TONGUE BASE AND HYOID SUSPENSION FOR TREATMENT OF OBSTRUCTIVE SLEEP APNEA (OSA)

COMMONLY BILLED CODES

EFFECTIVE JANUARY 2018

Medtronic

The following information is calculated per the footnotes included and does not take into effect Medicare payment reductions resulting from sequestration associated with the Budget Control Act of 2011. Sequestration reductions went into effect on April 1, 2013.

FOR QUESTIONS PLEASE CONTACT US AT **ENT.US.REIMBURSEMENT@MEDTRONIC.COM**

Surgical Options: The AIRvance™ System[1] enables surgical treatment of tongue- and hyoid-based obstructive sleep apnea (OSA). Tongue base suspension and hyoid myotomy and suspension are two surgical options for the treatment of OSA. The tongue suspension procedure can be done with or without the adjunct hyoid suspension procedure. Based on medical necessity, these procedures may be performed during the same encounter or independently of each other.

ICD-10-CM[2] Diagnosis Codes

Diagnosis codes are used by both physicians and hospitals to document the indication for the procedure. Because symptoms codes are generally not acceptable as the principal diagnosis, the principal diagnosis is coded to the underlying condition as shown.

Obstructive Sleep Apnea	**G47.33**	Obstructive sleep apnea (adult) (pediatric)
	G47.30	Sleep Apnea, unspecified
	K14.8	Other diseases of tongue
	Q38.2	Macroglossia

HCPCS II Device Codes[3]

These codes are used by the entity that purchased and supplied the medical device, DME, drug, or supply to the patient. Medicare provides C-codes for hospital use in billing Medicare for medical devices in the outpatient setting. Although other payers may also accept C-codes, regular HCPCS II device codes are generally used for billing non-Medicare payers.

ASCs, however, usually should not assign or report HCPCS II device codes for devices on claims sent to Medicare. Medicare generally does not make a separate payment for devices in the ASC. Instead, payment is "packaged" into the payment for the ASC procedure. ASCs are specifically instructed not to bill HCPCS II device codes to Medicare for devices that are packaged.[4]

Device or Product	HCPCS	Description / Comment
AIRvance™ Tongue and Hyoid (THS) Suspension System [1]	N/A[5]	Consider reporting associated charges under general revenue code 270 for medical-surgical supplies.

CONTINUED ON NEXT PAGE

Physician Coding and Payment — Effective January 1, 2018

CPT® Procedure Codes- Physicians use CPT codes for all services. Under Medicare's Resource-Based Relative Value Scale (RBRVS) methodology for physician payment, each CPT code is assigned a point value, known as the relative value unit (RVU), which is then converted to a flat payment amount.

Procedure	CPT Code and Description[6]	Surgical Global[7]	Medicare RVUs[8]		Medicare National Average[9]	
			For physician services provided in:[10]			
			Physician Office[11]	Facility	Physician Office[11]	Facility
Tongue Base & Hyoid Suspension	**21685** Hyoid myotomy and suspension	090	N/A	28.10	N/A	$1,012
	41512 Tongue base suspension, permanent suture technique	090	N/A	18.94	N/A	$682

1. AIRvance™ is a trademark of Medtronic, Inc.
2. Centers for Disease Control and Prevention, National Center for Health Statistics. International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). http:// www.cdc.gov/nchs/icd/icd10cm.htm. Updated October 1, 2017. Accessed November 14, 2017.
3. Device C-codes are HCPCS Level II codes and are maintained by the Centers for Medicare and Medicaid Services. Healthcare Common Procedure Coding System. http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html. Accessed November 14, 2017.
4. ASCs should report all charges incurred. However, only charges for non-packaged items should be billed as separate line items. Because of a Medicare requirement to pay the lesser of the ASC rate or the line-item charge, breaking these packaged charges out onto their own lines can result in incorrect payment to the ASC. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14—Ambulatory Surgical Centers, Section 40. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Accessed November 15, 2017. See also MLN Matters SE0742 p.9-10: Centers for Medicare and Medicaid Services. MLN Matters Number SE0742 Revised. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0742.pdf. Accessed November 15, 2017.
5. N/A indicates that CMS and other payers do not have a need for these items to be individually identified, although the associated charges must still be reported. When hospitals use a device or supply that does not have a HCPCS II code, they should report the charges in the general revenue code for the item, typically revenue code 270 for Medical-Surgical Supplies.
6. CPT copyright 2017 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
7. Surgical procedures are subject to a "global period." The global period defines other physician services that are generally considered part of the surgery package. The services are not separately coded, billed, or paid when rendered by the physician who performed the surgery. These services include: preoperative visits the day before or the day of the surgery, postoperative visits related to recovery from the surgery for 10 days or 90 days depending on the specific procedure, treatment of complications unless they require a return visit to the operating room, and minor postoperative services such as dressing changes and suture removal.
8. Centers for Medicare & Medicaid Services. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program Final Rule. 82 Fed. Reg. 52976-53371. https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf. Published November 15, 2017. Accessed November 15, 2017. The total RVU as shown here is the sum of three components: physician work RVU, practice expense RVU, and malpractice RVU.
9. Medicare national average payment is determined by multiplying the sum of the three RVUs by the conversion factor. The conversion factor for CY 2018 is $35.9996 per 82 Fed. Reg. 52976-53371. httpshttps://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf. Published November 15, 2017. Accessed November 15, 2017. Final payment to the physician is adjusted by the Geographic Practice Cost Indices (GPCI). Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.
10. The RVUs shown are for the physician's services and payment is made to the physician. However, there are different RVUs and payments depending on the setting in which the physician rendered the service. "Facility" includes physician services rendered in hospitals, ASCs, and SNFs. Physician RVUs and payments are generally lower in the "Facility" setting because the facility is incurring the cost of some of the supplies and other materials. Physician RVUs and payments are generally higher in the "Physician Office" setting because the physician incurs all costs there.
11. N/A" shown in Physician Office setting indicates that Medicare has not developed RVUs in the office setting because the service is typically performed in a facility (e.g. in hospital). However, if the local contractor determines that it will cover the service in the office, then it is paid using the facility RVUs at the facility rate. Centers for Medicare & Medicaid Services. Details for Title: CMS-1676-F. CY 2018 PFS Final Rule Addenda. Addendum A: Explanation of Addendum B and C. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html . Released November 2, 2017. Accessed November 17, 2017

TONGUE BASE AND HYOID SUSPENSION FOR TREATMENT OF OSA
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Hospital Outpatient Coding and Payment — Effective January 1, 2018

CPT® Procedure Codes- Hospitals use CPT codes for outpatient services. Under Medicare's APC methodology for hospital outpatient payment, each CPT code is assigned to an APC. Each APC has a relative weight that is then converted to a flat payment amount. Multiple APCs can sometimes be assigned for each encounter, depending on the number of procedures coded and whether any of the procedure codes map to a Comprehensive APC (C-APC).

A CPT procedure code assigned to C-APC is considered a primary service, and all other procedures and services coded on the bill are considered adjunctive to delivery of the primary service. This results in a single APC payment and a single beneficiary copayment for the entire outpatient encounter, based solely on the primary service. Separate payment is not made for any of the other adjunctive services. Instead, the payment level for the C-APC is calculated to include the costs of the other adjunctive services, which are packaged into the payment for the primary service.
When more than one primary service is coded for the same outpatient encounter, the codes are ranked according to a fixed hierarchy. The C-APC is then assigned according to the highest ranked code. In some special circumstances, the combination of two primary services leads to a "complexity adjustment" in which the entire encounter is re-mapped to another higher-level APC.

As shown on the tables below, the procedures that are subject to C-APCs are identified by status indicator J1.

Procedure	CPT Code and Description[1]	APC[2]	APC Title[2]	SI[2,3]	Relative Weight[2]	Medicare National Average[2,4]
Tongue Base & Hyoid Suspension	**21685** Hyoid myotomy and suspension	5165	Level 5 ENT Procedures	J1	55.1756	$4,339
	41512 Tongue base suspension, permanent suture technique	5165	Level 5 ENT Procedures	J1	55.1756	$4,339

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule. 82 Fed. Reg. 52356-52637. https://www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf Published November 13, 2017. Accessed November 16, 2017. Correction Notice CMS-1678-CN. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-CN.html . Published December 14, 2017. Accessed January 2, 2018.
3. Status Indicator (SI) shows how a code is handled for payment purposes: J1 = paid under a comprehensive APC, single payment based on primary service without separate payment for other adjunctive services.
4. Medicare national average payment is determined by multiplying the APC weight by the conversion factor. The conversion factor for 2018 is $78.636. The conversion factor of $78.636 assumes that hospitals meet reporting requirements of the Hospital Outpatient Quality Reporting Program. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule. 82 Fed. Reg. 52356-52637. https://www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf . Published November 13, 2017. Accessed November 16, 2017. Payment is adjusted by the wage index for each hospital's specific geographic locality so payment will vary from the national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.

TONGUE BASE AND HYOID SUSPENSION FOR TREATMENT OF OSA
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ASC Coding and Payment — Effective January 1, 2018

CPT® Procedure Codes- ASCs use CPT codes for their services. Medicare payment for procedures performed in an ambulatory surgery center is based on Medicare's ambulatory patient classification (APC) methodology for hospital outpatient payment. However, Comprehensive APCs (C-APCs) are used only for hospital outpatient services and are not applied to procedures performed in ASCs.

Each CPT code designated as a covered procedure in an ASC is assigned a comparable weight as under the hospital outpatient APC system. This is then converted to a flat payment amount using a conversion factor unique to ASCs. Multiple procedures can be paid for each claim. Certain ancillary services, such as imaging, are also covered when they are integral to covered surgical procedures, although they may not be separately payable. In general, there is no separate payment for devices; their payment is packaged into the payment for the procedure.

Procedure	CPT Code and Description[1]	Payment Indicator[2,3]	Multiple Procedure Discounting[5]	Relative Weight[2,4]	Medicare National Average[2,4,6]
Tongue Base & Hyoid Suspension	**21685** Hyoid myotomy and suspension	G2	Y	47.0099	$2,142
	41512 Tongue base suspension, permanent suture technique	G2	Y	47.0099	$2,142

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2. Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule. 82 Fed. Reg. 52356-52637. https://www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf . Published November 13, 2017. Accessed November 16, 2017. Correction Notice CMS-1678-CN. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-CN.html . Published December 14, 2017. Accessed January 2, 2018.
3. The Payment Indicator shows how a code is handled for payment purposes. G2= Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
4. Medicare national average payment is determined by multiplying the relative weight by the ASC conversion factor. The 2017 ASC conversion factor is $45.575. The conversion factor of $45.575 assumes the ASC meets quality reporting requirements. Medicare Program: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Final Rule. 82 Fed. Reg. 52356-52637. https://www.gpo.gov/fdsys/pkg/FR-2017-11-13/pdf/2017-23932.pdf . Published November 13, 2017. Accessed November 16, 2017. Payment is adjusted by the wage index for each ASC's specific geographic locality, so payment will vary from the stated national average Medicare payment levels displayed. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the national average payment amount shown.
5. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y." However, procedures marked "N" are not subject to this discounting and are paid at 100% of the rate regardless of whether they are submitted with other procedures.
6. For Medicare billing, ASCs use a CMS-1500 form.

Rx only. Refer to product instruction manual/package insert for instructions, warnings, precautions and contraindications.

For further information, please call Medtronic ENT at 800.874.5797 and/or consult Medtronic ENT website at www.medtronicent.com.

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