2013 Medicare Coding for Peripheral Interventions: General Overview
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Boston Scientific Corporation

GuidePoint
Simplifying Reimbursement
Peripheral Interventions
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Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed with this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.
Today’s Topics

• Introduction to Coding and Reimbursement
• Key terminology
• Coding for Peripheral Interventions
• Coverage: Medicare NCD and LCD and Policies
• FAQs and Clinical Scenarios
• Tips
• Resources
Introduction to Coding and Reimbursement
Site of Service Dictates Code Selection and Payment Schedules

ICD-9-CM Diagnosis Codes
(Why patient received treatment)

CPT/HCPCS Procedure Codes
Hospital outpatient, ASC & physician service(s)

- APC Payment (Hospital Outpatient)
- ASC Payment (Amb Surg Cntr)
- Physician Fee Schedule

Non Facility Payment
Facility Payment

ICD-9-CM Procedure Codes
Hospital inpatient service(s)

MS-DRG Payment (Hospital Inpatient)
Inpatient vs Outpatient Hospital

The decision to admit an individual is a complex medical judgment that is made by the physician. An explanation of medical necessity is required to justify “admit to inpatient” status. There is no formal time frame associated with inpatient; “24 hours” is a guideline.

Inpatient Hospital
- Physician documents “Admit to Inpatient”
- General Guideline: Patient can be treated and released >24 hours

Outpatient Facility
- Physician documents “Admit to Outpatient”
- General Guideline: Patient can be treated and released <24 hours

October 2008 Medicare Manual
Medicare’s definition in conjunction with how the provider is licensed by the state determines the site of service and appropriate Medicare payment system:

**Outpatient Hospital** as “A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.”

**Ambulatory Surgery Center** as “A freestanding facility other than a physician’s office, where surgical and diagnostic services are provided on an ambulatory basis.”

**Office** as a “Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.”

http://www.cms.gov/apps/glossary
• Physicians report
  – The patient’s medical condition with ICD-9-CM diagnosis codes.
  - ICD-10-CM (diagnosis) code set implementation is scheduled for 2014.
  – Services, procedures, and products with CPT, ICD-9 procedure or HCPCS codes.

• Physician Fee Schedule payment is based on:
  – CPT or HCPCS code describing service/procedure/product provided.
  – Site of service (in-facility or non-facility) where the procedure is performed.
  – Multiple procedure discounting is applicable for many peripheral interventions
    - 50% discount
    – Applied to the least intensive service(s) or procedure(s) when more than one service/procedure is performed in the same patient at the same visit.
Key Terminology
Key Interventional Terminology

- **Vascular Family**
  A group of vessels which is fed by a primary branch of the aorta, vena cava or vessel punctured, i.e., antegrade femoral stick.

- **Ipsilateral**
  - Situated or appearing on the same side; effecting the same side.
  - Example: Via a right common femoral puncture, the catheter is advanced into the right SFA with injection and filming of the right lower extremity.

- **Contralateral**
  - Located, pertaining, or occurring in or on the opposite side.
  - Example: Via a right common femoral puncture, the catheter is advanced retrograde up and over the aortic bifurcation into the left common iliac where an injection and filming is done of the left lower extremity.

Key Interventional Terminology (cont.)

• **Bifurcation**
  – A division or forking into two branches, or the point at which this occurs.
  – Simply stated - “a fork in the road”.
  – Example: In normal vascular anatomy, the common iliac bifurcates into the internal and external iliac arteries.

• **Antegrade**
  – Moving forward, extending forward, with the normal flow (i.e., downstream).
  – Example: Via a left common femoral puncture an injection was made through the needle to study the left lower extremity.

• **Retrograde**
  – Moving backward, reversing the normal order. “Against the Flow.”
  – Example: Via a right groin puncture, the catheter was advanced into the thoracic aorta for subsequent angiography.

Catheter / Device Placement:

Non-Selective

- A needle or catheter is placed directly into an artery or vein with no further advancement of the device (i.e., direct stick or direct puncture) past the punctured vessel OR the catheter is placed into any portion of the aorta or vena cava from any approach (i.e., TLA, femoral, axillary, brachial, jugular, etc.).
- Do not code for wire placement.

Selective

- Catheter is guided, negotiated or advanced into any arterial or venous vessel other than the aorta or vena cava or the original vessel punctured.
- Do not code for wire placement.
- Other terms that may be used are subselective, supraselective, segmental or subsegmental

Coding for Lower Extremity Peripheral Interventions
Component and Bundled CPT Coding

Component coding – traditional approach

• Each invasive or interventional procedure is described by two different types of codes:
  – Radiological
  – Surgical (Procedural)

• Codes from one or both section must be used to clearly, completely and appropriately define the work that was done.

All inclusive, bundled coding – new and growing approach

• Single comprehensive code that includes both the radiological and all surgical work to perform the procedure.

• New bundled lower extremity (LE) PTA, stent and atherectomy procedures were developed in 2011.

Coding for peripheral vascular interventions is evolving and bundling of other PI procedures is anticipated. Providers are encouraged to keep CPT coding materials current.

Bundled CPT Coding for LE Endovascular Revascularization
Open or Percutaneous, Transcatheter SFA Example

• Only one base code should be reported for each lower extremity vessel treated.
• Includes all work to perform.
• Use modifier -50 when treating bilateral.

NOTE: Code numbers do not have a direct relationship to increases in the amount of work performed.
Bundled LE PTA, Stent and Atherectomy CPT codes

- Built on progressive hierarchies with more intensive services inclusive of lesser intensive services
- Specifically include:
  - Accessing the vessel
  - Selectively catheterizing the vessel
  - Crossing the lesion
  - Radiological supervision and interpretation of the intervention
  - Closure of the arteriotomy
  - Post procedure imaging
Iliac Vascular Territory
Common, External and Internal Iliac

**Iliac Territory – open or percutaneous**
3 vessels (common iliac, internal iliac, external iliac)
3 possible codes: 1 base and up to 2 add on codes

37220 Iliac PTA
37221 Iliac PTA and Stent
  +37222 Iliac PTA, add’l vessel
  +37223 Iliac PTA and stent, add’l vessel
Femoral/Popliteal Territory – open or percutaneous
1 vessel
1 code – no add-on codes

37224 Fem/Pop PTA
37225 Fem/Pop PTA with Atherectomy
37226 Fem/Pop PTA with Stent
37227 Fem/Pop PTA with Stent and Atherectomy
Tibial/Peroneal Vasculature Territory
Anterior Tibial, Posterior Tibial and Peroneal

Tibial/Peroneal Territory – open or percutaneous
3 vessels (anterior tibial, posterior tibial, peroneal)
3 possible codes: 1 base and up to 2 add on codes

37228 Tibial PTA
37229 Tibial PTA with Atherectomy
37230 Tibial PTA with Stent
37231 Tibial PTA with Stent and Atherectomy
   +37232 Tibial PTA, add’l vessel
   +37233 Tibial PTA with Atherectomy, add’l vessel
   +37234 Tibial PTA with Stent, add’l vessel
   +37235 Tibial PTA with Stent and Atherectomy, add’l vessel
Tibial/Peroneal Vasculature Territory

Added Clarification

• +37223: Revascularization, endovascular, open or percutaneous, iliac artery each additional ipsilateral iliac vessel; with transluminal stent placement(s), included angioplasty within the same vessel, when performed
  (use in conjunction with 37221)

• +37233: Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed
  (use in conjunction with 37229,37231)

• +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
  (use 37234 in conjunction with 37229,37230,37231)
Coding Guidelines

• Only one stent code should be reported regardless of how many stents are placed in the same vessel.

• A single code intervention should be reported when a lesion extends from one vessel to another in the same vascular territory but is opened with only one intervention. Additional vessel codes should not be reported in this situation.

• Add on codes apply when different vessels are treated, they do not apply to separate lesions within the same vessel.

• Bilateral procedures should be designated with Modifier 50.
Diagnostic Angiography
Diagnostic angiography, including catheter placement, is included in the bundled LE interventional procedures.

Diagnostic Angiography and catheter placement may be separately coded IF:

- No prior cath base study is available and full diagnostic study is performed OR
- A prior study is available BUT:
  - Patient’s condition has changed OR
  - There is inadequate visualization of anatomy OR
  - There is a clinical change during the procedure that requires new evaluation outside the target area of intervention
- Modifier 59 must be appended to the diagnostic radiological S&I code(s) to indicate a distinct and separate procedure.
## Diagnostic Angiography Catheter Placement

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Supervision &amp; Interpretation as Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>36245</td>
<td>Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
<td>75710: Angiography, extremity, unilateral, radiological supervision and interpretation</td>
</tr>
<tr>
<td>36246</td>
<td>Selective catheter placement arterial system; initial second order abdominal, pelvic or lower extremity artery branch, within a vascular family</td>
<td>75716: Angiography, extremity, bilateral, radiological supervision and interpretation</td>
</tr>
<tr>
<td>36247</td>
<td>Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic or lower extremity artery branch, within a vascular family</td>
<td>75625: Aortography, abdominal, by serialography, radiological supervision and interpretation</td>
</tr>
<tr>
<td>36248</td>
<td>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)</td>
<td>+ 75774: Angiography, selective, <strong>each additional vessel</strong> studied after basic examination, radiological supervision and interpretation</td>
</tr>
</tbody>
</table>
Peripheral Angioplasty

PTA

Atherectomy

Stent

Stent & Atherectomy
## Peripheral Angioplasty

### ICD-9-CM Procedure Codes

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>MS-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.50</td>
<td>252: Other vascular procedure w/MCC†</td>
</tr>
<tr>
<td>Angioplasty of other non-coronary vessels</td>
<td>253: Other vascular procedure w/CC△</td>
</tr>
<tr>
<td></td>
<td>254: Other vascular procedure w/o MCC and/or CC</td>
</tr>
</tbody>
</table>

**Plus applicable number of vessel(s):**

- 00.40 Procedure on single vessel
- 00.41 Procedure on two vessels
- 00.42 Procedure on three vessels
- 00.43 Procedure on four or more vessels
- 00.44 Procedure on vessel bifurcation

† MCC: Major complications and co-morbidities
△ CC: Complications and co-morbidities
# Angioplasty alone – Percutaneous and component coded

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>35471</td>
<td>Transluminal balloon angioplasty, percutaneous; renal or visceral artery</td>
<td>15.67 (F)</td>
<td>0083 Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>78.22 (NF)</td>
<td></td>
</tr>
<tr>
<td>75966</td>
<td>Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation</td>
<td>5.29 (GL)</td>
<td>Item and Service packaged into primary procedure APC rate. No separate payment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.81 (26)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.48 (TC)</td>
<td></td>
</tr>
<tr>
<td>35475</td>
<td>Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel</td>
<td>9.31 (F)</td>
<td>0083 Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>49.62 (NF)</td>
<td></td>
</tr>
<tr>
<td>75962</td>
<td>Transluminal balloon angioplasty, peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation</td>
<td>4.51 (GL)</td>
<td>Item and Service packaged into primary procedure APC rate. No separate payment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.75 (26)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.76 (TC)</td>
<td></td>
</tr>
<tr>
<td>75964</td>
<td>Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac and lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)</td>
<td>2.92 (GL)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.52 (26)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.40 (TC)</td>
<td></td>
</tr>
</tbody>
</table>

**Code also for selective catheter placement (CPT 36215-36248)**


F=Facility; NF=Non-Facility; GL=Global; 26=Professional; TC=Technical

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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities.
# Angioplasty alone – Percutaneous and component coded (cont.)

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>35476</td>
<td>Transluminal balloon angioplasty, percutaneous; venous</td>
<td>7.21 (F)</td>
<td>0083 Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>44.1 (NF)</td>
<td></td>
</tr>
<tr>
<td>75978</td>
<td>Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation</td>
<td>4.47 (GL)</td>
<td>Item and Service packaged into primary procedure APC rate. No separate payment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0.75 (26)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.72 (TC)</td>
<td></td>
</tr>
</tbody>
</table>

**Code also for selective catheter placement (CPT 36215-36248)**
## Angioplasty alone –
Open and component coded

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>35450</td>
<td>Transluminal balloon angioplasty, open; renal or other visceral artery</td>
<td>15.56</td>
<td>N/A Inpatient Only Procedure.</td>
</tr>
<tr>
<td>75966</td>
<td>Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation</td>
<td>5.29 (GL) 1.81 (26) 3.48 (TC)</td>
<td>Item and Service packaged into primary procedure APC rate. No separate payment.</td>
</tr>
<tr>
<td>35458</td>
<td>Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel</td>
<td>14.93</td>
<td>0083 Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity.</td>
</tr>
<tr>
<td>75962</td>
<td>Transluminal balloon angioplasty, peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation</td>
<td>4.51 (GL) 0.75 (26) 3.76 (TC)</td>
<td>Item and Service packaged into primary procedure APC rate. No separate payment.</td>
</tr>
<tr>
<td>75964</td>
<td>Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac and lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)</td>
<td>2.92 (GL) 0.52 (26) 2.40 (TC)</td>
<td></td>
</tr>
</tbody>
</table>

GL=Global; 26=Professional; TC=Technical


BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities.
### Angioplasty alone – Open and component coded (cont).

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>35460</td>
<td>Transluminal balloon angioplasty, open; venous</td>
<td>9.56</td>
<td>0083 Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity.</td>
</tr>
</tbody>
</table>

| 75978 | Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation | 4.47 (GL) | Item and Service packaged into primary procedure APC rate. No separate payment. |
|       |                                                                                                           | 0.75 (26)   | |
|       |                                                                                                           | 3.72 (TC)   | |

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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
## Angioplasty alone – All-inclusive, bundled codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>37220</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>iliac artery</strong>, unilateral, initial vessel; with transluminal angioplasty</td>
<td>12.47 (F)  100.81 (NF)</td>
<td>0083 Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity.</td>
</tr>
<tr>
<td>+37222</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>iliac artery</strong>, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)</td>
<td>5.62 (F)  28.35 (NF)</td>
<td></td>
</tr>
<tr>
<td>37224</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>femoral, popliteal artery(s)</strong>, unilateral; with transluminal angioplasty</td>
<td>13.76 (F)  121.45 (NF)</td>
<td></td>
</tr>
<tr>
<td>37228</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>tibial, peroneal artery</strong>, unilateral, initial vessel; with transluminal angioplasty</td>
<td>16.8 (F)  173.14 (NF)</td>
<td></td>
</tr>
<tr>
<td>+37232</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>tibial/peroneal artery</strong>, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)</td>
<td>6.09 (F)  38.41 (NF)</td>
<td></td>
</tr>
</tbody>
</table>

These codes all include the surgical work of performing the intervention plus the radiological S&I, as well as accessing and selectively catheterizing the vessel, traversing the lesion, embolic protection (if used), and closure of the arteriotomy by any method.

F=Facility; NF=Non-Facility
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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
Peripheral Atherectomy with/without Angioplasty

PTA

Atherectomy

Stent

Stent & Atherectomy

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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
### Peripheral Atherectomy

#### ICD-9-CM Procedure Codes

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>MS-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.50</td>
<td>252: Other vascular procedure w/MCC&lt;sup&gt;†&lt;/sup&gt;</td>
</tr>
<tr>
<td>Angioplasty of other non-coronary vessels</td>
<td></td>
</tr>
<tr>
<td>17.56</td>
<td>253: Other vascular procedure w/CC&lt;sup&gt;△&lt;/sup&gt;</td>
</tr>
<tr>
<td>Atherectomy of other non-coronary vessel(s)</td>
<td></td>
</tr>
</tbody>
</table>

**Plus applicable number of vessel(s):**

- 00.40 Procedure on single vessel
- 00.41 Procedure on two vessels
- 00.42 Procedure on three vessels
- 00.43 Procedure on four or more vessels
- 00.44 Procedure on vessel bifurcation

<sup>†</sup> MCC: Major complications and co-morbidities  
<sup>△</sup> CC: Complications and co-morbidities

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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
**Atherectomy with/without Angioplasty Component Coding**

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>0234T</td>
<td>Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; <strong>renal artery</strong></td>
<td>N/A</td>
<td>0082 Contractor Priced. <strong>Coronary or Non-Coronary Atherectomy.</strong></td>
</tr>
<tr>
<td>0235T</td>
<td>Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; <strong>visceral artery</strong> (except renal), each vessel</td>
<td>N/A</td>
<td>N/A Contractor Inpatient Only Procedure. <strong>Coronary or Non-Coronary Atherectomy.</strong></td>
</tr>
<tr>
<td>0236T</td>
<td>Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; <strong>abdominal aorta</strong></td>
<td>N/A</td>
<td>0082 Contractor Priced. <strong>Coronary or Non-Coronary Atherectomy.</strong></td>
</tr>
<tr>
<td>0237T</td>
<td>Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; <strong>brachiocephalic trunk and branches, each vessel</strong></td>
<td>N/A</td>
<td>0082 Contractor Priced. <strong>Coronary or Non-Coronary Atherectomy.</strong></td>
</tr>
<tr>
<td>0238T</td>
<td>Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; <strong>iliac artery, each vessel</strong></td>
<td>N/A</td>
<td>0082 Contractor Priced. <strong>Coronary or Non-Coronary Atherectomy.</strong></td>
</tr>
</tbody>
</table>

- These codes all include the surgical work of performing the atherectomy plus the radiological S&I of the atherectomy.
- These codes **do not** include accessing and selectively catheterizing the vessel, traversing the lesion, embolic protection (if used), other intervention used to treat the same or other vessels, or closure of the arteriotomy by any method.

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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
## Atherectomy with/without Angioplasty: All-inclusive Codes

<table>
<thead>
<tr>
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<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>37225</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>femoral, popliteal artery(s)</strong>, unilateral; with atherectomy, includes angioplasty within the same vessel, when performed</td>
<td>18.58 (F)</td>
<td>348.39 (NF)</td>
</tr>
<tr>
<td>37229</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>tibial, peroneal artery</strong>, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed</td>
<td>21.69 (F)</td>
<td>343.15 (NF)</td>
</tr>
<tr>
<td>+37233</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>tibial/peroneal artery</strong>, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)</td>
<td>9.94 (F)</td>
<td>45.91 (NF)</td>
</tr>
</tbody>
</table>

These codes all include the surgical work of performing the intervention plus the radiological S&I, as well as accessing and selectively catheterizing the vessel, traversing the lesion, embolic protection (if used), angioplasty, if performed and closure of the arteriotomy by any method.

F=Facility; NF=Non-Facility


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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
Peripheral Stenting with/without Angioplasty
### Peripheral Stenting

#### ICD-9-CM Procedure Codes

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>MS-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.90 Insertion of non-drug-eluting peripheral (non-coronary) vessel stents(s)</td>
<td>252: Other vascular procedure w/MCC†</td>
</tr>
<tr>
<td></td>
<td>253: Other vascular procedure w/CC△</td>
</tr>
<tr>
<td></td>
<td>254: Other vascular procedure w/o MCC and/or CC</td>
</tr>
</tbody>
</table>

**Plus applicable number of vessel(s):**
- 00.40 Procedure on single vessel
- 00.41 Procedure on two vessels
- 00.42 Procedure on three vessels
- 00.43 Procedure on four or more vessels
- 00.44 Procedure on vessel bifurcation

**and number of stent(s):**
- 00.45 Insertion of one vascular stent
- 00.46 Insertion of two vascular stents
- 00.47 Insertion of three vascular stents
- 00.48 Insertion of four or more vascular stents

† MCC: Major complications and co-morbidities
△ CC: Complications and co-morbidities
## Stenting with/without Angioplasty
### Component Coding

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Percutaneous</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37205</td>
<td>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel</td>
<td>12.64 (F)</td>
<td>0229 Level II Endovascular Revascularization of the Lower Extremity</td>
</tr>
<tr>
<td>+37206</td>
<td>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)</td>
<td>6.29 (F)</td>
<td>79.47 (NF)</td>
</tr>
<tr>
<td></td>
<td><strong>Open</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37207</td>
<td>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel</td>
<td>12.93</td>
<td>0229 Level II Endovascular Revascularization of the Lower Extremity</td>
</tr>
<tr>
<td>+37208</td>
<td>Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)</td>
<td>6.20</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Radiological Supervision and Interpretation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75960</td>
<td>Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel</td>
<td>3.74 (GL)</td>
<td>Item and Service packaged into primary procedure APC rate. No separate payment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.14 (26)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.60 (TC)</td>
<td></td>
</tr>
</tbody>
</table>

**Code also for selective catheter placement (CPT 36215-36248)**  
**Code also angioplasty, if performed (CPT 35450-35476)**

---

F=Facility; NF=Non-Facility; GL=Global; 26=Professional; TC=Technical  

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BSC has no stents FDA-approved for use in the infringuinal regions of the lower extremities
## Stenting with/without Angioplasty – All-inclusive codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Facility</td>
<td>Non-Facility</td>
</tr>
<tr>
<td>37221</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>iliac artery</strong>, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>15.17 (F)</td>
<td>0229 Level II Endovascular Revascularization of the Lower Extremity 0083 Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity.</td>
</tr>
<tr>
<td>37223</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>iliac artery</strong>, <strong>each additional ipsilateral iliac vessel</strong>; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)</td>
<td>6.42 (F)</td>
<td>82.28 (NF)</td>
</tr>
<tr>
<td>37226</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>femoral, popliteal artery(s)</strong>, unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>15.23 (F)</td>
<td>0229 Level II Endovascular Revascularization of the Lower Extremity</td>
</tr>
<tr>
<td>37230</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>tibial, peroneal artery</strong>, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed</td>
<td>21.01 (F)</td>
<td>261.58 (NF)</td>
</tr>
<tr>
<td>37234</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>tibial/peroneal artery</strong>, unilateral, <strong>each additional vessel</strong>; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)</td>
<td>8.39 (F)</td>
<td>124.23 (NF)</td>
</tr>
</tbody>
</table>

These codes all include the surgical work of performing the intervention plus the radiological S&I, as well as accessing and selectively catheterizing the vessel, traversing the lesion, embolic protection (if used), angioplasty (if performed) and closure of the arteriotomy by any method.

F=Facility; NF=Non-Facility  
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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities.
Peripheral Stenting with Atherectomy with/without Angioplasty
<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>MS-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.50</td>
<td>252: Other vascular procedure w/MCC†</td>
</tr>
<tr>
<td>39.90</td>
<td>253: Other vascular procedure w/CCΔ</td>
</tr>
<tr>
<td>17.56</td>
<td>254: Other vascular procedure w/o MCC and/or CC</td>
</tr>
</tbody>
</table>

**Plus applicable number of vessel(s):**
- 00.40 Procedure on single vessel
- 00.41 Procedure on two vessels
- 00.42 Procedure on three vessels
- 00.43 Procedure on four or more vessels
- 00.44 Procedure on vessel bifurcation

**and number of stent(s):**
- 00.45 Insertion of one vascular stent
- 00.46 Insertion of two vascular stents
- 00.47 Insertion of three vascular stents
- 00.48 Insertion of four or more vascular stents

† MCC: Major complications and co-morbidities
Δ CC: Complications and co-morbidities

BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities.
### Stenting & Atherectomy with/without Angioplasty, All-inclusive codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>37227</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>femoral, popliteal artery(s)</strong>, unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed</td>
<td>22.41 (F)</td>
<td>0319</td>
</tr>
<tr>
<td></td>
<td></td>
<td>470.71 (NF)</td>
<td>Level III Endovascular Revascularization of the Lower Extremity</td>
</tr>
<tr>
<td>37231</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>tibial, peroneal artery</strong>, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed</td>
<td>22.85 (F)</td>
<td>0083</td>
</tr>
<tr>
<td></td>
<td></td>
<td>417.47 (NF)</td>
<td>Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity</td>
</tr>
<tr>
<td>+37235</td>
<td>Revascularization, endovascular, open or percutaneous, <strong>tibial/peroneal artery</strong>, unilateral, <strong>each additional vessel</strong>; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)</td>
<td>11.61 (F)</td>
<td>0083</td>
</tr>
<tr>
<td></td>
<td></td>
<td>126.67 (NF)</td>
<td>Coronary Angioplasty, Valvuloplasty and Level 1 Endovascular Revascularization of the Lower Extremity</td>
</tr>
</tbody>
</table>

These codes all include the surgical work of performing the intervention plus the radiological S&I, as well as accessing and selectively catheterizing the vessel, traversing the lesion, embolic protection (if used), angioplasty (if performed) and closure of the arteriotomy by any method.
Intravascular Ultrasound (IVUS)

37250  Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)

37251  Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)

There is no separate payment to the outpatient hospital or ASC for IVUS.

The physician portion for IVUS may be billed in conjunction with interventional therapeutic procedures (except for placement of endovascular IVC filter), including the lower extremity revascularization procedures, 37220 – 37235.

Medical record documentation should support medical necessity of the IVUS procedure.

If receiving physician payment denials for bundling of IVUS, appeals should be submitted to the MAC or other payer. Contact the Reimbursement Support line, if assistance is needed.
IVUS Procedure Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Codes</th>
<th>Possible Inpatient MS-DRG Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>00.23:</strong> Intravascular imaging of peripheral vessels</td>
<td></td>
</tr>
<tr>
<td><strong>00.28:</strong> Intravascular imaging, other specified vessel(s)</td>
<td>MS-DRG grouping is driven by other primary procedures that are performed in conjunction with this procedure</td>
</tr>
<tr>
<td><strong>00.29:</strong> Intravascular imaging unspecified vessel(s)</td>
<td></td>
</tr>
</tbody>
</table>

## IVUS CPT Codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>37250</td>
<td>Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)</td>
<td>3.19</td>
<td>Status N, Items and Services Packaged Into the primary procedure APC Rate. No Separate Payment.</td>
</tr>
<tr>
<td>+37251</td>
<td>(Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention) each additional vessel (List separately in addition to code for primary procedure)</td>
<td>2.40</td>
<td></td>
</tr>
<tr>
<td>75945</td>
<td>Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel</td>
<td>Contractor Priced (GL &amp; TC) 0.59 (-26)</td>
<td></td>
</tr>
<tr>
<td>75946</td>
<td>Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)</td>
<td>Contractor Priced (GL &amp; TC) 0.60 (-26)</td>
<td></td>
</tr>
</tbody>
</table>

Carotid Artery Stent
## Carotid Artery Stenting (CAS)

### ICD-9-CM Procedure Codes

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>MS-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>00.61</td>
<td>034: Carotid artery stent procedure w/MCC†</td>
</tr>
<tr>
<td></td>
<td>035: Carotid artery stent procedure w/CC△</td>
</tr>
<tr>
<td>00.63</td>
<td>036: Carotid artery stent procedure w/o MCC and/or CC</td>
</tr>
</tbody>
</table>

- **Plus applicable number of vessel(s):**
  - 00.40 Procedure on single vessel
  - 00.41 Procedure on two vessels
  - 00.42 Procedure on three vessels
  - 00.43 Procedure on four or more vessels
  - 00.44 Procedure on vessel bifurcation

- **And number of stent(s):**
  - 00.45 Insertion of one vascular stent
  - 00.46 Insertion of two vascular stents
  - 00.47 Insertion of three vascular stents
  - 00.48 Insertion of four or more vascular stents

† MCC: Major complications and co-morbidities

△ CC: Complications and co-morbidities
### CAS – All-inclusive codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>37215</td>
<td>Transcatheter placement of intravascular stent(s), cervical carotid artery,</td>
<td>32.28</td>
<td>Inpatient Only Procedure</td>
</tr>
<tr>
<td></td>
<td>percutaneous; with distal embolic protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37216</td>
<td>Transcatheter placement of intravascular stent(s), cervical carotid artery,</td>
<td>Not covered by Medicare.</td>
<td>Not covered by Medicare.</td>
</tr>
<tr>
<td></td>
<td>percutaneous; without distal embolic protection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CAS Coding Guidelines:**

- Includes all ipsilateral selective carotid catheterization
- Includes all diagnostic imaging for ipsilateral, cervical and cerebral arteriography
- If the catheterization and imaging confirm need for carotid stenting, these services are included within the codes
- If the catheterization and imaging do not confirm the need for carotid stent then diagnostic angiogram is reported separately.

## CAS - Changes to Carotid Artery Diagnostic Codes

### 2013 New Codes *

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36221</td>
<td>Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed</td>
</tr>
<tr>
<td>36222</td>
<td>Selective catheter placement, common carotid or innominate artery, unilateral, any approach with angiography of the ipsilateral extracranial carotid circulation, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed</td>
</tr>
<tr>
<td>36223</td>
<td>Selective catheter placement, common carotid or innominate artery, unilateral, any approach with angiography of the ipsilateral intracranial carotid circulation, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed</td>
</tr>
<tr>
<td>36224</td>
<td>Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed</td>
</tr>
<tr>
<td>36225</td>
<td>Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed</td>
</tr>
<tr>
<td>36226</td>
<td>Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed</td>
</tr>
<tr>
<td>36227</td>
<td>Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation, and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>36228</td>
<td>Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

### 2013 Deleted Codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Now Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>75660</td>
<td>Angiography, external carotid, unilateral, selective, radiological supervision and interpretation</td>
<td>36227</td>
</tr>
<tr>
<td>75662</td>
<td>Angiography, external carotid, bilateral, selective, radiological supervision and interpretation</td>
<td>36227</td>
</tr>
<tr>
<td>75665</td>
<td>Angiography, carotid, cerebral, unilateral, radiological supervision and interpretation</td>
<td>36223, 36224</td>
</tr>
<tr>
<td>75671</td>
<td>Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation</td>
<td>36223, 36224</td>
</tr>
<tr>
<td>75676</td>
<td>Angiography, carotid, cervical, unilateral, radiological supervision and interpretation</td>
<td>36222-36224</td>
</tr>
<tr>
<td>75680</td>
<td>Angiography, carotid, cervical, bilateral, radiological supervision and interpretation</td>
<td>36222-36224</td>
</tr>
<tr>
<td>75685</td>
<td>Angiography, vertebral, cervical, and/or intracranial, radiological supervision and interpretation</td>
<td>36225, 36226</td>
</tr>
</tbody>
</table>

* Codes 36221-36228 describe non-selective and selective arterial catheter placement and diagnostic imaging of the aortic arch, carotid, and vertebral arteries.
Transcatheter Embolization
### Uterine Artery Embolization

<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Codes</th>
<th>Description</th>
<th>MS-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.24 w/coils</td>
<td>Injection or infusion of other therapeutic or prophylactic substance</td>
<td>760: Menstrual &amp; other female reproductive system disorders with CC/MCC⁺△</td>
</tr>
<tr>
<td>68.25 w/o coils</td>
<td></td>
<td>761: Menstrual &amp; other female reproductive system disorders with w/o MCC and/or CC</td>
</tr>
</tbody>
</table>

⁺MCC: Major complications and co-morbidities
△CC: Complications and co-morbidities

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>37210</td>
<td>Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure</td>
<td>15.52 (F)</td>
<td>0229</td>
</tr>
<tr>
<td></td>
<td></td>
<td>112.08 (NF)</td>
<td>Level II Endovascular Revascularization of the Lower Extremity</td>
</tr>
</tbody>
</table>

CPT code is inclusive of

- Vascular access and vessel selection
- Embolization
- All radiological supervision and interpretation
- Intraprocedural roadmapping
- Imaging guidance necessary to complete the procedure

F=Facility; NF=Non-Facility

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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
## Y-90 Embolization

<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Codes</th>
<th>Description</th>
<th>MS-DRG</th>
</tr>
</thead>
</table>
| 38.80                   | Other surgical occlusion of vessels, unspecified site | 252: Other vascular procedure w/MCC†  
253: Other vascular procedure w/CC△  
254: Other vascular procedure w/o MCC and/or CC |
| 38.91                   | Arterial catheterization | 981: Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC†  
982: Extensive O.R. Procedure Unrelated to Principal Diagnosis with CC△  
983: Extensive O.R. Procedure Unrelated to Principal Diagnosis without CC/MCC |

† MCC: Major complications and co-morbidities  
△ CC: Complications and co-morbidities

NOTE: PRINCIPAL DIAGNOSIS MAY ALSO IMPACT DRG ASSIGNMENT
## Y-90 Embolization Component codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC</th>
</tr>
</thead>
<tbody>
<tr>
<td>37204</td>
<td>Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck</td>
<td>26.43</td>
<td>0082: Coronary or Non-Coronary Atherectomy</td>
</tr>
<tr>
<td>C2616</td>
<td>Brachytherapy source, nonstranded, yttrium-90, per source</td>
<td>N/A</td>
<td>2616 Brachytherapy, non-stranded, Yttrium-90</td>
</tr>
<tr>
<td>75894</td>
<td>Transcatheter therapy, embolization, any method, radiological supervision and interpretation</td>
<td>Contractor Priced (GL &amp; TC) 1.93 (26)</td>
<td>Item and Service packaged into primary procedure APC rate . No separate payment.</td>
</tr>
<tr>
<td>75898</td>
<td>Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion</td>
<td>Contractor Priced (GL &amp; TC) 2.44 (26)</td>
<td>Item and Service packaged into primary procedure APC rate if billed on same day Otherwise APC 0261 applies.</td>
</tr>
<tr>
<td>77790</td>
<td>Supervision, handling, loading of radiation source</td>
<td>2.78 (GL) 1.51 (26) 1.27 (TC)</td>
<td>Item and Service packaged into primary procedure APC rate . No separate payment.</td>
</tr>
</tbody>
</table>

Code also catheter placement and diagnostic angiography performed.

---

**Note:**
- F=Facility; NF=Non-Facility; GL=Global; 26=Professional; TC=Technical
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- BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
Vena Cava Filters
Vena Cava Filter – All-inclusive Codes

- 3 All-inclusive percutaneous CPT codes created in 2012
  - 37191 - Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
  - 37192 - Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed
  - 37193 - Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

- 1 open surgical CPT code:
  - 37619 - Ligation of inferior vena cava

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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities
Vena Cava Filter – All-inclusive codes

All-inclusive percutaneous CPT codes 37191, 37192 & 37193 include

- Venous non-selective and selective catheter manipulation required to image the vena cava (IVC) and renal veins
- Filter deployment/manipulation/removal
- Post-procedure completion angiography
- Ultrasound guidance for venous access
- **Intravascular ultrasound (IVUS)** – do not report separately
- Moderate sedation

# Hospital Inpatient ICD-9-CM Procedure Codes and Possible MS-DRG Assignments

## Vena Cava Filter

### ICD-9-CM Procedure Codes

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>MS-DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>38.7 Interruption of vena cava</td>
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</tbody>
</table>

**Plus:**
- 00.22 Intravascular imaging of intrathoracic vessels
- 39.99 Other operations on vessels
- 88.51 Angiocardiography of venae cavae

MS-DRG grouping is driven by other primary procedures that are performed in conjunction with this procedure

† MCC: Major complications and co-morbidities
△ CC: Complications and co-morbidities
# Vena Cava Filter – All-inclusive CPT codes

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>Physician RVU</th>
<th>Outpatient Hospital APC Group</th>
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<tbody>
<tr>
<td>37191</td>
<td>Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed. (For open surgical interruption of the inferior vena cava through a laparotomy or retroperitoneal exposure, use 37619)</td>
<td>7.09 (F)</td>
<td>0091 Level II Vascular Ligation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>82.54 (NF)</td>
<td></td>
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<tr>
<td>37192</td>
<td>Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed. (Do not report 37192 in conjunction with 37191)</td>
<td>10.89 (F)</td>
<td>0623 Level III Vascular Access Procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>53.65 (NF)</td>
<td></td>
</tr>
<tr>
<td>37193</td>
<td>Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed. (Do not report 37193 in conjunction with 37203, 75961)</td>
<td>10.92 (F)</td>
<td>0623 Level III Vascular Access Procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51.32 (NF)</td>
<td></td>
</tr>
<tr>
<td>37619</td>
<td>Ligation of inferior vena cava</td>
<td>50.79</td>
<td>0091 Level II Vascular Ligation</td>
</tr>
</tbody>
</table>
Chronic Total Occlusion (CTO)
Chronic Total Occlusion (CTO) Diagnosis

- ICD-9 Diagnosis code 440.4 Chronic total occlusion of artery of the extremities
  - Complete or total occlusion of artery of the extremities
- New Inpatient Hospital assignment in 2013
  - CC status (Complications or Comorbidities)
  - MS-DRG 253 – Other vascular procedures with complications or comorbidities.
  - “Monitoring” status, will map to MS-DRG 253 if a non-atherosclerosis code is the primary diagnosis or if another CC is listed in addition to 440.4.
Chronic Total Occlusion (CTO) Devices

- Designed to facilitate the crossing of CTOs, or complete blockages within the peripheral vasculature.
  - Not an atherectomy device
- Considered procedure enabling, allows for intended PTA or stenting in the occluded artery.
- Coding
  - Procedure coding is based on interventional procedure performed, i.e. PTA, stent, etc.
  - No separate procedure identification for CTO
  - No separate coding or additional payment for CTO procedure/device.
  - No Medicare C-code category for CTO devices. Check with the manufacturer for the C-code they are assigning to specific CTO devices.
Coverage
Types of Coverage Decisions

**National coverage decisions (NCD)** - set by CMS.
- Clinical situations, diagnosis, etc where coverage is/is not in place.
- Specific criteria (patient, practitioner, facility) for coverage.
- Allowed/not allowed diagnosis and procedure codes.

**Local coverage decisions (LCD)** - set by local Medicare contractors or fiscal intermediaries in the absence of a NCD or when an NCD requires further definition.
- Same specifics as in NCD.
- Geographic locations identified.

**Non-Medicare Insurer Coverage Decisions**
- May differ/be more limiting that Medicare
- Not always publically available
Coverage

• Don’t assume endovascular procedures will be covered
• Keep a close eye on your Medicare contractor policies
• Preauthorize non-Medicare cases to clarify benefits in advance
Medicare NCD for Percutaneous Transluminal Angioplasty*

- PTA is covered when used under the following conditions
  - In the lower extremities, i.e., the iliac, femoral and popliteal arteries, or in the upper extremities. The upper extremities do not include head or neck vessels.
  - Of the renal arteries for patients in whom there is an inadequate response to a thorough medical management of symptoms and for whom surgery is the likely alternative. PTA for this group of patients is an alternative to surgery, not simply an addition to medical management
  - Of anteriovenous dialysis fistulas and grafts when performed through either a venous or arterial approach.

All other indications are non-covered

*Medicare NCD for Percutaneous Transluminal Angioplasty (PTA) (20.7 version 9)
Medicare NCD* for Carotid Artery Stenting (CAS)

- Covered only with distal embolic protection (37215\(^1\))
- CAS without distal embolic protection is not covered
- Must be performed on an inpatient basis
- Covers PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent with embolic protection for the following\(^2\):
  - Symptomatic patients at high risk for Carotid Endarterectomy (CEA) who also have carotid artery stenosis \(\geq 70\%\).
  - Symptomatic patients at high risk for CEA with carotid artery stenosis between 50% and 70% in accordance with Category B IDE clinical trials regulation as a routine cost under clinical trials policy, or in accordance with the NCD on CAS post-approval studies.
- Covered only if performed in facilities determined to be competent in performing the evaluation, procedure and follow-up necessary to ensure optimal patient outcomes.

* Coverage policy has remained in place and unchanged since 2009.

\(^1\) Medicare Physician Fee Schedule, 2013
\(^2\) NCS for Percutaneous Transluminal Angioplasty. (20.7 v9)
Medicare Coverage for Stenting

- CMS has not issued an NCD specific to peripheral/extremity stenting.
- Consequently, coverage decisions and determinations for peripheral/extremity stenting are made at the local level and several are in place.
  - Refer to Medicare Contractor for additional criteria relating to these services.
FAQs and Clinical Scenarios

Can you bill for S&I codes with lower extremity interventions?
No, the S&I codes are bundled with lower extremity revascularizations.

Can you bill 36200 for the diagnostic study if you continue with a lower extremity intervention?
No, you cannot bill 36200 if you are performing a lower extremity intervention.

Are the cath placement codes (36245-36247) included in endovascular codes 37220-37235?
Yes, codes 36245-36247 are included in 37220-37235.

If multiple stents are placed in the same vessel, can we code for each of them?
No. Per CPT, when more than one stent is placed in the same vessel, the code should be reported only once.
FAQs and Clinical Scenarios (cont)

A 52-year-old female with history of smoking, coronary artery disease, hypertension, and hypercholesterolemia is evaluated for short-distance claudication of the right leg. Diagnostic studies demonstrate a 5-cm segment of total occlusion of the distal superficial femoral artery. The angioplasty catheter cannot be initially placed due to inability to cross the occlusion. A CTO crossing device is inserted to break through the occlusion, which enables catheter placement and completion of the angioplasty.

**Hospital Inpatient**

440.21  Atherosclerosis of the extremities with intermittent claudication  
440.4  Chronic total occlusion of artery of the extremities  
00.40  Procedure on single vessel  
39.50  Angioplasty of other non-coronary vessel(s)

**Physician, Hospital Outpatient & ASC**

37224  Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty.
FAQs and Clinical Scenarios (cont)

A 65-year-old male reporting groin pain at rest. Diagnostic aortogram with bilateral lower extremity arteriogram via a right femoral access; the catheter was advanced into the abdominal aorta for imaging. A proximal left common iliac stenosis is identified and treated by angioplasty and stenting via a puncture in the left common femoral artery.

**Hospital Inpatient**

- 440.22 Atherosclerosis of extremities with rest pain
- 38.91 Arterial catheterization
- 00.40 Procedure on single vessel
- 39.50 Angioplasty of other non-coronary vessel(s)
- 39.90 Insertion of non-drug eluting peripheral (non-coronary) vessel(s)
- 88.48 Arteriography of femoral and other lower extremity arteries

**Physician, Hospital Outpatient, ASC**

- 37221 Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel with transluminal stent(s) placement; includes angioplasty within the same vessel when performed.
- 36200 -59 Introduction of catheter, aorta
- 75710 Angiography, extremity, unilateral, radiological supervision and interpretation
Considerations for Correct Coding

• Report one code that represents the most intensive service performed in a single lower extremity vessel. All lesser services are included in that code.
• CPT codes are unilateral.
• If both legs are treated at the same session, use modifier 50
   Note: if the mode of therapy is different in each leg, still use 50
• Count the vessels carefully-each lower extremity territory has its own specific rules.
• If a lesion extends from one artery to another and is treated with a single intervention, then select a single code
• If multiple territories are treated in the same leg, then report multiple codes.
• If the stenotic lesions consists of two separate iliac arteries divided by a bifurcation with a break in stenosis requiring multiple therapies, then report an initial code as well as additional code
• Check for corrections throughout the year.
• Physicians must provide detailed documentation
Coding and Anatomy Resources
Coding and Anatomy Resources

- AMA CPT Procedural Coding Manuals and References
- Interventional Radiology Coders Users’ Guide, Society of Interventional Radiology (SIR)/American College of Radiologists
- Interventional Radiology Coder, Peripheral & Cardiology Coder, Anatomical Diagrams, MedLearn Inc.
- Interventional Radiology Coding Reference, Diagnostic & Interventional Cardiovascular Coding Reference, ZHealth Publishing
- Atlas of Human Anatomy, Dr. Frank Netter
- Level II HCPCS Manual
- Transmittals and regulatory information: www.cms.gov
- Local Coverage Determinations/National Coverage Determinations
- NCCI Coding Manual/Correct Coding Initiatives Edits
Boston Scientific Resources
We’re dedicated to providing physicians and allied health professionals with world-class programs and services to help advance the standard of patient care. We are proud to continue this spirit of partnership with GuidePoint.

2013 Procedural Payment Guide
Quickly find Medicare coding and payment information, for PI, IC and CRM procedures.

http://www.bostonscientific.com/reimbursement and select Interventional Radiology

2013 PI Coding Webcast Programs
Hear from nationally acclaimed experts addressing the 2012 Medicare PI coding process. Find the Archived, on demand presentation from the live March webcast:

http://www.bostonscientific.com/reimbursement/webcasts

E-mail Communications
Receive major policy changes and reimbursement updates affecting CRV service line procedures, including PI (approximately 3 to 4 communications per year).

To receive email communications, become a GuidePoint subscriber by accessing our website at: www.bostonscientific.com/reimbursement and click Join GuidePoint.

Reimbursement Customer Support Line
Call 1.800.CARDIAC (227.3422) and ask for the Reimbursement Customer Support Line.

Field Reimbursement Team
Specialized on-site support for documentation and coding education related to PI, IC and CRM procedures.

C-Code Cross Reference Guide for PI products
Quickly find Medicare C-Codes for BSC PI products.

http://www.bostonscientific.com/reimbursement and select division

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BSC has no stents FDA-approved for use in the infrainguinal regions of the lower extremities