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2017

Coding and Medicare payment guide

Coronary intravascular ultrasound (IVUS)

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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
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-I23.8	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[2]	Descriptor
B240ZZ3	Ultrasonography of single coronary artery, intravascular
B241ZZ3	Ultrasonography of multiple coronary arteries, intravascular

1.3 Hospital inpatient diagnosis related groups

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

DRG	Descriptor	Payment[5]
231	Coronary bypass with PTCA with MCC[4]	**$48,098**
232	Coronary bypass with PTCA without MCC[4]	**$35,106**
246	Percutaneous cardiovascular procedure with drug-eluting stent with MCC or 4+ vessels/stents[4]	**$19,394**
247	Perc cardiovasc proc with drug-eluting stent without MCC[4]	**$12,657**
248	Perc cardiovasc proc with non-drug-eluting stent with MCC or 4+ ves/stents[4]	**$18,154**
249	Perc cardiovasc proc with non-drug-eluting stent without MCC[4]	**$11,543**
250	Perc cardiovasc proc without coronary artery stent with MCC[4]	**$15,682**
251	Perc cardiovasc proc without coronary artery stent without MCC[4]	**$10,058**
286	Circulatory disorders except AMI, with card cath with MCC[4]	**$13,135**
287	Circulatory disorders except AMI, with card cath without MCC[4]	**$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[6]	Payment
Coronary IVUS			
+92978	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report: initial vessel (list separately in addition to code for primary procedure)	**Status: N**	**0**
+92979	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report: 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[6]	Payment
Coronary IVUS catheter			
C1753	Catheter, intravascular ultrasound	**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

		In hospital facility[7]		In office non-facility[8]	
CPT	Descriptor	Payment	RVU[9]	Payment	Global RVU[10]
Coronary IVUS					
+92978-26[11]	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report: initial vessel (list separately in addition to code for primary procedure)	$100	2.78	$100	2.78
+92979-26[11]	Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report: 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 ultrasound

- CPT codes 92978 and 92979 are add-on codes. An add-on code is always performed in conjunction with another primary service.
  - *CPT Assistant December 2014, Volume 24, Issue 12, pages 6-10)*

- Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement).
  - *CPT Changes: An Insider's View 2000-Medicine Cardiovascular*

- Codes 92978 and 92979 have been editorially revised to include optical coherence tomography (OCT), and in accordance with these revisions, Category III codes for OCT (0291T, 0292T) have been deleted. The guidelines and several parenthetical notes have been revised.

- 92978 may be reported with the following codes: 92975, 92920, 92924,92928, 92933, 92937, 92941, 92943, 93454-93461, 93563, 93564
  - *CPT Copyright© 2017 American Medical Association*

- 92978 is reported once per session.
  - *CPT Changes: An Insider's View 2017-Medicine Cardiovascular*

- 92979 is reported once per additional vessel.
  - *CPT Changes: An Insider's View 2017-Medicine Cardiovascular*

- Use 92979 in conjunction with 92978.
  - *CPT Copyright© 2017 American Medical Association*

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
- 2017 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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