Ambulatory Surgery Center Payment System, Hospital Outpatient Prospective Payment System and Physician Fee Schedule

Medicare has made some significant changes to its Ambulatory Surgery Center payment system (ASC) [Table 1], Hospital Outpatient Prospective Payment System (OPPS) [Table 2], and Physician Fee Schedule (PFS) [Tables 3] for 2016. In the charts below, we have identified some of the most significant changes. We have chosen to focus on changes greater than or equal to $100 for ASC, OPPS and PFS from 2015 to 2016. If you have questions about specific information in this document, or perhaps something you do not see in this document, please do not hesitate to contact our reimbursement team at 800.468.1379 or reimbursement@cookmedical.com.

Table 1: Changes in Ambulatory Surgery Center Reimbursement for Procedures of Interest

CPT Code	Procedural Description	2016 Ambulatory Surgery Center Fee Schedule	2015 Ambulatory Surgery Center Fee Schedule	Payment Difference
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	$1,113.86	$578.16	$535.70
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	$1,113.86	$1,236.39	($122.53)
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	$2,122.27	$1,225.38	$896.89
36566	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)	$2,122.27	$1,225.38	$896.89
36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	$2,122.27	$1,225.38	$896.89
37200	Transcatheter biopsy	$2,122.27	$1,225.38	$896.89

NOTE: This is not an all-inclusive list of procedural code changes.

Table 2: Changes in Hospital Outpatient Reimbursement for Procedures of Interest

CPT Code	Procedural Description	2016 Hospital Outpatient Payment	2015 Hospital Outpatient Payment	Payment Difference
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	$1,991.92	$1,055.12	$936.80
31629	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)	$1,991.92	$2,256.36	($264.44)
36563	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump	$3,795.28	$2,236.28	$1,559.00
36566	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)	$3,795.28	$2,236.28	$1,559.00
36583	Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access	$3,795.28	$2,236.28	$1,559.00
37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	$3,795.28	$2,236.28	$1,559.00
37200	Transcatheter biopsy	$3,795.28	$2,236.28	$1,559.00

NOTE: This is not an all-inclusive list of procedural code changes.

Table 3: Changes in Physician (Non-Facility) Fee Schedule Reimbursement for Procedures of Interest NOTE: This applies to procedures performed in a physician's office.				
CPT Code	Procedural Description	2016 Medicare Non-Facility Physician Fee Schedule	2015 Medicare Non-Facility Physician Fee Schedule	Payment Difference
36560	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age	$1,374.36	$1,097.05	$277.31
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	$1,579.29	$1,719.06	($139.77)
NOTE: This is not an all-inclusive list of procedural code changes.				

Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources that may include, but are not limited to, the CPT, coding system; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When you are making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.