

# Coding, Billing and Payment



## Coding of MIST Therapy®

The Category III CPT<sup>1</sup> Code for low frequency, non-contact, non-thermal ultrasound was effective January 1, 2008.

**0183T** *Low frequency, non-contact, non-thermal ultrasound, including topical application(s) when performed, wound assessment, and instruction(s) for ongoing care, per day.*

### Celleration encourages all providers to use CPT 0183T when coding for MIST Therapy®.

Category III CPT Codes are temporary codes for emerging technology, services, or procedures that allow physicians and other qualified healthcare professionals, insurers, health care researchers, and health policy experts to identify emerging technology, services, and procedures for clinical efficacy, utilization, and outcomes.

The AMA has this to say about Category III CPT Codes: "Since Category III codes are part of the CPT code set, all health care payers must be able to accept Category III codes into their systems to comply with the standards for transactions and code sets under HIPAA."<sup>2</sup>

## Payment of MIST Therapy

Payment of MIST Therapy varies according to payer fee schedules, payment methodology, and care setting. The Medicare published payment rates are shown at right. Common care settings for MIST Therapy include Hospital Outpatient departments, other free-standing outpatient clinics, and inpatient settings.

### Hospital Outpatient Wound Clinic

#### 2011 Medicare Ambulatory Payment Classification for 0183T<sup>3</sup>

##### **APC 0015** *Level III Debridement & Destruction \$103.14*

Medicare analyzed hospital outpatient claims from 2009 and found a median cost of \$119.74 for CPT 0183T. Therefore, Medicare assigned this code to APC 0015 for calendar year 2011.<sup>4</sup> Hospitals should review their billed charges for CPT 0183T – which Medicare adjusts to costs when establishing future APC group assignments – to accurately reflect the procedure, personnel, and Applicator Kit resources used during a MIST Therapy treatment.

### Hospital Outpatient Physical Therapy / SNF Outpatient Physical Therapy

Each local Medicare contractor sets the CPT 0183T payment rate for the Physical Therapy department using the Medicare Physician Fee Schedule (MPFS) for wound care services performed by a qualified therapist under a therapy plan of care.<sup>5</sup>

### Other Free-Standing Outpatient Clinics / Physician Office

Each local Medicare contractor sets the payment rate for CPT 0183T on the MPFS.

### Inpatient Settings

In most inpatient settings, such as inpatient Hospital, LTACs, and SNFs, Medicare payments are prospective payment rates. Providers can document use of MIST Therapy with the CPT 0183T procedure code, and appropriate equipment codes (e.g., A9900 Supply/accessory/service, A9999 DME supply or accessory, and/or E1399 DME miscellaneous).

**Contact the Celleration Reimbursement Hotline**  
at (866) 307-MIST, Option 3 with questions.

1. Current Procedural Terminology or CPT is a trademark of the American Medical Association ("AMA").  
2. <http://www.ama-assn.org/ama/no-index/physician-resources/3882.shtml>. Accessed 12/7/2009.  
3. 2011 Medicare Hospital OPPS Final Rule, Addendum B.  
4. Changes to the Hospital OPPS and CY 2011 Payment Rates, CMS-1504-FC, p470-481.

5. Changes to the Hospital OPPS and CY 2009 Payment Rates, CMS-1404-FC, p827-828. "[Medicare] directs contractors to pay under the MPFS if the service is identified on a hospital claim with a therapy modifier or therapy revenue code as a therapy service."

# Frequently Asked Questions

## Why did Medicare change the APC assigned to CPT 0183T for 2011?

Medicare uses actual claims data submitted by hospitals to establish APC group assignments and APC payment amounts. Medicare analyzed over 7,600 paid occurrences of CPT 0183T on 2009 claims, and calculated a median cost of \$119.74. Hospitals should review their billed charges for CPT 0183T—which Medicare adjusts to costs based on your cost-to-charge ratios—to adequately report the procedure, personnel, and Applicator Kit resources. Accurate and appropriate billed charges will impact the annual APC assignment for CPT 0183T.

## Should I use CPT 0183T or an alternate code?

Some payers have instructed providers to use an alternate CPT code for low frequency ultrasound treatments. In the absence of such instructions from the payer, Celleration encourages all providers to use CPT 0183T when coding for MIST Therapy.

## How much is the reimbursement for our location?

For providers reimbursed under the Medicare APC rate, your locally adjusted amount may vary  $\pm 15\%$  based on your wage index. For providers reimbursed under the Medicare Physician Fee Schedule (MPFS), the local Medicare contractor sets that rate after determining coverage. Some MPFS rates are \$65-\$70 for CPT 0183T.

## When can a Skilled Nursing Facility (SNF) be paid separately for MIST Therapy treatments performed on a Medicare patient in a Part B stay?

Physical therapy is a billable service for SNF inpatients who are not in a Part A stay. However, it must be billed by the SNF even when another entity renders the services under an arrangement with the SNF. Part B rehabilitation services must be billed by the SNF for Part B residents. The MPFS is the payment basis for these services. Please see Medicare's Claims Processing Manual, Chapter 7 for more information.

## Are CPT 0183T for MIST Therapy and CPT codes for other wound care procedures bundled?

The National Correct Coding Initiative (CCI) edits are lengthy and complex, and different for physician billing and hospital outpatient billing. As of October 2010, CPT 0183T is allowed with CPTs 11042, 11043, 11044, 97597, 97598, 97605, 97606 only when an appropriate modifier is needed and used on the second code reported. There are no CCI edits for CPT 29580 (unna boot) or 29581 (multi-layer compression) when billed with CPT 0183T. Remember that coverage and payment of CPT 0183T payment is always subject to payer's coverage determination regardless of the CCI edits.<sup>6</sup>

## What CPT modifiers do we use?

Please consult the CCI rules or your CPT Manual for appropriate modifier usage.

## Does Celleration seek payment from payers for MIST Therapy equipment and supplies?

Unlike negative pressure wound therapy, the MIST Therapy ultrasound device is used on multiple patients in a given month. Furthermore, it is recommended that MIST Therapy be performed by a licensed, trained clinician. In most cases, MIST Therapy is not considered a DME item, thus Celleration cannot bill payers as a DME supplier.

## Will insurers reimburse a provider additional amounts for the ultrasound device and applicator kits?

Some payers "carve-out" or "add-on" payments for new technology. It is reasonable to ask your payer to appropriately reimburse you for the MIST Therapy equipment and supplies when you perform low frequency ultrasound treatment.

THE INFORMATION PROVIDED IS GENERAL CODING INFORMATION ONLY. IT IS NOT ADVICE ABOUT HOW TO CODE, COMPLETE OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. ALTHOUGH CELLERATION SUPPLIES THIS INFORMATION TO THE BEST OF ITS KNOWLEDGE, IT IS ALWAYS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES, MODIFIERS AND BILLS FOR THE SERVICES THAT WERE RENDERED. PAYERS OR THEIR LOCAL BRANCHES MAY HAVE THEIR OWN CODING AND REIMBURSEMENT REQUIREMENTS. BEFORE FILING ANY CLAIMS, PROVIDERS SHOULD VERIFY THESE REQUIREMENTS WITH THE PAYER.

6. <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>, accessed 12/2010.