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) [Table 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
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
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	$2,122.27	$1,764.89	$357.38
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$2,122.27	$1,764.89	$357.38
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$1,256.68	$1,764.89	($508.21)
37200	Transcatheter biopsy	$2,122.27	$1,225.38	$896.89
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired)	$5,984.06	Added to ASC approved list for 2016	$5,984.06
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	$5,984.06	Added to ASC approved list for 2016	$5,984.06
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	$5,984.06	Added to ASC approved list for 2016	$5,984.06

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
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
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	$3,795.28	$3,220.86	$574.42
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$3,795.28	$3,220.86	$574.42
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$2,247.33	$3,220.86	($973.53)
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
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$14,612.17	$14,846.45	($234.28)
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$14,612.17	$14,846.45	($234.28)
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$14,612.17	$14,846.45	($234.28)
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$14,612.17	$14,846.45	($234.28)
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	$2,247.33	$2,501.17	($253.84)
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)
+37235	Revascularization, endovascular, open or percutaneous, tibial/ peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$4,159.26	$4,260.64	($101.38)
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired)	$4,871.16	$4,696.51	$174.65
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	$7,805.82	$7,916.15	($110.33)

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.