

**PHILIPS**

**VOLCANO**

2017

Coding and Medicare  
payment guide



**Fractional Flow Reserve (FFR)  
and instant wave-Free Ratio  
(The iFR modality)**

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# 1 Hospital inpatient

Hospitals are reimbursed by Medicare for inpatient procedures and services under the Inpatient Prospective Payment System (IPPS), which utilizes the Medicare Severity Diagnosis Related Group (MS-DRG) system.

## 1.1 Hospital inpatient diagnosis codes

Not an all-inclusive list. Refer to ICD-10-CM 2017: The Complete Official Codebook for additional codes. Depending on procedure performed, multiple codes may be reported.

ICD-10-CM <sup>1</sup>	Descriptor
I21.0-I21.4	ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
I22.0-I22.9	Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
I23.8-I23.0	Certain current complications following ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction (within the 28 day period)
I24.0-I24.9	Other acute ischemic heart disease
I25.1-I25.9	Chronic ischemic heart disease

## 1.2 Hospital inpatient procedure codes

Not an all-inclusive list. Refer to ICD-10-PCS 2017: The Complete Official Codebook for additional codes. Depending on procedure performed, multiple codes may be reported.

ICD-10-PCS <sup>2</sup>	Descriptor
4A033BC	Measurement of arterial pressure, coronary, percutaneous approach

## 1.3 Hospital inpatient diagnosis related groups

For cardiac primary interventional procedures; assignment varies based on patient condition.

DRG	Descriptor	Payment <sup>5</sup>
231	Coronary bypass with PTCA with MCC <sup>4</sup>	\$48,098
232	Coronary bypass with PTCA without MCC <sup>4</sup>	\$35,106
246	Percutaneous cardiovascular procedure with drug-eluting stent with MCC or 4+ vessels/stents <sup>4</sup>	\$19,394
247	Perc cardiovasc proc with drug-eluting stent without MCC <sup>4</sup>	\$12,657
248	Perc cardiovasc proc with non-drug-eluting stent with MCC or 4+ ves/stents <sup>4</sup>	\$18,154
249	Perc cardiovasc proc with non-drug-eluting stent without MCC <sup>4</sup>	\$11,543
250	Perc cardiovasc proc without coronary artery stent with MCC <sup>4</sup>	\$15,682
251	Perc cardiovasc proc without coronary artery stent without MCC <sup>4</sup>	\$10,058
286	Circulatory disorders except AMI, with card cath with MCC <sup>4</sup>	\$13,135
287	Circulatory disorders except AMI, with card cath without MCC <sup>4</sup>	\$6,972

## 2 Hospital outpatient

Hospitals are reimbursed by Medicare for outpatient procedures and services under the Outpatient Prospective Payment System (OPPS), which utilizes the Ambulatory Payment Classification (APC) system.

### 2.1 Hospital outpatient procedure codes

CPT	Descriptor	APC / status indicator <sup>6</sup>	Payment
<b>FFR/iFR</b>			
+93571	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel	Status: N	0
+93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (list separately in addition to code for primary procedure)	Status: N	0

### 2.2 HCPCS supply code

In the outpatient setting, when devices are used in combination with device-related procedures, hospitals report C codes. While the supply codes are not paid separately from the procedure, the assignment of charges and reporting these supply codes identify device-related costs. This information is important for future rate-setting by Medicare. Private payers' policies vary if they accept the use of these C codes.

HCPCS	Descriptor	APC / status indicator <sup>6</sup>	Payment
<b>FFR/iFR wire supply code</b>			
C1769	Guide wire	Status: N	0

## 3 Physician

Physicians services are paid by Medicare based on the Physician Fee Schedule.

### 3.1 Physician procedure codes - inpatient, outpatient and office

CPT	Descriptor	In hospital facility <sup>7</sup>		In office non-facility <sup>8</sup>	
		Payment	RVU <sup>9</sup>	Payment	Global RVU <sup>10</sup>
<b>FFR/iFR</b>					
+93571-26 <sup>11</sup>	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel	\$99.77	2.78	\$99.77	2.78
+93572-26 <sup>11</sup>	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (list separately in addition to code for primary procedure)	\$80.03	2.23	\$80.03	2.23

## 4 Moderate Sedation

Also known as conscious sedation.

### Effective January 1, 2017

Moderate sedation was removed from all procedural services it was previously inherently included. CPT codes have been revised to reflect the removal of the moderate sedation CPT symbol indicating which procedure included moderate sedation. Moderate sedation is now separately billed using the new moderate sedation codes. Six new CPT codes CPT 99151-99157 were created. Providers should report the appropriate moderate sedation code(s) in addition to the procedure CPT codes when moderate sedation is performed. For further coding instructions, please refer to the coding guidelines and moderate sedation table in 2017 CPT Professional.

# Highlights

For complete guidance, refer to CPT, Medicare and private payer edits and rules.

## Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement

- CPT codes 93571 and 93572 are add-on codes. An add-on code is always performed in conjunction with another primary service.
  - *CPT Assistant Archives (April 2000) Intravascular Distal Coronary Blood Flow Velocity Measurement*
- 93571 may be reported with the following codes: 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454–93461, 93563, 93564
  - *Copyright© 2017 American Medical Association*
- 93572 may be reported with 93571.
  - *Copyright© 2017 American Medical Association*
- For those cases not involving pharmacological-induced stress, modifier 52, Reduced Services, should be appended to the applicable FFR code(s).
  - *CPT Assistant Archives (4th Quarter 1990 - present)*  
– *Copyright American Medical Association Bonus Edition: Frequently Asked Questions (December 2015, Volume 25, Issue 12, pages 18, 19)*

## Third-party sources

- Medicare Physician Fee Schedule 2017 Final Rule (CMS-1654-FC) Federal Register Vol 81 No. 220, November 15, 2016
- Medicare Inpatient Prospective Payment System 2017 Final Rule (CMS-1655-F) Federal Register Vol 81 No. 162, August 22, 2016, Update October 31, 2016
- Medicare Outpatient Prospective Payment System 2017 Final Rule (CMS-1656-FC) Federal register Vol 81 No.219, November 14, 2016
- 2017 CPT Professional Edition
- 2016 CPT Changes, An Insider's View
- CPT Assistant
- 2017 ICD-10-CM and ICD-10-PCS

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1. Refer to ICD-10-CM 2017: The Complete Official Codebook for a complete list of codes and specific character codes
  2. Refer to ICD-10-PCS 2017: The Complete Official Codebook for a complete list of codes and specific character codes
  3. CC: Complications and Comorbidities
  4. MCC: Major Complications and Comorbidities
  5. Payment rates assume full update amount for hospitals which have submitted quality data and that hospitals have a wage index greater than 1. Actual payment rates will vary by locality. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.
  6. Status Indicator N; No separate APC payment. Packaged into payment for other services.
  7. Procedures performed by the physician in the hospital setting are reimbursed at the facility rate. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.
  8. Procedures performed in the physician office are reimbursed at the Medicare non-facility rate. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.
  9. RVU-Relative Value Units assigned under the Physician Fee Schedule. For each CPT code, RVUs are assigned to account for the relative resource costs used to provide the service.
  - 10.No RVUs have been established for the technical or global service in the office setting. Medicare local carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.
  11. Modifier 26 - Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

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