2024 Inpatient Coding & Payment Quick Reference

Interventional Cardiology – Coronary Therapies

Coding and Payment for Medicare Reimbursement: The following are the 2024 codes and Medicare national average payment rates for coronary therapies procedures performed in an inpatient hospital setting. Actual rates will vary by hospital.

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 within 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.

Admissions with Intraluminal Device		
MS-DRG[1]	**Abbreviated Description[2]**	**National Average Payment[3]**
321	PCI with Intraluminal Device with MCC	$20,127
322	PCI with Intraluminal Device without MCC	$12,767
323	IVL with Intraluminal Device with MCC	$28,987
324	IVL with Intraluminal Device without MCC	$20,785
Admissions without Intraluminal Device		
MS-DRG[1]	**Abbreviated Description[2]**	**National Average Payment[3]**
250	PCI without Intraluminal Device with MCC	$16,459
251	PCI without Intraluminal Device without MCC	$11,111
325	IVL without Intraluminal Device	$18,514

This coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

See important notes on the uses and limitations of this information on page 3.

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)1 is the system of codes used by facilities to report procedures and services provided in the inpatient setting. ICD-10-PCS alphanumeric codes are composed of seven characters that identify the general procedure type, body system, procedure objective, specific body part, procedure approach and device use.

Claims must contain the appropriate CPT®/HCPCS/ICD-10-PCS code(s) for the specific site of service to indicate the items and services that are furnished. The tables below contain a list of possible CPT/HCPCS/ICD-10-PCS codes that may be used. Providers should select the most appropriate code(s) and modifier(s) with the highest level of detail to describe the service(s) rendered.

Note: Effective October 1, 2016, coronary arteries are specified by the number of arteries (formerly sites) treated. (AHA Coding Clinic 4th Qtr. 2016)

ICD-10-PCS Coding					
Section: 0 - Medical and Surgical Body System: 2 - Heart and Great Vessel					
Abbreviated Description[2]	**Root Operation**	**Body Part**	**Approach**	**Device**	**Qualifier**
PTCA	7 - Dilation	0 – Coronary Artery, One Artery 1 – Coronary Artery, Two Arteries 2 – Coronary Artery, Three Arteries 3 – Coronary Artery, Four or more arteries	3 – Percutaneous	Z – No Device	6 – Bifurcation Z – No qualifier
Bare Metal Stent + PTCA				D – Intraluminal Device E – Intraluminal Device, Two F – Intraluminal Device, Three G – Intraluminal Device, Four or More	
Drug Eluting Stent + PTCA				4 – Intraluminal Device, Drug-eluting 5 – Intraluminal Device, Drug-eluting, Two 6 – Intraluminal Device, Drug-eluting, Three 7 – Intraluminal Device, Drug-eluting, Four or more	
Brachytherapy + PTCA				T – Intraluminal Device, Radioactive	
Atherectomy	C - Extirpation			Z – No Device	
Intravascular Lithotripsy (IVL)	F - Fragmentation				

See important notes on the uses and limitations of this information on page 3.

Resources for Interventional Cardiology: https://www.bostonscientific.com/en-US/reimbursement/interventional-cardiology.html
Reimbursement Help Desk: IC.Reimbursement@bsci.com

IMPORTANT INFORMATION

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. **It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered.** It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. 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 within 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. The coding options listed within 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. This coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

Information included herein is current as of January 2024 but is subject to change without notice. MS-DRG rates are set to expire on September 30, 2024.

Sequestration Disclaimer: Rates referenced in these guides do not reflect Sequestration**.**

[1] MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

[2] Descriptions have been abbreviated. For full code descriptions, please consult the Procedural Payment Guide. https://www.bostonscientific.com/en-US/reimbursement/interventional-cardiology.html

[3] Source: CMS. FY 2024 IPPS Final Rule: CMS-1785-F, including data files. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor, and capital amounts. Actual reimbursement will vary for each provider and institution for a variety of reasons including geographic differences in labor and non-labor costs, hospital teaching status, and/or proportion of low-income patients). Effective through September 30, 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page#CMS1785F