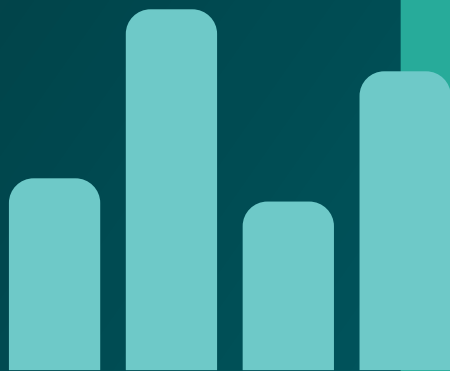


PHILIPS

VOLCANO

2017

Coding and Medicare
payment guide



Pioneer Plus IVUS guided re-entry catheter

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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.

ICD-10-CM	Descriptor
I70.90	Unspecified atherosclerosis
I70.91	Generalized atherosclerosis
I70.92	Chronic total occlusion of artery of the extremities Complete occlusion of artery of the extremities Total occlusion of artery of the extremities Code first atherosclerosis of arteries of the extremities (I70.2-, I70.3-, I70.4-, I70.5-, I70.6-, I70.7-.)

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 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

1.3 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
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
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

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. Report all applicable C codes.

HCPCS	Descriptor	APC / status indicator	Payment
Atherectomy and IVUS			
C1753	Catheter, intravascular ultrasound	Status: N ⁵	0
C1887	Catheter, guiding	Status: N ⁵	0
C1724	Catheter, transluminal atherectomy, rotational	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

CPT	Descriptor	In hospital facility ⁷		In office non-facility ⁸	
		Payment	RVU ⁹	Payment	Global RVU
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
Endovascular revascularization—iliac					
37220 ^{9,10}	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	\$422.76	11.78	\$3,113.70	86.76
37221 ^{9,10}	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 ¹⁰	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 ¹⁰	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

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

CPT	Descriptor	In hospital facility ⁷		In office non-facility ⁸	
		Payment	RVU ⁹	Payment	Global RVU
Endovascular revascularization–femoral/popliteal					
37224 ^{9,10}	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	\$467.27	13.02	\$3,776.56	105.23
37225 ^{9,10}	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 ^{9,10}	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 ^{9,10}	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
Endovascular revascularization–tibial/peroneal					
37228 ^{9,10}	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	\$572.78	15.96	\$5,408.78	150.71
37229 ^{9,10}	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 ^{9,10}	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 ^{9,10}	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	\$13,429.71	375.96
+37232 ¹⁰	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

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

CPT	Descriptor	In hospital facility ⁷		In office non-facility ⁸	
		Payment	RVU ⁹	Payment	Global RVU
+37233 ¹⁰	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
+37234 ¹⁰	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 ¹⁰	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

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-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 CPT changes, An Insider's View
 - 2017 ICD-10-CM and ICD-10-PCS
-

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. 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.
7. 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.
8. 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.
9. 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)
10. 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.

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