

2012 Procedural Payment Guide



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This Procedural Payment Guide for cardiology, rhythm and peripheral intervention procedures provides coding and reimbursement information for physicians and healthcare facilities.

The codes included in this guide are intended to represent typical cardiology, rhythm and peripheral intervention procedures where there is: 1) at least one device approved by the U.S. Food and Drug Administration (FDA) for use in the listed procedure; and 2) specific procedural coding guidance provided by a recognized coding or reimbursement authority such as the American Medical Association (AMA) or the Centers for Medicare and Medicaid Services (CMS). This guide is in no way intended to promote the off-label use of medical devices.

Please note that while these materials are intended to provide coding information for a range of cardiology, rhythm, and vascular peripheral intervention procedures, the FDA-approved/cleared labeling for all products may not be consistent with all uses described in these materials. Some payers, including some Medicare contractors, may treat a procedure which is not specifically covered by a product's FDA-approved labeling as a non-covered service.

The Medicare reimbursement amounts shown are currently published national average payments. 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, proportion of low-income patients, coverage, and/or payment rules. Please feel free to contact the Boston Scientific reimbursement department at 1-800-CARDIAC if you have any questions about the information in these materials. You can also find reimbursement updates on our website, www.bostonscientific.com/reimbursement.

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Disclaimer

Please note: 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.

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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 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.

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Physician Billing and Payment: Medicare and most other insurers typically reimburse physicians based on fee schedules tied to Current Procedural Terminology¹ (CPT®) codes. CPT codes are published by the AMA and used to report medical services and procedures performed by or under the direction of physicians. Physician payment for procedures performed in an outpatient or inpatient hospital or Ambulatory Surgical Center (ASC) setting is described as an in-facility fee payment while payment for procedures performed in the physician office is described as an in-office payment. In-facility payments reflect modifier -26 as applicable.

Hospital Outpatient Billing and Payment: Medicare reimburses hospitals for outpatient stays (typically stays of less than 24 hours) under Ambulatory Payment Classification (APC) groups. Medicare assigns an APC to a procedure based on the billed CPT/HCPCS (Healthcare Common Procedural Coding System) code. (Note that private insurers may require ICD-9 [International Classification of Diseases-Volume 9] procedure codes for outpatient payment.) While it is possible that separate APC payments may be deemed appropriate where more than one procedure is done during the same outpatient visit, many APCs are subject to reduced payment when multiple procedures are performed on the same day. In most cases, the most heavily weighted or highest paying procedure is paid at 100 percent and all other procedures are subject to a 50 percent payment reduction.

Hospitals are required to report device category codes (C-codes) on claims when such devices are used in conjunction with procedure(s) billed and paid for under the OPSS. This reporting provides claims data used annually to update the OPSS payment rates. These procedure-to-device code edits look at the procedure code billed and return the claim if the dominant device required to perform the service is not also billed on the same claim. Although separate payment is not typically available for C-Codes, denials may result if applicable C-Codes are not included with associated procedure codes. Quarterly updates can be found on the Medicare website (<http://www.cms.hhs.gov/HospitalOutpatientPPS/>).

Hospital Inpatient Billing and Payment: Medicare reimburses hospital inpatient procedures based on the Medicare Severity Diagnosis Related Group (MS-DRG). The MS-DRG is a system of classifying patients based on their diagnoses and the procedures performed during their hospital stay. MS-DRGs closely calibrate payment to the severity of a patient's illness. One single MS-DRG payment is intended to cover all hospital costs associated with treating an individual during his or her hospital stay, with the exception of "professional" (e.g., physician) charges associated with performing medical procedures. Private payers may also use MS-DRG-based systems or other payer-specific system to pay hospitals for providing inpatient services.

ASC Billing and Payment: Many elective procedures are performed outside of the hospital in Medicare certified facilities also known as Ambulatory Surgical Centers (ASCs). Not all procedures that Medicare covers in the hospital setting are eligible for payment in an ASC. Medicare has a list of all services (as defined by CPT/HCPCS codes), generally non-surgical, that it covers when offered in an ASC. ASC allowed procedures can be found at <http://www.cms.hhs.gov/ASCPayment/>. Payments made to ASCs from private insurers depend on the contract the facility has with the payer.

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Inpatient information effective through September 30, 2012 | **APC** and **ASC** Information effective through December 31, 2012 | **Physician fee** information effective through December 31, 2012.

**National Average Medicare physician payment rates calculated using the 2012 conversion factor of \$34.0376. Rates subject to change and do not reflect the projected 2012 Sustainable Growth Rate reduction of 27.4%*

+ signifies Add-on Code

CPT Code ¹	CPT Descriptions	*PHYSICIAN ²			ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Codes ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital (-26)	In-Office (Global)	Work RVU	ASC Payment ³	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Cardiac Rhythm Management Device Implant Procedures										
								go to APC list	go to ICD-9-CM list	
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	\$468	N/A	7.39	\$6,868	APC 089	\$7,827	37.73 37.76 37.80 37.81 37.82 37.85 37.86	Permanent cardiac pacemaker implant MS-DRG 244 without CC/MCC MS-DRG 243 with CC MS-DRG 242 with MCC	
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	\$497		8.05				37.71 37.76 37.80 37.81 37.82 37.85 37.86 00.50		\$11,565
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	\$536		8.77	\$8,617	APC 655	\$9,685	37.72 37.76 37.80 37.83 37.87 00.50		\$14,845
33212	Insertion of pacemaker pulse generator only; with existing single lead	\$339		5.26	\$5,851	APC 090	\$6,596	37.80 37.81 37.82 37.85 37.86 00.53		\$20,742
									Cardiac pacemaker replacement MS-DRG 259 without MCC MS-DRG 258 with MCC	\$10,258 \$16,732

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Cardiac Rhythm Management Device Implant Procedures <i>continued</i>										
							go to APC list		go to ICD-9-CM list	
33213	Insertion of pacemaker pulse generator only; with existing dual leads	358	N/A	5.53	\$6,447	APC 654	\$7,229	37.80 37.83 37.87 00.53	Cardiac pacemaker replacement MS-DRG 259 without MCC MS-DRG 258 with MCC	\$10,258
33221	Insertion of pacemaker pulse generator only; with existing multiple leads			5.80				00.53		\$16,732
33214	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generation)	\$493		7.84	\$8,617	APC 655	\$9,685	37.71 37.73 37.76 37.87 00.50	Permanent cardiac pacemaker implant MS-DRG 244 without CC/MCC MS-DRG 243 with CC MS-DRG 242 with MCC	\$11,565
33215	Repositioning of previously implanted transvenous pacemaker or pacing cardioverter-defibrillator (right atrial or right ventricular) electrode	\$311		4.92	\$920	APC 105	\$1,594	37.75		\$14,845
33216	Insertion of a single transvenous electrode, permanent pacemaker or cardioverter-defibrillator	\$384		5.87	\$2,004	APC 106	\$3,473	37.71 37.73 37.76 37.95 37.97		\$20,742
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or cardioverter-defibrillator	\$382		5.84				37.72 37.76 37.95 37.97	ICD lead procedures MS-DRG 265	\$13,027
33218	Repair of single transvenous electrode, permanent pacemaker or pacing cardioverter-defibrillator	\$401		6.07	\$920	APC 105	\$1,594	37.75 37.76		\$13,027
									Cardiac pacemaker revision except device replacement MS-DRG 262 without CC/MCC MS-DRG 261 with CC MS-DRG 260 with MCC	\$6,620
										\$9,432
										\$20,439

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Cardiac Rhythm Management Device Implant Procedures <i>continued</i>										
							go to APC list		go to ICD-9-CM list	
33220	Repair of 2 transvenous electrodes for permanent pacemaker or pacing cardioverter-defibrillator	\$405	N/A	6.15	\$920	APC 105	\$1,594	37.75 37.76	Cardiac pacemaker revision except device replacement	
									MS-DRG 262 without CC/MCC	\$6,620
33222	Revision or relocation of skin pocket for pacemaker	\$354		5.10	\$676	APC 136	\$1,171	37.79	MS-DRG 261 with CC	\$9,432
33223	Revision of skin pocket for cardioverter-defibrillator	\$423		6.55					MS-DRG 260 with MCC	\$20,439
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)	\$518		9.04	\$8,617	APC 655	\$9,685	00.52	ICD lead procedures	
									MS-DRG 265	\$13,027
33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system and pocket revision) (List separately in addition to code for primary procedure)	\$466		8.33				00.51	Cardiac defibrillator implant with cardiac catheterization with acute MI/HF/Shock	
									MS-DRG 222 with MCC	\$48,882
									MS-DRG 223 without MCC	\$35,650
									Cardiac defibrillator implant with cardiac catheterization without acute MI/HF/Shock	
									MS-DRG 224 with MCC	\$43,447
									MS-DRG 225 without MCC	\$33,512
									Cardiac defibrillator implant without cardiac catheterization	
									MS-DRG 226 with MCC	\$38,233
									MS-DRG 227 without MCC	\$29,000
									Permanent cardiac pacemaker implant	
									MS-DRG 242 with MCC	\$20,742
									MS-DRG 243 with CC	\$14,845
									MS-DRG 244 without CC/MCC	\$11,565
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	\$499		8.68	\$920	APC 105	\$1,594	37.75	Cardiac pacemaker revision except device replacement	
									MS-DRG 262 without CC/MCC	\$6,620
									MS-DRG 261 with CC	\$9,432
33233	Removal of permanent pacemaker pulse generator only	\$243		3.39				37.89	MS-DRG 260 with MCC	\$20,439

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		In-Hospital (-26)	In-Office (Global)	Work RVU	ASC Payment ³	APC Category	APC Payment ⁴	Possible ICD-9-CM Codes ⁵	Possible MS-DRG Assignment	MS-DRG Payment ⁶
Cardiac Rhythm Management Device Implant Procedures <i>continued</i>										
							go to APC list		go to ICD-9-CM list	
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	\$342	N/A	5.50	\$5,851	APC 090	\$6,596	37.80 37.85 37.86 37.89	Cardiac pacemaker revision except device replacement MS-DRG 262 without CC/MCC \$6,620 MS-DRG 261 with CC \$9,432 MS-DRG 260 with MCC \$20,439	
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	\$356		5.77	\$6,447	APC 654	\$7,229	37.80 37.87 37.89		
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	\$371		6.04				37.80 37.87 37.89 00.53		
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	\$497		7.91	\$920	APC 105	\$1,594	37.77		
33235	Removal of transvenous pacemaker electrode(s); dual lead system	\$650		10.15						
33240	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead	\$394		6.05	\$23,132	APC 107	\$24,268	37.96	AICD generator procedure MS-DRG 245 \$23,632	
33230	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing dual leads	\$385		6.32				37.96 00.54		
33231	Insertion of pacing cardioverter-defibrillator pulse generator only; with existing multiple leads	\$400		6.59				37.96 00.54		
33241	Removal of pacing cardioverter defibrillator pulse generator only	\$228		3.29	\$920	APC 105	\$1,594	37.98	Cardiac pacemaker revision except device replacement MS-DRG 262 without CC/MCC \$6,620 MS-DRG 261 with CC \$9,432 MS-DRG 260 with MCC \$20,439	

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Cardiac Rhythm Management Device Implant Procedures <i>continued</i>										
						go to APC list			go to ICD-9-CM list	
33262	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; single lead system	\$371	N/A	6.06	\$23,132	APC 107	\$24,268	37.98	Cardiac defibrillator implant with cardiac catheterization with acute M/HF/Shock	
									MS-DRG 222 with MCC	\$48,882
33263	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; dual lead system	\$386		6.33				37.98 00.54	MS-DRG 223 without MCC	\$35,650
									Cardiac defibrillator implant with cardiac catheterization without acute MI/HF/Shock	
									MS-DRG 224 with MCC	\$43,447
									MS-DRG 225 without MCC	\$33,512
									Cardiac defibrillator implant without cardiac catheterization	
									MS-DRG 226 with MCC	\$38,233
									MS-DRG 227 without MCC	\$29,000
33264	Removal of pacing cardioverter-defibrillator pulse generator with replacement of pacing cardioverter-defibrillator pulse generator; multiple lead system	\$401		6.60				00.54	Cardiac defibrillator implant with cardiac catheterization with acute MI/HF/Shock	
									MS-DRG 222 with MCC	\$48,882
									MS-DRG 223 without MCC	\$35,650
									Cardiac defibrillator implant with cardiac catheterization without acute MI/HF/Shock	
									MS-DRG 224 with MCC	\$43,447
									MS-DRG 225 without MCC	\$33,512
									Cardiac defibrillator implant without cardiac catheterization	
									MS-DRG 226 with MCC	\$38,233
									MS-DRG 227 without MCC	\$29,000
33244	Removal of single or dual chamber pacing cardioverter defibrillator electrode(s); by transvenous extraction	\$872		13.99	Not covered for ASC payment	APC 105	\$1,594	37.77	Cardiac pacemaker revision except device replacement	
									MS-DRG 262 without CC/MCC	\$6,620
									MS-DRG 261 with CC	\$9,432
									MS-DRG 260 with MCC	\$20,439

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		In-Hospital (-26)	In-Office (Global)	Work RVU	ASC Payment ³	APC Category	APC Payment ⁴	Possible ICD-9-CM Codes ⁵	Possible MS-DRG Assignment	MS-DRG Payment ⁶
Cardiac Rhythm Management Device Implant Procedures <i>continued</i>										
					go to APC list		go to ICD-9-CM list			
33249	Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber	\$925	N/A	15.17	\$28,043	APC 108	\$29,741	37.94 37.98 00.51	Cardiac defibrillator implant with cardiac catheterization with acute MI/HF/Shock MS-DRG 222 with MCC \$48,882 MS-DRG 223 without MCC \$35,650 Cardiac defibrillator implant with cardiac catheterization without acute MI/HF/Shock MS-DRG 224 with MCC \$43,447 MS-DRG 225 without MCC \$33,512 Cardiac defibrillator implant without cardiac catheterization MS-DRG 226 with MCC \$38,233 MS-DRG 227 without MCC \$29,000	

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		In-Hospital (-26)	In-Office (Global)	Work RVU	ASC Payment ³	APC Category	APC Payment ⁴	Possible ICD-9-CM Codes ⁵	Possible MS-DRG Assignment	MS-DRG Payment ⁶				
Cardiac Rhythm Management Device Evaluation Codes														
						go to APC list	go to ICD-9-CM list							
93279	Programming device evaluation (in person) with iterative adjustments of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system	\$33	\$51	0.65	Not covered for ASC payment	APC 690	\$34	89.45	N/A					
								89.46						
								89.47						
								89.48						
93280	Programming device evaluation (in person) with iterative adjustments of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead pacemaker system	\$39	\$59	0.77										
93281	Programming device evaluation (in person) with iterative adjustments of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead pacemaker system	\$45	\$68	0.90										
93282	Programming device evaluation (in person) with iterative adjustments of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter defibrillator system	\$42	\$63	0.85				ICD-9-CM procedure code does not impact the MS-DRG						
93283	Programming device evaluation (in person) with iterative adjustments of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead cardioverter defibrillator system	\$57	\$81	1.15										
93284	Programming device evaluation (in person) with iterative adjustments of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; multiple lead cardioverter defibrillator system	\$63	\$90	1.25										
93285	Programming device evaluation (in person) with iterative adjustments of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system	\$26	\$42	0.52				89.59						
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with physician analysis, review and report; single, dual, or multiple lead pacemaker system	\$14	\$26	0.30		N/A	N/A	not coded		N/A				

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Cardiac Rhythm Management Device Evaluation Codes										
						go to APC list		go to ICD-9-CM list		
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with physician analysis, review and report; single, dual, or multiple lead implantable cardioverter-defibrillator system	\$21	\$34	0.45	Not covered for ASC payment	N/A	N/A	not coded	N/A	
93288	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system		\$38	0.43		APC 690	\$34	89.45	ICD-9-CM procedure code does not impact the MS-DRG	
93289	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements	\$45	\$66	0.92				89.49		
93290	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	\$20	\$30	0.43		APC 035	\$19	89.59		
93291	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis	\$21	\$36			APC 690	\$34			
93292	Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system		\$33					N/A	N/A	
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days	\$15	\$54	0.32						
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim physician analysis, review(s) and report(s)	\$33	\$33	0.65		N/A	N/A			

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²			ASC ³	HOSPITAL OUPATIENT ⁴		HOSPITAL INPATIENT ⁶			
		In-Hospital (-26)	In-Office (Global)	Work RVU	ASC Payment ³	APC Category	APC Payment ⁴	Possible ICD-9-CM Codes ⁵	Possible MS-DRG Assignment	MS-DRG Payment ⁶	
Cardiac Rhythm Management Device Evaluation Codes <i>continued</i>											
						go to APC list		go to ICD-9-CM list			
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter defibrillator system with interim physician analysis, review(s) and report(s)	\$65	\$65	1.29	Not Covered for ASC payment	N/A	N/A	N/A		N/A	
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	N/A	\$30	0.00		APC 690	\$34				
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s)	\$25	\$25	0.52		N/A	N/A				
93298	Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)	\$27	\$27								
93299	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	\$0	\$0	0.00		APC 690	\$34				

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²			ASC ³	HOSPITAL OUPATIENT ⁴		HOSPITAL INPATIENT ⁶		
		In-Hospital (-26)	In-Office (Global)	Work RVU	ASC Payment ³	APC Category	APC Payment ⁴	Possible ICD-9-CM Codes ⁵	Possible MS-DRG Assignment	MS-DRG Payment ⁶
Intracardiac Electrophysiology Procedures/Studies										
						go to APC list		go to ICD-9-CM list		
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)	\$202	N/A	3.73	Not covered for ASC payment	APC 080	\$2,718	37.22	Percutaneous cardiovascular procedure without coronary artery stent MS-DRG 251 without MCC \$10,388 MS-DRG 250 with MCC \$16,286	
93600	Bundle of His recording	\$118		2.12		APC 084	\$694	37.29	ICD-9-CM procedure code does not impact the MS-DRG	
93602	Intra-atrial recording									
93603	Right ventricular recording									
93609 +	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia (list separately in addition to code for primary procedure)	\$279		4.99		Map tachycardia add-on		37.26 37.27	Percutaneous cardiovascular procedure without coronary artery stent MS-DRG 251 without MCC \$10,388 MS-DRG 250 with MCC \$16,286	
93610	Intra-atrial pacing	\$168		3.02		APC 084	\$694	37.29	ICD-9-CM procedure code does not impact the MS-DRG	
93612	Intraventricular pacing	\$167								
93613 +	Intracardiac electrophysiologic 3-dimensional mapping (list separately in addition to code for primary procedure)	\$391		6.99		Map 3D add-on	N/A	37.27 37.26	Percutaneous cardiovascular procedure without coronary artery stent MS-DRG 251 without MCC \$10,388 MS-DRG 250 with MCC \$16,286	
93615	Esophageal recording of atrial electrogram with or without ventricular electrogram(s)	\$49		0.99		APC 084	\$694	37.29	ICD-9-CM procedure code does not impact the MS-DRG	
93616	Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing	\$67		1.49						
93618	Induction of arrhythmia by electrical pacing	\$238		4.25						
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia	\$410		7.31		APC 085	\$3,759	37.26	Percutaneous cardiovascular procedure without coronary artery stent MS-DRG 251 without MCC \$10,388 MS-DRG 250 with MCC \$16,286	

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+ signifies Add-on Code

CPT Code ¹	CPT Descriptions	*PHYSICIAN ²			ASC ³	HOSPITAL OUPATIENT ⁴		HOSPITAL INPATIENT ⁶		
		In-Hospital (-26)	In-Office (Global)	Work RVU	ASC Payment ³	APC Category	APC Payment ⁴	Possible ICD-9-CM Codes ⁵	Possible MS-DRG Assignment	MS-DRG Payment ⁶
Intracardiac Electrophysiology Procedures/Studies <i>continued</i>										
						go to APC list	go to ICD-9-CM list			
93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	\$648	N/A	11.57	Not covered for ASC payment	APC 085	\$3,759	37.26	Percutaneous cardiovascular procedure without coronary artery stent	
									MS-DRG 251 without MCC	\$10,388
									MS-DRG 250 with MCC	\$16,286
93621 +	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (list separately in addition to code for primary procedure)	\$117		2.10		Electrophysiology evaluation				
93622 +	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (list separately in addition to code for primary procedure)	\$173		3.10						
93623 +	Programmed stimulation and pacing after intravenous drug infusion (list separately in addition to code for primary procedure)	\$160		2.85		Stimulation pacing heart				
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	\$269		4.80		APC 085	\$3,759			
93640	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement;	\$196		3.51		Evaluation heart device		not coded at time of device implant	ICD-9-CM procedure code does not impact the MS-DRG	
93641	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator	\$331		5.92		Electrophysiology evaluation				
93642	Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	\$244		4.88		APC 084	\$694	37.20		

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²			ASC ³	HOSPITAL OUPATIENT ⁴		HOSPITAL INPATIENT ⁶		
		In-Hospital (-26)	In-Office (Global)	Work RVU	ASC Payment ³	APC Category	APC Payment ⁴	Possible ICD-9-CM Codes ⁵	Possible MS-DRG Assignment	MS-DRG Payment ⁶
Intracardiac Electrophysiology Procedures/Studies <i>continued</i>										
						go to APC list		go to ICD-9-CM list		
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of completer heart block, with or without temporary pacemaker placement	\$596	N/A	10.49	Not covered for ASC payment	APC 085	\$694	37.34 37.78	Percutaneous cardiovascular procedure without coronary artery stent MS-DRG 251 without MCC MS-DRG 250 with MCC	\$10,388
93651	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination	\$908		16.23		APC 086	\$8,971	37.34		\$16,286
93652	Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia	\$988		17.65						
93660	Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention	\$94	\$158	1.89		APC 101	\$298	89.54		
93662 +	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (list separately in addition to code for primary procedure)	\$143	\$143	2.80	N/A	N/A	37.28 plus primary procedure	ICD-9-CM procedure code does not impact the MS-DRG		

Note: Some of the codes presented above may be used to code for a variety of procedures (diagnostic and therapeutic) employed in the field of electrophysiology, including atrial fibrillation, atrial flutter, AV Node, SVT and VT ablations. Please note that no Boston Scientific products are approved for sale in the US for atrial fibrillation ablations.

¹ Current Procedural Terminology (CPT) © 2011 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association.

² Sources: December 30, 2011 CMS Update. <http://www.cms.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1255291&intNumPerPage=10>. National Average Medicare physician payment rates calculated using a 2012 conversion factor of \$34.0376. Rates subject to change and do not reflect the projected 2012 Sustainable Growth Rate reduction of 27.4%.

³ Source: CMS website. Final Rule CY2012 ASC Regulations and Notices: <http://www.cms.gov/ASCPayment/ASCRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1253623&intNumPerPage=10>

⁴ Source: October 27, 2011 CMS update. Addendum B. https://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS-1525-FC_Addenda.zip

⁵ Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2012. Craig D. Puckett, Sixth Edition.

⁶ Source: November 7, 2011 updated data tables (FY2012 IPPS Final Rule). CMS Website. National average (wage index greater than one) MS- DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,631.16). 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).

<https://www.cms.gov/AcuteInpatientPPS/FR2012/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1250520&intNumPerPage=10>

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.

Inpatient information effective through September 30, 2012 | **APC** and **ASC** Information effective through December 31, 2012 | **Physician fee** information effective through December 31, 2012.

**National Average Medicare physician payment rates calculated using the 2012 conversion factor of \$34.0376. Rates subject to change and do not reflect the projected 2012 Sustainable Growth Rate reduction of 27.4%*

CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		Possible ICD-9-CM Codes ⁴	HOSPITAL INPATIENT	
		In-Hospital ²	Work RVU	APC Category	APC Payment ³		Possible MS-DRG Assignment	MS-DRG Payment ⁵
Diagnostic Cardiac Catheterization (Use physician modifier -26 as appropriate)				go to APC list		go to ICD-9-CM list		
93451 <i>right</i>	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	\$147	2.72	APC 080	\$2,718	37.21 37.22 37.23 38.91	Cardiac valve and other major cardiothoracic procedures with cardiac catheterization	
93530 <i>right</i>	Right heart catheterization, for congenital cardiac anomalies	\$235	4.22				MS-DRG 216 with MCC	\$54,578
93452 <i>left</i>	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	\$257	4.75				MS-DRG 217 with CC	\$36,595
93462 <i>left</i>	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	\$202	3.73				MS-DRG 218 without CC/MCC	\$29,132
93453 <i>combined</i>	Combined right heart catheterization and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	\$337	6.24				Cardiac defibrillator implant with cardiac catheterization with AMI/HF/Shock	
93531 <i>combined</i>	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	\$463	8.34				MS-DRG 222 with MCC ⁶	\$48,882
93532 <i>combined</i>	Combined right heart catheterization and transseptal left heart catheterization through intact septum, with or without retrograde left heart catheterization, for congenital cardiac anomalies	\$553	9.99				MS-DRG 223 without MCC ⁶	\$35,650
93533 <i>combined</i>	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	\$371	6.69				Cardiac defibrillator implant with cardiac catheterization without AMI/HF/Shock	
							MS-DRG 224 with MCC ⁶	\$43,447
							MS-DRG 225 without MCC ⁶	\$33,512
							Coronary bypass with cardiac catheterization	
							MS-DRG 233 with MCC	\$40,217
							MS-DRG 234 without MCC	\$27,206
							Circulatory disorders except AMI with cardiac catheterization	
							MS-DRG 286 with MCC	\$11,465
							MS-DRG 287 without MCC	\$6,050

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CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		HOSPITAL INPATIENT		
		In-Hospital ²	Work RVU	APC Category	APC Payment ³	Possible ICD-9-CM Codes ⁴	Possible MS-DRG Assignment	MS-DRG Payment ⁵
Diagnostic Cardiac Catheterization (Use physician modifier -26 as appropriate) <i>continued</i>								
				go to APC list		go to ICD-9-CM list		
93454 <i>placement</i>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	\$259	4.79	APC 080	\$2,718	37.21 37.22 37.23 38.91	Cardiac valve and other major cardiothoracic procedures with cardiac catheterization	
							MS-DRG 216 with MCC	\$54,578
93455 <i>placement</i>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography	\$299	5.54				MS-DRG 217 with CC	\$36,595
							MS-DRG 218 without CC/MCC	\$29,132
93456 <i>placement</i>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	\$331	6.15				Cardiac defibrillator implant with cardiac catheterization with AMI/HF/Shock	
							MS-DRG 222 with MCC ⁶	\$48,882
93457 <i>placement</i>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	\$371	6.89				MS-DRG 223 without MCC ⁶	\$35,650
93458 <i>placement</i>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	\$316	5.85				Cardiac defibrillator implant with cardiac catheterization without AMI/HF/Shock	
							MS-DRG 224 with MCC ⁶	\$43,447
93459 <i>placement</i>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	\$356	6.60				MS-DRG 225 without MCC ⁶	\$33,512
93460 <i>placement</i>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	\$396	7.35				Coronary bypass with cardiac catheterization	
							MS-DRG 233 with MCC	\$40,217
93461 <i>placement</i>	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	\$437	8.10				MS-DRG 234 without MCC	\$27,206
							Circulatory disorders except AMI with cardiac catheterization	
							MS-DRG 286 with MCC	\$11,465
							MS-DRG 287 without MCC	\$6,050

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CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		HOSPITAL INPATIENT		
		In-Hospital ²	Work RVU	APC Category	APC Payment ³	Possible ICD-9-CM Codes ⁴	Possible MS-DRG Assignment	MS-DRG Payment ⁵
Injection Diagnostic Cardiac Catheterization (Each site may be injected multiple times, only report each code once)								
				go to APC list		go to ICD-9-CM list		
93563	Injection procedure during cardiac catheterization including imaging supervision and interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)	\$55	1.11	Status N, items and services packaged into primary procedure APC rate. No separate payment		88.52 88.53 88.54 88.55 88.56 88.57		N/A ⁸
93564	Injection procedure during cardiac catheterization including imaging supervision and interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)	\$57	1.13					
93565	Injection procedure during cardiac catheterization including imaging supervision and interpretation, and report; for selective left ventricular or left arterial angiography (List separately in addition to code for primary procedure)	\$43	0.86					
93566	Injection procedure during cardiac catheterization including imaging supervision and interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)	\$43	0.86					
93567	Injection procedure during cardiac catheterization including imaging supervision and interpretation, and report; for supraaortic angiography (List separately in addition to code for primary procedure)	\$48	0.97					
93568	Injection procedure during cardiac catheterization including imaging supervision and interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)	\$44	0.88					

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CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		HOSPITAL INPATIENT		
		In-Hospital ²	Work RVU	APC Category	APC Payment ³	Possible ICD-9-CM Codes ⁴	Possible MS-DRG Assignment	MS-DRG Payment ⁵
Coronary Angioplasty (PTCA), Percutaneous								
				go to APC list		go to ICD-9-CM list		
92982	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel	\$621	10.96	APC 083	\$4,620	00.66	Percutaneous cardiovascular procedures without coronary artery stent MS-DRG 250 with MCC MS-DRG 251 without MCC	\$16,286
92984	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	\$166	2.97					\$10,388
Coronary Atherectomy, Percutaneous								
92995	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel	\$683	12.07	APC 082	\$7,356	17.55	Percutaneous cardiovascular procedures without coronary artery stent MS-DRG 250 with MCC MS-DRG 251 without MCC	\$16,286
92996	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	\$182	3.26					\$10,388
Coronary Stent Placement, Percutaneous								
92980	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	\$838	14.82	APC 104	\$5,689	36.06 00.66 17.55 00.40 00.41 00.42 00.43 00.44 00.45 00.46 00.47 00.48	Percutaneous cardiovascular procedure with non-drug eluting stent MS-DRG 248 with MCC or 4+ vessels/stents MS-DRG 249 without MCC	\$16,553
92981	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)	\$233	4.16					\$10,210

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CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		HOSPITAL INPATIENT		
		In-Hospital ²	Work RVU	APC Category	APC Payment ³	Possible ICD-9-CM Codes ⁴	Possible MS-DRG Assignment	MS-DRG Payment ⁵
Coronary Drug-Eluting Stent Placement, Percutaneous								
				go to APC list		go to ICD-9-CM list		
G0290	Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	N/A Physicians use 92980-see coronary stent	0.00	APC 656	\$7,403	36.07 00.66 17.55 00.40 00.41 00.42 00.43 00.44 00.45 00.46 00.47 00.48	Percutaneous cardiovascular procedure with drug-eluting stent MS-DRG 246 with MCC or 4+ vessels/stents MS-DRG 247 without MCC	\$17,866 \$11,165
G0291	Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel	N/A Physicians use 92981-see coronary stent						

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CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		HOSPITAL INPATIENT		
		In-Hospital ²	Work RVU	APC Category	APC Payment ³	Possible ICD-9-CM Codes ⁴	Possible MS-DRG Assignment	MS-DRG Payment ⁵
Intravascular Ultrasound (Use physician modifier-26 as appropriate)						go to APC list	go to ICD-9-CM list	
92978	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)	\$92	1.80	Status N, Items and Services packaged into primary procedure APC rate. No separate payment		00.24 00.28 00.29	Coronary bypass with PTCA	
							MS-DRG 231 with MCC	\$44,533
							MS-DRG 232 without MCC	\$31,923
							Percutaneous cardiovascular procedure with drug-eluting stent	
							MS-DRG 246 with MCC or 4+ vessels/stents	\$17,866
							MS-DRG 247 without MCC	\$11,165
							Percutaneous cardiovascular procedure with non-drug eluting stent	
							MS-DRG 248 with MCC or 4+ vessels/stents	\$16,553
							MS-DRG 249 without MCC	\$10,210
							Percutaneous cardiovascular procedure without coronary artery stent	
							MS-DRG 250 with MCC	\$16,286
							MS-DRG 251 without MCC	\$10,388
							Circulatory disorders except AMI, with cardiac catheterization	
							MS-DRG 286 with MCC	\$11,465
							MS-DRG 287 without MCC	\$6,050

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CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		HOSPITAL INPATIENT		
		In-Hospital ²	Work RVU	APC Category	APC Payment ³	Possible ICD-9-CM Codes ⁴	Possible MS-DRG Assignment	MS-DRG Payment ⁵
Fractional Flow Reserve (FFR) (Use physician modifier-26 as appropriate)						go to APC list	go to ICD-9-CM list	
93571	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)	\$91	1.80	Status N, Items and Services packaged into primary procedure APC rate. No separate payment	00.59 00.69	Coronary bypass with PTCA		
						MS-DRG 231 with MCC	\$44,533	
						MS-DRG 232 without MCC	\$31,923	
93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)	\$73	1.44			Percutaneous cardiovascular procedure with drug-eluting stent		
						MS-DRG 246 with MCC or 4+ vessels/stents	\$17,866	
						MS-DRG 247 without MCC	\$11,165	
						Percutaneous cardiovascular procedure with non-drug eluting stent		
						MS-DRG 248 with MCC or 4+ vessels/stents	\$16,553	
						MS-DRG 249 without MCC	\$10,210	
						Percutaneous cardiovascular procedure without coronary artery stent		
						MS-DRG 250 with MCC	\$16,286	
						MS-DRG 251 without MCC	\$10,388	
						Circulatory disorders except AMI, with cardiac catheterization		
						MS-DRG 286 with MCC	\$11,465	
						MS-DRG 287 without MCC	\$6,050	

*National Average Medicare physician payment rates calculated using the 2012 conversion factor of \$34.0376. Rates subject to change and do not reflect the projected 2012 Sustainable Growth Rate reduction of 27.4%

CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		Possible ICD-9-CM Codes ⁴	HOSPITAL INPATIENT	
		In-Hospital ²	Work RVU	APC Category	APC Payment ³		Possible MS-DRG Assignment	MS-DRG Payment ⁵
Percutaneous Balloon Valvuloplasty; Aortic Valve								
				go to APC list		go to ICD-9-CM list		
92986	Percutaneous balloon valvuloplasty; aortic valve	\$1,387	22.85	APC 083	\$4,620	35.96	Coronary bypass with PTCA	
							MS-DRG 231 with MCC	\$44,533
92987	Percutaneous balloon valvuloplasty; mitral valve	\$1,429	23.63				MS-DRG 232 without MCC	\$31,923
92990	Percutaneous balloon valvuloplasty; pulmonary valve	\$1,117	18.27				Percutaneous cardiovascular procedure with drug-eluting stent	
							MS-DRG 246 with MCC or 4+ vessels/stents	\$17,866
							MS-DRG 247 without MCC	\$11,165
							Percutaneous cardiovascular procedure with non-drug eluting stent	
							MS-DRG 248 with MCC or 4+ vessels/stents	\$16,553
							MS-DRG 249 without MCC	\$10,210
							Percutaneous cardiovascular procedure without coronary artery stent	
							MS-DRG 250 with MCC	\$16,286
							MS-DRG 251 without MCC	\$10,388
							Circulatory disorders except AMI, with cardiac catheterization	
							MS-DRG 286 with MCC	\$11,465
							MS-DRG 287 without MCC	\$6,050

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CPT Code ¹	CPT Descriptions	*PHYSICIAN		HOSPITAL OUTPATIENT		HOSPITAL INPATIENT		
		In-Hospital ²	Work RVU	APC Category	APC Payment ³	Possible ICD-9-CM Codes ⁴	Possible MS-DRG Assignment	MS-DRG Payment ⁵
Endovascular or Transthoracic Valves								
				go to APC list		go to ICD-9-CM list		
0256T <i>Aortic</i>	Implantation of catheter-delivered prosthetic aortic heart valve; endovascular approach	Carrier Priced	0.00	N/A		35.05	Cardiac valve and other major cardiothoracic procedures with cardiac catheterization	
						35.09		
0257T <i>Aortic</i>	Implantation of catheter-delivered prosthetic aortic heart valve; open thoracic approach (eg, transapical, transventricular)					35.06		
0258T <i>Aortic</i>	Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; without cardiopulmonary bypass							
0259T <i>Aortic</i>	Transthoracic cardiac exposure (eg, sternotomy, thoracotomy, subxiphoid) for catheter-delivered aortic valve replacement; with cardiopulmonary bypass							
0262T <i>Pulmonary</i>	Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach					35.07 35.09		
93799 <i>Pulmonary</i>	Unlisted cardiovascular service or procedure			APC 097	\$65	35.08		
93799 <i>Mitral</i>	Unlisted cardiovascular service or procedure					35.97	Percutaneous cardiovascular procedure without coronary artery stent	
							MS-DRG 250 with MCC	\$16,286
							MS-DRG 251 without MCC	\$10,388
Embolic Protection Device (Use physician modifier -26 as appropriate)								
93799	Unlisted cardiovascular service or procedure	Carrier Priced	0.00	APC 097	\$65	N/A ⁷		N/A ⁸

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- ² Sources: December 30, 2011 CMS Update. <http://www.cms.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1255291&intNumPerPage=10>. National Average Medicare physician payment rates calculated using a 2012 conversion factor of \$34.0376. Rates subject to change and do not reflect the projected 2012 Sustainable Growth Rate reduction of 27.4%.
- ³ Source: January 2012 CMS update. Addendum B. <http://www.cms.gov/HospitalOutpatientPPS/AU/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1255194&intNumPerPage=10>
- ⁴ Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2011. Craig D. Puckett, Fifth Edition.
- ⁵ Source: August 18, 2011 Federal Register. National average (wage index greater than one) MS- DRG rates calculated using the national adjusted full update, standardized labor, non-labor and capital amounts (\$5,631.16). (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).
- ⁶ Not intended as an all inclusive list of Cardiac Defibrillator Implant MS-DRGs as those listed include MS-DRGs with cardiac catheterization.
- ⁷ Procedure codes do not exist for this procedure because it does not drive the MS-DRG grouping.
- ⁸ MS-DRG grouping is driven by other primary procedures that are performed in conjunction with this procedure.

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.

Inpatient information effective through September 30, 2012 | **APC** and **ASC** Information effective through December 31, 2012 | **Physician fee** information effective through December 31, 2012.

**National Average Medicare physician payment rates calculated using the 2012 conversion factor of \$34.0376. Rates subject to change and do not reflect the projected 2012 Sustainable Growth Rate reduction of 27.4%*

CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³ Payment	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office			APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Peripheral Percutaneous Transluminal Balloon Angioplasty										
						go to APC list		go to ICD-9-CM list		
35471	Transluminal balloon angioplasty, percutaneous; renal or visceral artery	\$551	\$2,802	10.05	N/A	APC 083	\$4,620	39.50	Other vascular procedures	
35472	Transluminal balloon angioplasty, percutaneous; aortic	\$378	\$2,083	6.90					MS-DRG 252 with MCC	\$16,817
									MS-DRG 253 with CC	\$13,758
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	\$501	\$2,346	9.48	\$1,429				MS-DRG 254 without CC/MCC	\$9,303
35476	Transluminal balloon angioplasty, percutaneous; venous	\$318	\$1,775	6.03	\$1,118					

Radiological S&I Codes – Billed in Conjunction with Procedure Code (Use physician modifier -26 as appropriate)

75962	Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal or other visceral artery, iliac and lower extremity, radiological supervision and interpretation	\$26	\$26	0.54	N/A	APC 083	\$4,620	N/A ⁷	N/A ⁸	
75964	Transluminal balloon angioplasty, each additional peripheral artery other than cervical carotid, renal or other visceral artery iliac and lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)	\$18	\$18	0.36		Status N, items and services packaged into primary procedure APC rate. No separate payment				
75966	Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation.	\$64	\$64	1.31		APC 083	\$4,620			
75968	Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)	\$17	\$17	0.36		Status N, items and services packaged into primary procedure APC rate. No separate payment				
75978	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation	\$26	\$26	0.54		APC 093	\$2,156			

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³ Payment	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office			APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Biliary Stenting										
						go to APC list		go to ICD-9-CM list		
47556	Biliary endoscopy, percutaneous via T-Tube or other tract; with dilation of biliary duct stricture(s) with stent	\$425	N/A	8.55	\$2,360	APC 423	\$4,090	51.98 51.87	Malignancy of hepatobiliary system of pancreas MS-DRG 435 with MCC \$10,108 MS-DRG 436 with CC \$6,738 MS-DRG 437 without CC/MCC \$5,242 Disorders of the biliary tract MS-DRG 444 with MCC \$9,057 MS-DRG 445 with CC \$6,013 MS-DRG 446 without CC/MCC \$4,067	
<i>Radiological S&I Codes – Billed in Conjunction with Procedure Code (Use physician modifier -26 as appropriate)</i>										
74363	Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation	\$44	\$44	0.88	N/A	Status N, items and services packaged into primary procedure APC rate. No separate payment		N/A ⁷		N/A ⁸

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Iliac Artery Revascularization										
							go to APC list		go to ICD-9-CM list	
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	\$427	\$3,300	8.15	\$2,657	APC 083	\$4,620	39.50		Other vascular procedures MS-DRG 252 with MCC \$16,817 MS-DRG 253 with CC \$13,758 MS-DRG 254 without CC/MCC \$9,303
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	\$520	\$4,928	10.00	\$4,611	APC 229	\$8,089	39.50 39.90		
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)	\$194	\$947	3.73	\$2,657	APC 083	\$4,620	39.50		
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)	\$220	\$2,701	4.25				39.50 39.90		
Femoral/Popliteal Artery Revascularization										
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	\$470	\$3,969	9.00	N/A	APC 083	\$4,620	39.50		Other vascular procedures MS-DRG 252 with MCC \$16,817 MS-DRG 253 with CC \$13,758 MS-DRG 254 without CC/MCC \$9,303
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	\$635	\$11,271	12.00		APC 229	\$8,089	39.50 39.90		
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	\$522	\$9,507	10.49						
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	\$767	\$15,244	14.50		APC 319	\$14,198			

NOTE: BSC has no atherectomy devices FDA-approved for use in the peripheral vasculature and no stents FDA-approved for use in the infrainguinal regions of the lower extremities.

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³ ASC Payment	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office			APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Tibial/Peroneal Artery Revascularization										
						go to APC list		go to ICD-9-CM list		
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	\$575	\$5,672	11.00	N/A	APC 083	\$4,620	39.50	Other vascular procedures MS-DRG 252 with MCC \$16,817 MS-DRG 253 with CC \$13,758 MS-DRG 254 without CC/MCC \$9,303	
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	\$743	\$11,146	14.05		APC 229	\$8,089			
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	\$717	\$8,829	13.80				39.50 39.90		
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	\$779	\$14,195	15.00		APC 319	\$14,198			
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)	\$208	\$1,266	4.00		APC 083	\$4,620			
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)	\$342	\$1,540	6.50		APC 229	\$8,089	39.50		
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)	\$285	\$4,062	5.50		APC 083	\$4,620	39.50 39.90		
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)	\$404	\$4,333	7.80						

NOTE: BSC has no atherectomy devices FDA-approved for use in the peripheral vasculature and no stents FDA-approved for use in the infrainguinal regions of the lower extremities.

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³ Payment	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office			APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
<p>Transcatheter Placement of Carotid Stents with embolic protection (Boston Scientific's carotid WALLSTENT[®] Monorail[®] Endoprosthesis device is indicated for carotid artery stenting with embolic protection only. Medicare will not consider payment for the procedure when performed without embolic protection.)</p> <p style="text-align: right;">go to APC list go to ICD-9-CM list</p>										
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection	\$1,128	N/A	19.68	N/A	N/A		00.61 00.63	Carotid artery stent procedure	
									MS-DRG 034 with MCC	\$19,711
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection	\$1,018		18.95					MS-DRG 035 with CC	\$12,084
									MS-DRG 036 without CC/MCC	\$9,320
<p>Transcatheter Placement of Intravascular Stents (Peripheral stenting is covered at local Medicare contractor discretion. Payment amounts assume procedure is covered.)</p>										
37205	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel	\$442	\$4,346	8.27	N/A	APC 229	\$8,089	39.50 39.90	Other vascular procedures	
									MS-DRG 252 with MCC	\$16,817
37206	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)	\$218	\$2,598	4.12					MS-DRG 253 with CC	\$13,758
									MS-DRG 254 without CC/MCC	\$9,303
37207	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), open; initial vessel	\$445	N/A	8.27	\$4,611					
37208	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)	\$215		4.12						
<p>Radiological S&I Codes – Billed in Conjunction with Procedure Code (Use physician modifier -26 as appropriate)</p>										
75960	Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous and/or open, radiological supervision and interpretation, each vessel	\$40	\$40	0.82	N/A	Status N, items and services packaged into primary procedure APC rate. No separate payment		N/A ⁷		N/A ⁸

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶		
		In-Hospital	In-Office			APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶	
Placement of Vena Cava Filters											
						go to APC list	go to ICD-9-CM list				
37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiologic supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed.	\$240	\$2,672	4.71	N/A	APC 091	\$3,093	38.7	Other vascular procedures		
									MS-DRG 252 with MCC	\$16,817	
									MS-DRG 253 with CC	\$13,758	
									MS-DRG 254 without CC/MCC	\$9,303	
37192	Repositioning of vena cava filter, endovascular approach including vascular access, vessel selection, and radiologic supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed.	\$372	\$1,793	7.35		APC 623	\$2,123				
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiologic supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed.	\$372	\$1,711	7.35							
Intravascular Ultrasound											
37250	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)	\$112	N/A	2.10	N/A	Status N, items and services packaged into primary procedure APC rate. No separate payment		00.21 00.22 00.23 00.28 00.29	Other vascular procedures		
									MS-DRG 252 with MCC	\$16,817	
									MS-DRG 253 with CC	\$13,758	
									MS-DRG 254 without CC/MCC	\$9,303	
									Peripheral vascular disorders		
									MS-DRG 299 with MCC	\$7,725	
									MS-DRG 300 with CC	\$5,461	
									MS-DRG 301 without CC/MCC	\$3,742	
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)	\$86		1.60							
Radiological S&I Codes – Billed in Conjunction with Procedure Code (Use physician modifier -26 as appropriate)											
75945	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel	\$20	\$20	0.40	N/A	APC 267	\$152	N/A ⁷	N/A ⁸		
75946	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)					Status N, items and services packaged into primary procedure APC rate. No separate payment					

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Catheter Access										
						go to APC list		go to ICD-9-CM list		
36140	Introduction of needle or intracatheter; extremity artery	\$106	\$477	2.01	N/A	Status N, items and services packaged into primary procedure APC rate. No separate payment		N/A ⁷		N/A ⁸
36147	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow, including the inferior or superior vena cava)	\$189	\$876	3.72	\$658	APC 668 \$659				
36148	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)	\$50	\$269	1.00	N/A	Status N, items and services packaged into primary procedure APC rate. No separate payment				
36160	Introduction of needle or intracatheter, aortic, translumbar	\$131	\$538	2.52						
36200	Introduction of catheter, aorta	\$159	\$678	3.02						

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		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Catheter Placement										
						go to APC list		go to ICD-9-CM list		
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	\$249	\$1,173	4.67	N/A	Status N, items and services packaged into primary procedure APC rate. No separate payment	N/A ⁷			N/A ⁸
36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	\$283	\$1,303	5.27						
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	\$336	\$2,158	6.29						
36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	\$54	\$198	1.01						
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$252	\$1,130	4.67						
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$279	\$1,037	5.27						
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$332	\$1,754	6.29						
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	\$52	\$160	1.01						

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Catheter Placement <i>continued</i>										
						go to APC list		go to ICD-9-CM list		
36251	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed and flush aortogram when performed; unilateral.	\$282	\$1,468	5.35	N/A	APC 279	\$2,087	N/A ⁷		N/A ⁸
36252	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed and flush aortogram when performed; bilateral.	\$367	\$1,614	6.99						
36253	Superselective catheter placement (one or more second order or higher renal artery branches), renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed and flush aortogram when performed; unilateral.	\$392	\$2,250	7.55						
36254	Superselective catheter placement (one or more second order or higher renal artery branches), renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed and flush aortogram when performed; bilateral.	\$423	\$2,340	8.15						

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Angiography (Use physician modifier -26 as appropriate)										
						go to APC list	go to ICD-9-CM list			
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	\$55	\$55	1.14	N/A	APC 279	\$2,087	88.45 88.47	N/A ⁸	
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	\$64	\$64	1.31				88.48 88.49		
75726	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	\$56	\$56	1.14						
75731	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	\$56	\$56	1.14						
75733	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	\$65	\$65	1.31						
75736	Angiography, pelvic, selective or supraseductive, radiological supervision and interpretation	\$55	\$55	1.14						
Bronchoscopy										
31631	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required)	\$232	N/A	4.36	\$1,166	APC 415	\$2,023	31.93 31.99	N/A ⁸	
Transhepatic Shunts (TIPS)										
37182	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)	\$854	N/A	16.97	N/A	N/A		39.1	Major cardiovascular procedures MS-DRG 237 with MCC or thoracic aortic aneurysm repair \$28,843 MS-DRG 238 without MCC \$17,445	
37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)	\$403	\$5,746	7.99		APC 229	\$8,089			

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶		
		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶	
Procedures on Arteriovenous Fistula (AVF) and Thrombectomy											
						go to APC list	go to ICD-9-CM list				
36830	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)	\$687	N/A	12.03	\$1,656	APC 088	\$2,871	38.03 39.27 39.42 39.49 39.94	Other vascular procedures		
									MS-DRG 252 with MCC	\$16,817	
36831	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	\$478		8.04					MS-DRG 253 with CC	\$13,758	
36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	\$606		10.53					MS-DRG 254 without CC/MCC	\$9,303	
36833	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	\$685		11.98					Other circulatory system O.R. procedures		
									MS-DRG 264	\$14,405	
36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	\$309	\$1,942	5.20	\$1,767	APC 653	\$3,046	39.49 38.03 38.05 38.91	Other vascular procedures		
									MS-DRG 252 with MCC	\$16,817	
34101	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision	\$640	N/A	10.93	N/A	APC 088	\$2,871		MS-DRG 253 with CC	\$13,758	
34111	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision			10.93					MS-DRG 254 without CC/MCC	\$9,303	
34201	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	\$1,089		19.48					Other circulatory system O.R. procedures		
34490	Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision	\$651		10.91	\$1,656				MS-DRG 264	\$14,405	
Uterine Artery Embolization											
37210	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 procedure	\$536	\$3,662	10.60	\$4,661	APC 229	\$8,089	99.29	Menstrual and other female reproductive system disorders		
									MS-DRG 760 with CC/MCC	\$4,444	
									MS-DRG 761 without CC/MCC	\$2,900	

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Arterial Embolization										
						go to APC list		go to ICD-9-CM list		
37204	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	\$914	N/A	18.11	\$4,239	APC 082	\$7,358	38.80 38.91	Other vascular procedures	
									MS-DRG 252 with MCC	\$16,817
									MS-DRG 253 with CC	\$13,758
									MS-DRG 254 without CC/MCC	\$9,303
									Extensive O.R. procedure unrelated to principal diagnosis	
									MS-DRG 981 with MCC	\$28,535
									MS-DRG 982 with CC	\$16,529
									MS-DRG 983 without CC/ MCC	\$9,800
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	N/A		N/A	\$16,569	APC 2616	\$15,716	N/A ⁷		N/A ⁸

Radiological S&I Codes – Billed in Conjunction with Procedure Code (Use physician modifier -26 as appropriate)

75726	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	\$55	\$56	1.14	N/A	APC 279	\$2,087	17.71		N/A ⁸
75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	\$18	\$18	0.36		Status N, items and services packaged into primary procedure APC rate. No separate payment		88.40 88.49		
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	\$68	\$66	1.31						
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	\$84	\$84	1.65		APC 261	\$75			
77790	Supervision, handling, loading of radiation source	\$51	\$51	1.05		Status N, items and services packaged into primary procedure APC rate. No separate payment		92.21		

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
Drainage										
						go to APC list		go to ICD-9-CM list		
47510	Introduction of percutaneous transhepatic catheter for biliary drainage	\$474	N/A	8.03	\$1,176	APC 152	\$2,041	51.43 51.98 51.99	Pancreas, liver and shunt procedures	
									MS-DRG 405 with MCC	\$32,192
									MS-DRG 406 with CC	\$14,966
									MS-DRG 407 without CC/MCC	\$10,450
47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	\$584		10.77					Biliary tract procedures except only cholecystectomy	
									MS-DRG 408 with or without C.D.E. with MCC	\$22,636
									MS-DRG 409 with or without C.D.E. with CC	\$13,019
									MS-DRG 410 with or without C.D.E. without CC/MCC	\$8,584
47525	Change of percutaneous biliary drainage catheter	\$99	\$514	1.54	\$655	APC 427	\$1,137	97.05	N/A ⁸	
47530	Revision and/or reinsertion of transhepatic tube	\$365	\$1,444	6.05						
49421	Insertion of intraperitoneal cannula or catheter for drainage or dialysis, open	\$250	N/A	4.21	\$1,245	APC 652	\$2,154	51.94		
49423	Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)	\$74	\$574	1.46	\$655	APC 427	\$1,137	97.15		
50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	\$180	N/A	3.37	\$705	APC 161	\$1,224	55.29	Kidney and ureter procedures for neoplasm	
									MS-DRG 656 with MCC	\$20,474
									MS-DRG 657 with CC	\$11,334
									MS-DRG 658 without CC/MCC	\$8,277
									Kidney and ureter procedures for non-neoplasm	
									MS-DRG 659 with MCC	\$19,503
									MS-DRG 660 with CC	\$10,615
									MS-DRG 661 without CC/MCC	\$7,332

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CPT Code ¹	CPT Descriptions	*PHYSICIAN ²		Work RVU	ASC ³	HOSPITAL OUPATIENT ⁴		Possible ICD-9-CM Code ⁵	HOSPITAL INPATIENT ⁶	
		In-Hospital	In-Office		ASC Payment	APC Category	APC Payment ⁴		Possible MS-DRG Assignment	MS-DRG Payment ⁶
<p>Drainage continued go to APC list go to ICD-9-CM list</p> <p><i>Radiological S&I Codes – Billed in Conjunction with Procedure Code (Use physician modifier -26 as appropriate)</i></p>										
75980	Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation	\$71	\$71	1.44	N/A	Status N, items and services packaged into primary procedure APC rate. No separate payment	N/A ⁷			N/A ⁸
75982	Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation			1.44						
75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation	\$35	\$35	0.72						

NOTE: BSC has no atherectomy devices FDA-approved for use in the peripheral vasculature and no stents FDA-approved for use in the infrainguinal regions of the lower extremities.

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² Sources: December 30, 2011 CMS Update. <http://www.cms.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1255291&intNumPerPage=10>. National Average Medicare physician payment rates calculated using a 2012 conversion factor of \$34.0376. Rates subject to change and do not reflect the projected 2012 Sustainable Growth Rate reduction of 27.4%.

³ Source: CMS website. Final Rule CY2012 ASC Regulations and Notices: <http://www.cms.gov/ASCPayment/ASCRN/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1253623&intNumPerPage=10>

⁴ Source: October 27, 2011 CMS update. Addendum B. https://www.cms.gov/apps/ama/license.asp?file=/HospitalOutpatientPPS/Downloads/CMS-1525-FC_Addenda.zip

⁵ Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2012. Craig D. Puckett, Sixth Edition.

⁶ Source: November 7, 2011 updated data tables (FY2012 IPPS Final Rule). CMS Website. National average (wage index greater than one) MS- DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,631.16). 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). <https://www.cms.gov/AcutelInpatientPPS/FR2012/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1250520&intNumPerPage=10>

⁷ Procedure codes do not exist for this procedure because it does not drive the MS- DRG grouping.

⁸ MS-DRG grouping is driven by other primary procedures that are performed in conjunction with this procedure.

APC Reference Table

To return to the place last viewed: *Alt+left arrow or right click mouse and select previous view*

APC Category	APC Payment	APC Description
35	\$19	Vascular puncture and minor diagnostic procedures
80	\$2,718	Diagnostic cardiac catheterization
82	\$7,356	Coronary or non-coronary atherectomy
83	\$4,620	Coronary angioplasty, valvuloplasty and Level I endovascular revascularization of the lower extremity
84	\$695	Level I electrophysiologic procedures
85	\$3,759	Level II electrophysiologic procedures
86	\$8,970	Level III electrophysiologic procedures
88	\$2,873	Thrombectomy
89	\$7,826	Insertion/replacement of permanent pacemaker and electrodes
90	\$6,597	Level I insertion/replacement of permanent pacemaker
91	\$3,097	Level II vascular ligation
97	\$65	Level I noninvasive physiologic studies
101	\$299	Tilt table evaluation
104	\$5,689	Transcatheter placement of intracoronary stents
105	\$1,594	Repair/revision/removal of pacemakers AICDs or vascular devices
106	\$3,473	Insertion/replacement of pacemaker leads and/or electrodes
107	\$24,268	Insertion of cardioverter-defibrillator pulse generator
108	\$29,741	Insertion/replacement/repair of AICD leads, generator, and pacing electrodes
136	\$1,174	Level IV skin repair
152	\$2,040	Level I percutaneous abdominal and biliary procedures
161	\$1,223	Level II cystourethroscopy and other genitourinary procedures
229	\$8,087	Level II endovascular revascularization of the lower extremity
279	\$2,087	Level II angiography and venography
319	\$14,198	Level III endovascular revascularization of the lower extremity

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APC Reference Table – continued

To return to the place last viewed: Alt+left arrow or right click mouse and select previous view

APC Category	APC Payment	APC Description
415	\$2,024	Level II endoscopy lower airway
423	\$4,090	Level II percutaneous abdominal and biliary procedures
427	\$1,137	Level II tube or catheter changes or repositioning
623	\$2,125	Level III vascular access procedures
652	\$2,154	Insertion of intraperitoneal and pleural catheters
654	\$7,229	Insertion/replacement of a permanent dual chamber pacemaker
655	\$9,685	Insertion/replacement/conversion of a permanent dual chamber pacemaker
656	\$7,403	Transcatheter placement of intracoronary drug-eluting stents
676	\$161	Thrombolysis and other device revisions
690	\$35	Level I electronic analysis of devices
2616	\$15,716	Brachytx, non-str, Yttrium-90

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Category C-Code Reference Guide 2012

Interventional Cardiology and Peripheral Interventions

Background: C-Codes are used for hospital outpatient device reporting for Medicare and some private payers. A limited number of C-Codes are eligible for additional pass-through payment from Medicare for the associated device. Medicare mandated reporting of certain C-Codes for device categories with edits mapped to corresponding CPT®¹ codes starting January 1, 2005 and additional edits are added quarterly (see effective date).

C-Codes are VERY important to future reimbursement. Use of all applicable C-Codes on a claim allows identification of device(s) utilized in a procedure and may affect future payment rates.

Coronary

Category C-Codes ²	Category C-Code Description ²	Edit Effective Date	APC ³
C1724	Catheter, transluminal atherectomy, rotational	April 1, 2005	82
C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	April 1, 2005	83
C1753	Catheter, intravascular ultrasound	October 1, 2005	
C1769	Guide Wire	October 1, 2005	82
C1874	Stent, coated/covered, with delivery system	April 1, 2005	83
		October 1, 2005	104, 656
C1876	Stent, noncoated/noncovered, with delivery system	April 1, 2005	83
		October 1, 2005	104
C1884	Embolization protective system		
C1885	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	April 1, 2005	82, 83
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, nonlaser	October 1, 2005	84

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² Source: http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage

³ Source: Device Edits, http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage. October 2009 procedure-to-Device Edit

Peripheral			
Category C-Codes ²	Category C-Code Description ²	Edit Effective Date	APC ³
C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	October 1, 2005	83
C1753	Catheter, intravascular ultrasound		
C1757	Catheter, thrombectomy, embolectom	October 1, 2005	653
C1769	Guide Wire	April 1, 2005	83
C1874	Stent, coated/covered, with delivery system	April 1, 2005	83
		October 1, 2005	229
C1876	Stent, non-coated/non-covered, with delivery system	April 1, 2005	83
		October 1, 2005	229
C1880	Vena Cava Filter		
C1884	Embolization protective system		
C1887	Catheter, guiding (may include infusion/perfusion capability)	April 1, 2005	82
C2628	Catheter, occlusion	April 1, 2005	82

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² Source: http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage

³ Source: Device Edits, http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage. October 2009 procedure-to-Device Edit

ICD-9-CM Code Reference Table

To return to the place last viewed: *Alt+left arrow or right click mouse and select previous view*

ICD-9-CM Code	Code Description
00.21	Intravascular imaging of extracranial cerebral vessels
00.22	Intravascular imaging of intrathoracic vessels
00.23	Intravascular imaging of peripheral vessels
00.24	Intravascular imaging of coronary vessels
00.28	Intravascular imaging, other specified vessel(s)
00.29	Intravascular imaging unspecified 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
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
00.59	Intravascular pressure measurement of coronary arteries
00.61	Percutaneous angioplasty or atherectomy of precerebral, extracranial vessel(s)
00.63	Percutaneous insertion of carotid artery stent(s)
00.66	Percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy
00.69	Intravascular pressure measurement, other specified and unspecified vessels
17.55	Transluminal coronary atherectomy
17.71	Non-coronary intra-operative fluorescence vascular angiography [IFVA]
31.93	Replacement of laryngeal or tracheal stent
31.99	Other operations on trachea
35.05	Endovascular replacement of aortic valve

35.06	Transapical replacement of aortic valve
35.07	Endovascular replacement of pulmonary valve
35.08	Transapical replacement of pulmonary valve
35.09	Endovascular replacement of unspecified heart valve
35.97	Percutaneous mitral valve repair with implant
36.06	Insertion of non-drug-eluting coronary artery stent(s)
36.07	Insertion of drug-eluting coronary artery stent(s)

ICD-9-CM Code Reference Table – continued

To return to the place last viewed: *Alt+left arrow or right click mouse and select previous view*

ICD-9-CM Code	Code Description
37.21	Right heart cardiac catheterization
37.22	Left heart cardiac catheterization
37.23	Combined right and left heart cardiac catheterization
38.03	Incision of upper limb vessels
38.05	Incision of other thoracic vessels
38.70	Interruption of the vena cava
38.80	Other surgical occlusion of vessels, unspecified site
38.91	Arterial catheterization
39.10	Intra-abdominal venous shunt
39.27	Arteriovenostomy for renal dialysis
39.42	Revision of arteriovenous shunt for renal dialysis
39.49	Other revision of vascular procedure
39.50	Angioplasty or atherectomy of other non-coronary vessel(s)
39.90	Insertion of non-drug-eluting peripheral (non-coronary) vessel stent(s)
39.94	Replacement of vessel-to-vessel cannula
51.43	Insertion of choledochohepatic tube for decompression
51.87	Endoscopic insertion of stent (tube) into the bile duct

51.98	Other percutaneous procedures on biliary tract
51.99	Other operations on biliary tract
55.29	Other diagnostic procedures on kidney
88.40	Arteriography using contrast material, unspecified site
88.45	Arteriography of renal arteries
88.47	Arteriography of other intra-abdominal arteries
88.48	Arteriography of femoral and other lower extremity arteries
88.49	Arteriography of other specified sites

ICD-9-CM Code Reference Table – continued

To return to the place last viewed: *Alt+left arrow or right click mouse and select previous view*

ICD-9-CM Code Code Description

88.52	Angiocardiology of: pulmonary valve, right atrium, right ventricle (outflow tract)
88.53	Angiocardiology of: aortic valve, left atrium, left ventricle (outflow tract)
88.54	Combined right and left heart angiocardiology
88.55	Coronary arteriography using a single catheter
88.56	Coronary arteriography using two catheters
88.57	Coronary arteriography NOS
92.21	Superficial radiation
97.05	Replacement of stent (tube) in biliary or pancreatic duct
97.15	Replacement of wound catheter
99.29	Injection or infusion of other therapeutic or prophylactic substance

Disclaimer

Please note: this coding information may include some 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.

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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 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.

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