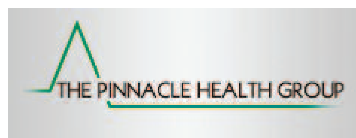
2011 Coding & Coverage for the SAVI® Applicator

Prepared for:

Prepared by: 

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Procedure coding should be 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. Cianna Medical® and The Pinnacle Health Group make no guarantee of coverage or reimbursement of fees. Contact your local Medicare Fiscal Intermediary, Carrier 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. Current Procedural Terminology, numeric codes, descriptions, and modifiers are trademarks and copyrights of the AMA.

Introduction

The information contained in this document is provided to assist health care facilities understand reimbursement guidelines and procedures. It is intended to help obtain accurate coverage and reimbursement for medically necessary health care services provided to patients under physician orders. It is not intended to increase or maximize reimbursement.

The information referenced is based upon coding experience and research of current coding practices and published payer policies. They are based upon commonly used codes and procedures. The final decision for coding of any procedure must be made by the provider of care considering the medical necessity of the services and supplies provided, the regulations of insurance carriers and any local, state or federal laws that apply to the supplies and services rendered.

Although a particular service or supply may be considered medically necessary, the final coverage decision is based upon a review of the available clinical information and does not mean the service or supply will be covered by any payer. Each payer and benefit plan contains its own specific provisions for coverage and exclusions. Please consult individual payers to determine policy specific guidelines and whether there are any exclusions or other benefit limitations applicable to a particular service or supply.

Always code appropriately based upon procedures performed and medical necessity

Be aware of local coverage policies and correct coding initiative quarterly updates

Actual reimbursement will vary by geographic region and payer

Contact local carriers for specific coding guidelines for any procedure

This information is provided for educational purposes only

Coding Methodology

The Physicians' Current Procedural Terminology (CPT) developed by the American Medical Association (AMA) and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive and identifying codes for medical services and procedures performed by health care providers and reported to third party carriers. The codes in the CPT Manual are copyrighted by the AMA, and updated annually by the CPT Editorial Panel.

Third party payers have adopted the CPT coding system for use by providers to communicate payable services. Therefore, it is important to identify the various potential combinations of services to accurately adjudicate claims.

In order for this system to be effective, it is essential the coding description accurately describes what actually transpired at the patient encounter. Because many physician activities are so integral to a procedure, it is impractical and unnecessary to list every event common to all procedures of a similar nature as part of the narrative description for a code. Many of these common activities reflect simply normal principles of medical/surgical care.

Correct Coding Initiative

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative to ensure that payment policies and procedures were standardized for all carriers and to promote national correct coding methodologies. The coding policies developed are based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and reviews of current coding practice.

Procedures should be reported with the CPT/HCPCS codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code or when a single payment episode is split into two or more episodes so multiple payments can be collected.

The National Correct Coding Policy edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The National Correct Coding Initiative represents a more comprehensive approach to unifying coding practices.

Quarterly updates are available for hospitals and physicians. Updates can be located on the web at:
http://www.cms.hhs.gov/NationalCorrectCodInitEd

Procedure Coding for Surgery and Catheter Implant

All codes utilized during the patient's course of treatment may not be indicated below. The total course of therapy may consist of patient consultation, surgery, treatment planning, treatment mapping, treatment delivery and management and follow-up care. Coding for each medically necessary service provided should follow appropriate clinical and coding guidelines. Actual reimbursement will vary by geographic region and payer.

Breast Surgery

CPT-4®	Description	Hospital Outpatient*	Physician Professional*	Freestanding Facility*
19301	Partial mastectomy (e.g. lumpectomy, tylectomy, quadrantectomy, segmentectomy)	$1,762.61	$628.90	$628.90
19302	Partial mastectomy (e.g. lumpectomy, tylectomy, quadrantectomy, segmentectomy) with axillary lymphadenectomy	$3,099.61	$867.42	$867.42
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	$1,762.61	$442.37	$520.18
19126	Each additional excision separately identified by preoperative placement of radiological marker (list separately in addition to primary procedure)	$1,762.61	$160.37	$160.37

Catheter Placement

CPT-4®	Description	Hospital Outpatient*	Physician Professional*	Freestanding Facility*
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	$4,407.45	$207.60	$3,948.74
19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (list separately in addition to code for primary procedure)	$4,407.45	$93.77	$93.77
C1728	Catheters, brachytherapy seed administration	Packaged**	N/A	N/A
19499	Unlisted procedure, breast (e.g. placement of SAVI Prep™ Catheter)	$1,762.61	Individual Consideration***	
A4649 or 99070	Supplies and materials provided by the physician over/above those usually included with the services rendered (e.g. SAVI Prep™ Catheter)	N/A	Individual Consideration or based upon payer contract***	

Procedure Coding for Radiation Therapy

Treatment Planning and Management

CPT-4®	Description	Hospital Outpatient*	Physician Professional*	Freestanding Facility*
77014	CT guidance for placement of radiation therapy fields	Packaged**	$42.47	$191.97
76645	Ultrasound breast	$62.25	$27.18	$96.49
77263	Therapeutic radiology treatment planning, complex	N/A	$161.73	$161.73
77290	Complex simulation	$271.61	$78.15	$530.03
77295	3-D Treatment Planning	$926.74	$229.34	$564.69
77326	Brachytherapy plan simple	$104.48	$46.21	$145.08
77370	Special medical radiation physics consultation	$104.48	N/A	$116.54
77470	Special treatment procedure	$388.58	$104.99	$202.16

Treatment Delivery

CPT-4®	Description	Hospital Outpatient*	Physician Professional*	Freestanding Facility*
77786	HDR 2–12 channels****	$700.10	$161.73	$571.14
77280	Simple simulation (verification simulation)	$104.48	$35.00	$188.91
77300	Basic radiation dosimetry calculation	$104.48	$31.26	$69.99
77332	Simple treatment device	$199.71	$27.18	$78.83
77334	Complex treatment device	$199.71	$61.84	$153.57
77336	Weekly continuing medical physics	$104.48	N/A	$52.32
C1717	Brachytherapy source, Iridium	$218.87	N/A	N/A
77799	Unlisted procedure, Clinical brachytherapy (e.g. catheter removal by non-implanting physician)	$354.95	Individual Consideration***	

**Payment based upon the national Medicare fee schedule for the location indicated*
***Medicare payment for this procedure is packaged into the primary procedure code*
****Individual Consideration requires submission of payer requested information to support appropriate reimbursement*
*****Multiple treatment sessions are generally permitted by payers as long as there treatments are separately identifiable sessions*
NA = reimbursement not available in this setting/fee schedule
Source reimbursed at flat rate effective 01/01/2010

Common Modifiers Reported

Modifiers are required by payers in situations where the SAVI applicator is implanted. Modifiers provide the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers are used to indicate many things, including:

- Only a professional or technical component of the procedure was furnished,
- More than one provider participated in the performance of the procedure,
- A service or procedure was increased or reduced,
- Another related or non-related service/procedure was performed at the same visit,
- A bilateral procedure was performed,
- A service or procedure was provided more than once,
- Unusual events occurred

CPT Modifier 58

Description:

Indicates a Staged or Related Procedure or Service by the Same Physician during the Postoperative Period

Appropriate Use:

- Surgery procedure codes with 010 or 090 global periods on the Medicare Physician Fee Schedule Database
- To report a staged procedure planned at the time of the original procedure
- When the staged procedure is more extensive than the original procedure
- For therapy following a diagnostic surgical procedure
- When performing a second or related procedure during the postoperative period.

Inappropriate Usage:

- Appending the modifier to ASC facility fee claims
- Appending the modifier to a procedure with XXX global period on the MPFSDB
- Appending the modifier to services listed in CPT as multiple sessions,
- Reporting the treatment of a complication form the original surgery that requires a return to the operating room,
- Unrelated procedures during the postoperative period.

Facts:

- A new postoperative period begins when the next procedure in the staged procedure series is billed.
- Staged procedures do not apply to claims for assistant at surgery or services of an ASC.
- Used during the post-operative period starting the day after the initial procedure.

Example:

The same physician that performed the lumpectomy implanted the SAVI applicator on a different date of service.

- Append modifier 58 to CPT 19296 to bypass the 90 day global period assigned to the lumpectomy

CPT Modifier 78

Description:

Indicates the return to the Operating/Procedure Room for a related procedure, by the same physician, during the post-operative period

Appropriate Usage:

- Surgery procedure codes with 010 or 090 global periods on the Medicare Physician Fee Schedule
- To report a procedure, related to the original procedure, performed in an operating room* (OR) during the post-operative period
- Used to identify a return to the OR* on the same day as the procedure or during the post-operative period
- To treat the patient for complications resulting from the original surgery
- When the procedure code used to describe a service for treatment of complications is the same as the procedure code used in the original procedure, modifier 78 is the correct modifier to use.

Inappropriate Usage:

- For any procedure code other than a surgery with 010 or 090 global periods on the Medicare Physician Fee Schedule
- When the surgery is unrelated to the original procedure
- When performed any place other than the OR*.
- When the procedure performed by a different physician who is not related to the physician performing the original procedure (must be outside the original physician group practice).

Facts:

- Modifier 78 does not begin a new post-operative period.

Examples:

The same physician that implanted the initial SAVI catheter must remove and replace the catheter for a clinical purpose during the post-operative period.

- Append modifier 78 to CPT 19296 to bypass the 90 day global period assigned to the lumpectomy (NOTE: for most payers reimbursement includes the cost of the SAVI applicator)

*An OR is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a special procedures room, a laser suite, or an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit.

SAVI Prep™ Catheter Device

The physician can bill for the placement of the SAVI Prep Catheter when implanted at the time of lumpectomy. Since the SAVI Prep Catheter is implanted at the time of lumpectomy, the implant must be reported using CPT 19499 in addition to the CPT code for the Lumpectomy.

To report the SAVI Prep Catheter device, report A4649 for Medicare claims or 99070 for commercial payers. Payment for these supply codes (A4649 and 99070) are typically 'packaged' into the reimbursement for the procedure reported by 19499.

Since CPT 19499 is an unlisted code it is important to make sure that the clinical documentation is clear and outlines the procedure performed. Payers will review the claim and documentation related to the use of CPT 19499 to determine appropriate coverage and payment. The operative report must be available and a description of the procedure such as "Placement of the SAVI Prep Catheter for Cavity Evaluation" should be entered in the comment field of the electronic claim. The description will then appear on the electronic claim. The claim may be pended and a request for clinical documentation sent to the provider. Attach the operative report to the request letter and forward to the payer immediately to avoid delay in reimbursement.

Coverage

Most payers permit coverage for breast brachytherapy based upon specific coverage criteria. In most cases the criteria considers coverage for accelerated partial breast irradiation when the patient is:

In women undergoing initial treatment for stage I or II breast cancer; and
Who are also treated with breast-conserving surgery and whole-breast external beam radiation therapy

For Medicare, the national coverage determination permits coverage if three requirements are met:

The tumor being treated is less than 3cm or 2cm if stage T1
There is no cancer at the surgical margins
There are 3 or fewer lymph nodes containing cancer

Always check with the patient's plan coverage/policy guidelines for appropriate coverage criteria prior to treatment.

Sample Operative Report

RE: (Patient Name) **DOB:** **DATE:**
PREOPERATIVE DIAGNOSIS:
POSTOPERATIVE DIAGNOSIS:
PROCEDURE PERFORMED: (e.g. Placement of an expandable catheter into the right/left breast, using imaging guidance, to be used for interstitial radioelement application).

SURGEON: **ASSISTANT:**
ANESTHESIA: **ESTIMATED BLOOD LOSS:**

PROCEDURE:

(Note: Begin note with a brief description of any imaging studies (i.e. pre-insertion CT scan, three dimensional imaging) that may have been done prior to the procedure to localize the best path to the lumpectomy cavity. If that path is through the original lumpectomy scar then the remainder of the report may be slightly different than the sample below. If a prep catheter was placed at the time of lumpectomy or was used to evaluate the cavity for choice of device size this should also be reflected in the note)

Using *(imaging guidance)* the size and shape of the lumpectomy cavity was evaluated to determine the appropriate angle of entry for the implantation of the applicator.

The appropriate size expandable catheter was selected and tested by opening and closing it, confirming that the applicator expanded symmetrically. The breast was cleansed with _________ *(antiseptic)* and local anesthesia was injected *(if local anesthesia is used)*. Next, a separate "stab-like" incision was made to allow device placement along the long axis of the lumpectomy cavity. Through this incision, using imaging guidance, a trocar was inserted to create a separate pathway to the lumpectomy cavity. Fluid that may have accumulated in the cavity was drained. The expandable applicator was then inserted into the lumpectomy cavity via this separate pathway. The surgeon then expanded the catheter and verified with imaging guidance that it expanded symmetrically and conformed to the cavity. Imaging guidance was also used to confirm optimal orientation of the applicator within the lumpectomy cavity. Having verified that the catheter was secure and appropriately placed antibiotic ointment was applied to the entry site and sterile dressings were applied.

(Optional note by the radiation oncologist regarding radiation treatment added here)

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