Ambulatory Surgical Center Fees - 2016

For the Calendar Year (CY) 2016 ASC wage indexes, Center for Medicare Services (CMS) is using the new core based statistical area (CBSA) delineations. Please review the charts below to determine your 2016 Maryland (MD) Novitas CMS Region number, CBSA number, Facility Fee rate location name.

MD County	MD Region	2015 CBSA#	2016 CBSA#	2016 Facility Fee Rate	2016 CBSA Official Name
ALLEGANY	**99**	19060	19060	**$415.14**	Cumberland, MD-WV
ANNE ARUNDEL	**1**	12580	12580	**$415.14**	Baltimore-Columbia-Towson, MD
BALTIMORE CITY	**1**	12580	12580	**$415.14**	Baltimore-Columbia-Towson, MD
BALTIMORE Co	**1**	12580	12580	**$415.14**	Baltimore-Columbia-Towson, MD
CALVERT	**99**	47894	47894	**$429.01**	Washington-Arlington-Alexandria, DC-VA-MD-WV
CAROLINE	**99**	21	21	**$393.00**	MARYLAND
CARROLL	**1**	12580	12580	**$415.14**	Baltimore-Columbia-Towson, MD
CECIL	**99**	48864	48864	**$434.44**	Wilmington, DE-MD-NJ
CHARLES	**99**	47894	47894	**$429.01**	Washington-Arlington-Alexandria, DC-VA-MD-WV
DORCHESTER	**99**	21	21	**$393.00**	MARYLAND
FREDERICK	**99**	43524	43524	**$413.35**	Silver Spring-Frederick-Rockville, MD
GARRETT	**99**	21	21	**$393.00**	MARYLAND
HARFORD	**1**	12580	12580	**$415.14**	Baltimore-Columbia-Towson, MD
HOWARD	**1**	12580	12580	**$415.14**	Baltimore-Columbia-Towson, MD
KENT	**99**	21	21	**$393.00**	MARYLAND
MONTGOMERY	**DC01**	43524	43524	**$413.35**	Silver Spring-Frederick-Rockville, MD
PRINCE GEORGES	**DC01**	47894	47894	**$429.01**	Washington-Arlington-Alexandria, DC-VA-MD-WV
QUEEN ANNES	**99**	12580	12580	**$415.14**	Baltimore-Columbia-Towson, MD
SOMERSET	**99**	41540	41540	**$406.39**	Salisbury, MD-DE
ST. MARYS	**99**	15680	15680	**$415.14**	California-Lexington Park, MD
TALBOT	**99**	21	21	**$393.00**	MARYLAND
WASHINGTON	**99**	25180	25180	**$415.14**	Hagerstown-Martinsburg, MD-WV
WICOMICO	**99**	41540	41540	**$406.39**	Salisbury, MD-DE
WORCESTER	**99**	50091	41540	**$406.39**	Salisbury, MD-DE Alt 50091

As of 01/20/2016

CENTERS FOR MARYLAND MEDICARE SCREENING COLONOSCOPY COST - CY 2016

Listed below are the Centers for Maryland (MD) CMS Jurisdiction (JL) Colonoscopy physician fee schedule reimbursment rates for the Calendar Year (CY) 2016 for Medicare Part B by Current Procedural Terminology (CPT) Codes with the CY15 Maryland Medical Assistance (MMA) reimbursement rates until the CY16 MMA rates are published.

MD CMS Regions →	MD Region 01 Part B Rate	MD Region 99 Part B Rate	DC Metro 01 Part B Rate	
MD County Jurisdictions→	Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, and Howard counties.	Allegany, Calvert, Caroline, Cecil, Charles, Dorchester, Frederick, Garrett, Kent, Queen Annes, St. Mary's, Somerset, Talbot, Washington, Wicomico, and Worcester counties.	Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, and Howard counties.	**2015 MMA Physician Fee Schedule Reimbursement Rates**
COLONOSCOPY CPT Codes ↓				
00810-Anesthesia Professional Fee (5BU)	**$22.97**	**$22.33**	**$23.95**	See "Part B"
44388-Colonoscopy thru STOMA (44388-408)	**$180.06**	**$172.65**	**$190.16**	**$119.18**
45378-Base or Completed Colonoscopy	**$211.78**	**$203.34**	**$223.51**	**$155.38**
45379-Foreign Body(s)	**$272.24**	**$261.62**	**$287.26**	**$194.09**
45380-Biopsy during Colonoscopy	**$229.40**	**$220.52**	**$242.16**	**$186.45**
45381-Submucosal Injection	**$229.37**	**$220.55**	**$242.13**	**$176.04**
45382-Control the Bleeding	**$294.83**	**$283.56**	**$311.08**	**$237.59**
45383-Deleted CPT Code (Ablation)	**N/A**	**N/A**	**N/A**	**N/A**
45384-Hot Biopsy during Colonoscopy	**$260.29**	**$249.86**	**$274.67**	**$194.71**
45385-Snare Technique Polyp Removal	**$289.60**	**$278.41**	**$305.56**	**$221.04**
45386-Balloon Dialation (NEW)	**$241.99**	**$232.47**	**$255.40**	**$190.83**
45387-Deleted CPT Code (Stent)	**N/A**	**N/A**	**N/A**	**N/A**
45388-Ablation,Guidewire,Balloon Dial.	**$307.48**	**$295.43**	**$324.35**	**REPORT**
45389-Stent Replacement with Dial,/Wire	**$329.00**	**$316.23**	**$347.03**	**REPORT**
45390-Endoscopic Mucosal Resection (NEW)	**$375.68**	**$360.88**	**$396.12**	**REPORT**
45391-Endoscopic Ultrasound (EUS)	**$292.89**	**$281.75**	**$309.01**	**$214.84**
45392-Endoscopic Ultrasound with FNA	**$344.81**	**$331.62**	**$363.72**	**$269.79**
45393-Decompression for Pathology (NEW)	**$287.13**	**$275.97**	**$302.53**	**REPORT**
45398-Band Ligation (Lesion)	**$267.89**	**$257.11**	**$282.66**	**REPORT**
81528-Cologuard (Multitarget Stool DNA Test)	**$508.87**	**$508.87**	**$508.87**	**N/A**
G0105-Colonoscopy on individual at high risk	**$211.29**	**$202.99**	**$223.05**	**N/A**
G0121-Col. on individual not meeting high risk	**$211.71**	**$203.34**	**$223.51**	**N/A**

as of 01/20/2016

Colonoscopy Coding Updates

CPT Code	Short Description	Summary of Changes
	Guidelines	New definition. Colonoscopy is the examination of the entire colon, from the rectum to the cecum or colon-small intestine anastomosis, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis. For screening or diagnostic colonoscopy, report 45378 with modifier 53 if unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances and provide appropriate documentation. For therapeutic examinations that do not reach the cecum or colon-small intestine anastomosis, report the appropriate therapeutic colonoscopy code with modifier 52 and provide appropriate documentation.
45399	Transabdominal colonoscopy via colotomy	Code 45355 has been deleted. Report with new code for unlisted colon procedure, 45399.
45378	Colonoscopy	Colonoscopy is the examination of the entire colon, from the rectum to the cecum or small-intestine anastomosis, and may include the examination of the terminal ileum or small intestine proximal to an anastomosis.
45379	Foreign body(s) removal	"Foreign body(s)" replaces "foreign body."
45380	Biopsy	Not separately reportable with EMR code 45390 for the same lesion.
45381	Submucosal injection	Not separately reportable with EMR or control of bleeding described by 45382 and 45390 for the same lesion.
45382	Control of bleeding	"Any method" replaces previous examples. Not separately reportable with injection or banding of hemorrhoids described by 45381, 45398 for same lesion.
45384	Hot biopsy	Bipolar cautery was deleted as an example.
45385	Snare	Not separately reportable with endoscopic mucosal resection described by 45390 for the same lesion.
45386	Dilation	New language specifies use of transendoscopic balloon. Dilation of multiple strictures can be reported with the 59 modifier for each additional stricture dilated. Not separately reportable with ablation or stent placement described by 45388, 45389. Use 74360 if fluoroscopic guidance is performed.

Do not report this service with code 46600, anoscopy.

G-Codes

CMS has established HCPCS code G0464 for colorectal cancer screening via stool-based DNA and fecal occult hemoglobin tests, such as Cologuard™.

- **G0464** Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)
  NOTE: Do not bill this code with codes 82270, 82274, G0328.

Frequently Asked Coding Questions

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JOEL V. BRILL, MD; CHRISTOPHER Y. KIM, MD, MBA; AND GLENN D. LITTENBERG, MD

QUESTION: One of the most confusing aspects of gastroenterology billing is submitting claims for screening colonoscopy. Can you explain the differences between average risk and high risk screening?

ANSWER: Commercial payors may decide to follow Medicare policy on colorectal cancer (CRC) screening or use their own definitions on coverage policies and benefits, which can make billing screening colonoscopies more difficult. Listed below are the definitions of average and high risk, and some associated billing tips.

Average risk screening: Lack of symptoms and abnormalities

- Screening, by definition, is a service performed on a patient in the absence of signs and symptoms.
- Medicare's definition of average risk is no personal history of adenomatous polyps, colorectal cancer or inflammatory bowel disease, including Crohn's disease and ulcerative colitis; no family history of colorectal cancers or an adenomatous polyp, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.
- For most payors, a patient is eligible for screening colonoscopy on or after age 50. Some payors allow for screening to begin at age 45 for patients of certain gender and/or ethnic origin. If there are questions, check the summary of plan documents (SPD) and/or the plan's coverage policies.
- Since Jan. 1, 2011, Medicare waives the co-pay and deductible for the professional and facility fees for screening colonoscopy at 100 percent with no patient financial responsibility.
- In the final rule for 2015, Medicare expanded the waiver of co-pay and deductible to include anesthesia for screening colonoscopy. A -33 modifier should be added to the 00810 anesthesia code to indicate the circumstance was preventive. This coverage "trumps" local contractor medical necessity policies now in existence in a screening circumstance. In the circumstance when a screening procedure becomes therapeutic (see next bullet), the PT modifier should be applied to the anesthesia service. A copay will still apply, but the deductible should be waived.
- If the screening colonoscopy is negative, a follow-up procedure is allowed every 10 years by Medicare. The frequency for follow-up for commercial payors is dependent upon the patient coverage/plan, but most follow either CMS policy or the U.S. Multi-Specialty Task Force (MSTF) recommendations.
- Billing for a screening colonoscopy in an average risk patient:
  - Medicare: G0121
  - Commercial, Medicaid, exchange/marketplace, Tricare: 45378 with the appropriate ICD-9 (through Sept. 30,