2019 SpaceOAR® Coding and Payment Quick Reference Guide

Effective January 1, 2019

This Quick Coding Guide includes the most commonly used procedure codes recommended when reporting the SpaceOAR Hydrogel System. It is the provider's responsibility to verify eligibility and benefits to determine and submit appropriate codes, charges and modifiers that best reflect the actual service(s) provided. Providers should consult with the appropriate payer(s) regarding billing, coding and payer guidelines. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list.

CPT® Code – For Outpatient Services

CPT® Code	Code Description
SpaceOAR Surgery Procedure	
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed

ICD-10 CM Diagnosis Code

ICD-10 CM Diagnosis Code	Code Description
SpaceOAR Surgery Procedure	
C61	Malignant neoplasm of prostate

Physician Professional and Physician Office Payments – Medicare National Average

All rates shown are 2019 Medicare national averages; actual rates will vary geographically and/or by individual facility.

CPT® Code	Short Descriptor	Multiple Surgery Procedure Indicator	MD In-Office Medicare Unadjusted Allowed Amount	MD In-Facility Medicare Unadjusted Allowed Amount	MD In-Facility Total RVUs
SpaceOAR Surgery Procedure					
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	2	$3,555	$173	4.80

Hospital Outpatient Payment – Medicare National Average

CPT® Code	Short Descriptor	Payment Status Indicator[5]	APC[3]	Hospital Outpatient Medicare National Unadjusted Allowed Amount
SpaceOAR Surgery Procedure				
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	T	5375	$4,021

SpaceOAR System Reimbursement Support

Augmenix offers assistance and resources to providers in their efforts to obtain benefit coverage and payment.
Contact a SpaceOAR Reimbursement Specialist at:
(781) 902-1657 or reimbursement@augmenix.com

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ASC Payment – Medicare National Average

CPT® Code	Short Descriptor	Subject to Multiple Procedure Reduction Indicator	Final Payment Indicator	ASC Medicare National Unadjusted Allowed Amount
SpaceOAR Surgery Procedure				
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	**Y**	**G2**	**$1,912**

REFERENCES:

1. Current Procedural Terminology (CPT) is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals, or entities. The use of CPT codes simplifies the reporting of such procedures and services.
2. Ambulatory Payment Classification (APC) is the government's method of paying facilities for outpatient services for the Medicare program. A part of the Federal Balanced Budget Act of 1997 that required Centers for Medicare and Medicaid Services (CMS) to create a new Medicare "Outpatient Prospective Payment System" (OPPS) for hospital outpatient services to differentiate from hospital inpatient services.
3. HOPPS Payment Status Indicators (SI)- Medicare has assigned each HCPCS/CPT code a letter that signifies whether Medicare will reimburse the service and how it will be reimbursed. The indicator also helps in determining whether policy rules, such as packaging and discounting, apply. SI, "T" = Significant procedure subject to multiple procedure discounting.
4. Physician Fee Schedule Status Indicator (SI), 2 = Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html
5. Hospital Outpatient Place of Service 19 and 22 – OPPS – National Average Medicare Payment rates https://www.cms.gov/ apps/ama/license.asp file=/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS-1695- FC
6. Ambulatory Surgical Center Place of Service 24 - Status Indicator "G2" description: Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
7. Ambulatory Surgical Center Place of Service 24 - National Average Payment Rate as of January 2019 https://www.cms.gov/ apps/ama/license.aspfile=/Medicare/Medicare-Fee-for-Service-Payment/ascpayment/downloads/CMS-1695
8. Relative Value Units are a measure of value used in the United States Medicare reimbursement formula for physician services.
9. Facility (Professional Component) and Non-Facility (Place of Service 11) Procedure Status "C" Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

DISCLAIMER:

It is the responsibility of the provider to determine and report the appropriate procedure and supply codes based upon medical necessity and procedures and supplies provided to the patient. Coding and reimbursement information is provided for educational purposes and does not assure coverage of the specific item or service in a given case. The information provided is for educational purposes only and does not constitute reimbursement or legal advice. Augmexin recommends that you consult with payers, consultants and/ or legal advice for any reimbursement questions. Contact your local Medicare Administrator Contractor (MAC) or CMS for specific information as payment rates listed are subject to change. To the extent that you submit cost information to Medicare, Medicaid or any other reimbursement program to support claims for services or items, you are obligated to accurately report the actual price paid for such items, including any subsequent adjustments. CPT® five-digit numeric codes, descriptions, and numeric modifiers only are Copyright AMA. All rights reserved.

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CPT does not include fee schedule, relative values or related listings. The source for this information is the Center for Medicare and Medicaid Services. The content provided by the Center for Medicare and Medicaid Services is updated frequently. It is the responsibility of the health services provider to confirm the appropriate coding required by their local MAC and commercial payers.

SOURCES:

OPPS and ASC Final Rule, Federal Register (81 FR 79562) November1, 2018. Current Procedural Terminology 2018 American Medical Association. Chicago, IL 2017. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2018 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

CY 2019 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes and Payment Rates 2019 Final. CMS-1695-FC-2019-OPPS-FR-Addenda.zip; Ambulatory Surgical Center Payment System Policy Changes and Payment Rates 2019 Final. CMS-1695-FC-2019-FR-ASC-Addendum A.

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