The information contained in this document is provided for informational purposes only and represents no statement, promise, or guarantee by Cordis Corporation concerning levels of reimbursement, payment, or charge. Similarly, all CPT, ICD-10 and HCPCS codes are supplied for informational purposes only and represent no statement, promise, or guarantee by Cordis that these codes will be appropriate to specific circumstances or products or services provided or that reimbursement will be made. Providers are ultimately responsible for exercising their independent clinical judgment to determine medical necessity for individual patients and the appropriate billing process according to the applicable payer's current policy. CPT codes and descriptions are copyright 2018 American Medical Association. ICD-10 codes and descriptions are copyright 2018 World Health Organization; revised for use in the United States by the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) as ICD-10-CM / ICD-10-PCS. Healthcare Common Procedure Coding System (HCPCS) Level II codes and descriptions are maintained by the CMS HCPCS Workgroup. The information contained in this document is taken from various publicly available documents, is current at the date of publication and is subject to change at any time.

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 biliary diagnostic and therapeutic procedures.

Procedure Codes and Physician Reimbursement for Endovascular Procedures

CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
Nonselective and Selective Catheter Placement - Arterial				
36100	Introduction of needle or intracatheter, carotid or vertebral artery	3.02	$496	$162
36120	Introduction of needle or intracatheter; retrograde brachial artery	2.01	$427	$106
36140	Extremity artery	1.76	$437	$95
36200	Introduction of catheter, aorta	2.77	$572	$146
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	4.17	$1,031	$222
36216	Initial second order thoracic or brachiocephalic branch, within a vascular family	5.27	$1,118	$286
36217	Initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	6.29	$1,899	$342
+36218	Additional second order, third order, and beyond, thoracic or brachiocephalic, within a vascular family	1.01	$258	$54
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	4.65	$1,337	$250
36246	Initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	5.02	$840	$267
36247	Initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	6.04	$1,530	$317

[1] 2018 Current Procedural Terminology (CPT®), ©2018 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-1677-F) in the Final Rule [CMS-1654-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 Endovascular Procedures				
CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
+36248	Additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family	1.01	$156	$51
Diagnostic Imaging - Arterial				
75600	Aortography, thoracic, without serialography, radiological S&I	0.49	$204	$25
75605	Aortography, thoracic, by serialography, radiological S&I	1.14	$140	$57
75625	Aortography, abdominal, by serialography, radiological S&I	1.14	$139	$57
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological S&I	1.79	$174	$90
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s)	2.40	$449	$121
75658	Angiography, brachial, retrograde, radiological S&I	1.31	$171	$66
75705	Angiography, spinal, selective, radiological S&I	2.18	$258	$118
75710	Angiography, extremity, unilateral, radiological S&I	1.75	$175	$88
75716	Angiography, extremity, bilateral, radiological S&I	1.97	$199	$99
75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological S&I	1.14	$152	$57
75731	Angiography, adrenal, unilateral, selective, radiological S&I	1.14	$175	$59
75733	Angiography, adrenal, bilateral, selective, radiological S&I	1.31	$188	$65
75736	Angiography, pelvic, selective or supraselective, radiological S&I	1.14	$163	$56
75741	Angiography, pulmonary, unilateral, selective, radiological S&I	1.31	$153	$64
75743	Angiography, pulmonary, bilateral, selective, radiological S&I	1.66	$172	$82
75746	Angiography, pulmonary, by nonselective catheter or venous injection, radiological S&I	1.14	$154	$57
75756	Angiography, internal mammary, radiological S&I	1.14	$176	$58
+75774	Angiography, selective, each additional vessel studied after basic examination, radiological S&I	0.36	$88	$18
Nonselective and Selective Catheter Placement - Venous				
36005	Injection procedure for extremity venography	0.95	$332	$50
36010	Introduction of catheter, superior or inferior vena cava	2.18	$492	$114
36011	Selective catheter placement, venous system; first order branch	3.14	$847	$164
36012	Second order, or more selective, branch	3.51	$868	$181
Diagnostic Imaging - Venous				
75820	Venography, extremity, unilateral, radiological S&I	0.70	$118	$36
75822	Venography, extremity, bilateral, radiological S&I	1.06	$138	$53
75825	Venography, caval, inferior, with serialography, radiological S&I	1.14	$137	$57
75827	Venography, caval, superior, with serialography, radiological S&I	1.14	$141	$58

Procedure Codes and Physician Reimbursement for Endovascular Procedures				
CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
75831	Venography, renal, unilateral, selective, radiological S&I	1.14	$143	$57
75833	Venography, renal, bilateral, selective, radiological S&I	1.49	$169	$75
75840	Venography, adrenal, unilateral, selective, radiological S&I	1.14	$151	$59
75842	Venography, adrenal, bilateral, selective, radiological S&I	1.49	$181	$77
75860	Venography, venous sinus (eg, petrosal and inferior sagittal) or jugular, catheter, radiological S&I	1.14	$147	$57
75870	Venography, superior sagittal sinus, radiological S&I	1.14	$151	$59
75872	Venography, epidural, radiological S&I	1.14	$151	$59
75880	Venography, orbital, radiological S&I	0.70	$128	$36
Renal Artery Angiography				
36251	Selective catheter placement and radiological S&I, main renal artery and any accessory renal artery(s) and renal angiography S&I; unilateral	5.10	$1,412	$273
36252	Bilateral	6.74	$1,527	$378
36253	Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) and renal angiography S&I; unilateral	7.30	$2,255	$375
36254	Bilateral	7.90	$2,205	$442
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	$296
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, includes angiography of the extracranial carotid and cervicocerebral arch	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
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 radiological S&I	2.09	$263	$122

Procedure Codes and Physician Reimbursement for Endovascular Procedures				
CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
+36228	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation	4.25	$1,352	$252
Lower Extremity Interventions				
37220	Angioplasty, iliac artery, unilateral, initial vessel	7.90	$3,121	$422
37221	Stent placement(s), iliac artery, unilateral, initial vessel;	9.75	$4,631	$521
+37222	Angioplasty, iliac artery, each additional ipsilateral iliac vessel	3.73	$877	$196
+37223	Stent placement(s), iliac artery, each additional ipsilateral iliac vessel	4.25	$2,595	$224
37224	Angioplasty, femoral, popliteal artery(s), unilateral	8.75	$3,790	$467
37225	Atherectomy, femoral, popliteal artery(s), unilateral	11.75	$11,130	$637
37226	Stent placement(s), femoral, popliteal artery(s), unilateral	10.24	$9,100	$549
37227	Stent placement(s) and atherectomy, femoral, popliteal artery(s), unilateral	14.25	$15,061	$765
37228	Angioplasty, tibial, peroneal artery, unilateral, initial vessel	10.75	$5,424	$572
37229	Atherectomy, tibial, peroneal artery, unilateral, initial vessel	13.80	$10,976	$742
37230	Stent placement(s), tibial, peroneal artery, unilateral, initial vessel	13.55	$8,389	$735
37231	Stent and atherectomy, tibial/peroneal artery, unilateral, initial vessel	14.75	$13,605	$799
+37232	Angioplasty, tibial, peroneal artery, unilateral, each additional vessel	4.00	$1,210	$212
+37233	Atherectomy, tibial/peroneal artery, unilateral, each additional vessel	6.50	$1,465	$346
+37234	Stent placement(s), tibial/peroneal artery, unilateral, each additional vessel	5.50	$3,969	$300
+37235	Stent and atherectomy, tibial/peroneal artery, unilateral, each additional vessel	7.80	$4,194	$420
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	$0	$0
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
Angioplasty / Atherectomy / Stenting in Other Vessels				
37236	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological S&I and angioplasty; initial artery	8.75	$3,923	$467
+37237	Each additional artery	4.25	$2,469	$224

Procedure Codes and Physician Reimbursement for Endovascular Procedures				
CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological S&I and angioplasty; initial vein	6.04	$4,250	$314
37239	Each additional vein	2.97	$2,058	$159
37246	Transluminal balloon angioplasty, open or percutaneous, including radiological S&I; initial artery	7.00	$2,182	$365
+37247	Each additional artery	3.50	$882	$179
37248	Transluminal balloon angioplasty, open or percutaneous, including radiological S&I; initial vein	6.00	$1,514	$312
+37249	Each additional vein	2.97	$648	$152
0234T	Transluminal atherectomy, open or percutaneous, including radiological S&I; renal artery	0.00	$0	$0
0235T	Visceral artery (except renal), each vessel	0.00	$0	$0
0236T	Abdominal aorta	0.00	$0	$0
0237T	Brachiocephalic trunk and branches, each vessel	0.00	$0	$0
0238T	Iliac artery, each vessel	0.00	$0	$0
Vena Cava Filters				
37191	Insertion of intravascular vena cava filter, endovascular approach	4.46	$2,618	$235
37192	Repositioning of intravascular vena cava filter, endovascular approach	7.10	$1,318	$368
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach	7.10	$1,562	$367
Dialysis Circuit Imaging and Intervention				
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including inferior or superior vena cava;	3.36	$611	$176
36902	With transluminal balloon angioplasty, peripheral dialysis segment	4.83	$1,272	$251
36903	With transcatheter placement of intravascular stent(s), peripheral dialysis segment	6.39	$5,725	$333
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural thrombolytic injection(s);	7.50	$1,849	$388
36905	With balloon angioplasty, peripheral dialysis segment	9.00	$2,344	$466
36906	With placement of intravascular stent(s), includes angioplasty	10.42	$6,949	$538
+36907	Transluminal balloon angioplasty, central dialysis segment	3.00	$770	$154
+36908	Transcatheter placement of intravascular stent(s), central dialysis segment	4.25	$2,763	$220
+36909	Dialysis circuit permanent vascular embolization or occlusion	4.12	$2,008	$217
Thrombolysis				
37211	Transcatheter arterial infusion for thrombolysis, initial treatment day	7.75	$0	$404
37212	Transcatheter venous infusion for thrombolysis, initial treatment day	6.81	$0	$354

Procedure Codes and Physician Reimbursement for Endovascular Procedures				
CPT® Code	Description	2018 Work RVUs	2018 Medicare Base Payment Rate[2]	
			Non-Facility	Facility
37213	Transcatheter arterial or venous infusion for thrombolysis, continued treatment on subsequent day; including follow-up catheter contrast injection, position change, or exchange, when performed;	4.75	$0	$244
37214	Cessation of thrombolysis including removal of catheter and vessel closure by any method	2.49	$0	$128
Mechanical Thrombectomy				
37184	Primary percutaneous transluminal mechanical thrombectomy; initial vessel	8.41	$2,261	$471
+37185	Second and all subsequent vessel(s) in the same vascular family	3.28	$719	$176
+37186	Secondary percutaneous transluminal thrombectomy in conjunction with another percutaneous intervention	4.92	$1,361	$257
37187	Percutaneous transluminal mechanical thrombectomy, vein(s)	7.78	$2,025	$411
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), repeat treatment on subsequent day during course of thrombolytic therapy	5.46	$1,708	$293
Embolization / Occlusion				
37241	Vascular embolization or occlusion, inclusive of all radiological S&I; venous, other than hemorrhage	8.75	$4,830	$465
37242	Arterial, other than hemorrhage or tumor	9.80	$7,474	$502
37243	For tumors, organ ischemia, or infarction	11.74	$9,900	$590
37244	For arterial or venous hemorrhage or lymphatic extravasation	13.75	$6,901	$697
75894	Transcatheter therapy, embolization, any method, radiological S&I	1.31	$0	$74
Other Supportive Procedures				
+37252	Intravascular ultrasound; initial noncoronary vessel	1.80	$1,398	$96
+37253	Each additional noncoronary vessel	1.44	$211	$77
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	1.65	$0	$92
37197	Transcatheter retrieval, percutaneous, of intravascular foreign body	6.04	$1,481	$316

Ambulatory Surgery Center (ASC) Reimbursement

In general, the ASC payment rate for services is set at approximately 65% of the payment rate for the same service under the HOPPS, with some exceptions.[3] For example, for device-intensive services (where device costs account for more than 50 percent of the total cost of the service), ASCs receive the same payment rate for the device cost as under the HOPPS, with payment for the service portion of the ASC rate calculated at the usual percentage rate of the corresponding OPPS service payment. ASCs will not typically bill separately for these devices.[4]

CMS has assigned APC-based payment rates in an Ambulatory Surgery Center only to surgical procedure codes – CPT® codes in the range 10000 – 69999, plus a few Category III codes, C-codes, and G-codes. Radiology procedures, supplies, and devices

[3] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs Questions and Answers. https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/downloads/asc_qas_03072008.pdf

[4] Revised Payment System Policies for Services Furnished in ASCs Beginning CY 2008. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS1213393.html.

are considered ancillary to the surgical procedure; while some are reimbursed additionally, no separate payment is made for cholangiography imaging procedures.

Ambulatory Surgery Center Reimbursement for Endovascular Procedures		
CPT® Code	**Description**	**2018 Medicare Base Payment Rate[5]**
Lower Extremity Interventions		
37220	Angioplasty, iliac artery, unilateral, initial vessel	$4,846
37221	Stent placement(s), iliac artery, unilateral, initial vessel;	$8,600
37224	Angioplasty, femoral, popliteal artery(s), unilateral	$4,846
37225	Atherectomy, femoral, popliteal artery(s), unilateral	$8,600
37226	Stent placement(s), femoral, popliteal artery(s), unilateral	$8,600
37227	Stent placement(s) and atherectomy, femoral, popliteal artery(s), unilateral	$13,292
37228	Angioplasty, tibial, peroneal artery, unilateral, initial vessel	$4,187
37229	Atherectomy, tibial, peroneal artery, unilateral, initial vessel	$13,292
37230	Stent placement(s), tibial, peroneal artery, unilateral, initial vessel	$13,292
0238T	Transluminal atherectomy; iliac artery, each vessel	$7,589
Angioplasty / Stenting in Other Vessels		
37236	Transcatheter placement of an intravascular stent(s), open or percutaneous, with radiological S&I and angioplasty; initial artery	$3,923
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, with radiological S&I and angioplasty; initial vein	$4,250
37246	Transluminal balloon angioplasty, open / percutaneous, with radiological S&I; initial artery	$2,182
37248	Transluminal balloon angioplasty, open / percutaneous, with radiological S&I; initial vein	$2,182
Dialysis Circuit Imaging and Intervention		
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including inferior or superior vena cava	$612
36902	With transluminal balloon angioplasty, peripheral dialysis segment	$4,846
36903	With transcatheter placement of intravascular stent(s), peripheral dialysis segment	$8,600
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including S&I, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);	$4,846
36905	With balloon angioplasty	$8,600
36906	With intravascular stent(s)	$13,293
Thrombolysis / Mechanical Thrombectomy		
37211	Transcatheter therapy, arterial infusion for thrombolysis, initial treatment day	$4,264.67
37212	Transcatheter therapy, venous infusion for thrombolysis, initial treatment day	$2,492.57
37184	Primary percutaneous transluminal mechanical thrombectomy; initial vessel	$4,845.97

[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-1678-FC) in the Final Rule [CMS-1656-FC] on August 14, 2017, and published in the Federal Register on December 14, 2017.

Ambulatory Surgery Center Reimbursement for Endovascular Procedures		
CPT® Code	**Description**	**2018 Medicare Base Payment Rate[5]**
37187	Percutaneous transluminal mechanical thrombectomy, vein(s)	$4,845.97
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), repeat treatment on subsequent day during course of thrombolytic therapy	$2,492.57
Other Supportive Procedures		
37197	Transcatheter retrieval, percutaneous, of intravascular foreign body	$2,492.57

Notes: Most add-on codes are status "N1", indicating they are packaged into the primary procedure.

Hospital Outpatient Reimbursement

Outpatient facility claims also report CPT® and HCPCS 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.

Common APCs for Endovascular Procedures[7]				
APC	**Description**	**Status Indicator**	**2017 Relative Weight**	**2017 Medicare Base Payment Rate**
5181	Level 1 Vascular Procedures (codes 36901, 37213, 37214, 76731, 75746, 75820, 75822, 75827, 75870, 75872, 75880, 75898)	T	7.7894	$612.53
5182	Level 2 Vascular Procedures (codes 36221, 36222, 36225, 36251, 36252, 36254, 37192, 37193, 37213, 37214, 37188, 37192, 37193, 37197, 37212, 75600, 75625, 75630, 75658, 75710, 75716, 75733, 75741, 75743, 75756, 75825, 75831, 75833, 75840, 75860)	(Q2) T	12.4994	$983
5183	Level 3 Vascular Procedures (codes 36223, 36224, 36226, 36253, 37191, 37211, 37184, 37187, 37191, 37211, 75605, 75705, 75726, 75736, 75842)	T	31.6976	$2.493
5191	Level 1 Endovascular Procedures (codes 37220, 37224)	J1	37.7543	$2,832
5192	Level 2 Endovascular Procedures (codes 36902, 36904, 37220, 37224, 37236, 37238, 37246, 37248)	J1	61.6254	$4,845.97
5193	Level 3 Endovascular Procedures (codes 36903, 36905, 37221, 37225, 37226, 37228, 37236, 37238, 37241-37244, 0234T, 0236T, 0237T)	J1	129.9758	$9,748
5194	Level 4 Endovascular Procedures (codes 36906, 37227, 37229, 37230, 37231, 0238T)	J1	169.0312	$13291.94
5571	Level 1 Imaging with Contrast (code 75635)	Q2 (S)	3.2138	$252.72

Notes: Diagnostic catheter placement codes are packaged with the related imaging procedure, whereas imaging guidance is packaged with interventional procedures. Carotid

[6] Healthcare Common Procedural Coding System (HCPCS) codes are developed by CMS and available in book form from several different publishers.

artery stenting procedures (37215-37218) are not reimbursed through HOPPS, but are classified as inpatient-only procedures. 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 circumstances, 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.

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.

The following table lists some of the most commonly used code categories for endovascular diagnostic and therapeutic 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.

Comon ICD-10-PCS Endovascular Procedure Code Categories[7]			
Procedure	**Description**	**Procedure**	**Description**
Angiography and Other Imaging		**Percutaneous Atherectomy or Thrombectomy**	
B21– – – –	Imaging of heart, fluoroscopy	03C–3Z –	Percutaneous extirpation of upper arteries
B31– – – –	Imaging of upper arteries, fluoroscopy	04C–3Z –	Percutaneous extirpation of lower arteries
B41– – – –	Imaging of lower arteries, fluoroscopy	05C–3ZZ	Percutaneous extirpation of upper veins
B51– – – –	Imaging of veins, fluoroscopy	06C–3ZZ	Percutaneous extirpation of lower veins
B34–ZZ3	Intravascular imaging of upper arteries	**Occlusion / Embolization**	

[7] Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Addendum D1; http://www.cms.gov/HospitalOutpatientPPS, [CMS-1677-F].

Comon ICD-10-PCS Endovascular Procedure Code Categories[7]			
Procedure	**Description**	**Procedure**	**Description**
B44–ZZ3	Intravascular imaging of lower arteries	03L– – – Z	Occlusion, upper arteries
B54–ZZ3	Intravascular imaging of upper veins	04L– – – Z	Occlusion, lower arteries
B64–ZZ3	Intravascular imaging of lower veins	05L– – – Z	Occlusion, upper veins
B32– – – –	Computed tomography, upper arteries	06L– – – Z	Occlusion, lower veins
B42– – – –	Computed tomography, lower arteries	**Insertion of Other Devices**	
B52– – – –	Computed tomography, upper veins	03H– – – Z	Insertion, upper arteries
B62– – – –	Computed tomography, lower veins	04H– – – Z	Insertion, lower arteries
Percutaneous Angioplasty / Stent Placement		05H– – – Z	Insertion, upper veins
037–3 – –	Percutaneous dilation of upper arteries	06H– – – Z	Insertion, lower veins
047–3 – –	Percutaneous dilation of lower arteries	**Measurement and Monitoring**	
057–3 – –	Percutaneous dilation of upper veins	4A033– –	Measurement, arterial, percutaneous
067–3 – –	Percutaneous dilation of lower veins	4A043– –	Measurement, venous, percutaneous
Other Supportive Therapies		03WY– – Z	Revision (of device), upper artery
03PY– – Z	Removal (of device), upper artery	04WY– – Z	Revision (of device), lower artery
04PY– – Z	Removal (of device), lower artery	05WY– – Z	Revision (of device), upper vein
05PY– – Z	Removal (of device), upper vein	06WY– – Z	Revision (of device), lower vein
06PY– – Z	Removal (of device), lower vein	3E0– – – –	Injection or infusion

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.[8]

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 Endovascular Procedures[9]				
MS-DRG	**Description**	**2018 Mean Length of Stay**	**2018 Relative Weight**	**2018 Medicare Base Payment Rate[10]**
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
166	Other respiratory system O.R. procedures with MCC	10.4	3.547	$21,382
167	Other respiratory system O.R. procedures with CC	5.7	1.8497	$11,150

Common MS-DRGs for Endovascular Procedures[9]				
MS-DRG	**Description**	**2018 Mean Length of Stay**	**2018 Relative Weight**	**2018 Medicare Base Payment Rate[10]**
168	Other respiratory system O.R. procedures without CC/MCC	3.1	1.2904	$7,779
252	Other vascular procedures with MCC	7.6	3.2334	$19,491
253	Other vascular procedures with CC	5.5	2.535	$15,281
254	Other vascular procedures without CC/MCC	2.9	1.8127	$10,927
270	Other major cardiovascular procedures with MCC	9.5	4.9411	$29,785
271	Other major cardiovascular procedures with CC	5.8	3.3836	$20,397
272	Other major cardiovascular procedures without CC/MCC	2.8	2.4538	$14,792
299	Peripheral vascular disorders with MCC	5.3	1.4112	$8,507
300	Peripheral vascular disorders with CC	4.2	1.0184	$6,139
301	Peripheral vascular disorders without CC/MCC	3	0.7251	$4,371
673	Other kidney and urinary tract procedures with MCC	10.7	3.5242	$21,244
674	Other kidney and urinary tract procedures with CC	7	2.3165	$13,964
675	Other kidney and urinary tract procedures without CC/MCC	3.3	1.6406	$9,890

MCC = major complication or comorbidity
CC = complication or comorbidity

[8] 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

[9] Centers for Medicare and Medicaid Services, FY17 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)

[10] 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 $6208.08 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 12/14/17; Tables 1A and 1D,Table 5, and assume that all hospitals are receiving the full 1.65% quality reporting and meaningful use updates. Actual payment may vary based on various hospital-specific factors not reflected in the source data.

100514438 04/18