AMERICAN ACADEMY OF OTOLARYNGOLOGY– HEAD AND NECK SURGERY

AAO-HNS SUMMARY OF CY 2013 FINAL MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)

On November 1, 2012, the Centers for Medicare & Medicaid Services (CMS) posted the final rule for payments in the Medicare physician fee schedule (MPFS) for calendar year (CY) 2013. In addition to payment policy and payment rate updates, the MPFS addresses a number of quality initiatives. The Academy will submit comments to CMS on the MPFS final rule by the December 31, 2012 deadline.

CMS FINAL PAYMENT POLICY CHANGES

1) Impact on Otolaryngology-Head and Neck Surgery for 2013 (p. 1272)

Overall, our specialty fared well regarding the impact of policy changes within the Medicare physician fee schedule for CY 2013. Policies with the most significant impact are discussed below in detail and include, several changes to methodologies used to calculate practice expenses, expansion of the Multiple Procedure Payment Reduction (MPPR), the development of new codes to reimburse for care coordination, and changes to payment for radiation therapy procedure. The small graphic below outlines how each policy impacts our specialty, and reflects a cumulative impact to ENT of +2% for CY 2013.

CY 2013 PFS Final Rule with Comment Period Estimated Impact on Total Allowed Charges by Specialty by Selected Policy*

Specialty	Allowed Charges (mil)	Impact of end of PPIS transition	New and Revised Codes, MPPR, New utilization and other factors	Updated Equipment Interest Rate Assumption	Transitional Care Management	Impact changes for Certain Radiation Therapy Procedures	Total (Cumulative Impact)
Otolaryngology	$1,076	1%	1%	1%	-1%	0%	2%

2) Medicare Sustainable Growth Rate (SGR) (p. 726)

On January 2nd, the President signed legislation into law passing a one year patch for the Sustainable Growth Rate, averting a 26.5% reduction to Medicare payment rates. The conversion factor for 2013 now stands at **$34.0230**. The Academy continues to strongly urge Congress to act and find a permanent fix to the SGR.

3) Practice Expense (p. 24)

Otolaryngology-head and neck surgeons may see fluctuations in the Practice Expense (PE) for some services. This is due to several policy changes for the calculation of practice expense. One modification in the final rule is the change in formula for determining a maximum interest rate for equipment-related PE RVUs. CMS is finalizing the policy to use a "sliding scale" approach based on the current Small Business Administration (SBA) maximum interest rates for different categories of loan size (price of equipment) and maturity (useful life of the equipment) for their calculations of equipment-related Practice Expense (PE) RVUs. This change was suggested in 2012 by the AMA RUC and supported in comments to the proposed rule by the AMA and MedPAC. In addition, increases to some PE RVUs for otolaryngology-head and neck surgery services may also occur as a result of the last of a four year transition of the Physician Practice Expense Information Survey (PPIS) data used to calculate practice expense RVUs for services. ***This policy change has impacted the specialty positively over the last four years because many of the services members perform are heavily weighted in practice expense.***

4) Potentially Misvalued Services Under the Fee Schedule (p. 56)

Within the final rule CMS identified 16 Harvard valued codes with annual allowed charges of greater than or equal to $10 million that warrant review as potentially misvalued services. Of these 16 codes, **three had minor otolaryngology-head and neck surgeon use, including:** 66180 *Implant eye shunt;* 67036 *Removal of inner eye fluid;* and 67917 *Repair eyelid defect.* The Academy staff and RUC team will monitor the review process for these procedures and determine if direct Academy involvement is warranted.

5) CY 2013 Values for Otolaryngology Procedures Reviewed in the CY 2012 RUC Cycle (p. 391)

During the CY 2012 AMA RUC cycle, the Academy surveyed several CPT codes that represent services provided by Otolaryngology-Head and Neck Surgeons. Within the CY 2013 final rule, CMS finalized values, or interim values which the public can comment on, for these services. **Appendix A** provides a table which summarizes the modifications members can expect to see for CY 2013 reimbursement for these services. In addition, CMS issued two new G codes for negative pressure wound therapy within the 2013 final rule, which may be utilized by some Academy members. These codes are intended to provide a payment mechanism for negative pressure wound therapy services furnished to beneficiaries through means unrelated

to the durable medical equipment (DME) benefit. The codes will be carrier priced for 2013 and CMS solicits feedback on what the appropriate value for these services should be.

6) Improving Valuation of the Global Surgical Package (p. 64)

CMS noted that since 1992, different methodologies have been used in valuing global surgical services and more recently reviewed codes tend to have fewer evaluation and management (E/M) visits in their global periods. They observed that codes reviewed less recently did not appear to have the full work RVUs of each E/M service in the global surgical package, resulting in inconsistent numbers of E/M visits during the post-operative period across families of procedures. CMS pointed out that under current policy, the surgeon is not required to document in the medical record what level of E/M visit they are providing, making it difficult to determine whether the number and type of visits provided in association with a surgical procedure is appropriate. As a result, CMS requested input on how best to obtain accurate and current data on E/M services typically furnished as part of a global surgical package. CMS received a wealth of feedback on different methods to verify the number of E/M services, including the Academy's comments noting serious concerns regarding CMS' proposal of a claims based process to track E/M visits. ***CMS notes that they will carefully review and consider all input provided by commenters and did not finalize any new requirements for tracking or reporting E/M visits associated with the global surgical period for CY 2013. The Agency was clear, however, that they do intend to finalize new requirements during CY 2014 rulemaking.***

7) Validating RVUs of Services (p. 63)

Under the "Affordable Care Act" (ACA), the Secretary is directed to validate a sampling of RVUs for services identified by the seven categories listed above. In the CY 2013 proposed rule CMS stated their intent to, "enter into a contract to assist them in validating RVUs of potentially misvalued codes that will explore a model for the validation of physician work under the PFS, both for new and existing services." ***CMS notes in the final rule that they entered into two contracts, in September 2012, to assist them in validating RVUs of potentially misvalued codes. They will be working with the Urban Institute and RAND to explore models for the validation of physician work under the PFS, both for new and existing services.*** The Academy expressed concern about the Agency's engagement of an outside contractor and strongly urged CMS to be transparent with this process. Further, we noted our support for continuing to use the AMA RUC as the primary method of validating RVUs for physician services.

8) Therapy Caps and Changes to Reporting Requirements for Therapy Services in 2013 (p. 219)

CMS announces the therapy cap amounts for CY 2013, $1,900 for occupational therapy services and $1,900 for combined physical therapy and speech-language pathology services, and notes that its authority to provide for an exceptions process to these caps expires on December 31, 2012.

CMS also finalizes several key changes to reporting requirements associated with the provision of therapy services, and beginning on January 1, 2013, will implement a claims-based data collection strategy to collect data on patient function. This policy encompasses a wide array of therapy services, including the Medicare Part B outpatient therapy benefit, therapy services under the Comprehensive Outpatient Rehabilitation Facility (CORF) benefit, and "incident to" services furnished by physicians or nonphysician practitioners and will include services furnished in hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), CORFs, rehabilitation agencies, home health agencies (when the beneficiary is not under a home health plan of care) and private offices. CMS defines the term "therapists" as all practitioners who furnish outpatient therapy services, including physical therapists, occupational therapists, and speech-language pathologists in private practice and those therapists who furnish services in the institutional settings, physicians and nonphysician practitioners (including physician assistants, nurse practitioners, clinical nurse specialists, as applicable). Under this policy, claims for therapy services must now include nonpayable G-codes and modifiers, which will allow the agency to capture data on the beneficiary's functional limitations at various points during the provision of therapy. For therapy services being furnished are not intended to treat a functional limitation, the therapist should use the G-code for "other" and the modifier representing zero (see below for relevant explanations).

Table 21 of the final rule provides a complete list of the codes that will be available for reporting functional limitations. For each set of codes, one code will be used to report the patient's current status (at therapy episode outset and at reporting intervals), a second will be used to report the projected goal status (at therapy episode outset, at reporting intervals, and at discharge or to end reporting), and the third will be used to report the discharge status (at discharge from therapy or to end reporting). CMS also finalized a list of modifiers for reporting which uses a 7-point scale for therapists to report the severity or complexity of the functional limitation involved and directs therapists to use their professional judgment in the selection of the appropriate modifier when reporting. This information can be found in Table 23 of the final rule.

CMS acknowledges that ensuring compliance with these new reporting requirements will take extensive provider education and states they intend to use their usual methods for providing additional information, including manual changes, Medicare Learning

Network (MLN) Matters articles, Open Door Forums, and National Provider Calls. **Members should note, that CMS is allowing a testing period from January 1, 2013 until July 1, 2013, therefore, effective July 1, 2013, claims without the appropriate G-codes and modifiers will be returned unpaid.**

9) Expanding the Multiple Procedure Payment Reduction Policy (MPPR) (p. 116)

In CY 2013 CMS will expand the MPPR to the Professional Component (PC) of certain diagnostic imaging services when two or more physicians in the SAME GROUP PRACTICE furnish services to the same patient, in the same session, on the same day" for services provided after January 1, 2013. Under this policy, full payment will be made for the PC and TC of the highest paid procedure, and payment would be reduced by 25 percent for the PC and TC for each additional procedure furnished to the same patient, in the same session, on the same day, by the same physician or a member of the physician's group practice. ***Upon initial analysis, while this may impact some otolaryngology-head and neck surgeons, the proposal will not be an issue for a majority and will not significantly impact the specialty.***

10) Primary Care Coordination: New CPT Codes for Care Coordination (p. 279)

Within the proposed rule, CMS proposed the creation of a HCPCS G-code to describe the work involved with care management and coordination furnished by a treating physician during a hospital stay, SNF stay, or Community Mental Health Center partial hospitalization to transition the beneficiary back to their primary care provider in the community. However, in the final rule, CMS states that in lieu of their proposed G code, they will adopt two new CPT codes developed by an AMA Chronic Care Coordination workgroup (C3W). The new codes are 99495 and 99496. ***Like the proposed G code, CMS states that the new codes ARE NOT billable by a physician or non-physician billing for a procedure with a 10 or 90 day global period because they consider such management "included in the post-operative portions of the global period." However, CMS does clarify that the use of these codes is NOT restricted to primary care physicians and specialist who furnish the requisite services in the code descriptions may also bill the new TCM codes, so some otolaryngology-head and neck surgeons may be able to use these codes.***

FINAL QUALITY PROGRAM CHANGES

11) Physician Quality Reporting System (PQRS) (p. 839)

Within the final rule, CMS finalizes several changes to the PQRS program, the highlights of which are listed below:

***Two Methods to Participate in the PQRS program*:**

There are two ways an EP may participate in the PQRS: (1) as an individual EP; OR (2) as part of a group practice under the PQRS group practice reporting option (GPRO). For more information on which professionals are eligible to participate in the PQRS, we refer readers to the "List of Eligible Professionals" download located in the "How to Get Started section of the Physician Quality Reporting CMS Web site at: http://www.cms.gov/PQRS/03_How_To_Get_Started.asp.

New Reporting Mechanism for 2015 payment adjustment

CMS finalizes a new administrative claims-based reporting option for the 2015 payment adjustment. EPs and groups can elect to participate in this reporting method by October 15th of 2013 via the web, or if this method is unavailable, they may elect through the mail.

Changes to Group Reporting:

In the final rule CMS modifies the definition of a "group practice" from requiring the practice to consist of 25 or more EPs, to defining a group as 2 or more EPs, as identified by their individual NPIs, who have reassigned their Medicare billing rights to a single TIN. This will allow groups of a smaller size to participate in the GPRO option.

Modification of Payment Adjustment Reporting Periods:

CMS has established 2013 (Jan. 1, 2013 – Dec. 31, 2013) as the reporting period for the 2015 payment adjustment. This 12 month reporting period applies to both individual EPs and group practices. Further, CMS is adding an additional 6 month reporting period (July 1, 2013 – Dec. 31, 2013) for reporting measure groups via registry for the 2015 payment adjustment. For the 2016 payment adjustment, CMS establishes a 12 month reporting period of (Jan. 1, 2014 – Dec. 31, 2014). Additionally, EPs reporting measure groups via registry may report over a 6-month period (July 1, 2014 – Dec. 31, 2014). ***CMS also states payment adjustments occurring in 2017 and beyond will specified by only a 12-month reporting period (Jan. 1 – Dec. 31) that falls 2 years prior to the applicable payment adjustment (e.g. Jan. 1, 2015 – Dec. 31, 2015 for the 2017 payment adjustment).***

Reporting Requirements for the 2013 and 2014 Incentive:

Individual EPs: Individual EPs participating in PQRS may utilize any of the following methods to report quality measures: claims based reporting, registries, and EHR reporting.

GPRO: Groups participating in PQRS may utilize either of the following methods to report quality measures: GPRO web interface (groups of 25 or more ONLY), registry based reporting. EHR reporting (beginning in 2014).

2015 and 2016 Payment Penalties for EPs and Groups who Fail to Satisfactorily Report:
EPs will be subject to a payment adjustment, during 2015 and subsequent years, if the EP does not satisfactorily report quality measures during the reporting period for the respective year. **The payment adjustment will represent a 1.5 percent penalty in 2015 and a 2 percent penalty in 2016. Payment penalties and incentives in 2015 and 2016 will be determined by EP and group performance in 2013 and 2014, respectively.**

Reporting Requirements for the 2015 and 2016 payment adjustment:
EPs and groups have 3 options to satisfactorily report for the 2015 payment adjustment; 1) meet the 2013 reporting requirements for the PQRS incentive, 2) report 1 applicable measure, or for eligible professionals, measures group for at least 1 applicable patient, 3) elect to be analyzed under the administrative claims option. For the 2016 payment adjustment, CMS has finalized only 1 option for satisfactorily reporting, satisfactorily reporting for the 2014 PQRS incentive.

Changes to PQRS individual quality measures for 2013 and beyond
Within the final rule, CMS is adding 13 new PQRS individual quality measures in 2013. ***Of note, CMS declined the Academy's request to include the AAO-HNS/AMA PCPI developed 'Adult Sinusitis' measures which are not included in 2013 or 2014.*** A total of 212 measures will be available for reporting in 2013. CMS is also removing 14 measures from the 2012 PQRS that will no longer be available in 2013 and beyond. ***This includes the measure on 'Acute Otitis Externa (AOE): Pain Assessment'.*** For 2014, a total of 210 measures will be available for reporting.

12) Value Based Payment Modifier and Physician Feedback Reporting Program (p. 1134)
Beginning **January 1, 2015,** CMS is required to apply a value-based payment (VBP) modifier to specific physicians and groups of physicians under the PFS. During the first phase of this program CMS will include all groups, identified by a single TIN and based upon their PECOS enrollment as of October 15, 2013, with 100 or more eligible professionals (EPs) (physician, practitioner, therapist, speech-language pathologist, or audiologist) who have reassigned their Medicare billing rights to the TIN. **CMS had previously finalized CY 2013 as the initial performance period for the VBP modifier that will be applied in CY 2015 and CY 2014 will be used to calculate the payment modifier applied in CY 2016. In CY 2017, CMS will apply the VBP modifier to all physicians and groups of physicians regardless of group size based on their performance during 2015.**

Proposed Penalties:
The statute requires that the VBP modifier be implemented in a budget neutral manner. CMS proposes two categories for EPs: 1) those that have met reporting criteria on PQRS measures OR those that have self nominated for the PQRS GPRO and reported at least one measure, or who elected the PQRS administrative claims measure for 2013; and 2) those that have elected not to participate in PQRS. **Professionals that meet the criteria, and those that participate in PQRS but fail to meet the criteria, will not have their Medicare payments reduced in 2015 by the VBP modifier; while professionals that elect not to participate in PQRS will have their Medicare payments reduced by the VBP modifier of 1 percent in 2015 *IN ADDITION TO* PQRS reductions.**

For those that meet the above criteria, professionals will have the ability to choose whether or not to have their modifier calculated using a quality-tiering approach. This approach would subject poor performers to a 1 percent reduction in Medicare payment, while top performers who use the same approach would receive a bonus payment. Due to budget neutrality, the bonus amount for high performers is not identified, as the amount of bonuses distributed must be balanced out by the total payment reductions. The quality-tiering model compares the quality of care composite with the cost composite to determine the VBP modifier. CMS will classify groups of physicians into high, average, and low cost categories based on whether they are significantly above, equal to, or below average cost composite scores.

Physician Feedback Program:
In **Fall 2012,** CMS will distribute reports to all physicians in nine states (California, Iowa, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska, and Wisconsin) the reports will be based on 2011 data. They also plan to disseminate reports to groups that reported measures through the PQRS GPRO web interface in 2011. **In 2013**, CMS plans to circulate reports to all groups of physicians with 25 or more EPs (based on their TINs) and to individual physicians that satisfactorily reported

measures through PQRS in 2012regarding their performance on 15 administrative claims based measures. Finally, in the **Fall of 2014**, CMS plans to issue reports based on 2013 data that show the amount of the VBP modifier and the basis for its determination to groups with 25 or more EPs, and is considering issuing reports to groups of less than 25 professionals as well as individual professionals in the future.

13) Electronic Prescribing (eRx) Incentive Program (p. 1077)

CMS finalized reducing the minimum group practice size for participation in the eRx incentive program from 25 to 2 EPs for 2013. This is consistent with changes to the PQRS program for 2013. Groups of 2-24 EPs who wish to participate must have reassigned their Medicare billing rights to a single TIN to be eligible. ***In the final rule, CMS reduced the eRx reporting threshold for groups to 75, rather than the proposed 225, meaning groups of 2-24 will have to report the eRx numerator code during a denominator-eligible encounter at least 75 times from January 1, 2013- December 31, 2013. CMS also lowered the 2014 reporting threshold for groups during the six month reporting period to 75. This may allow more otolaryngology-head and neck surgeon practices the opportunity to participate in the program, but the requirement to report the encounter 75 times would still need to be met.***

New Hardship Exemptions:

CMS also finalized two new hardship exemptions to the 2013 and 2014 eRx payment penalties. Most otolaryngology-head and neck surgeons are unable to meet Meaningful Use due to the requirements, so the first exemption may not apply. But if otolaryngology head and neck surgeons intend to meet Meaningful Use, they could apply for exemption for either 2013 or 2014. The deadline to submit all hardship requests for the six established exemptions by January 31st, 2013 for 2013 requests and by June 30th, 2013 for 2014 hardship requests. The new exemptions include:

1) An exemption for professionals or groups that achieve Meaningful Use during certain 2013 and 2014 eRx reporting periods; and
2) An exemption for groups that demonstrate intent to participate in the EHR Incentive Program and adopt Certified EHR technology (CEHRT).

14) Physician Compare Website (p. 814)

CMS finalized lowering the threshold of patients for reporting PQRS quality measures under the group practice reporting option from 25, which was the threshold in 2012, to 20 beginning in 2013. This data is used to compile the published performance rates posted on the Physician Compare website. CMS also finalized a policy allowing the reporting of the following information on the publicly available website:

- measures that have been developed and collected by specialty societies
- physician information such as successful participation in the Medicare E-prescribing (eRx) Incentive Program and Physician Quality Reporting System (PQRS)
- whether a professional is accepting new Medicare patients
- board certification information
- whether or not a professional participates in the electronic health record (EHR) Incentive Program
- foreign language and hospital affiliation data
- patient experience survey measures such as Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for groups participating in the PQRS GPRO and ACO programs

CMS also will begin posting whether or not a physician received a Maintenance of Certification Program incentive payment, in 2014. ***These changes will likely impact otolaryngology-head and neck surgeons as more information about physicians will be publicly posted.***

15) Medicare Shared Savings Program (MSSP) (p. 1118)

CMS announced in their final Medicare Shared Savings Program (MSSP) rule they will incorporate certain PQRS reporting requirements and incentive payments into the MSSP. The reporting period for 2015 payment adjustment will also match that of the PQRS program, and will be based on performance from January 1, 2013 through December 31, 2013. Incentive payments will be.5 percent of an EPs total Part B PFS allowed charges for years 2012-2014. **In 2015, EPs that do not successfully report at least one quality measure will be subject to a 1.5 percent payment penalty, and a 2 percent penalty in 2016.**

Additional Information The CY 2013 Final MPFS rule with comment period is published at http://www.ofr.gov/OFRUpload/OFRData/2012-26900_PI.pdf. CMS will respond to comments in the CY 2014 MPFS final rule. The electronic submissions of comment can be made at URL: www.Regulations.gov search for CMS and final rules.

APPENDIX A

It is critical that Academy members keep in mind that maintaining value for otolaryngology-head and neck surgery services is an enormous success in light of the rigorous review and cost-saving focus of both the AMA RUC and CMS. Therefore, the Academy is pleased that we were able to maintain, or increase, relative value units for nearly all codes reviewed in the 2012 RUC cycle. The table below includes values approved by CMS for CY 2013. The Academy participated either directly, or via comment and/or monitoring, in the development of recommendations to the AMA RUC for all of the following procedures. For several codes, such as the complex wound repair family of codes, the Academy was asked to collaborate with other specialty societies (e.g. American Society of Plastic Surgery and American Academy of Dermatology) to develop relative value and practice expense recommendations. Those recommendations are then reviewed by the AMA RUC and either approved or modified. CMS is then presented with the AMA RUC's value recommendations and may either approve or modify the value for these services. They then post their final determinations in the final Medicare physician fee schedule each year.

	CPT Code	Descriptor	Work RVU	PE Non-facility RVU	Malpractice RVU	TOTAL RVU	Change in RVUs	% Change in RVUs
Endoscopy / Surgery								
2012	31231	Nasal Endoscopy, Dx	1.10	4.57	0.12	5.79		
2013	**31231**	**Nasal Endoscopy, Dx**	**1.10**	**5.38**	**0.12**	**6.60**	**0.81**	**12%**
Complex Repair / Surgery								
2012	13132	Cmplx rpr f/c/c/m/n/ax/g/h/f	6.58	9.49	0.98	17.05		
2013	**13132**	**Cmplx rpr f/c/c/m/n/ax/g/h/f**	**4.78**	**8.77**	**0.71**	**14.26**	**-2.79**	**-20%**
2012	13150	Cmplx rpr e/n/e/l 1.0 cm/<	3.85	6.06	0.61	10.52		
2013	**13150**	**Cmplx rpr e/n/e/l 1.0 cm/<**	**3.58**	**6.89**	**0.57**	**11.04**	**0.52**	**5%**
2012	13151	Cmplx rpr e/n/e/l 1.1-2.5 cm	4.49	6.76	0.67	11.92		
2013	**13151**	**Cmplx rpr e/n/e/l 1.1-2.5 cm**	**4.35**	**7.64**	**0.65**	**12.64**	**0.72**	**6%**
2012	13152	Cmplx rpr e/n/e/l 2.6-7.5 cm	6.37	9.16	0.95	16.48		
2013	**13152**	**Cmplx rpr e/n/e/l 2.6-7.5 cm**	**4.90**	**8.70**	**0.73**	**14.33**	**-2.15**	**-15%**
Excision / Surgery								
2012	40490	Biopsy of lip	1.22	2.42	0.18	3.82		
2013	**40490**	**Biopsy of lip**	**1.22**	**2.52**	**0.18**	**3.92**	**0.10**	**3%**
Auditory								
2012	69200	Clear outer ear canal	0.77	2.87	0.10	3.74		
2013	**69200**	**Clear outer ear canal**	**0.77**	**2.93**	**0.10**	**3.80**	**0.06**	**2%**
2012	69433	Create eardrum opening	1.57	4.28	0.22	6.07		
2013	**69433**	**Create eardrum opening**	**1.57**	**4.48**	**0.22**	**6.27**	**0.20**	**3%**
Sleep Medicine								
2012	95782	Polysom <6 yrs 4/> paramtrs	n/a	n/a	n/a	0.00	n/a	n/a
2013	**95782**	**Polysom <6 yrs 4/> paramtrs**	**2.60**	**28.46**	**0.29**	**31.35**	**31.35**	**100%**
2012	95783	Polysom <6 yrs cpap/bilvl	n/a	n/a	n/a	0.00	n/a	n/a
2013	**95783**	**Polysom <6 yrs cpap/bilvl**	**2.83**	**29.67**	**0.33**	**32.83**	**32.83**	**100%**
Negative Wound Pressure Therapy								
2012	G0456	Neg pre wound <=50 sq cm	n/a	n/a	n/a	0.00	n/a	n/a
2013	**G0456**	Neg pre wound <=50 sq cm	**Carrier Priced**	**Carrier Priced**	**Carrier Priced**	**Carrier Priced**	**Carrier Priced**	**Carrier Priced**
2012	G0457	Neg pres wound >50 sq cm	n/a	n/a	n/a	0.00	n/a	n/a
2013	**G0457**	Neg pres wound >50 sq cm	**Carrier Priced**	**Carrier Priced**	**Carrier Priced**	**Carrier Priced**	**Carrier Priced**	**Carrier Priced**

**Indicates a new CPT code for CY 2013, therefore, there are not 2012 values for these services.*