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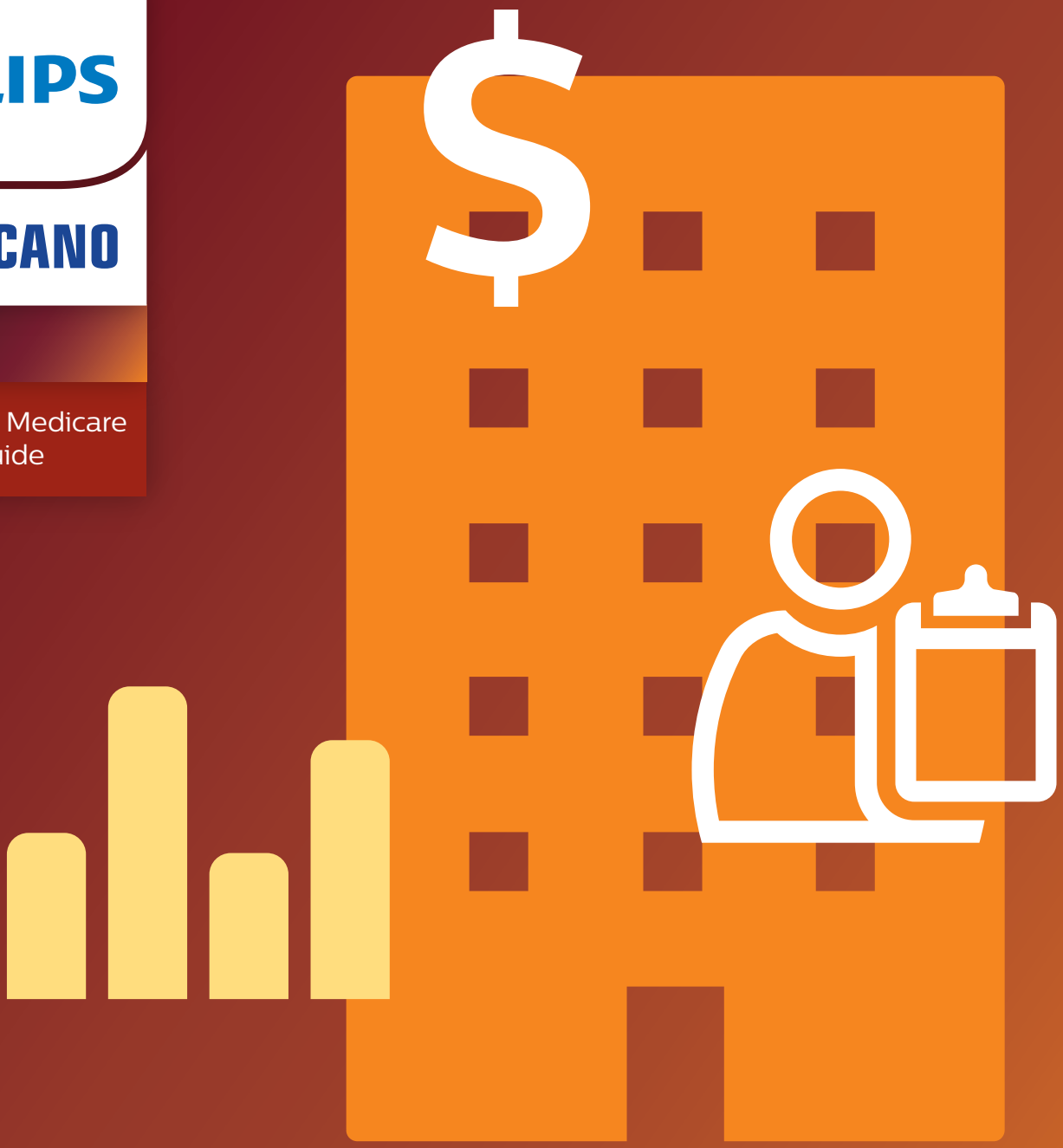
2017

Coding and Medicare payment guide



# Diagnostic and interventional arterial 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 procedure codes

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

| ICD-10-PCS | Descriptor |
|---|---|
| **B44GZZ3** | Ultrasonography of left lower extremity arteries, intravascular |
| **B44FZZ3** | Ultrasonography of right lower extremity arteries, intravascular |
| **B44LZZ3** | Ultrasonography of femoral artery, intravascular |
| **047K3ZZ** | Dilation of right femoral artery, percutaneous approach |
| **047K3DZ** | Dilation of right femoral artery with intraluminal device, percutaneous approach |
| **047K34Z** | Dilation of right femoral artery with drug-eluting intraluminal device, percutaneous approach |
| **047K3Z1** | Dilation of right femoral artery using drug-coated balloon, percutaneous approach |
| **04CK3ZZ** | Extirpation of matter from right femoral artery, percutaneous approach |
| **047L3ZZ** | Dilation of left femoral artery, percutaneous approach |
| **047L3DZ** | Dilation of left femoral artery with intraluminal device, percutaneous approach |
| **047L34Z** | Dilation of left femoral artery with drug-eluting intraluminal device, percutaneous approach |
| **047L341** | Dilation of left femoral artery with drug-eluting intraluminal device, using drug-coated balloon, percutaneous approach |
| **04CL3ZZ** | Extirpation of matter from left femoral artery, percutaneous approach |
| **047M3ZZ** | Dilation of right popliteal artery, percutaneous approach |
| **047M3DZ** | Dilation of right popliteal artery with intraluminal device, percutaneous approach |
| **047N3ZZ** | Dilation of left popliteal artery, percutaneous approach |
| **047N3DZ** | Dilation of left popliteal artery with intraluminal device, percutaneous approach |
| **047T3ZZ** | Dilation of right peroneal artery, percutaneous approach |
| **04CT3ZZ** | Extirpation of matter from right peroneal artery, percutaneous approach |
| **047U3ZZ** | Dilation of left peroneal artery, percutaneous approach |
| **04CU3ZZ** | Extirpation of matter from left peroneal artery, percutaneous approach |
| **047P3ZZ** | Dilation of right anterior tibial artery, percutaneous approach |
| **04CP3ZZ** | Extirpation of matter from right anterior tibial artery, percutaneous approach |
| **047Q3ZZ** | Dilation of left anterior tibial artery, percutaneous approach |
| **04CS3ZZ** | Extirpation of matter from left posterior tibial artery, percutaneous approach |
| **047E3ZZ** | Dilation of right internal iliac artery, percutaneous approach |
| **047E3DZ** | Dilation of right internal iliac artery with intraluminal device, percutaneous approach |

continued from 1.1 Hospital inpatient procedure codes

| ICD-10-PCS | Descriptor |
|---|---|
| **047F3ZZ** | Dilation of left internal iliac artery, percutaneous approach |
| **047F3DZ** | Dilation of left internal iliac artery with intraluminal device, percutaneous approach |
| **047H3ZZ** | Dilation of right external iliac artery, percutaneous approach |
| **047H3DZ** | Dilation of right external iliac artery with intraluminal device, percutaneous approach |
| **047J3ZZ** | Dilation of left external iliac artery, percutaneous approach |
| **047J3DZ** | Dilation of left external iliac artery with intraluminal device, percutaneous approach |
| **047C3ZZ** | Dilation of right common iliac artery, percutaneous approach |
| **047C3DZ** | Dilation of right common iliac artery with intraluminal device, percutaneous approach |
| **047D3ZZ** | Dilation of left common iliac artery, percutaneous approach |
| **047D3DZ** | Dilation of left common iliac artery with intraluminal device, percutaneous approach |
| **04HC33Z** | Insertion of infusion device into right common iliac artery, percutaneous approach |
| **04HD33Z** | Insertion of infusion device into left common iliac artery, percutaneous approach |
| **B41FYZZ** | Fluoroscopy of right lower extremity arteries using other contrast |
| **B41GYZZ** | Fluoroscopy of left lower extremity arteries using other contrast |
| **047K356** | Dilation of right femoral artery, with intraluminal device, drug-eluting, two, bifurcation, percutaneous approach |
| **047K3E6** | Dilation of right femoral artery, with intraluminal device, two, bifurcation, percutaneous approach |
| **047K35Z** | Dilation of right femoral artery, with intraluminal device, drug-eluting, two, percutaneous approach |
| **047K3EZ** | Dilation of right femoral artery, with intraluminal device, two, percutaneous approach |
| **047L366** | Dilation of left femoral artery, with intraluminal device, drug-eluting, three, bifurcation, percutaneous approach |
| **047L36Z** | Dilation of left femoral artery, with intraluminal device, drug-eluting, three, percutaneous approach |
| **047L3F6** | Dilation of left femoral artery, with intraluminal device, three, bifurcation, percutaneous approach |
| **047L3FZ** | Dilation of left femoral artery, with intraluminal device, three, percutaneous approach |
| **047M376** | Dilation of right popliteal artery, with intraluminal device, drug-eluting, four or more, bifurcation, percutaneous approach |
| **047M37Z** | Dilation of right popliteal artery, with intraluminal device, drug-eluting, four or more, percutaneous approach |
| **047M3G6** | Dilation of right popliteal artery, with intraluminal device, four or more, bifurcation, percutaneous approach |
| **047M3GZ** | Dilation of right popliteal artery, with intraluminal device, four or more, percutaneous approach |
| **047N356** | Dilation of left popliteal artery, with intraluminal device, drug-eluting, two, bifurcation, percutaneous approach |
| **047N35Z** | Dilation of left popliteal artery, with intraluminal device, drug-eluting, two, percutaneous approach |
| **047N3F6** | Dilation of left popliteal artery, with intraluminal device, three, bifurcation, percutaneous approach |
| **047N3FZ** | Dilation of left popliteal artery, with intraluminal device, three, percutaneous approach |

## 1.2 Hospital inpatient diagnosis related groups

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

| DRG | Descriptor | Payment[1] |
|---|---|---|
| **252** | Other vascular procedures with MCC[2] | **$19,753** |
| **253** | Other vascular procedures with CC[3] | **$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 |
|---|---|---|---|
| **Endovascular revascularization–iliac** | | | |
| **37220** | Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty | **5192**[4] | **$4,823** |
| **37221** | Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed | **5193**[4] | **$9,748** |
| **+37222** | Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (list separately in addition to code for primary procedure) | **Status: N**[5] | **0** |
| **+37223** | Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) | **Status: N**[5] | **0** |
| **Endovascular revascularization–femoral/popliteal** | | | |
| **37224** | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty | **5192**[4] | **$4,823** |
| **37225** | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed | **5193**[4] | **$9,748** |
| **37226** | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed | **5193**[4] | **$9,748** |
| **37227** | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed | **5194**[4] | **$14,776** |

continued from 2.1 Hospital outpatient procedure codes

| CPT | Descriptor | APC / status indicator | Payment |
|---|---|---|---|
| **Endovascular revascularization–tibial/peroneal** | | | |
| **37228** | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty | **5193**[4] | **$9,748** |
| **37229** | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed | **5194**[4] | **$14,776** |
| **37230** | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed | **5194**[4] | **$14,776** |
| **37231** | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed | **5194**[4] | **$14,776** |
| **+37232** | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (list separately in addition to code for primary procedure) | **Status: N**[5] | **0** |
| **+37233** | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) | **Status: N**[5] | **0** |
| **+37234** | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) | **Status: N**[5] | **0** |
| **+37235** | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) | **Status: N**[5] | **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**[5] | **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**[5] | **0** |

continued from 2.1 Hospital outpatient procedure codes

| CPT | Descriptor | APC / status indicator | Payment |
|---|---|---|---|
| **Diagnostic angiography** | | | |
| **75710** | Angiography, extremity, unilateral, radiological supervision and interpretation | **5182**[6] | **$2,360** |
| **75716** | Angiography, extremity, bilateral, radiological supervision and interpretation | **5182**[6] | **$2,360** |
| **+75774** | Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (list separately in addition to code for primary procedure) | **Status:N** | **0** |
| **Selective catheter placement** | | | |
| **36245** | Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family | **Status: N**[5] | **0** |
| **36246** | Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family | **Status: N**[5] | **0** |
| **36247** | Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family | **Status: N**[5] | **0** |
| **+36248** | Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (list in addition to code for initial second or third order vessel as appropriate) | **Status: N**[5] | **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 | Payment |
|---|---|---|---|
| **Atherectomy and IVUS** | | | |
| **C1724** | Catheter, transluminal atherectomy, rotational | **Status: N**[5] | **0** |
| **C1753** | Catheter, intravascular ultrasound | **Status: N**[5] | **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[7] | | In office non-facility[8] | |
|---|---|---|---|---|---|
| CPT | Descriptor | Payment | RVU[9] | Payment | Global RVU |
| **Endovascular revascularization–iliac** | | | | | |
| **37220**[10,11] | Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty | **$422.76** | **11.78** | **$3,113.70** | **86.76** |
| **37221**[10,11] | Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed | **$522.53** | **14.56** | **$4,617.08** | **128.65** |
| **+37222**[11] | Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (list separately in addition to code for primary procedure) | **$196.67** | **5.48** | **$873.88** | **24.35** |
| **+37223**[11] | Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) | **$225.38** | **6.28** | **$2,590.44** | **72.18** |
| **Endovascular revascularization–femoral/popliteal** | | | | | |
| **37224**[10,11] | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty | **$467.27** | **13.02** | **$3,776.56** | **105.23** |
| **37225**[10,11] | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed | **$638.10** | **17.78** | **$11,063.05** | **308.26** |
| **37226**[10,11] | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed | **$550.89** | **15.35** | **$9,065.12** | **252.59** |
| **37227**[10,11] | Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed | **$769.09** | **21.43** | **$14,986.76** | **417.59** |

continued from 3.1 Physician procedure codes – inpatient, outpatient and office

| | | In hospital facility[7] | | In office non-facility[8] | |
|---|---|---|---|---|---|
| **CPT** | **Descriptor** | **Payment** | **RVU[9]** | **Payment** | **Global RVU** |
| **Endovascular revascularization–tibial/peroneal** | | | | | |
| **37228**[10,11] | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty | **$572.78** | **15.96** | **$5,408.78** | **150.71** |
| **37229**[10,11] | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed | **$746.12** | **20.79** | **$10,905.85** | **303.88** |
| **37230**[10,11] | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed | **$736.79** | **20.53** | **$8,332.63** | **232.18** |
| **37231**[10,11] | Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed | **$799.60** | **22.28** | **$13,492.71** | **375.96** |
| **+37232**[11] | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (list separately in addition to code for primary procedure) | **$213.17** | **5.94** | **$1,206.93** | **33.63** |
| **+37233**[11] | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) | **$346.32** | **9.65** | **$1,458.87** | **40.65** |

continued from 3.1 Physician procedure codes – inpatient, outpatient and office

| | | In hospital facility[7] | | In office non-facility[8] | |
|---|---|---|---|---|---|
| **CPT** | **Descriptor** | **Payment** | **RVU[9]** | **Payment** | **Global RVU** |
| **+37234**[11] | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) | **$300.02** | **8.36** | **$3,948.47** | **110.02** |
| **+37235**[11] | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure) | **$415.95** | **11.59** | **$4,242.04** | **118.20** |
| **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) | **$96.54** | **2.69** | **$1,401.45** | **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) | **$77.87** | **2.17** | **$211.02** | **5.88** |

## 3.2 Diagnostic angiography and selective catheterization

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

| | | In hospital facility[7] | | In office non-facility[8] | |
|---|---|---|---|---|---|
| CPT | Descriptor | Payment | RVU[9] | Payment | Global RVU |
| **Diagnostic angiography** | | | | | |
| 75710[12] | Angiography, extremity, unilateral, radiological supervision and interpretation | $57.42 | 1.60 | $164.37 | 4.58 |
| 75716[12] | Angiography, extremity, bilateral, radiological supervision and interpretation | $65.31 | 1.82 | $189.13 | 5.27 |
| +75774 | Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (list separately in addition to code for primary procedure) | $17.94 | 0.50 | $87.56 | 2.44 |
| **Selective catheter placement** | | | | | |
| 36245[10,11] | Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family | $250.50 | 6.98 | $1,324.29 | 36.90 |
| 36246[10,11] | Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family | $267.72 | 7.46 | $837.64 | 23.34 |
| 36247[10,11] | Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family | $318.33 | 8.87 | $1,523.47 | 42.45 |
| +36248 | Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (list in addition to code for initial second or third order vessel as appropriate) | $51.32 | 1.43 | $155.39 | 4.33 |

# 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.

## Angiography

Angiography/venography is included in the description of the interventional codes unless it meets the following criteria for diagnostic angiogram/venogram.

- No prior or recent angiogram/venogram is available to guide therapy
- The patient's condition has changed
- The treatment plan may be affected
- Other vessels may be identified for treatment
  - *CPT Assistant Archives, 2011 - Coding Communication: Lower Extremity Revascularization*

## 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 Insider's View, Surgery, 2016*

## Arterial interventions

- The lower extremity arterial system is considered 3 separate territories for interventional coding purposes; Iliac, Femoral/Popliteal and Tibial/Peroneal.
  - *CPT Copyright© 2017 American Medical Association (diagram)*
  - *CPT Changes: An Insider's View: Cardiovascular System, 2011*

- Use modifier 59 (or applicable distinct procedural modifiers) to denote that different legs are being treated, even if the mode of therapy is different.
  - *CPT Copyright© 2017 American Medical Association*

- The intervention should be reported only once (first vessel CPT code) if a lesion extends across the margins of one vessel into another, but can be treated with a single therapy.
  - *CPT Copyright© 2017 American Medical Association*

- When treating multiple vessels within a territory report each additional vessel using an add-on code as applicable. Select the base code that represents the most complex service.
  - *CPT Copyright© 2017 American Medical Association*

- When treating multiple lesions within the same vessel report one service that reflects the combined procedures whether done on one lesion or different lesions using the same hierarchy.
  - *CPT Copyright© 2017 American Medical Association*
  - *CPT Changes: An Insider's View: Cardiovascular System, 2011*

## 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-162-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
- 2017 CPT Changes, An Insider's View
- CPT Assistant
- 2017 ICD-10-CM and ICD-10-PCS

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1. 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.
2. Major Complications and Comorbidities
3. Complications and Comorbidities
4. Status J1: Comprehensive APC – accounts for all costs and component services typically involved in the provision of the complete primary procedure
5. Status N: No separate APC payment. Packaged into payment for other services.
6. 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.
7. 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.
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. 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)
11. 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.
12. 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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