CPT® Codes and Physician Reimbursement

Medicare Part B pays for physician services based upon the Medicare Physician Fee Schedule (MPFS). Fee schedule amounts are calculated according to the Resource-Based Relative Value Scale (RBRVS), which is updated each year. Procedures are reported using CPT® codes.[1] The 2018 CPT Professional Edition Manual also provides specific instructions for reporting particular families of codes. Individual payers may also have guidelines and coverage policies regarding certain services. The following table lists the most commonly used codes for carotid procedures.

Procedure Codes and Physician Reimbursement for Carotid Artery Procedures

CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
Cerebrovascular Angiography				
36221	Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological S&I, includes arch, when performed	3.92	$1,048	$210
36222	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological S&I, includes arch	5.28	$1,234	$295
36223	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological S&I, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	5.75	$1,546	$329
36224	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological S&I, includes angiography of the extracranial carotid and cervicocerebral arch, when performed	6.25	$1,964	$373
36225	Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological S&I, includes angiography of the arch, when performed	5.75	$1,488	$328

[1] 2018 Current Procedural Terminology (CPT®), ©2016 American Medical Association. CPT® is a registered trademark of the American Medical Association.
[2] The MPFS payment amounts are based upon data elements published by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule [CMS-1677-F] on August 14, 2017, and published in the Federal Register on December 14, 2017, with a conversion factor of $35.99. CMS may make adjustments to any or all of the data inputs from time to time.

Procedure Codes and Physician Reimbursement for Carotid Artery Procedures				
CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
36226	Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological S&I, includes angiography of the arch, when performed	6.25	$1,904	$370
+36227	Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological S&I	2.09	$263	$121
+36228	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological S&I	4.25	$1,352	$252
Carotid Artery Stent Placement				
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological S&I; with distal embolic protection	17.75	$0	$1,050
37216	Without distal embolic protection	0.00	N/A	N/A
37217	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, and radiological S&I	20.38	$0	$1,135
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, and radiological S&I	14.75	$0	$851
Other Supportive Procedures				
+37252	Intravascular ultrasound; initial noncoronary vessel	1.80	$1,398	$96
+37253	Intravascular ultrasound; each additional noncoronary vessel	1.44	$211	$77

Notes: Carotid stent placement without distal embolic protection (37216) is not a covered Medicare service. All other carotid stenting procedures are inpatient only.

Ambulatory Surgery Center Reimbursement

Those surgical procedures that would be expected to pose a significant safety risk to beneficiaries or that would be expected to require an overnight stay following the procedure are excluded from the ASC list, which includes carotid stenting procedures. Radiology procedures, supplies, and devices are considered ancillary to the surgical procedure; while some are reimbursed additionally, no separate payment is made for cerebrovascular diagnostic angiography codes 36221-36228 or intravascular ultrasound (IVUS).

[3] Ambulatory Surgical Center Payment System; Addendum EE -- Surgical Procedures to be Excluded from Payment in ASCs for CY 2017, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html/, [CMS-1656-F].
[4] Healthcare Common Procedural Coding System (HCPCS) codes are developed by CMS and available in book form from several different publishers.

Outpatient Hospital Reimbursement

Outpatient facility claims also report CPT® and HCPCS[4] codes, which map to Ambulatory Payment Classifications (APCs), which assign a Medicare hospital outpatient payment rate for the service. Depending upon the services provided, hospitals may receive payment for more than one APC per patient encounter. If a claim contains services that result in an APC payment but also contains packaged services, no separate payment for the packaged services will be provided, as these are included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) as well as for future rate setting. Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT® and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately or is packaged.

APCs for Carotid Imaging Procedures[5]

APC	Description	Status Indicator	2018 Relative Weight	2018 Medicare Base Payment Rate[6]
5182	Level 2 Vascular Procedures (codes 36221, 36222, 36225)	Q2	31.4609	$983
5183	Level 3 Vascular Procedures (codes 36223, 36224, 36226)	Q2	52.3009	$2,493

Notes: Carotid artery stenting procedures (37215-37218) are not reimbursed through HOPPS, but are classified as inpatient-only procedures. Therefore, most add-on codes are status "N", indicating they are packaged into the primary procedure.

OPPS payment status indicators (SIs) indicate whether a service represented by a HCPCS or CPT® code is payable under the OPPS or another payment system, and also whether particular OPPS policies apply to the code (eg, multiple procedure discounts or other payment reductions, full separate payment, or is a service packaged with another procedure). Relevant OPPS Status Indicators include:

C Inpatient Procedures; not paid under OPPS.
J1 Comprehensive code: all covered Part B services on the claim are packaged with the primary J1 service for the claim, except services with OPPS SI = F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
N Payment is packaged into payment for other services, including outliers; no separate APC payment.
Q2 T-Packaged Codes: (1) packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T"; (2) in other circum stances, payment is made through a separate APC payment.
S Procedure or service not discounted when multiple; separate APC payment.
T Significant procedure, multiple procedure reduction applies; separate APC payment.

Modifiers

When submitting a particular service on a claim, it is sometimes necessary to report a modifier with the CPT® code. A modifier allows a way to 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. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. Some modifiers apply to either physician or hospital outpatient claims; some may only be relevant for one or the other. A complete list of modifiers is included in the HCPCS and CPT® coding books; the concept of modifiers does not apply to ICD-10-PCS procedure codes.

[5] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Addenda AA, BB, and D1; http://www.cms.gov/HospitalOutpatientPPS, published by the Centers for Medicare and Medicaid Services (CMS) in the Final Rule [CMS-1678-FC] on August 2, 2017, and published in the Federal Register on October 1, 2017.
[6] Ibid.

Hospital Inpatient Reimbursement

Selecting the Appropriate ICD-10-PCS Code

ICD-10-PCS, including the ICD-10-PCS Official Guidelines for Coding and Reporting, replaced ICD-9-CM procedure codes for dates of discharge for inpatients that occur on or after October 1, 2015. ICD-10-PCS is not related to ICD-10-CM, but was developed specifically to meet healthcare needs for a procedure code system.[7] The ICD-10 updates for the Fiscal Year (FY) 2018 represents the first code update since the implementation of ICD-10-CM/PCS in the US. 2018 Updates to ICD-10-PCS include new Device characters to indicate placement of multiple arterial stents and Qualifiers for interventions involving a bifurcation. The following table lists some of the most commonly used code categories for carotid procedures. Given the large number of individual procedure codes available for procedures in ICD-10-PCS, please refer to your coding reference book or coding software to look up the associated Body Part, Approach, Contrast, Device and/or Qualifier that best align to the procedure performed as identified below.

Common ICD-10-PCS Carotid Procedure Code Categories

Procedure	Description
Imaging	
B31– – – –	Imaging of upper arteries, fluoroscopy (4th character for vessel, 5th character for type of contrast)
B32– – – –	Imaging of upper arteries, computed tomography (4th character for vessel, 5th character for type of contrast)
B33– – – –	Imaging of upper arteries, magnetic resonance imaging
B34 – ZZ –	Imaging of upper arteries, ultrasound, (7th character for intravascular)
Therapeutic Procedures	
037 – 3 – –	Percutaneous dilation of upper arteries (4th character for vessel, 6th character for device [includes options for multiple stents], 7th character for bifurcation)
03C – 3Z –	Percutaneous extirpation of upper arteries (4th character for vessel, 7th character for bifurcation)
03PY – – Z	Removal (of device), upper artery
03WY – – Z	Revision (of device), upper artery
Other Supportive Therapies	
3E0– – – –	Injection or infusion (select 4th character for body part, 5th character for approach, and 6th or 7th characters for substance infused)

If different methodologies are used in different sites of a single vessel (eg, angioplasty only, angioplasty with stenting, or atherectomy), the same root operation is performed on multiple body parts (eg, peripheral vessels), or if multiple root operations with different objectives are performed on the same body part, code each separately.[7]

[7] CMS Fact Sheet: ICD-10-CM/PCS, The Next Generation of Coding, https://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10Overview.pdf and 2016 ICD-10-PCS Reference Manual, https://www.cms.gov/Medicare/Coding/ICD10/2016-ICD-10-PCS-and-GEMs.html.
[8] Centers for Medicare and Medicaid Services, FY18 Final Notice Data, Table 5 - List of Medicare Severity Diagnosis-Related Groups (MS-DRGs), Relative Weighting Factors, and Geometric and Arithmetic Mean Length of Stay; http://www.cms.gov/AcuteInpatientPPS/ (under Acute Inpatient – Files for Download)
[9] The MS-DRG payment amounts indicated are estimates only based upon data elements derived from various CMS sources. MS-DRG national average payments were calculated with a base rate of $6,028.08 using the national adjusted operating standardized amounts and the capital standard federal payment rate as issued in the Medicare Inpatient Prospective Payment System Final Rule published in the Federal Register (Vol. 82, Issue 239) on 8/22/16; Tables 1A and 1D,Table 5, and assume that all hospitals are receiving the full 1.35% quality reporting and meaningful use updates. Actual payment may vary based on various hospital-specific factors not reflected in the source data.

MS-DRGs

Medicare reimburses inpatient hospital services under the Inpatient Prospective Payment System (IPPS), which bases payment on Medicare Severity Diagnosis-Related Groups (MS-DRGs). The MS-DRG payment system groups similar diagnoses into a single payment level, and reimburses the hospital according to the extent of resources typically required to treat patients with similar diagnoses undergoing similar treatments. All services and supplies provided during the inpatient admission are bundled into a single MS-DRG reimbursement rate, regardless of the length of the inpatient stay, the intensity of treatments, or the number of procedures performed for the specific individual.

Common MS-DRGs for Carotid Procedures[8]

MS-DRG	Description	2018 Mean Length of Stay	2018 Relative Weight	2018 Medicare Base Payment Rate[9]
034	Carotid artery stent procedure with MCC	7.6	3.9913	$24,060
035	Carotid artery stent procedure with CC	3.1	2.2276	$13,428
036	Carotid artery stent procedure without CC/MCC	1.5	1.7636	$10,631

MCC = major complication or comorbidity
CC = complication or comorbidity

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