TheraSphere™ Customers:

This alert addresses CPT® coding and Medicare's final payment rates for procedures using Boston Scientific's TheraSphere product and other related procedures furnished under the Physician Fee Schedule (PFS) on January 1, 2021. Medicare's PFS payment rates, payment policies, and other provisions are relevant to Medicare beneficiaries treated in the physician office, including Office Based Labs (OBLs) setting.

CY2021 Reimbursement: Physician Office (POS 11)

Congress passed H.R. 133, a compromise bill to fund the government, provide relief for the COVID-19 pandemic and within it $73 billion was allocated to HHS. As a result, Medicare revised the PFS on December 29, 2020. Changes were made to the Relative Value Units (RVU) as well as the Geographic Practice Cost Indices (GPCI) that determines the locality-specific payment rates. Also included was a 3-month reprieve of the 2% Medicare sequester cuts. Policies and payment rates are effective January 1, 2021.

CMS is decreasing reimbursement overall by 3.3% through a reduction in the Conversion Factor (CF) to $34.8931 from the current rate of $36.0896. Individual procedures will vary based on RVU changes. A table with a more comprehensive summary of the changes is included at the end of this communication.

The changes in physician office reimbursement are stemming from the revaluation of Practice Expense RVUs, which are devised from inputs that reflect the cost of labor, equipment and supplies for any given procedure. In the CY2019 PFS, CMS completed a Market-Based Supply and Equipment Update. This update caused changes in the supply and equipment costs associated with many procedures. These changes are being phased in over a 4-year period, with CY2021 being the third year.

The rates represent the Medicare national average payment rate for items and services. The rates will be adjusted for each Medicare payment locality for each of the three components of a procedure's RVUs (Relative Value Units) for work, practice expense, and malpractice by the Medicare Geographic Practice Cost Index (GPCI). Non-Medicare payers, including Medicare Advantage (Part C) plans, payment rates will vary, though their payment rates may be based on Medicare payment rates or RVUs.

CPT codes, RVUs and Medicare payment rates do not guarantee any payer will cover or reimburse procedures. Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National coverage determinations (NCDs) are made through an evidence-based process. In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare Administrative Contractor (MAC) based on a local coverage determination (LCD).

Peripheral Interventions (PI) Interventional Oncology Embolics product, TheraSphere, and related procedures most impacted by the 2021 Medicare Final Rule payment rate changes are:

- Tumor embolization (CPT code 37243) payment is increasing by 0.6% to $9,933.37.
- Vascular coil embolization (CPT code 37242) payment is increasing by 3.2% to $8,069.73.
- TheraSphere delivery (CPT code 79445) payment is decreasing by 3.9% to $112.36.
- 3-D radiotherapy plan (CPT code 77295) payment is decreasing by 1.5% to $490.95.
- Brachytherapy isodose plan with dosimetry calcs (CPT code 77316) payment is increasing 6.2% to $236.58.

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Physician office (OBL) claims must contain the appropriate HCPCS/CPT code(s) to indicate the items and services that are furnished. The table below contains a list of possible HCPCS/CPT codes that may be used to bill for Boston Scientific's TheraSphere product and other related procedures. Providers should select the most appropriate code(s) and modifier(s) with the highest level of detail to describe the service(s) actually rendered.

Final 2021 Physician Office/OBL (POS 11) Reimbursement

Pre-Treatment

Abbreviated Descriptor	CPT® Code	2020	FR 2021	$ Change	% Change	2020 RVU	FR 2021 RVU	% Change
Therapeutic Radiology Tx Planning, Complex	77263	$174	$170	-$4	-2.5%	4.83	4.87	0.8%
Sel Cath Place, Art, Init, 1st Order, Abd	36245	$1,378	$1,400	$22	1.6%	38.19	40.13	5.1%
Sel Cath Place, Art, Init, 2nd Order, Abd (2 vsls)	36246	$886	$912	$26	2.9%	24.55	26.13	6.4%
Sel Cath Place, Art, Init 3rd Order or >, Abd (3+ vsls)	36247	$1,560	$1,589	$29	1.9%	43.23	45.55	5.4%
Sel Cath Place, Art, Add'l 2nd Ord or >, Abd (ea vsl)	36248	$141	$134	-$7	-5.0%	3.92	3.85	-1.8%
Angiography, Visceral, Sel or Suprasel, RS&I	75726	$188	$181	-$6	-3.3%	5.20	5.20	0.0%
Angiography, RS&I (ea add'l vsl)	75774	$110	$106	-$4	-3.3%	3.04	3.04	0.0%
Therapeutic Radiology Simulation, Complex	77290	$508	$501	-$7	-1.3%	14.08	14.37	2.1%
Rp localization tumor/distrib Rp agent, incl vasc flow, (SPECT), 1 area, 1 day	78803	$401	$397	-$4	-1.1%	11.12	11.38	2.3%
Rp localization tumor/distrib Rp agent, incl vasc flow, planar, 1 area, 1 day	78800	$267	$263	-$4	-1.6%	7.40	7.53	1.8%
Vasc Embo, RS&I, Intraproc Roadmap, RS&I, Art	37242	$7,824	$8,070	$246	3.2%	216.78	231.27	6.7%

Clinical Treatment Planning and Dosimetry

Abbreviated Descriptor	CPT® Code	2020	FR 2021	$ Change	% Change	2020 RVU	FR 2021 RVU	% Change
Basic dosimetry calc (req Rx treating physician)	77300	$68	$67	-$1	-0.7%	1.88	1.93	2.7%
Brachy isodose plan, 1-4 srcs, incl basic dosim calc	77316	$223	$237	$14	6.2%	6.17	6.78	9.9%
3-D radiother plan, incl dose-vol histograms, BEV	77295	$498	$491	-$7	-1.4%	13.80	14.07	2.0%
Special Medical Radiation Physics Consult	77370	$127	$131	$4	3.3%	3.51	3.75	6.8%

Treatment

Abbreviated Descriptor	CPT® Code	2020	FR 2021	$ Change	% Change	2020 RVU	FR 2021 RVU	% Change
Sel Cath Place, Art, Init 3rd Ord or >, Abd (3+ vsls)	36247	$1,560	$1,589	$29	1.9%	43.23	45.55	5.4%
Sel Cath Place, Art, Add'l 2nd Ord or >, Abd (ea vsl)	36248	$141	$134	-$7	-5.0%	3.92	3.85	-1.8%
Angiography, Visceral, Sel or Suprasel, RS&I	75726	$188	$181	-$6	-3.3%	5.20	5.20	0.0%
Angiography, RS&I (ea add'l vsl)	75774	$110	$106	-$4	-3.3%	3.04	3.04	0.0%
Vasc Embo, RS&I, Intraproc Roadmap, Tumor	37243	$9,873	$9,933	$60	0.6%	273.58	284.68	4.1%
Radiopharmaceutical Tx (intra-arterial) [IR = AU]	79445	$117	$112	-$5	-3.9%	3.24	3.22	-0.6%
Interstitial Rad Src App, Complex [ONLY if IR ≠ AU]	77778	$886	$900	$14	1.6%	24.56	25.80	5.1%

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list.
We recommend consulting your relevant manuals for appropriate coding options.

CY2021 Reimbursement: Hospital Outpatient (POS 22) and Ambulatory Surgery Center (POS 24)

On **December 2, 2020**, the Centers for Medicare and Medicaid Services (CMS) released the 2021 final policies and payment rates for the Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems. The OPPS/ASC rule contains policy and payment information for Medicare beneficiary services furnished in the hospital outpatient (place of service 22) and ambulatory surgical center (place of service 24) settings.

The facility rates, Ambulatory Payment Classifications (APCs), represent the Medicare national average payment rate for items and services delivered by the hospital in the outpatient setting of care. The APC rates will be adjusted by the Hospital Wage Index (HWI) value assigned to the specific facility or their CBSA (Core-Based Statistical Area). Non-Medicare payers, including Medicare Advantage (Part C) plans, payment rates will vary, for both physician and hospital facility services, though their payment rates may be based on Medicare payment rates.

CPT codes, RVUs, and Medicare payment rates do not guarantee any payer will cover or reimburse procedures. Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). National coverage determinations (NCDs) are made through an evidence-based process. In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare Administrative Contractor (MAC) based on a local coverage determination (LCD).

Policies and payment rates will be made effective January 1, 2021**.**

[2] CMS-1736-FC Hospital OPPS/ASC CY 2021 Final Rule Link

Hospital outpatient and ASC claims must contain the appropriate HCPCS/CPT code(s) to indicate the items and services that are furnished. The table below contains a list of possible HCPCS/CPT codes that may be used to bill for Boston Scientific's TheraSphere product and other related procedures. Providers should select the most appropriate code(s) and modifier(s) with the highest level of detail to describe the service(s) actually rendered.

The final Medicare allowable payment for HCPCS C2616 (APC 2616)**,** utilized for TheraSphere treatments will increase to $17,397.64.[1,2]

		2020 Medicare Final Rule	2021 Medicare Final Rule	Change 2020-2021
HCPCS Code	Description	OPPS / ASC Payment	OPPS / ASC Payment	% Change
C2616	Brachytherapy source, non-stranded, yttrium-90, per source	$ 17,091.57	$ 17,397.64	+1.8%

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list.
We recommend consulting your relevant manuals for appropriate coding options.

Please contact your TheraSphere sales representative who will connect you with one of our Regional Field Reimbursement Managers to address any questions.

Important Information

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. **It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered.** It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters.

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This coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgment of the HCP.

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[1] CMS-1734-F Physician Fee Schedule CY 2021 Final Rule Link