

# 2018 SpaceOAR® Coding and Payment Quick Reference Guide

Effective January 1, 2018

This Quick Coding Guide includes the most commonly used procedure codes when reporting the SpaceOAR Hydrogel System. It is always 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) furnished. 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.

The following codes are thought to be relevant to SpaceOAR procedures and are referenced throughout this guide.

## CPT Code – All Sites of Service

CPT® <sup>1</sup>	Code Description
<b>SpaceOAR Surgery Procedure</b>	
<b>55874</b>	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 <sup>2</sup>	Code Description
<b>SpaceOAR Surgery Procedure</b>	
<b>C61</b>	Malignant neoplasm of prostate

## Physician Professional and Physician Office Payments – Medicare National Average

All rates shown are 2018 Medicare national averages; actual rates will vary geographically and/or by individual facility.

CPT® Code <sup>1</sup>	Short Descriptor	Multiple Payment Reduction Status Indicator <sup>3</sup>	MD In-Office Medicare Unadjusted Allowed Amount	MD In-Facility Medicare Unadjusted Allowed Amount	MD In-Facility Total RVUs <sup>4</sup>
<b>SpaceOAR Surgery Procedure</b>					
<b>55874</b>	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	<b>2</b>	<b>\$3,797.24</b>	<b>\$173.16</b>	<b>4.81</b>

## Hospital Outpatient Payment – Medicare National Average

CPT® Code <sup>1</sup>	Short Descriptor	Payment Status Indicator <sup>5</sup>	APC <sup>6</sup>	Hospital Outpatient Medicare National Unadjusted Allowed Amount <sup>7,8</sup>
<b>SpaceOAR Surgery Procedure</b>				
<b>55874</b>	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	<b>T</b>	<b>5375</b>	<b>\$3,706.03</b>

### 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 <sup>9</sup>	ASC Medicare National Unadjusted Allowed Amount <sup>10</sup>
<b>SpaceOAR Surgery Procedure</b>				
<b>55874</b>	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	<b>Y</b>	<b>G2</b>	<b>\$1,757.24</b>

### 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. ICD-10-CM Medical Diagnosis Codes. The ICD-10-CM diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U.S. health care treatment settings.
3. 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.
4. Relative Value Units are a measure of value used in the United States Medicare reimbursement formula for physician services.
5. 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.
6. 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.
7. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates-Items/2018-January-Addendum-B.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending>
8. 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-1656-FC-2017-OPPS-FR-Addenda.zip>
9. 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.
10. Ambulatory Surgical Center Place of Service 24 - National Average Payment Rate as of January 2018 <https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/ascpayment/downloads/CMS-1656-FC-2017-FR-ASC-Addenda.zip>

### DISCLAIMER:

It is always the provider's responsibility 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. 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) November 14, 2017. 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 2017 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

CY 2018 Hospital Outpatient Prospective Payment System (OPPS) Policy Changes and Payment Rates (2017 Final Addendum A.11.01.17); Ambulatory Surgical Center Payment System Policy Changes and Payment Rates (2018 Final ASC Addenda CY 2018 FN ASC AA).

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