2021 Coding & Coverage for the SAVI® Applicator

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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 Medicare Administrative Contractor (MAC) 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 CMS developed the National Correct Coding Initiative to ensure that payment policies and procedures were standardized for all Medicare Administrative Contractors (MACs) to promote national correct coding methodologies. The coding policies developed are based on coding conventions defined in the AMA'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

TERMS, ACRONYMS AND FOOTNOTES

APC	Ambulatory Payment Classification assigned by CMS for hospital payment classification
Contractor Priced	Payment is determined by Medicare Administrator Contractor (MAC)
CMS	Center for Medicare and Medicaid Services
MAC	Medicare Administrator Contractor
MPFS	Medicare Physician Fee Schedule
N/A	Reimbursement not available in this setting/fee schedule by CMS
OPPS	Hospital Outpatient Perspective Payment System
Packaged	Separate payment for this procedure is not made as the service is paid within the primary procedure by CMS
SI	Status Indicator assigned by CMS

Status Indicator(s):

B = Not paid under OPPS

N = OPPS Items and Services Packaged into Primary APC Rate

J1 = Paid under OPPS; all covered Part B services on the claim are packaged with the primary service for the claim, except services with OPPS SI=F, G, H, L and U

Q1 = Paid under OPPS; Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S," "T," or "V"; otherwise paid separately.

T = Paid separately under OPPS; Significant Procedure, Multiple Reduction Applies

U = Paid under OPPS; Separate APC payment

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

HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER

CPT-4	Description	Status Indicator	APC	Hospital Outpatient[1]	Ambulatory Surgery[1] Center
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	J1	5091	$3,157.74	$1,176.26
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure	N	N/A	Packaged	Packaged
19301	Mastectomy, partial (e.g. lumpectomy, tylectomy, quadrantectomy, segmentectomy)	J1	5091	$3,157.74	$1,176.26
19302	Mastectomy, partial (e.g. lumpectomy, tylectomy, quadrantectomy, segmentectomy) with axillary lymph nodes	J1	5092	$5,533.94	$2,250.70

PHYSICIAN FACILITY AND NON-FACILITY

CPT-4	Description	Facility RVUs	MPFS Facility[2]	Non-Facility RVUs	MPFS Non-Facility[2]
19125	Excision of breast lesion identified by preoperative placement of radiological marker, open; single lesion	13.62	$475.24	16.89	$589.34
19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; each additional lesion separately identified by a preoperative radiological marker (List separately in addition to code for primary procedure	4.74	$165.39	N/A	N/A
19301	Mastectomy, partial (e.g. lumpectomy, tylectomy, quadrantectomy, segmentectomy)	19.49	$680.07	N/A	N/A
19302	Mastectomy, partial (e.g. lumpectomy, tylectomy, quadrantectomy, segmentectomy) with axillary lymph nodes	26.79	$934.79	N/A	N/A

1. CY 2021 Changes to Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule with Comment and Final CY2021 Payment Rates (CMS-1736-FC) Addendum B and ASC Addenda.
2. CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1734-IFC); Addendum B. All MPFS Fee Schedules calculated using CF of $34.8931 effective January 1, 2021
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CATHETER IMPLANT

HOSPITAL OUTPATIENT AND AMBULATORY SURGERY CENTER

CPT-4	Description	Status Indicator	APC	Hospital Outpatient[1]	Ambulatory Surgery[1] Center
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	J1	5093	$8,920.04	$4,297.56
19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)	N	N/A	Packaged	Packaged
C1728	Catheter, brachytherapy seed administration	N	N/A	Packaged	Packaged
19499	Unlisted procedure, breast (e.g. placement of SAVI Prep™ Catheter)	J1	5091	$3,157.74	N/A

PHYSICIAN FACILITY AND NON-FACILITY

CPT-4	Description	MPFS Facility RVUs	MPFS Facility[2]	Non-Facility RVUs	MPFS Non-Facility[2]
19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy	6.17	$215.29	123.51	$4,309.65
19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)	2.80	$97.70	N/A	N/A
19499	Unlisted procedure, breast (e.g. placement of SAVI Prep™ Catheter, see p. 10 for additional information)	N/A	By Report	N/A	By Report
A4649 or 99070	Surgical supply; miscellaneous supplies and materials provided by the physician over/above those usually included with the services rendered (e.g. SAVI Prep™ Catheter, see p. 10 for additional information)	N/A	Contractor Priced	N/A	Contractor Priced

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RADIATION THERAPY: TREATMENT PLANNING AND MANAGEMENT

HOSPITAL OUTPATIENT

CPT-4	Description	Status Indicator	APC	Hospital Outpatient[1]
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	Q1	5522	$108.97
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	Q1	5521	$80.90
77263	Therapeutic radiology treatment planning, complex	B	N/A	N/A
77290	Complex simulation	S	5612	$338.68
77295	3-D Treatment Planning	S	5613	$1,262.18
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2–12 channels), includes basic dosimetry calculation(s)	S	5612	$338.68
77370	Special medical radiation physics consultation	S	5611	$126.87
77470	Special treatment procedure	S	5623	$542.55

PHYSICIAN FACILITY AND NON-FACILITY

CPT-4	Description	MPFS Facility RVUs	MPFS Facility[2]	Non-Facility RVUs	MPFS Non-Facility[2]
76641	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete	1.03	$35.94	3.12	$108.87
76642	Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited	0.97	$33.85	2.57	$89.68
77263	Therapeutic radiology treatment planning, complex	4.87	$169.93	4.87	$169.93
77290	Complex simulation	2.36	$82.35	14.37	$501.41
77295	3-D Treatment Planning	6.49	$226.46	14.07	$490.95
77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2–12 channels), includes basic dosimetry calculation(s)	2.77	$96.65	8.90	$310.55
77370	Special medical radiation physics consultation	N/A	N/A	3.75	$130.85
77470	Special treatment procedure	3.10	$108.17	3.86	$134.69

Note: 77470 is typically reported where brachytherapy is part of multi-modality treatment and there is significant work beyond what is involved for typical course of brachytherapy.

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RADIATION THERAPY: TREATMENT DELIVERY

HOSPITAL OUTPATIENT

CPT-4	Description	Status Indicator	APC	Hospital Outpatient[1]
77280	Simple simulation (verification simulation)	S	5611	$126.87
77336	Weekly continuing medical physics	S	5611	$126.87
77771	HDR 2-12 channels****	S	5624	$708.46
77799	Unlisted procedure, Clinical brachytherapy (e.g. catheter removal by non-implanting physician)	S	5621	$120.54
C1717	Brachytherapy source, Iridium	U	2646	$334.69

PHYSICIAN FACILITY AND NON-FACILITY

CPT-4	Description	MPFS Facility RVUs	MPFS Facility[2]	Non-Facility RVUs	MPFS Non-Facility[2]
77280	Simple simulation (verification simulation)	1.10	$38.38	8.30	$289.61
77336	Weekly continuing medical physics	N/A	N/A	2.37	$82.70
77771	HDR 2-12 channels	5.76	$200.98	17.66	$616.21
77799	Unlisted procedure, Clinical brachytherapy (e.g. catheter removal by non-implanting physician)	N/A	Contractor Priced	N/A	Contractor Priced
Q3001	Brachytherapy source, Iridium	N/A	N/A	N/A	Report Invoice Cost

Note: Per ASTRO, the weekly continuing physics consult (77336) is should only be reported once per five fractions of brachytherapy regardless of the actual time period in which services are provided. CPT 77280 may be reported per treatment fraction if medically necessary.

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COMMON MODIFIERS REPORTED

In some circumstances, payers require modifiers when 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. Common reasons for Modifiers when using the SAVI applicator include:

- 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. Plans typically adopt the coverage criteria established by one or more of the professional societies such as the American Society for Therapeutic Radiation Oncology (ASTRO), American Society of Breast Surgeons (ASBS) or American Brachytherapy Society (ABS).

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

This sample report is provided as a resource and reference during the development of the narrative physician report for the SAVI applicator implant procedure. The actual procedure performed should be dictated to support the medical necessity of the procedure and should become a permanent part of the patient's medical record.

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)

CY 2021 PAYMENT RATE FOR CPT 19296 BY LOCALITY

19296 - Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy.

Medicare Administrative Contractor	State	Locality Number	Locality Name	CPT 19296 Payment
			NATIONAL	$4,153.67
10112	AL	00	ALABAMA	$3,688.46
02102	AK	01	ALASKA*	$4,643.81
03102	AZ	00	ARIZONA	$3,950.14
07102	AR	13	ARKANSAS	$3,518.16
01112	CA	54	BAKERSFIELD	$4,423.66
01112	CA	55	CHICO	$4,423.66
01182	CA	71	EL CENTRO	$4,423.66
01112	CA	56	FRESNO	$4,423.66
01112	CA	57	HANFORD-CORCORAN	$4,423.66
01182	CA	18	LOS ANGELES-LONG BEACH-ANA-HEIM (LOS ANGELES CNTY)	$4,880.57
01182	CA	26	LOS ANGELES-LONG BEACH-ANA-HEIM (ORANGE CNTY)	$4,880.57
01112	CA	58	MADERA	$4,423.66
01112	CA	59	MERCED	$4,423.66
01112	CA	60	MODESTO	$4,423.66
01112	CA	51	NAPA	$5,067.48
01112	CA	07	SAN FRANCISCO-OAKLAND-BERKE-LEY (ALAMEDA/CONTRA COSTA CNTY)	$5,520.23
01182	CA	17	OXNARD-THOUSAND OAKS-VENTURA	$4,897.18
01112	CA	61	REDDING	$4,423.66
01112	CA	62	RIVERSIDE-SAN BERNARDINO-ON-TARIO	$4,423.66
01112	CA	63	SACRAMENTO-ROSEVILLE-FOLSOM	$4,481.81
01112	CA	64	SALINAS	$4,660.42
01182	CA	72	SAN DIEGO-CHULA VISTA-CARLSBAD	$4,755.96
01112	CA	05	SAN FRANCISCO-OAKLAND-BERKE-LEY (SAN FRANCISCO CNTY)	$5,520.23
01112	CA	52	SAN FRANCISCO-OAKLAND-BERKE-LEY (MARIN CNTY)	$5,445.47
01112	CA	65	SAN JOSE-SUNNYVALE-SANTA CLARA (SAN BENITO CNTY)	$5,524.39
01182	CA	73	SAN LUIS OBISPO-PASO ROBLES	$4,506.74
01112	CA	06	SAN FRANCISCO-OAKLAND-BERKE-LEY (SAN MATEO CNTY)	$5,520.23
01112	CA	09	SAN JOSE-SUNNYVALE-SANTA CLARA (SANTA CLARA CNTY)	$5,744.53
01112	CA	66	SANTA CRUZ-WATSONVILLE	$4,905.49
01182	CA	74	SANTA MARIA-SANTA BARBARA	$4,805.80
01112	CA	67	SANTA ROSA-PETALUMA	$4,814.11
01112	CA	68	STOCKTON	$4,423.66
01112	CA	53	VALLEJO	$5,067.48
01112	CA	69	VISALIA	$4,423.66
01112	CA	70	YUBA CITY	$4,423.66
01112	CA	75	REST OF CALIFORNIA	$4,423.66

Medicare Administrative Contractor	State	Locality Number	Locality Name	CPT 19296 Payment
04112	CO	01	COLORADO	$4,348.90
13102	CT	00	CONNECTICUT	$4,627.19
12202	DC	01	DC + MD/VA SUBURBS	$5,133.94
12102	DE	01	DELAWARE	$4,245.06
09102	FL	03	FORT LAUDERDALE	$4,157.83
09102	FL	04	MIAMI	$4,249.21
09102	FL	99	REST OF FLORIDA	$3,900.30
10212	GA	01	ATLANTA	$4,145.37
10212	GA	99	REST OF GEORGIA	$3,646.93
01212	HI	01	HAWAII, GUAM	$4,747.65
02202	ID	00	IDAHO	$3,642.77
06102	IL	16	CHICAGO	$4,336.44
06102	IL	12	EAST ST. LOUIS	$3,912.76
06102	IL	15	SUBURBAN CHICAGO	$4,411.20
06102	IL	99	REST OF ILLINOIS	$3,788.15
08102	IN	00	INDIANA	$3,738.31
05102	IA	00	IOWA	$3,767.38
05202	KS	00	KANSAS	$3,771.54
15102	KY	00	KENTUCKY	$3,609.54
07202	LA	01	NEW ORLEANS	$3,850.46
07202	LA	99	REST OF LOUISIANA	$3,622.00
14112	ME	03	SOUTHERN MAINE	$4,141.21
14112	ME	99	REST OF MAINE	$3,730.00
12302	MD	01	BALTIMORE/SURR. CNTYS	$4,552.43
12302	MD	99	REST OF MARYLAND	$4,307.36
14212	MA	01	METROPOLITAN BOSTON	$4,996.87
14212	MA	99	REST OF MASSACHUSETTS	$4,407.05
08202	MI	01	DETROIT	$4,141.21
08202	MI	99	REST OF MICHIGAN	$3,784.00
06202	MN	00	MINNESOTA	$4,207.67
07302	MS	00	MISSISSIPPI	$3,497.39
05302	MO	02	METROPOLITAN KANSAS CITY	$3,966.76
05302	MO	01	METROPOLITAN ST. LOUIS	$4,053.99
05302	MO	99	REST OF MISSOURI	$3,538.93
03202	MT	01	MONTANA**	$4,153.67
05402	NE	00	NEBRASKA	$3,771.54
01312	NV	00	NEVADA**	$4,153.67
14312	NH	40	NEW HAMPSHIRE	$4,311.51
12402	NJ	01	NORTHERN NJ	$4,980.26
12402	NJ	99	REST OF NEW JERSEY	$4,739.34
04212	NM	05	NEW MEXICO	$3,721.69
13202	NY	01	MANHATTAN	$4,996.87
13202	NY	02	NYC SUBURBS/LONG ISLAND	$5,079.94
13202	NY	03	POUGHKPSIE/N NYC SUBURBS	$4,589.81
13292	NY	04	QUEENS	$5,100.71
13282	NY	99	REST OF NEW YORK	$3,966.76
11502	NC	00	NORTH CAROLINA	$3,854.61
03302	ND	01	NORTH DAKOTA**	$4,153.67
15202	OH	00	OHIO	$3,792.30

Medicare Administrative Contractor	State	Locality Number	Locality Name	CPT 19296 Payment
04312	OK	00	OKLAHOMA	$3,659.39
02302	OR	01	PORTLAND	$4,415.36
02302	OR	99	REST OF OREGON	$3,933.53
12502	PA	01	METROPOLITAN PHILADELPHIA	$4,498.43
12502	PA	99	REST OF PENNSYLVANIA	$3,900.30
09202	PR	20	PUERTO RICO	$4,186.90
14412	RI	01	RHODE ISLAND	$4,353.05
11202	SC	01	SOUTH CAROLINA	$3,750.77
03402	SD	02	SOUTH DAKOTA**	$4,153.67
10312	TN	35	TENNESSEE	$3,705.08
04412	TX	31	AUSTIN	$4,398.74
04412	TX	20	BEAUMONT	$3,921.07
04412	TX	09	BRAZORIA	$4,249.21
04412	TX	11	DALLAS	$4,261.67
04412	TX	28	FORT WORTH	$4,132.91
04412	TX	15	GALVESTON	$4,261.67
04412	TX	18	HOUSTON	$4,274.13
04412	TX	99	REST OF TEXAS	$3,966.76
03502	UT	09	UTAH	$3,817.23
14512	VT	50	VERMONT	$4,157.83
11302	VA	00	VIRGINIA	$4,132.91
09202	VI	50	VIRGIN ISLANDS	$4,186.90
02402	WA	02	SEATTLE (KING CNTY)	$4,959.49
02402	WA	99	REST OF WASHINGTON	$4,211.83
11402	WV	16	WEST VIRGINIA	$3,563.85
06302	WI	00	WISCONSIN	$3,912.76
03602	WY	21	WYOMING**	$4,153.67

MAC Assignments as of October 27, 2020

*Work GPCI reflects a 1.5 floor in Alaska established by the MIPPA.

**PE GPCI reflects a 1.0 floor for frontier states established by the ACA.

Note: The 1.0 Work GPCI floor required by Section 101 of the Consolidated Appropriations Act, 2021 [December 27, 2020] extended the Work GPCI floor through January 1, 2024.

Note: Beginning in CY 2021, the locality names in California are updated to reflect the revised delineations of Metropolitan Statistical Areas as indicated in OMB Bulletin No. 20-01 (March 6, 2020). A detailed discussion of the requirement to use MSAs for the fee schedule areas in California can be found in the CY 2017 PFS Final Rule (81 FR 80265).

Before using refer to Instructions for Use for indications, contraindications, warnings, precautions, and directions for use.

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