPS providers who provide these services:
  - There must be an established relationship with the patient as a requirement for billing and payment under the OPPS

- Patient must have been either admitted to the hospital as an inpatient OR

- A registered outpatient of the hospital within the last 12 months and has received therapeutic services from the hospital
  - Patient’s physician/practitioner must have discussed with the beneficiary that the hospital clinical staff will furnish these services and the beneficiary may be liable for two separate copayments

- Documentation of this discussion is a requirement under the MPFS
Chronic Care Management

- Additional requirements, continued:
  - Documentation Requirements
  - Must be either in the hospital medical record OR in a beneficiary’s medical record that the hospital can access
  - Patient’s agreement to have the services provided All elements of the CCM services were explained and offered to the beneficiary
Chronic Care Management

- A notation of the beneficiary’s decision to accept or decline the services.
  - Only one hospital under the OPPS can furnish and be paid for these services during the calendar month service period as defined in CPT 99490
  - Only one practitioner can furnish and be paid for these services under the MPFS
  - One claim under OPPS and one claim under MPFS
Chronic Care Management

- Additional requirements, continued:
  - Scope of service elements must be met:
  - Under direction of a physician or other qualified non-physician practitioner (NPP)
  - Specific demographic elements, full list of problems, medications, allergies, care plan, care coordination, ongoing clinical care
  - Access to care management services 24 hours a day/7 days a week
Chronic Care Management

- Designated practitioner or member of care team for continuity of care and successive routine appointments
- Documentation of creation of comprehensive care plan for all health issues. Must be available 24/7 to all practitioners furnishing CCM
- Other requirements, including specific electronic health record requirements (pages 608 – 614 of display copy)
Advance Care Planning Services

- CPT code 99497 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
  - New code for CY 2015
  - Assigned to status indicator N for CY 2015
  - Assigned status indicator Q1 for CY 2016
  - Will be separately reimbursed when this is only service provided.
Advance Care Planning Services

- CPT code 99498 - *each additional 30 minutes (List separately in addition to code for primary procedure)*
  - Add on code – status indicator N still applies for CY 2016
Advanced Care Planning Service's

- There is a lot of discussion about this service in the MPFS – including much about who can provide the service and where.

- CMS language is clear that the Agency is expecting the MD/NPP to be actively involved in the service, but does recognize that it could be an interdisciplinary team approach, parts provided by other qualified health professionals, etc.
Changes for Payment for Computed Tomography

- Section 218(a)(1) of the Protecting Access to Medicare Act of 2014 (PAMA) amended section 1834 of the Act
- Effective for services furnished on or after 1/1/16
- Reduction of payment for the technical component (TC) of CT services when the equipment does not meet the NEMA Standard (XR-29-2013)
Changes for Payment for Computed Tomography

- NEMA = National Electrical Manufacturers Association
  - Payment reduction
- 2016 = 5%
- 2017 = 15%
- Subsequent years = 15%
- Statutory provision date – January 1, 2016
Changes for Payment for Computed Tomography

- Applies to the following HCPCS codes:
  - 70450 – 70498
  - 71250 – 71275
  - 72125 – 72133
  - 72191 – 72194
  - 73200 – 73206
  - 73700 – 76706
  - 74150 – 74178
  - 74261 – 74263
  - 75571 – 75574
- And any succeeding codes
Changes for Payment for Computed Tomography

- Information must be provided and attested to by a supplier and an HOPD that states these services were furnished with equipment that was not consistent with the NEMA standard
Changes for Payment for Computed Tomography

- New modifier **CT** – *Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard.*
  - Applied to claims for CT scans performed on scanners that don’t meet the NEMA standard
  - Modifier will trigger the applicable payment reduction for the service
Changes for Payment for Computed Tomography

- Payment Reduction
  - Applied when the service is paid separately
  - Not applied when the service is packaged (no service specific payment)

Corneal Tissue

- Payment for Procurement of Corneal Tissue Used in Procedures Performed in the HOPD
  - V2785 – *Processing, preserving and transporting corneal tissue*
    - Represents cost of procurement or acquisition of the tissue
    - Reimbursed separately based on hospital’s reasonable cost
Corneal Tissue

- Separate payment will be made only when the tissue is used in corneal transplant procedures.
  - Other procedures - considered to be a packaged surgical supply

- January 2016 OPPS update transmittal will contain a list of corneal transplant procedures when separate payment will be made
Laboratory Drug Testing

- Medicare deleted codes G0431 and G0434
  - **G0431** Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter
  - **G0434** Drug screen, other than chromatographic; any number of drug classes, by clia waived test or moderate complexity test, per patient encounter
Drug Testing

- Also deleted drug testing codes
  - G6030 through G6058 (28 codes)

- CPT Codes 80300-80304 remain with Status Indicator “B”
  - Not reportable by hospitals on the UB claim to Medicare

- For Presumptive testing, created three new G codes. Only one of the three presumptive G codes may be billed per day.
Drug Testing

- For definitive testing, created four new G codes. Only one of the four definitive G codes may be billed per day.

- For definitive testing, the unit used to determine the appropriate definitive G code to bill is “drug class.”

- Each drug class may only be used once per day in determining the appropriate definitive G code to bill.
Drug Testing

- Drug classes are listed on the next slide and are consistent with their usage in the AMA CPT Manual. The AMA CPT Manual may be consulted for examples of individual drugs within each class.
• Alcohol(s)
• Alcohol Biomarkers
• Alkaloids, not otherwise Specified
• Amphetamines
• Anabolic steroids
• Analgesics, non-opioid
• Antidepressants, serotonergic class
• Antidepressants, Tricyclic and other cyclicals
• Antidepressants, not otherwise specified
• Antiepileptics, not otherwise specified
• Antipsychotics, not otherwise specified
• Barbiturates
• Benzodiazepines
• Buprenorphine
• Cannabinoids, natural
• Cannabinoids, synthetic
• Cocaine
• Fentanyl(s)
• Gabapentin, non-blood
• Heroin metabolite
• Ketamine and Norketamine
• Methadone
• Methyleneoxyamphetamine
• Methylphenidate
• Opiates
• Opioids and opiate analogs
• Oxycodone
• Phencyclidine
• Pregabalin
• Propoxyphene
• Sedative Hypnotics (nonbenzodiazepines)
• Skeletal muscle relaxants
• Stereoisomer (enantiomer) analysis
• Stimulants, synthetic
• Tapentadol
• Tramadol
• Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified;
Drug Testing

- New Codes 2016
  - Presumptive Drug Testing
    - New G0479
    - New G0477 or G0478

- Definitive Drug Testing
  - New Codes - G0480, G0481, G0482, G0483
Drug Testing

- **G0479** Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers (eg, immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service.

- **Medicare Payment $79.25**
Drug Testing

**G0477** Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) capable of being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.

**Medicare Payment $14.86**
Drug Testing

- **G0478** Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) read by instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service.

- **Medicare Payment $19.81**
G0480 Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed.

- Medicare Payment $79.94
Drug Testing

- **G0481** Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed.

- Medicare Payment $122.99
Drug Testing

- **G0482** Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed.

- **Medicare Payment $166.03**
Drug Testing

- **G0483** Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed.

- **Medicate Payment $215.23**
Other New and Reconsidered Laboratory Test Codes

- **Deleted Code** G0464 *(Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3))*

- **New Code 81528** *(Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result)*
Other New and Reconsidered Laboratory Test Codes

- CPT 81528 – Status Indicator A

- 2016 Lab Fee Schedule Payment $493.21
HCPC Q3014

- For CY 2016, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $25.10. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)
Modifier PO (Off-Campus Provider Based Dept.)

- The “PO” HCPCS modifier is to be reported with every code for outpatient hospital services furnished in an off-campus PBD of a hospital. Reporting of this new modifier will be voluntary for 1 year (CY 2015), with reporting required beginning on January 1, 2016. The modifier should not be reported for remote locations of a hospital, satellite facilities of a hospital, or for services furnished in an emergency department.
 Modifier PO (Off-Campus Provider Based Dept.)

- CMS is updating the “Medicare Claims Processing Manual,” (Chapter 4, Section 20.6.11) to include the use of the “PO” HCPCS modifier.
## New Place of Service Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Place of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Off Campus-Outpatient Hospital</td>
</tr>
</tbody>
</table>

A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
## Place of Service Code 22

| 22 | On Campus-Outpatient Hospital | A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016) |
Billing Instructions for Corneal Tissue

- In the CY 2016 OPPS/ASC Final Rule with Comment Period (80 FR 70472), procurement /acquisition of corneal tissue will be paid separately only when it is used in corneal transplant procedures. Specifically, corneal tissue will be separately paid when used in procedures performed in the Hospital Outpatient Department (HOPD) only when the corneal tissue is used in a corneal transplant procedure described by one of the following CPT codes:
Billing Instructions for Corneal Tissue

- 65710 (Keratoplasty (corneal transplant); anterior lamellar);
- 65730 (Keratoplasty (corneal transplant); penetrating (except in aphakia or pseudophakia));
- 65750 (Keratoplasty (corneal transplant); penetrating (in aphakia));
- 65755 (Keratoplasty (corneal transplant); penetrating (in pseudophakia));
- 65756 (Keratoplasty (corneal transplant); endothelial);
- 65765 (Keratophakia);
- 65767 (Epikeratoplasty); and
- Any successor code or new code describing a new type of corneal transplant procedure that uses eye banked corneal tissue.
Billing Instructions for Corneal Tissue

- HCPCS code V2785 (Processing, preserving and transporting corneal tissue) should only be reported when corneal tissue is used in a corneal transplant procedure; V2785 should not be reported in any other circumstances.
Interventional Radiology Updates for 2016

Tammy Moss, RHIT, CCS, COC, CIRCC
Intravascular Ultrasound (non-coronary)

- Deleted CPT Component Codes
  - + 37250 (surgical) – 75945 (Rad S&I) – Initial vessel
  - + 37251 (surgical) – 75946 (Rad S&I) – each addl. vessel

- New CPT codes that includes both components
  - + 37252 – Initial vessel (non-coronary vessel)  SI - N
  - + 37253 – each addl. vessel (non-coronary vessel)
    - SI - N
Guideline changes for 37252 & 37253

- Services that are inherently included as part of IVUS procedure
  - Transducer manipulations and repositioning within the specific vessel
  - before/during/after therapeutic or diagnostic services (stent, atherectomy, embolization, etc.)
- Services that IVUS may be reported with include:
  - Diagnostic angiography
  - Therapeutic interventions (stent, PTA, atherectomy, etc)
Intravascular Ultrasound (non-coronary)

- Guideline changes for 37252 & 37253
  - Services that IVUS is included in & should not be separately reported:
    - IVC filter placement, repositioning or removal
    - Intravascular foreign body retrieval
  - What about catheter placement
    - Non-selective and/or selective catheterization may be separately reported **BUT**
    - **CPT codes for the diagnostic/therapeutic procedures may include this component**
  - Report a single IVUS code for a lesion extending across more than 1 vessel
Percutaneous Genitourinary Changes

Percutaneous nephrostomy

Kidney

Percutaneous nephrostomy tube

Catheter bag
Indications for a Nephrostomy

A nephrostomy is done to drain urine from your kidney. This needs to be done when urine cannot come out as it normally does. Specific conditions that may cause this include:

- Damage to the bladder
- Blockage in the ureter, which is the tube that carries urine from the kidney to the bladder, due to:
  - Infection
  - Tumor
  - Kidney stone
  - Scar tissue
  - A condition that is present at birth
Percutaneous Genitourinary Changes

Deleted Codes for 2016

- 50394 – Nephrostogram – No change to 74425
- 50392 & 74475 – Percutaneous nephrostomy
- 50398 – Nephrostomy tube change
- 50393 & 74480 – Percutaneous drainage or stent placement
Genitourinary Procedures (Kidney)

Editorial change only

- CPT 50387 – Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation
  - Language change from transnephric-ureteral stent to match guidelines for nephroureteral catheters
  - Reflects current terminology
  - SI - T
Genitourinary Procedures (Kidney)

NEW Codes

- 50430 – Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; **new access**
  - SI Q2

- 50431 – **existing access**
  - Diagnostic procedures that include
    - Contrast injections
    - Associated RS&I
    - Procedural image guidance (eg. Ultrasound. Fluoroscopy)
  - SI Q2
Genitourinary Procedures: Nephrostomy

New codes for Introduction of Catheter into Renal Pelvis

- 50432 – Placement of **nephrostomy catheter**, percutaneous, including **diagnostic nephrostogram and/or ureterogram** when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
  - SI - T

- 50433 - Placement of **nephroureteral catheter**, percutaneous, including **diagnostic nephrostogram and/or ureterogram** when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, **new access**
  - Additional accessing of the ureter/bladder to place a catheter
  - Allows for drainage internally, externally or both
  - SI - T
Genitourinary Procedures: Nephrostomy

New codes for Introduction of Catheter into Renal Pelvis

- **50434 - Convert** nephrostomy catheter to nephroureteral catheter, percutaneous, including *diagnostic nephrostogram and/or ureterogram* when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract
  - SI - T

- **50435 - Exchange** nephrostomy catheter, percutaneous, including *diagnostic nephrostogram and/or ureterogram* when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation
  - SI - T
Genitourinary Procedures: Nephrostomy

New CPT Procedure Codes include:

- Access
- Contrast injections and catheter manipulation
- Image guidance (e.g., ultrasound, fluoroscopy)
- Rad S&I,
- Diagnostic nephrostogram/ureterogram when performed

Existing code

- 50389 – Removal of nephrostomy tube, requiring fluoroscopic guidance (e.g., with concurrent indwelling ureteral stent)
  - Removal of nephrostomy tube not requiring fluoroscopic guidance is considered inherent to E/M services.
Genitourinary Procedures: Nephrostomy

CPT Guidelines for these new codes state:

- Renal pelvis and its associated ureter are considered a single entity for reporting purposes
- Can be reported more than once for each renal collecting system/ureter accessed
  - Bilateral tube placement
  - Unilateral duplicated collecting system/ureters requiring two separate procedures
Genitourinary Procedures - Ureteral Stent

New codes

- **50693** – Placement of ureteral stent, percutaneous, including **diagnostic nephrostogram and/or ureterogram** when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; **pre-existing** nephrostomy tract
  - SI - T

- **50694** – **new access**, without separate nephrostomy catheter
  - SI - T

- **50695** – **new access**, with separate nephrostomy catheter
  - SI - T
Genitourinary Procedures - Ureteral Stent

Existing codes

- 50382-50386 – Percutaneous removal and/or replacement ureteral stent

CPT Guidelines for 50693-50695

- Codes include access, drainage, catheter manipulation, diagnostic nephrostogram/ureterogram, guidance, and Rad S&I
Genitourinary Procedures - Ureteral Biopsy

New CPT code

- + 50606 - Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
  - Add on code  SI - N
  - Describes endoluminal biopsy using non-endoscopic imaging guidance i.e. De novo transrenal, existing renal/ureteral access, ileal conduit
  - Includes
    - Biopsy, Image Guidance, RS&I
Genitourinary Procedures – Ureteral Embolization

New codes

- + 50705 – Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
  - SI - N

- + 50706 - Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
  - SI - N
Genitourinary Procedures – Ureteral Embolization

- Add on codes of the ureter using non-endoscopic imaging guidance
- Reported once per ureter per day
- Gaining access may be reported separately
- Diagnostic pyelography/ureterography is not included in 50705 and 50706 and may be reported separately
- Performed through de novo transrenal access, an existing renal/ureteral access, transurethral access, an ileal conduit, or ureterostomy
Percutaneous Biliary Changes
Indications for a Cholangiogram or Biliary Drainage Catheter (PTBD)

X-ray of the bile ducts from liver to gallbladder and small intestine

- Blockage in the bile duct causing jaundice, due to:
  - Infection
  - Tumor in the ducts, liver, gallbladder, pancrease
  - Stone
  - Scarring
Percutaneous Biliary Changes

Deleted Codes for 2016

- 47500 & 74320 – Percutaneous transhepatic cholangiogram
- 47505 & 74305 – T-tube/injection existing biliary drainage catheter
- 47510 & 75980 – External biliary drainage
- 47511 & 75982 – Internal & External biliary drainage
Percutaneous Biliary Changes

Deleted Codes for 2016

- 47525 – Change of biliary drainage tube - No change to 75984
- 47530 – Revision/reinsertion of transhepatic tube
  - – No change to 75984
- 47630 & 74327 – Biliary stone removal
Percutaneous Biliary Procedures
Diagnostic Cholangiography

New codes

- **47531** – Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; **existing access**
  - eg, biliary drainage catheter, T-tube
  - SI – Q2

- **47532** – **new access**
  - SI – Q2

- Codes include
  - Contrast injections
  - RS&I
  - Imaging guidance (eg. Ultrasound, Fluoroscopy)
Percutaneous Biliary Procedures
Diagnostic Cholangiography

Do not report Diagnostic cholangiogram with Therapeutic procedures

- Perc placement of biliary drainage catheters (47533, 47534)
- Conversion (47535), exchange of perc biliary drainage catheter (47536)
- Removal of per biliary drainage catheters (47537)
- Perc stent placement bile duct (47538-47540)
- De novo placement of access through biliary tree to assist endo procedure (47541)
Percutaneous Biliary Procedures
Biliary Drainage Catheter

New Codes

- 47533 – Placement biliary drainage catheter, external  SI - T
- 47534 – Internal-external  SI - T
- 47535 – Conversion of External to Internal-external  SI - T
- 47536 – Exchange of biliary drainage catheter  SI - T
- 47537 – Removal of biliary drainage catheter  SI – Q2

These procedures include diagnostic cholangiography when performed
An **external biliary drainage** catheter goes through your skin and into your bile ducts. The end of the catheter that is in your bile ducts is placed above the blockage. After this procedure you will have a catheter coming out of your body, attached to a drainage bag.
An **internal-external biliary drainage catheter** goes through your skin and into the bile ducts, across the obstruction. One end of the catheter will sit in the small intestine, and the other will come out of the body and will be attached to a drainage bag. This catheter lets bile flow in 2 directions; out to the external collecting bag or into the small intestine. This is the most common kind of drainage catheter, however it is not always possible.
Percutaneous Biliary Procedures
Stent Placement in Bile Duct

New Codes
- 47538 – Placement of stent(s) into a bile duct, existing access \( SI - T \)
- 47539 – new access w/o placement of separate biliary drainage catheter \( SI - T \)
- 47540 - new access with placement of separate biliary drainage catheter \( SI - T \)

See Illustration of stent placement on page 305, *CPT 2016 Professional Edition*

These procedures include diagnostic cholangiography when performed
Percutaneous Biliary Procedures
Other Biliary Percutaneous

New Codes

- **47541** – Placement of access through biliary tree into small bowel to assist w/endoscopic biliary procedure, new access
  - Do not report when there is existing catheter access see 47535, 47536, 47537
  - SI - T

- **+ 47542** – Biliary dilation of biliary duct  SI - N
  - Do not report with 47544 when balloon is used for removal of calculi, debris and/or sludge rather than dilation
  - If dilation of multiple ducts during same session
    - Report 47542 for initial duct, 47542-59 for additional duct(s)
Percutaneous Biliary Procedures
Other Biliary Percutaneous

New Codes
- + 47543 – Endoluminal biopsy(ies) of biliary tree
  - SI - N
  - Report once per session

- + 47544 – Removal of calculi/debris from biliary duct and/or gallbladder
  - SI - N
  - Does not include removal of incidental sludge
  - Do not report if no calculi/debris are found even if removal device is deployed
Interventional Neurology Updates for 2016
2016 CPT Changes

- Inclusion of “non-intracranial” reference in 2016 CPT description for arterial mechanical thrombectomy
  - 37184
  - 37185
  - 37186

- Description change for 37211 – Transcatheter therapy, arterial infusion for thrombolysis
  - Added other than coronary “or intracranial”

- Deleted codes for 2016
  - 37202 & 75896 – Transcatheter infusion therapy other than for thrombolysis
Intracranial Endovascular Interventions

New codes

- 61645 – Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)
  - SI - E
Intracranial Endovascular Interventions

New codes

- 61650 – Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory
  - SI - C

- 61651 – each additional vascular territory (List separately in addition to code for primary procedure)
  - SI - C
  - Clotbuster drugs - tPA
New codes 61645, 61650, 61651

- Are for cerebral endovascular therapeutic interventions in any intracranial artery
- Arteries are divided into 3 vascular territories
  - Right carotid circulation
  - Left carotid circulation
  - Vertebro-basilar circulation
61645 describes endovascular revascularization of thrombotic or embolic occlusion of intracranial arterial vessels
  - Any method
  - Administration of any agent for purpose of revascularization

61650, 61651 are used for prolonged administration of non-thrombolytic agents
  - Of at least 10 minutes continuous duration
Intracranial Endovascular Interventions Guidelines

61645, 61650, 61651

- Include selective catheterization
- Diagnostic angiography and all subsequent angiography & RS&I within the treated vascular territory
  - Diagnostic angiography of a non-treated vascular territory may be separately reported
- Fluoroscopic guidance
- Neurologic and hemodynamic monitoring
- Closure of arteriotomy
Typical Patient

- Stroke alert (often ED patient)
  - Cerebral infarction
  - Carotid artery occlusion
  - Vertebral artery occlusion
Radiology
Updates for 2016
Film and Written Report

- A written report (eg, handwritten or electronic) signed by the interpreting individual should be considered an integral part of a radiologic procedure or interpretation.

- With regard to CPT description for radiography services, “images” refer to those acquired in either an analog (ie, film) or digital (ie, electronic) manner.
Diagnostic Radiology Changes

- Revision of spinal CPT codes for scoliosis studies
  - Entire thoracic and lumbar
  - 1 view
  - 2 or 3 views
  - 4 or 5 views
  - Minimum of 6 views
Spine X-rays
Count the number of views!

Thoracolumbar x-ray studies
- Revised description for 72080 – 2+ views
- Address current changes in clinical practice
- Provide a coding structure similar to other plain film imaging families
- Deleted codes (scoliosis evaluation)
  - 72010, 72069, 72090
Spine X-rays
Count the number of views!

New Codes for Complete Spine X-rays of entire thoracic and lumbar, including skull, cervical and sacral spine (e.g. Scoliosis evaluation)

- 72081 – 1 view  SI – Q1
- 72082 – 2-3 views  SI – Q1
- 72083 – 4-5 views  SI - S
- 72084 – 6+ views  SI - S
Spine X-rays
Count the number of views!

New Parenthetical notes

- For a 1V that includes the entire thoracic and lumbar spine
  - Use 72081

- For a 1V of the thoracolumbar junction
  - Use 72020
Hip and Pelvis X-rays

Changes made to address age old coding questions

- How do you report a single view bilateral hip and pelvis study?
  - Modifier -52??

- How do you report a single view of the femur study
  - Modifier -52??
# Hip and Pelvis X-rays

- New codes specify the number of views
- Include statement “with pelvis when performed”

<table>
<thead>
<tr>
<th>Unilateral</th>
<th>CPT</th>
<th>Bilateral</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 View</td>
<td>73501</td>
<td>2 Views</td>
<td>73521</td>
</tr>
<tr>
<td>2-3 Views</td>
<td>73502</td>
<td>3-4 Views</td>
<td>73522</td>
</tr>
<tr>
<td>4+ Views</td>
<td>73503</td>
<td>5+ Views</td>
<td>73523</td>
</tr>
</tbody>
</table>

Deleted Codes: 73500, 73510, 73520, 73530, 73540
Femur X-rays

- New codes specify the number of views
  - 73551 – 1 view
  - 73552 – 2+ views
- Deleted Code: 73550
Fetal MRI

New Codes for imaging of fetus only:
• 74712 – single or first gestation
• 74713 – each addl. gestation

Allow for reporting of the fetus, placenta, and maternal pelvis, when performed.

http://radnet.bidmc.harvard.edu/fetalatlas/
Fetal MRI

Parenthetical notes state:

- Do not report with pelvis MRI codes, 72195, 72196, 72197
- Do not use new codes if only placenta or maternal pelvis is imaged without fetal imaging
  - Report 72195, 72196, 72197
CPT 78264, Gastric emptying study has been revised to specify that the test may be performed using a:

- Solid meal, liquid meal or both
New Codes 78265 and 78266

- 78265 – Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit
  - SI - S
- 78266 – with small bowel and colon transit, multiple days
  - SI - S

New parenthetical – report 78264, 78265, 78266 only once per imaging study
Nuclear Medicine - Radioisotope

New HCPCS Code

- **C9458** – Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries
  - **Trade name** - Neuraceq™ SI - G
- **C9459** - Flutemetamol f18, diagnostic, per study dose, up to 5 millicuries
  - **Trade name** - Vizamyl™ SI – G
- Used in PET Imaging of Beta-Amyloid neuritic plaque in the brain
Low Dose CT for Lung Cancer Screening (LDCT)

- CMS issued NCD for coverage of LDCT on February 5, 2015
- Beneficiaries must meet all of the following eligibility criteria:
  - Age 55 – 77 years;
  - Asymptomatic (no signs or symptoms of lung cancer);
  - Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
  - Current smoker or one who has quit smoking within the last 15 years; and
  - Receives a written order for lung cancer screening with LDCT that meets the requirements described in the NCD. Written orders for lung cancer LDCT screenings must be appropriately documented in the beneficiary’s medical records.
Low Dose CT for Lung Cancer Screening (LDCT)

Two new* HCPCS codes:

- G0296 - Counseling visit to discuss need for lung cancer screening (ldct) using low dose CT scan (service is for eligibility determination and shared decision making)
  - SI – S  APC 5822  $69.65
- G0297 - Low dose CT scan (ldct) for lung cancer screening
  - SI – S  APC 5570  $112.49

*CMS has issued and deleted these codes previously
Low Dose CT for Lung Cancer Screening (LDCT)

- Effective retroactively to February 5, 2015;
  - CMS did not extend the timely filing deadline, stating “We believe that hospitals will have sufficient time to file claims prior to the 1-year deadline.”
  - Considered additional preventive services (NCD) so coinsurance and deductible are waived.

- Further guidelines
  - Medicare Claims Processing Manual,” Chapter 18, Section 220,
  - MLN Matters® Article MM9246, published on October 15, 2015.
Ultrasound Guidance

New Category III code

- 0404T - Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency
  - VizAblate system by Gynsonics
  - SI – J1
Cardiovascular Updates for 2016
New CPT Code for Leadless Pacemaker
Leadless Pacemaker

Both Medtronic and St. Jude Medical will need to earn FDA approval for their leadless pacemakers, but that's a few years away.
New CPT Codes for Leadless Pacemaker

- **0387T** - Transcatheter insertion or replacement of permanent leadless pacemaker, ventricular
  - SI – J1

- **0388T** - Transcatheter removal of permanent leadless pacemaker, ventricular
  - SI - T
New CPT Codes for Leadless Pacemaker

- 0389T – Programming device evaluation
  - SI – Q1
- 0390T – Peri-procedural device evaluation before/after surgery – SI – N
- 0391T – Interrogation device evaluation
  - SI- N
New CPT code for Cardiac Contractility Modulation

- Treatment for patients with moderate-to-severe congestive heart failure
- Electrical pulses delivered to enhance ventricular contractile strength
- Optimizer III™
  - Sub-q pulse generator
  - 3 electrodes

[https://www.youtube.com/watch?v=wNCcXNSq_ls](https://www.youtube.com/watch?v=wNCcXNSq_ls)
New CPT codes for Cardiac Contractility Modulation System

- **0408T** - Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes
  - SI – J1

- **0409T** - Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only
  - SI – J1
New CPT codes for Cardiac Contractility Modulation System

- **0410T** - Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only
  - SI – J1

- **0411T** - Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only
  - SI- J1
New CPT codes for Cardiac Contractility Modulation System

- **0412T** - Removal of permanent cardiac contractility modulation system; pulse generator only
  - SI – Q2

- **0413T** - Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)
  - SI- Q2

- **0414T** - Removal and replacement of permanent cardiac contractility modulation system pulse generator only
  - SI – J1
New CPT codes for Cardiac Contractility Modulation System

- **0415T** - Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)
  - **SI - T**

- **0416T** - Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)
  - **SI - T**

- **0417T** – Programming device evaluation – **SI - Q1**

- **0418T** – Interrogation device evaluation – **Si - Q1**
Myocardial Strain Imaging

- +0399T - Myocardial strain imaging (quantitative assessment of myocardial mechanics using image-based analysis of local myocardial dynamics) (List separately in addition to code for primary procedure)
  - SI – N
  - Tissue Doppler and Speckle Tracking used to gain greater understanding of pathophysiology of
    - cardiac ischemia and infarction,
    - primary diseases of the myocardium,
    - effects of valvular disease and
    - Patients undergoing chemotherapy
Myocardial Strain Imaging

Add on code, report once per session

- Report appropriate primary code:
  - Transthoracic echocardiography (TTE) codes 93303-93308
  - Transesophageal echo (TEE) codes 93312, 93314, 93315, and 93317
  - Stress echo codes 93350 and 93351
  - Intervention guidance TEE code 93355
2016 CPT Code Update for Surgery

Lori Hagen, COC, CPMA, SCP-OR, CASCC
Integumentary
Integumentary

- **Add 10035** - Placement of soft tissue localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion

  - **SI = T**
  - **$480.64**
Integumentary

- Add add-on code 10036 - Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion

  - SI = N
  - $0
Soft Tissue Localization Device
Soft Tissue Localization Device

- Used to mark lesions prior to therapy

- Often a lesion will no longer be visible or palpable after therapy

- Marking allows the area to be found once therapy is complete
Soft Tissue Localization Device

- Codes already exist for marker placement into other organs
  - Use most specific code possible

- New codes are for soft tissue marker placement such as axilla and groin
Soft Tissue Localization Device

- Imaging is bundled
- Should only be used once per target regardless of the number of markers placed
Add **0400T** - Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; one to five lesions

- **SI = N**
- **$0**
Integumentary

- Add **0401T** - Multi-spectral digital skin lesion analysis of clinically atypical cutaneous pigmented lesions for detection of melanomas and high risk melanocytic atypia; six or more lesions

- $SI = N$
- $\$0$
Integumentary - MSDSLA

- Prior to determining if a biopsy is appropriate, multi-spectral digital skin lesion analysis (MSDSLA) is ordered for lesions that are declared high risk and deemed suspicious for melanoma

- Typically performed on the same DOS as an E&M
Integumentary - MSDSLA

- If after performing MSDSLA it is determined that a biopsy is necessary, skin biopsy codes 11100 and 11101 would also be reported on the same day.

- Not inclusive components

- Check the NCCI Edits
Musculoskeletal

- Delete 21805 - Open treatment of rib fracture without fixation, each

- No further instructions as there is no need
Musculoskeletal

- Add add-on code **0396T** - Intra-operative use of kinetic balance sensor for implant stability during knee replacement arthroplasty (List separately in addition to code for primary procedure)

  - SI = N
  - $0
Musculoskeletal – Kinetic Balance Sensor

- VERASENSE enables surgeons to quantify ligament balance and improves surgeon skill by giving them real-time, evidence-based data.

- This Sensor-Assisted TKA disposable instrument delivers evidence-based data wirelessly to an intra-operative monitor that enables surgeons to make informed decisions on soft tissue balance and implant position in real time.
Respiratory
Respiratory

- Delete **31620** - Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s)

-
Respiratory

- New parenthetic
  - For bronchoscopy with EBUS guided transtracheal/transbronchial sampling of mediastinal and/or hilar lymph node stations or structures, see 31652, 31653.
  - For transendoscopic ultrasound during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s), use 31654
Respiratory

- Add **31652** - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures

  - SI = T
  - $1,991.92
Respiratory

- Add 31653 - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures

- SI = T
- $1,991.92
Respiratory

- Add **31654** - Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])

- SI = N
- $0
Mediastinum

- Delete 39400 - Mediastinoscopy, includes biopsy(ies), when performed

- To report mediastinoscopy with biopsy, see 39401, 39402
Mediastinum

- Add **39401** - Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed

- **SI = T**
- **$3,152.92**
Mediastinum

- Add 39402 - Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)

- SI = T
- $3,152.92
Digestive System
Digestive

- Add **43210** - Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed

- SI = J1
- $3,613.57
Digestive

- 43210 was added to describe a transoral approach to a surgical fundoplasty

- Do not report with 43180, 43191, 43197, 43200, 43235
Digestive

- For patients with chronic GERD who cannot be managed with medications

- Performed transoral rather than by laparotomy, thoracotomy, or laparoscopy
Digestive

- Add **0392T** - Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band)

- **SI = J1**
- **$6,860.91**
Esophageal Sphincter Augmentation Device
Digestive

- Add **0393T** - Removal of esophageal sphincter augmentation device

  - **SI = Q2**
  - **$4,001.15**
Digestive

- Add add-on code **0397T** - Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)

- SI = N
- $0
Optical Endomicroscopy

- Technique for obtaining histology-like images without physical sampling

- Prior to 2016, OE of the pancreas and biliary tract was reported with unlisted codes
According to the AMA:

- Clarification needed for inclusion of diagnostic anoscopy in anal-related procedures

- Consistency needed in reporting conventions with other anal codes in section and Category III codes

- Identification lacking for coding restrictions via exclusionary parentheticals
Digestive – Anus Surgery

- Do not report 46600 (Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)) in conjunction with 46020-46942, 0184T, 0249T, 0377T during the same operative session

- 46600 is included in procedures from these sections:
  - Incision, Excision, Introduction, Endoscopy, Repair, Destruction
Digestive – Anus Surgery

- **Anoscope**: ~ 10 cm
- **Proctoscope**: ~ 13 cm
- **Rectoscope**: ~ 25 cm
Sclerotherapy

- Add 49185 - Sclerotherapy of a fluid collection (eg, lymphocele, cyst, or seroma), percutaneous, including contrast injection(s), sclerosant injection(s), diagnostic study, imaging guidance (eg, ultrasound, fluoroscopy) and radiological supervision and interpretation when performed

- SI = T
- $941.98
Catheter Drainage

Patient sitting upright and leaning on table

Fluid pushes on left lung

Pleural space filled with excess fluid

Fluid collects in bag or syringe
Catheter Drainage – New Parentheticals

- Codes needed to report specific drainage sites
- Outdated coding instructions
Catheter Drainage – New Parentheticals

- **49405** - Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous

- SI = T
- $941.98
Catheter Drainage – New Parentheticals

- For percutaneous pleural drainage see 32556-32557

- For open visceral drainage, see 32200 (lung abscess or cyst), 47010 (liver abscess or cyst), 48510 (pseudocyst of pancreas), 50020 (perineal or renal abscess)
Catheter Drainage – New Parentheticals

- **49406** - Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous

- **SI = T**
- **$1,414.28**
Catheter Drainage – New Parentheticals

- For transrectal or transvaginal image-guided peritoneal or retroperitoneal fluid collection drainage by catheter, use 49407

- For open transrectal drainage of pelvis abscess, use 45000
For open peritoneal or retroperitoneal drainage, see 44900 (appendiceal abscess), 49020 (peritoneal abscess or localized peritonitis), 49040 (subdiaphragmatic or subphrenic abscess), 49060 (retroperitoneal abscess), 49062 (extraperitoneal lymphocele), 49084 (peritoneal lavage), 50020 (perirenal or renal abscess), 58805 (ovarian cyst), 58822 ovarian abscess

For percutaneous paracentesis, see 49082, 49083
Catheter Drainage – New Parentheticals

- **49407** - Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal

  - **SI = T**
  - **$941.98**
Catheter Drainage – New Parentheticals

- For open transrectal or transvaginal drainage, see 45000 (pelvic abscess), 58800 (ovarian cyst), 58820 (ovarian abscess)
Revision 65855 - Trabeculoplasty by laser surgery, one or more sessions (defined treatment series)

- SI = T
- $3,380.77
Ophthalmology – Laser Trabeculoplasty

- Revision of 65855
  - Used to treat glaucoma
  - Can be used more than once in each eye
  - Describes multiple laser applications to the trabecular meshwork through a contact lens to reduce intraocular pressure
Add 65785 - Implantation of intrastromal corneal ring segments

- SI = J1
- $3,380.77
Ophthalmology – Surgery Section

- Conversion of 0099T (from 2006) to 65785
Ophthalmology – Corneal Surgery

- Intrastromal Corneal Ring Segments
Intrastromal Corneal Ring Segments (INTACS)
Ophthalmology – Repair of Retinal Detachment

- Retinal Detachment
  - Inner layer of the eye peels off on the inside of the eye and floats toward the center
  - Without repair, total visual loss is likely
  - Repair requires multiple surgical approaches
Ophthalmology – Repair of Retinal Detachment

- Deleted 67112 - Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques
Ophthalmology – Repair of Retinal Detachment

- To report, see Retinal Detachment Repair codes:
  - 67107 - scleral buckling – included when performed
  - 67108 – vitrectomy – included when performed
  - 67110 – injection of air or other gas
  - 67113 – complex – included when performed
Ophthalmology – Destruction of Retinopathy

- Retinal Lesion Destruction
  - Generalized
    - Diabetic retinopathy
    - Sickle cell retinopathy
  - Focal
    - Small tumor
    - Vascular anomaly
    - Macular edema
Ophthalmology – Destruction of Retinopathy

- Revised 67227 – Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), 1 or more sessions, cryotherapy, diathermy
- Revised 67228 – Treatment of extensive or progressive retinopathy, 1 or more sessions (eg, diabetic retinopathy), photocoagulation

- Approximately 2.4 treatments is common
Add **0402T** – Collagen cross-linking of the cornea (CXL)

New technology to stiffen/strengthen the corneal stroma by creating covalent bonds (cross-links) to help prevent vision impairment associated with:

- Keratoconus
- Pellucid marginal degeneration
- Corneal ectasia
- Drug-resistant, infectious keratitis with corneal melting
Keratoconus
- Thinning and protrusion of the cornea
- Can no longer focus on an image and cannot be corrected with glasses or contacts
- Worst cases get scarring and may require corneal transplant (penetrating keratoplasty)
Ophthalmology – Corneal Collagen Cross-Linking (CXL)

- 0402T – Collagen cross-linking of the cornea
- Includes a bundle of services:
  - Removal of corneal epithelium (65435)
  - Intraoperative pachymetry (76514)
  - Use of operating microscope (69990)
    - This is never billed with ophthalmology codes

- SI = T
- $696.71
Ophthalmology – Corneal Collagen Cross-Linking (CXL)

- 0402T – Collagen cross-linking of the cornea
  - Scrape cornea

- Drop in riboflavin

- Collagen is changed to stiffer and stronger
Ophthalmology – Medicine Section

- Revision 99174 - Instrument-based ocular screening (e.g., photoscreening, automated-refraction), bilateral; with remote analysis and report

- Add 99177 - Instrument-based ocular screening (e.g., photoscreening, automated-refraction), bilateral; with on-site analysis

- Both SI = E
Ophthalmology – Medicine Section

- For 99174
  - Data transmitted to an off-site facility for analysis and report subsequently received

- For 99177
  - Data analyzed on-site and report readily available
  - Machine provides analysis
Otolaryngology
Otolaryngology – Cerumen Impaction

- Add **69209** – Removal impacted cerumen using irrigation/lavage, unilateral
  - Do not report with 69210
  - Can be performed by nurse
  - No physician work is associated with RUC value

- $SI = Q1$
- $\$55.94$
Otolaryngology – Cerumen Impaction

- Existing code 69210 – Removal impacted cerumen requiring instrumentation, unilateral
  - Physician performs since physician work units assigned to code
  - SI = Q1
  - $55.94
Otolaryngology – Drug Eluting Sinus Implant

- Add 0406T - Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant

- Add 0407T - Nasal endoscopy, surgical, ethmoid sinus, placement of drug eluting implant; with biopsy, polypectomy or debridement

- SI = N
- $0
Otolaryngology – Drug Eluting Sinus Implant

- Intended to remain in place for days to weeks and slowly elute a drug (currently a corticosteroid) into the nasal/sinus cavity mucosa while disintegrating

- Use with classic endoscopic sinus surgery is inherent to the service

- Use with sinus dilation (frontal, maxillary, sphenoid) are uncommon
Otolaryngology – Drug Eluting Sinus Implant

- Code 31288 should not be included in the parenthetical under the 0406T & 0407T per the presenter at the AMA CPT Symposium

- Report with 31299 for remainder of 2015

- To report implantation in sinuses *other than the ethmoid* after 1/1/16 use code 31299
Otolaryngology – Drug Eluting Sinus Implant

- S1090 – Mometasone furoate sinus implant, 370 micrograms

- SI = E
Otolaryngology

- Add **92537** – Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)
  - (For 3 irrigations, use modifier 52)

- **SI = S**
- **$220.35**
Otolaryngology – New Codes

- Add 92538 - Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)
  - For one irrigation, use modifier 52

- SI = S
- $220.35
Otolaryngology

- Deleted 92543 - Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests), with recording

- (92543 has been deleted. To report caloric vestibular testing, see 92537, 92538)
Genital Systems
Male Genital System

- Add 54437 - Repair of traumatic corporeal tear(s)
  - Penile fractures

- SI = J1
- $1,506.42
Male Genital System

- Add **54438** - Replantation, penis, complete amputation including urethral repair

- SI = C
- Inpatient Only
Female Genital System

- Add **0404T** - Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency
  
  - SI = J1
  - $5,698.95
Neurostimulator Pulse Generator System Analysis

- Revised Guidelines
- Revised Code 95972
- Deleted Code 95973
Neurostimulator Pulse Generator System Analysis

- Revised Guidelines only deletes the mention of code 95973
- Code 95972 has been revised to remove “up to 1 hour”
- Deleted code 95973 was for the “each additional 30 minutes after first hour” of intraoperative electronic analysis of an implanted complex spinal cord or peripheral neurostimulator pulse generator system
Neurostimulator Pulse Generator System Analysis

- Be sure you have proper documentation to support coding an analysis of a neurostimulator pulse generator

- Check with your vendor
Pain Medicine
Pain Medicine

- Three codes were added to identify paravertebral block injections at single or multiple levels, as well as for continuous infusion for the administration of local anesthetic
Add 64461 – Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)

- SI = T
- $585.17
Add **64462** – Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed)

- SI = N
- $0
Add **64463** – Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (included imaging guidance, when performed)

- \( SI = T \)
- $585.17$
Pain Medicine – New Codes

- Always done in thoracic region

- Medication injected into the paravertebral area as a single injection, multiple injections, or continuous infusion at an level of the thoracic spine.
Paravertebral blocks target the sympathetic chain of nerves and somatic nerves (intercostal and spinal nerves and their branches) and may be utilized for dermatomal coverage from T2-L1. (Injected at T2-T12.)

These blocks are useful to treat pain after thoracotomy, mastectomy, or in patients with rib fractures.
Pain Medicine – Paravertebral Block

- Not reported with spinal injections
- Not reported with somatic nerve injections
- Not reported with nerve blocks
- Not reported with US or fluoro guidance
Pain Medicine – Paravertebral Block

- Only reported once per day
- Can be billed bilateral per MPFS but CPT Changes says to use 64462 for second injection regardless of laterality?
- Continuous infusions can be intermittent boluses
- Catheter is placed in the paraspinal space
  - As opposed to the epidural space
Pain Medicine – Differences Between Paravertebral Block and Transforaminal Injection

<table>
<thead>
<tr>
<th>Transforaminal Injection (64479-64484)</th>
<th>Paravertebral Block (64461-64463)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires a needle to be placed along the transverse process of the vertebra to deliver drugs into the epidural space via the foramen</td>
<td>Requires needle to be placed lateral to the vertebral body beyond and anterior to the transverse process outside the neuraxial canal to affect the nerves at the point of exit from the neural foramen</td>
</tr>
<tr>
<td>Includes guidance under CT or fluoroscopy</td>
<td>Includes imaging guidance of any type, including US</td>
</tr>
<tr>
<td>The injection volume is less and is intended to block a single nerve within the epidural space</td>
<td>The injection volume is greater and is intended to block several nerves at the point of exit from the spinal column</td>
</tr>
<tr>
<td>Only done with a needle, never a catheter</td>
<td>Can be done with needle or catheter</td>
</tr>
<tr>
<td>Small area with very specific coverage</td>
<td>Covers large area with one injection</td>
</tr>
</tbody>
</table>
Pain Medicine

- **Delete 64412** - Injection, anesthetic agent; spinal accessory nerve

- **Report code 64999** for spinal accessory nerve injections
  - **Very limited use**
Outpatient Rehab

Kathy Dean, CPMA, CPC, COC, CPC-P, CCS-P
Outpatient Rehab

- For physical therapy and speech-language pathology combined, the 2016 therapy cap will be $1,960. For occupational therapy, the cap for 2016 will be $1,960.

- Up $20.00
## 2016 Payment Comparison Example

<table>
<thead>
<tr>
<th>Code</th>
<th>2016</th>
<th>2015</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>97001</td>
<td>$71.38</td>
<td>$71.60</td>
<td>($0.22)</td>
</tr>
<tr>
<td>97003</td>
<td>$80.12</td>
<td>$80.36</td>
<td>($0.24)</td>
</tr>
<tr>
<td>97004</td>
<td>$48.97</td>
<td>$49.11</td>
<td>($0.14)</td>
</tr>
<tr>
<td>97012</td>
<td>$15.20</td>
<td>$15.24</td>
<td>($0.04)</td>
</tr>
<tr>
<td>97016</td>
<td>$17.69</td>
<td>$17.74</td>
<td>($0.05)</td>
</tr>
<tr>
<td>97110</td>
<td>$30.47</td>
<td>$30.56</td>
<td>($0.09)</td>
</tr>
<tr>
<td>97112</td>
<td>$31.72</td>
<td>$31.51</td>
<td>$0.21</td>
</tr>
<tr>
<td>97113</td>
<td>$39.81</td>
<td>$39.93</td>
<td>($0.12)</td>
</tr>
<tr>
<td>97116</td>
<td>$26.82</td>
<td>$26.90</td>
<td>($0.08)</td>
</tr>
<tr>
<td>97124</td>
<td>$24.71</td>
<td>$25.09</td>
<td>($0.38)</td>
</tr>
<tr>
<td>97140</td>
<td>$28.21</td>
<td>$28.29</td>
<td>($0.08)</td>
</tr>
<tr>
<td>G0283</td>
<td>$13.00</td>
<td>$13.04</td>
<td>($0.04)</td>
</tr>
</tbody>
</table>
Radiation Oncology
# Deleted Codes

<table>
<thead>
<tr>
<th>Deleted Code</th>
<th>Description</th>
<th>2016 Cross Code</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>77776</td>
<td>Interstitial radiation source application; simple</td>
<td>77799</td>
<td>Unlisted procedure, clinical brachytherapy</td>
</tr>
<tr>
<td>77777</td>
<td>Interstitial radiation source application; intermediate</td>
<td>77799</td>
<td>Unlisted procedure, clinical brachytherapy</td>
</tr>
</tbody>
</table>

77799 – Status “S”  APC Payment $110.34
## Radiation Oncology

### Deleted Codes

<table>
<thead>
<tr>
<th>Deleted Code</th>
<th>Description</th>
<th>2016 Cross Code</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>77785</td>
<td>Remote afterloading high dose rate radionuclide brachytherapy; 1 channel</td>
<td>77770</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel</td>
</tr>
<tr>
<td>77786</td>
<td>Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels</td>
<td>77771</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels</td>
</tr>
<tr>
<td>77787</td>
<td>Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels</td>
<td>77772</td>
<td>Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels</td>
</tr>
</tbody>
</table>

77770-77772 = Status “S” APC Payment $696.21
## Radiation Oncology

### Deleted Code

<table>
<thead>
<tr>
<th>Deleted Code</th>
<th>Description</th>
<th>2016 Cross Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0182T</td>
<td>High dose rate electronic brachytherapy, per fraction</td>
<td>0394T</td>
<td>High dose rate electronic brachytherapy, skin surface application, per fraction, includes basic dosimetry, when performed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0395T</td>
<td>High dose rate electronic brachytherapy, interstitial or intracavitary treatment, per fraction, includes basic dosimetry, when performed</td>
</tr>
<tr>
<td>Code</td>
<td>Short Description</td>
<td>OPSI</td>
<td>2016 APC Payment</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------</td>
<td>------</td>
<td>------------------</td>
</tr>
<tr>
<td>0394T</td>
<td>Hdr elctrnc skn surf brchtx</td>
<td>S</td>
<td>$194.35</td>
</tr>
<tr>
<td>0395T</td>
<td>Hdr elctr ntrst/ntrcv brchtx</td>
<td>S</td>
<td>$696.21</td>
</tr>
</tbody>
</table>
## Radiation Oncology

### New Codes

<table>
<thead>
<tr>
<th>Codes</th>
<th>Description</th>
<th>SI</th>
<th>2016 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>77767</td>
<td>Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel</td>
<td>$</td>
<td>$194.35</td>
</tr>
<tr>
<td>77768</td>
<td>Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions</td>
<td>$</td>
<td>$194.35</td>
</tr>
</tbody>
</table>
## Table 3 – New Brachytherapy Source Code, Effective January 1, 2016

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Effective Date</th>
<th>SI</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>Payment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C2645</td>
<td>1/1/2016</td>
<td>U</td>
<td>2648</td>
<td>Brachytx planar, p-103</td>
<td>Brachytherapy planar source, palladium - 103, per square millimeter</td>
<td>$4.69</td>
<td>$0.94</td>
</tr>
</tbody>
</table>
Billing Instructions for IMRT Planning

- Payment for the services identified by CPT codes 77014, 77280 through 77295, 77305 through 77321, 77331, and 77370 is included in the APC payment for CPT code 77301 (Intensity Modulated Radiation Therapy (IMRT) planning). These codes should not be reported in addition to CPT code 77301 (on either the same or a different date of service) unless these services are being performed in support of a separate and distinct non-IMRT radiation therapy for a different tumor.
Supply & Device Updates
Supply and Device Updates

- **New Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8607</td>
<td>Injectable bulking agent for vocal cord medialization, 0.1 ml, includes shipping and necessary supplies</td>
</tr>
<tr>
<td>C1822</td>
<td>Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system</td>
</tr>
</tbody>
</table>
Devices

- Pass-Through status expiring December 31, 2015
  - **C1841** - Retinal prosthesis, includes all internal and external components
    - SI becomes N
Devices

Four Devices continue to have Pass-Through status for CY 2016

- **C2623** - Catheter, transluminal angioplasty, drug-coated, non-laser
  - The Lutonix® 035 DCB—the first FDA-approved DCB— is an angioplasty balloon coated with a therapeutic dose of the drug paclitaxel, and also utilizes standard mechanical dilatation of the vessel to restore blood flow for patients with peripheral arterial disease (PAD) in the femoropopliteal arteries.
Devices

- **C1822** - Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
  - Restore Sensor Neurostimulator

- **C2624** - Implantable wireless pulmonary artery pressure sensor with delivery catheter, including all system components
  - The CardioMEMS HF System is indicated for wirelessly measuring and monitoring pulmonary artery (PA) pressure and heart rate
Devices

- **C2613 - Lung biopsy plug with delivery system**
  - The BioSentry™ tract sealant system is the first biopsy sealant system of its kind and represents a major advance in the prevention of lung biopsy-related pneumothorax.
  - The BioSentry™ system deploys a self-expanding hydrogel plug into the pleural space following biopsy. The plug expands, creating an airtight seal that closes the pleural puncture, reducing the risk of pneumothorax by more than 50%.
Argus Retinal Prosthesis System – an active implantable medical device that is intended to provide electrical stimulation of the retina to induce visual perception in patients who are profoundly blind due to retinitis pigmentosa
  - Approved for ICD-10-CM procedure codes:
    - 08H005Z Insertion of Epiretinal Visual Prosthesis into Right Eye,
  - Open Approach
    - 08H105Z Insertion of Epiretinal Visual Prosthesis into Left Eye,

C1841 Retinal prosthesis, includes all internal and external components
  - Status Indicator “H”
  - Add-on Payment is $72,028.75
New Technology Add-On (Inpatient)

- CardioMEMS™ HF Monitoring System
  - 02HQ30Z (*Insertion of pressure sensor monitoring device into right pulmonary artery, percutaneous approach*)
  - 02HR30Z (*Insertion of pressure sensor monitoring device into left pulmonary artery, percutaneous approach*)
    - Maximum Add-On Reimbursement Opportunity is $8,875
New Technology Add-On (Inpatient)

- **MitraClip System**
  - includes a MitraClip® device implant, a steerable Guide Catheter, and a Clip Delivery System
  - Used in the reconstruction of the insufficient mitral valve for high-risk patients who are not candidates for conventional open mitral valve repair surgery

- **ICD-10-PCS:**
  - 02UG3JZ *Supplement mitral valve with synthetic substitute, percutaneous approach*
  - Maximum add-on payment is $15,000
New Technology Add-On (Inpatient)

- **RNS System (Responsive Neurostimulator System)**
  - Implantable medical device for treating persons diagnosed with epilepsy whose partial onset seizures have not been adequately controlled with antiepileptic medications
  - Incorporates remote monitoring, which allows patients to share information with their physicians remotely
  - Maximum Add-on Payment $18,475

- **ICD-10-PCS:**
  - 0NH00NZ *Insertion of neurostimulator generator into skull, open approach* in combination with
  - 00H00MZ *Insertion of neurostimulator lead into brain, open Approach*
New Technology Add-On (Inpatient)

- LUTONIX® Drug-Coated Balloon (DCB) Percutaneous
  - Transluminal Angioplasty (PTA) Catheter and IN.PACT™
  - Admiral™ Paclitaxel Coated Percutaneous Transluminal
  - Angioplasty (PTA) Balloon Catheter
  - First drug coated balloons that can be used for treatment of patients who are diagnosed with PAD
  - Maximum Add on Payment $1,035.72

- ICD-10-PCS procedure codes are numerous, totaling 36 possible PCS codes
Respiratory Therapy
## 2016 Deleted Codes

<table>
<thead>
<tr>
<th>Deleted Code</th>
<th>Description</th>
<th>2016 Cross Code</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0243T</td>
<td>Intermittent measurement of wheeze rate for bronchodilator or bronchial-challenge diagnostic evaluation(s), with interpretation and report</td>
<td>94799</td>
<td>To report intermittent measurement of wheeze rate for bronchodilator or bronchial challenge diagnostic evaluation, use 94799.</td>
</tr>
<tr>
<td>0244T</td>
<td>Continuous measurement of wheeze rate during treatment assessment or during sleep for documentation of nocturnal wheeze and cough for diagnostic evaluation 3 to 24 hours, with interpretation and report</td>
<td>94799</td>
<td>To report intermittent measurement of wheeze rate for bronchodilator or bronchial challenge diagnostic evaluation, use 94799.</td>
</tr>
<tr>
<td>----------</td>
<td>--------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>0410, 0419</td>
<td>Q1</td>
<td>DESC</td>
<td>94640</td>
</tr>
<tr>
<td>0410, 0419</td>
<td>Q1</td>
<td>DESC</td>
<td>94640</td>
</tr>
</tbody>
</table>
Medically Unlikely Edit Change

- CPT 94640 (Inhalation Treatment)
  - 4th Quarter 2015 – 10 units per date of service
  - 1st Quarter 2016 – 2 units per date of service
- MAI - 3
Respiratory Therapy

*CPT Code Book Instruction*

- New instructional note for CPT 94640 states:
  - Do not report 94640 in conjunction with 94060, 94070, or 94400
  - NCCI Edits exist at present to prohibit the reporting of CPT 94060 and 94070 with 94640

- NCCI Edits do not exist at present to disallow the reporting of CPT 94640 and 94400 together

- New instructional note with CPT 94400 states “*Do not report 94400 in conjunction with 94640*”
Wound Care & HBO Therapy

ADMINISTRATIVE CONSULTANT SERVICE
### 2016 New HCPCS Codes

<table>
<thead>
<tr>
<th>HCPC</th>
<th>OPSI</th>
<th>Payment</th>
<th>LONG DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4161</td>
<td>N</td>
<td></td>
<td>Bio-connekt wound matrix, per square centimeter</td>
</tr>
<tr>
<td>Q4162</td>
<td>N</td>
<td></td>
<td>Amniopro flow, bioskin flow, biorenew flow, woundex flow, amniogen-a, amniogen-c, 0.5 cc</td>
</tr>
<tr>
<td>Q4163</td>
<td>N</td>
<td></td>
<td>Amniopro, bioskin, biorenew, woundex, amniogen-45, amniogen-200, per square centimeter</td>
</tr>
<tr>
<td>Q4164</td>
<td>N</td>
<td></td>
<td>Helicoll, per square centimeter</td>
</tr>
<tr>
<td>Q4165</td>
<td>N</td>
<td></td>
<td>Keramatrix, per square centimeter</td>
</tr>
</tbody>
</table>
### Hyperbaric Oxygen Therapy

#### HBO Therapy Payment Comparison

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Description</th>
<th>SI</th>
<th>APC</th>
<th>2015 Payment</th>
<th>2016 Payment</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0277</td>
<td>Hbot, full body chamber, 30m</td>
<td>S</td>
<td>5061</td>
<td>$109.29</td>
<td>$107.71</td>
<td>-$1.58</td>
</tr>
</tbody>
</table>
Skin Substitute Procedures

- Skin Procedures
  - High and Low Cost category coding still in effect
    - See Table 50 in Final Rule for Skin Substitute cost designation
  - Combined debridement and skin procedures to create more appropriate categories
  - Skin Procedures and related services – Levels 1 - 5
    - SI changed to Q1 for 36 codes in these APCs
  - Negative Pressure Wound Therapy Services
    - CPT 97605 and 97606 represent the therapy provided with DME
    - SI changed to Q1 for these codes
## Wound Care

### Payment Packaging

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>SI</th>
<th>APC</th>
<th>2016 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>11042</td>
<td>Deb subq tissue 20 sq cm/</td>
<td>T</td>
<td>5052</td>
<td>$225.55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>SI</th>
<th>APC</th>
<th>2016 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>97605</td>
<td>Neg press wound tx &lt;/=50 cm</td>
<td>Q1</td>
<td>5051</td>
<td>$117.83</td>
</tr>
</tbody>
</table>

If Debridement is done on the same date as negative pressure wound therapy then only the debridement will be paid. This is due to CPT 97605 being changed to Q1 status indicator.
## Autologous Platelet Rich Plasma

### APC Payment Change

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>2016 SI</th>
<th>2015 APC</th>
<th>2016 APC</th>
<th>2015 Payment Rate</th>
<th>2016 Payment Rate</th>
<th>Difference +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0460</td>
<td>Autologous prp for ulcers</td>
<td>T</td>
<td>0327</td>
<td>5054</td>
<td>$430.12</td>
<td>$1,411.21</td>
<td>$981.09</td>
</tr>
</tbody>
</table>

G0460 - Autologous platelet rich plasma for chronic wounds/ulcers, including phlebotomy, centrifugation, and all other preparatory procedures, administration and dressings, per treatment
## Wound Care

### 2016 New HCPCS Codes

<table>
<thead>
<tr>
<th>HCPC</th>
<th>Action</th>
<th>OPSI</th>
<th>CI</th>
<th>Payment</th>
<th>LONG DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4161</td>
<td>Add</td>
<td>N</td>
<td>NI</td>
<td></td>
<td>Bio-connekt wound matrix, per square centimeter</td>
</tr>
<tr>
<td>Q4162</td>
<td>Add</td>
<td>N</td>
<td>NI</td>
<td></td>
<td>Amniopro flow, bioskin flow, biorenew flow, woundex flow, amniogen-a, amniogen-c, 0.5 cc</td>
</tr>
<tr>
<td>Q4163</td>
<td>Add</td>
<td>N</td>
<td>NI</td>
<td></td>
<td>Amniopro, bioskin, biorenew, woundex, amniogen-45, amniogen-200, per square centimeter</td>
</tr>
<tr>
<td>Q4164</td>
<td>Add</td>
<td>N</td>
<td>NI</td>
<td></td>
<td>Helicoll, per square centimeter</td>
</tr>
<tr>
<td>Q4165</td>
<td>Add</td>
<td>N</td>
<td>NI</td>
<td></td>
<td>Keramatrix, per square centimeter</td>
</tr>
</tbody>
</table>
Pharmacy Department
## Code and Description Changes

<table>
<thead>
<tr>
<th>Deleted HCPC</th>
<th>LONG DESCRIPTION</th>
<th>2016 Cross Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9443</td>
<td>Injection, dalbavancin, 10 mg</td>
<td>J0875</td>
<td>Injection, dalbavancin, 5mg</td>
</tr>
<tr>
<td>J0886</td>
<td>Injection, epoetin alfa, 1000 units (for esrd on dialysis)</td>
<td>Q4081</td>
<td>Injection, epoetin alfa, 100 units (for esrd on dialysis)</td>
</tr>
<tr>
<td>J1446</td>
<td>Injection, tbo-filgrastim, 5 micrograms</td>
<td>J1447</td>
<td>Injection, tbo-filgrastim, 1 microgram</td>
</tr>
<tr>
<td>J7506</td>
<td>Prednisone, oral, per 5 mg</td>
<td>J7512</td>
<td>Prednisone, immediate release or delayed release, oral, 1 mg</td>
</tr>
<tr>
<td>J9010</td>
<td>Injection, alemtuzumab, 10 mg</td>
<td>J0202</td>
<td>Injection, alemtuzumab, 1 mg</td>
</tr>
</tbody>
</table>
# New Vaccine Codes

## 2016 New CPT Codes

<table>
<thead>
<tr>
<th>New Code</th>
<th>Description</th>
<th>SI</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>90620</td>
<td>Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use</td>
<td>K</td>
<td>$155.70</td>
</tr>
<tr>
<td>90621</td>
<td>Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use</td>
<td>K</td>
<td>$122.70</td>
</tr>
<tr>
<td>90625</td>
<td>Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>90697</td>
<td>Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use</td>
<td>E</td>
<td></td>
</tr>
</tbody>
</table>
## New Drug HCPCS Codes

<table>
<thead>
<tr>
<th>New HCPCS</th>
<th>SI</th>
<th>Payment</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0202</td>
<td>K</td>
<td>$1,743.19</td>
<td>Injection, alemtuzumab, 1 mg</td>
</tr>
<tr>
<td>J0596</td>
<td>G</td>
<td>$23.29</td>
<td>Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units</td>
</tr>
<tr>
<td>J0695</td>
<td>G</td>
<td>$0.42</td>
<td>Injection, ceftolozane 50 mg and tazobactam 25 mg</td>
</tr>
<tr>
<td>J0714</td>
<td>K</td>
<td>$75.53</td>
<td>Injection, ceftazidime and avibactam, 0.5 g/0.125 g</td>
</tr>
<tr>
<td>J0875</td>
<td>G</td>
<td>$14.28</td>
<td>Injection, dalbavancin, 5mg</td>
</tr>
<tr>
<td>J1443</td>
<td>E</td>
<td></td>
<td>Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron</td>
</tr>
<tr>
<td>J1447</td>
<td>G</td>
<td>$3.86</td>
<td>Injection, tbo-filgrastim, 1 microgram</td>
</tr>
<tr>
<td>J1575</td>
<td>K</td>
<td>$10.96</td>
<td>Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin</td>
</tr>
</tbody>
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## New Drug HCPCS Codes

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<tr>
<th>New HCPCS</th>
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<tbody>
<tr>
<td>J1833</td>
<td>G</td>
<td>$0.68</td>
<td>Injection, isavuconazonium, 1 mg</td>
</tr>
<tr>
<td>J2407</td>
<td>G</td>
<td>$25.07</td>
<td>Injection, oritavancin, 10 mg</td>
</tr>
<tr>
<td>J2502</td>
<td>G</td>
<td>$251.26</td>
<td>Injection, pasireotide long acting, 1 mg</td>
</tr>
<tr>
<td>J2547</td>
<td>G</td>
<td>$1.68</td>
<td>Injection, peramivir, 1 mg</td>
</tr>
<tr>
<td>J2860</td>
<td>G</td>
<td>$8.90</td>
<td>Injection, siltuximab, 1 mg</td>
</tr>
<tr>
<td>J3090</td>
<td>G</td>
<td>$0.12</td>
<td>Injection, tedizolid phosphate, 1 mg</td>
</tr>
<tr>
<td>J3380</td>
<td>G</td>
<td>$17.03</td>
<td>Injection, vedolizumab, 1 mg</td>
</tr>
<tr>
<td>J7121</td>
<td>N</td>
<td></td>
<td>5% dextrose in lactated ringers infusion, up to 1000 cc</td>
</tr>
<tr>
<td>J7188</td>
<td>K</td>
<td>$4.90</td>
<td>Injection, factor viii (antihemophilic factor, recombinant), (obizur), per i.u.</td>
</tr>
</tbody>
</table>
# New Drug HCPCS Codes

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<tbody>
<tr>
<td>J7205</td>
<td>G</td>
<td>$1.90</td>
<td>Injection, factor viii fc fusion (recombinant), per iu</td>
</tr>
<tr>
<td>J7297</td>
<td>E</td>
<td></td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration</td>
</tr>
<tr>
<td>J7298</td>
<td>E</td>
<td></td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration</td>
</tr>
<tr>
<td>J7313</td>
<td>G</td>
<td>$490.95</td>
<td>Injection, fluocinolone acetonide, intravitreal implant, 0.01 mg</td>
</tr>
<tr>
<td>J7328</td>
<td>E</td>
<td></td>
<td>Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg</td>
</tr>
<tr>
<td>J7340</td>
<td>K</td>
<td>$2.14</td>
<td>Carbidopa 5 mg/levodopa 20 mg enteral suspension</td>
</tr>
<tr>
<td>J7503</td>
<td>E</td>
<td></td>
<td>Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg</td>
</tr>
</tbody>
</table>
# New Drug HCPCS Codes

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<thead>
<tr>
<th>New HCPCS</th>
<th>SI</th>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7512</td>
<td>N</td>
<td></td>
<td>Prednisone, immediate release or delayed release, oral, 1 mg</td>
</tr>
<tr>
<td>J7999</td>
<td>N</td>
<td></td>
<td>Compounded drug, not otherwise classified</td>
</tr>
<tr>
<td>J8655</td>
<td>G</td>
<td>$474.85</td>
<td>Netupitant 300 mg and palonosetron 0.5 mg</td>
</tr>
<tr>
<td>J9032</td>
<td>G</td>
<td>$31.64</td>
<td>Injection, belinostat, 10 mg</td>
</tr>
<tr>
<td>J9039</td>
<td>G</td>
<td>$96.00</td>
<td>Injection, blinatumomab, 1 microgram</td>
</tr>
</tbody>
</table>
### New Drug HCPCS Codes

<table>
<thead>
<tr>
<th>New HCPCS</th>
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<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9271</td>
<td>G</td>
<td>$45.69</td>
<td>Injection, pembrolizumab, 1 mg</td>
</tr>
<tr>
<td>J9299</td>
<td>G</td>
<td>$25.38</td>
<td>Injection, nivolumab, 1 mg</td>
</tr>
<tr>
<td>J9308</td>
<td>G</td>
<td>$53.97</td>
<td>Injection, ramucirumab, 5 mg</td>
</tr>
<tr>
<td>J7999</td>
<td>N</td>
<td></td>
<td>Compounded drug, not otherwise classified</td>
</tr>
<tr>
<td>Q9980</td>
<td>E</td>
<td></td>
<td>Hyaluronan or derivative, genvisc 850, for intra-articular injection, 1 mg</td>
</tr>
</tbody>
</table>
New Technology Add-On (Inpatient)

- **Kcentra** – replacement therapy for fresh frozen plasma for patients with an acquired coagulation factor deficiency due to warfarin and who are experiencing a severe bleed
  - ICD-10-CM procedure code 30283B1, *Transfusion of nonautologous 4-Factor prothrombin complex concentrate into vein, percutaneous approach*
- C9132 Prothrombin complex concentrate (human),
- Kcentra, per i.u. of Factor IX activity
  - Status Indicator “G”
  - $1,587.50 maximum add-on payment
New Technology Add-On (Inpatient)

- **Blinatumomab** (BLINCYTO)
  - a single treatment cycle using the BLINCYTO™ consists of 28 days of continuous infusion, and each cycle of treatment is separated by a 2-week treatment-free interval

- Maximum Add on Payment $27,017.85
  - XW03351 *Introduction of Blinatumomab Antineoplastic Immunotherapy into Peripheral Vein, Percutaneous Approach, New Technology Group 1*
  - XW04351 *Introduction of Blinatumomab Antineoplastic Immunotherapy into Central Vein, Percutaneous Approach, New Technology Group 1*
Questions?

Administrative Consultant Service, LLC

(405) 878-0118

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