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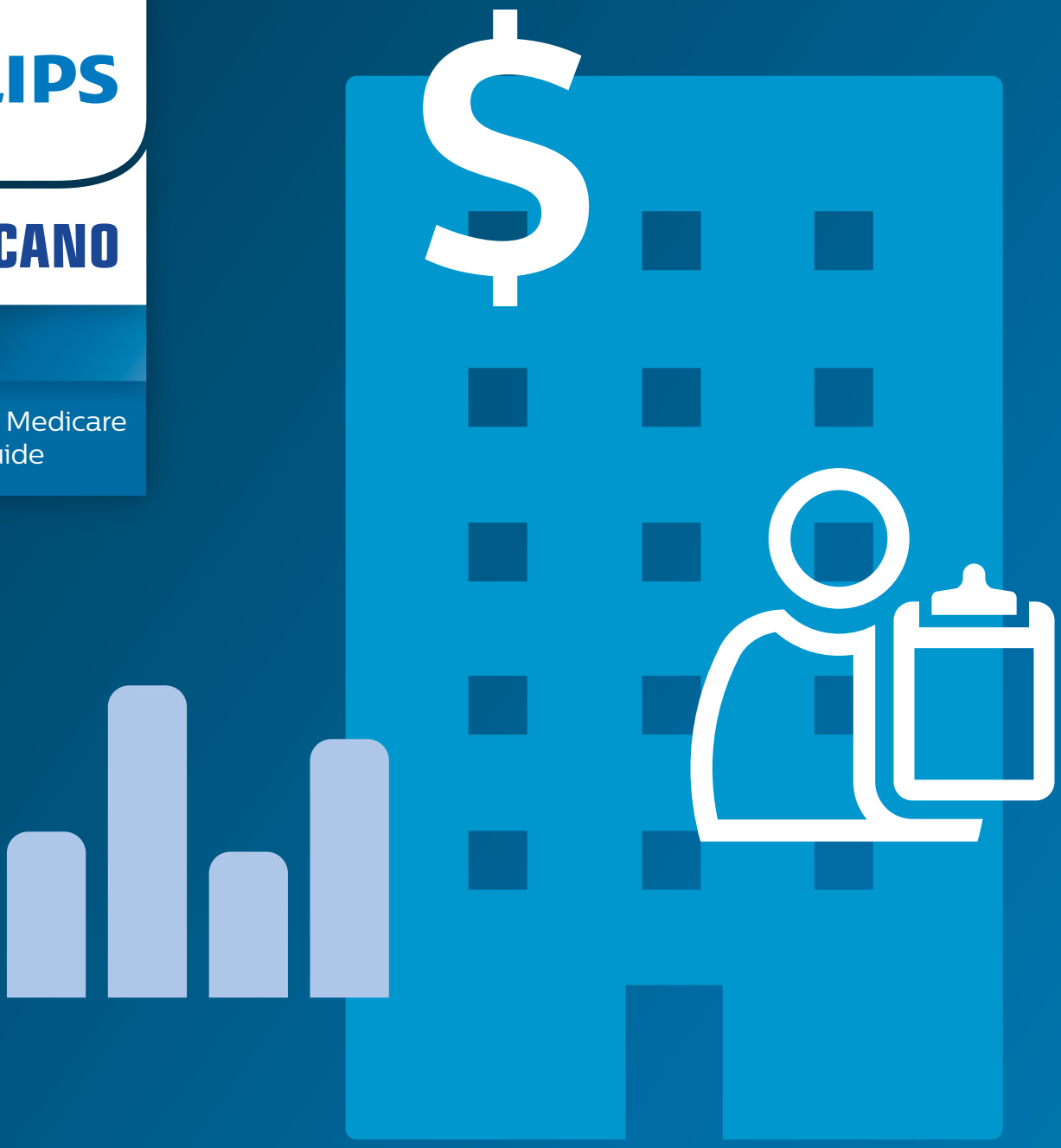
2017

Coding and Medicare payment guide



Diagnostic and interventional venous procedures (lower extremity)

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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[1]	Descriptor
I82.___	Venous embolism and thrombosis; requires additional characters
I80.___	Phlebitis and thrombophlebitis; requires additional characters
I87.2	Venous insufficiency (chronic) (peripheral)

1.2 Hospital inpatient procedure codes

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

ICD-10-PCS[2]	Descriptor
B54_ZZ3	IVUS, veins; requires additional characters
B50__ZZ	Venography; requires additional characters
O67_3DZ	Venous stent; requires additional characters

1.2 Hospital inpatient diagnosis related groups

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

DRG	Descriptor	Payment[3]
252	Other vascular procedures with MCC[4]	**$19,753**
253	Other vascular procedures with CC[5]	**$15,767**
254	Other vascular procedures without CC/MCC	**$10,593**

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	Payment
Diagnostic venography			
36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)	**Status: N**[6]	**0**
75820	Venography, extremity, unilateral, radiological supervision and interpretation	**5181**[7]	**$684**
75822	Venography, extremity, bilateral, radiological supervision and interpretation	**5181**[7]	**$684**
Selective catheter placement			
36011	Selective catheter placement, venous system; first order branch (e.g., renal vein, jugular vein)	**Status: N**[6]	**0**
36012	Selective catheter placement, venous system; second order, or more selective, branch (e.g., left adrenal vein, petrosal sinus)	**Status: N**[6]	**0**
Venous stent placement			
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	**5193**[8]	**$9,748**
+37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (list separately in addition to code for primary procedure)	**Status: N**[6]	**0**
Intravascular ultrasound (IVUS)			
+37252	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial non-coronary vessel (list separately in addition to code for primary procedure)	**Status: N**[6]	**0**
+37253	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional non-coronary vessel (list separately in addition to code for primary procedure)	**Status: N**[6]	**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 IVUS supply code is 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	Payment
Intravascular ultrasound (IVUS)			
C1753	Catheter, intravascular ultrasound	**Status: N**[6]	**0**

3 Physician

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

3.1 Physician procedure codes - inpatient, outpatient and office

		In hospital facility[9]		In office non-facility[10]	
CPT	Descriptor	Payment	RVU[11]	Payment	Global RVU
Venous stent placement					
37238[12,13]	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	**$314**	**8.76**	**$4,190**	**116.75**
+37239[13]	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (list separately in addition to code for primary procedure)	**$159**	**4.42**	**$2,035**	**56.71**
Intravascular ultrasound (IVUS)					
+37252	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial non-coronary vessel (list separately in addition to code for primary procedure)	**$97**	**2.69**	**$1,401**	**39.05**
+37253	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional non-coronary vessel (list separately in addition to code for primary procedure)	**$78**	**217**	**$211**	**5.88**

3.2 Diagnostic venography and selective catheterization

Only reportable at the time of lower extremity venous revascularization in certain circumstances; refer to CPT manual for guidance.

		In hospital facility[9]		In office non-facility[10]	
CPT	Descriptor	Payment	RVU[11]	Payment	Global RVU
Diagnostic venography					
36005[12,14]	Injection procedure for extremity venography (including introduction of needle or intracatheter)	**$50**	**1.40**	**$328**	**9.15**
75820[14]	Venography, extremity, unilateral, radiological supervision and interpretation	**$36**	**0.99**	**$117**	**3.26**
75822[13,14]	Venography, extremity, bilateral, radiological supervision and interpretation	**$53**	**1.49**	**$139**	**3.87**
Selective catheter placement					
36011[12,13]	Selective catheter placement, venous system; first order branch (e.g., renal vein, jugular vein)	**$164**	**4.57**	**$842**	**23.46**
36012[12,13]	Selective catheter placement, venous system; second order, or more selective, branch (e.g., left adrenal vein, petrosal sinus)	**$181**	**5.05**	**$868**	**24.18**

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 ultrasound

- Services described by the IVUS CPT codes include all transducer manipulations and repositioning within the specific vessel being examined during a diagnostic procedure or before, during, and/or after therapeutic intervention (e.g., stent or stent graft placement, angioplasty, atherectomy, embolization, thrombolysis, transcatheter biopsy).
  - *CPT Copyright© 2017 American Medical Association*
  - *CPT Changes: An Insider's View, Surgery, 2016*
- IVUS is designated as an add-on procedure and is always performed in conjunction with a primary procedure.
  - *CPT Copyright© 2017 American Medical Association*
  - *CPT Changes: An Insider's View, Surgery, 2016*
- The catheter supply cost is packaged into the facility payment for the primary procedure. IVUS codes 37252, 37253 are designated as status "N" in the facility setting by Medicare, which means the payment for IVUS has been packaged into other services and there is no separate payment.
  - *Medicare Claims Processing Manual Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS): 10.4*
- If a lesion extending across the margins of one vessel into another is imaged with IVUS, report using only 37252 (first vessel) despite imaging more than one vessel.
  - *CPT Copyright© 2017 American Medical Association*
  - *CPT Changes: An Insiders View, Surgery, 2016*

Intervention

- 37238, 37239 includes any and all balloon angioplasty(s) performed in the treated vessel, including any predilation (whether performed as a primary or secondary angioplasty), post-dilation following stent placement, treatment of a lesion outside the stented segment but in the same vessel, or use of larger/smaller balloon to achieve therapeutic result. Angioplasty in a separate and distinct vessel may be reported separately. Non-selective and/or selective catheterization(s) is reported separately. Intravascular ultrasound may be reported separately (ie, 37252, 37253).
  - *CPT Changes: An Insiders View, Surgery 2016*
- If a lesion extends across the margins of one vessel into another, but can be treated with a single therapy, the intervention should be reported only once. When additional, different vessels are treated in the same session, report 37239 as appropriate.
  - *CPT® Copyright 2017 American Medical Association*
  - *CPT Changes: An Insiders View, Surgery 2016*

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 80 No. 162, August 22, 2016, Update October 31, 2016
- Medicare Outpatient Prospective Payment System 2017 Final Rule (CMS-1633-FC) Federal register Vol 80 No.219, November 13, 2015
- 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. 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.
4. Major comorbidities and complications
5. Comorbidities and complications
6. Status N: No separate APC. Packaged into payment for other services.
7. Status Q2: T-Packaged Codes - Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In other circumstances, payment is made through a separate APC payment.
8. Status J1-Comprehensive APC–accounts for all costs and component services typically involved in the provision of the complete primary procedure
9. Procedures performed in the hospital inpatient or hospital outpatient setting are reimbursed at the Medicare facility rate. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.
10. 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.
11. 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.
12. Multiple Procedure payment adjustment Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. (Modifier -51)
13. 150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.
14. Diagnostic Cardiovascular Services Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services, effective for services January 1, 2013, and thereafter. (Modifier -51)

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