2015 Procedural Reimbursement Guide--Select Percutaneous Coronary Interventions

Interventional Cardiology

Procedural Payment Guide

This Procedural Payment Guide for interventional cardiology procedures provides coding and reimbursement information for physicians and healthcare facilities.

The codes included in this guide are intended to represent typical interventional cardiology 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 interventional cardiology 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 if you have any questions about the information in these materials. You can also find reimbursement updates on our website, www.bostonscientific.com/reimbursement.

Physician Billing and Payment: Medicare and most other insurers typically reimburse physicians based on fee schedules tied to Current Procedural Terminology[1] (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 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. Rates referenced in these guides do not reflect Sequestration, automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates through March 31, 2015. While CMS is mandated by law to reduce payment by 21.2% effective April 1, 2015, the expectation is that Congress will once again provide a short term fix to minimize the SGR which may impact rates for the remainder of 2015.

Hospital Outpatient Billing and Payment: Medicare reimburses hospitals for outpatient stays (typically stays of less than two midnights) 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. Some Comprehensive APCs in 2015 packages payments for items and service rather than separate multiple payments for each individual service. Comprehensive APCs will reimburse a single all-inclusive payment for the primary service with no additional reimbursement for additional adjunctive services and supplies used during the delivery of the primary procedure and applies to percutaneous coronary interventions.

Hospitals are encouraged 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 OPPS. This reporting provides claims data used annually to update the OPPS payment rates.

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. Effective October 1, 2013, Medicare implemented two-midnight stay guidance. Inpatient admittance is presumed to be appropriate if a physician expects a beneficiary's surgical procedure, diagnostic test or other treatment to require a stay in the hospital lasting at least two midnights, and admits the beneficiary to the hospital based on that expectation. Documentation in the medical record must support a reasonable expectation of the need for the beneficiary to require a medically necessary stay lasting at least two midnights. If the inpatient admission lasts fewer than two midnights due to an unforeseen circumstance this also must be clearly documented in the medical record.

ASC Billing and Payment: Many elective procedures are performed outside of the hospital in Medicare certified facilities also known as Ambulatory Surgical Center (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.

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. This information is provided for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges, and modifiers for services that are rendered. Boston Scientific recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

[1] CPT Disclaimer

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***National Average Medicare physician payment rates calculated using the 2015 conversion factor of $35.8013 and CY2015 Final Rule Addendum B**

	CPT®[1] Code	CPT Description[1]	Physician: 2015 Medicare National Average Physician Payment[2] In-Facility	Physician: Work RVUs	Hospital: Outpatient: APC Category and 2015 Medicare National Average Outpatient Hospital Payment[3]	Hospital: Inpatient: ICD-9-CM Procedure Codes[4]	Hospital: Inpatient: Possible MS-DRG Assignments and 2015 Medicare National Average Inpatient Hospital Payment[5]
Diagnostic Cardiac Catheterization							
Use physician modifier -26 as appropriate							
Right	**93451**	Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed	**$149**	2.72	**80:** Diagnostic cardiac catheterization **$2,575**	**37.21:** Right heart cardiac catheterization **37.22:** Left heart cardiac catheterization **37.23:** Combined right and left heart cardiac catheterization **38.91**: Arterial catheterization **88.50:** Angiocardiography, not otherwise specified **88.53:** Angiocardiography of left heart structures	**216:** Cardiac valve & other major cardiothoracic procedures with cardiac catheterization with MCC **$55,862** **217:** Cardiac valve & other major cardiothoracic procedures with cardiac catheterization with CC **$37,123** **218:** Cardiac valve & other major cardiothoracic procedures with cardiac catheterization without CC/MCC **$32,667** **222:** Cardiac defibrillator implant with cardiac catheterization with AMI/HF/Shock with MCC[6] **$50,777** **223:** Cardiac defibrillator implant with cardiac catheterization with AMI/HF/Shock without MCC[6] **$36,908** **224:** Cardiac defibrillator implant with cardiac cath without AMI/HF/Shock with MCC[6] **$45,008** **225:** Cardiac defibrillator implant with cardiac catheterization without AMI/HF/Shock without MCC[6] **$34,378** **233:** Coronary bypass with cardiac cath with MCC **$43,107** **234:** Coronary bypass with cardiac catheterization without MCC **$28,633** **286:** Circulatory disorders except AMI, with cardiac catheterization with MCC **$12,458** **287:** Circulatory disorders except AMI, with cardiac catheterization without MCC **$6,622** Atherosclerosis with MCC **302:** Atherosclerosis with MCC **$6,048** **303:** Atherosclerosis with without MCC **$3,579**
Left	**93452**	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	**$262**	4.75			
	93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)	**$215**	3.73			
Combined	**93453**	Combined right heart cath and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed	**$345**	6.24			
	93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	**$451**	8.34			
	93532	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	**$560**	9.99			
	93533	Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies	**$374**	6.69			
Placement	**93454**	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	**$263**	4.79			
	93455	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	**$305**	5.54			
	93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	**$339**	6.15			
	93457	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	**$379**	6.89			
	93458	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	**$321**	5.85			
	93459	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	**$362**	6.60			
	93460	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	**$403**	7.35			
	93461	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	**$446**	8.10			

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Injection with Diagnostic Cardiac Catheterization						
Each site may be injected multiple times, only report each code once						
+ 93563	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)	**$61**	1.11	Status N, items and services packaged Into the primary procedure APC Rate. No separate payment.	**88.50:** Angiocardiography, not otherwise specified **88.53:** Angiocardiography of left heart structures **92.28:** Injection or instillation of radioisotopes	NA[8]
+ 93564	Injection procedure during cardiac catheterization including imaging supervision, 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)	**$63**	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)	**$48**	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)	**$48**	0.86			
93567	Injection procedure during cardiac catheterization including imaging supervision and interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)	**$54**	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)	**$49**	0.88			
Coronary Angioplasty (PTCA), without Stent ***(See page 10 for APC Complexity Adjustment Code Combinations)***						
Billed in conjunction with Procedure Code. Use physician modifier -26 as appropriate						
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	**$564**	10.10	**83:** Coronary angioplasty, valvuloplasty and Level I endovascular revascularization of the lower extremity **$4,537**	**00.66:** Percutaneous transluminal coronary angioplasty	**250:** Percutaneous cardiovascular procedures without coronary artery stent with MCC **$17,529** **251:** Percutaneous cardiovascular procedures without coronary artery stent without MCC **$11,965**
+ 92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	**$0.00**	0.00	**N/A**		
Coronary Atherectomy, without Stent ***(See page 10 for APC Complexity Adjustment Code Combinations)***						
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	**$670**	11.99	**229:** Level II Endovascular Procedures **$9,624**	**17.55:** Transluminal coronary atherectomy	**250:** Percutaneous cardiovascular procedures without coronary artery stent with MCC **$17,529** **251:** Percutaneous cardiovascular procedures without coronary artery stent without MCC **$11,965**
+ 92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	**$0.00**	0.00	**N/A**		

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Non-Drug-Eluting Stent with Angioplasty (PTCA) ***(See page 10 for APC Complexity Adjustment Code Combinations)***						
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	**$627**	11.21	**229:** Level II Endovascular procedures **$9,624**	**36.06:** Insertion of non-drug-eluting coronary artery stent(s) **00.66:** Percutaneous transluminal coronary angioplasty Code Also: **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	**248:** Percutaneous cardiovascular proc w non-drug-eluting stent with MCC or 4+ vessels/stents **$17,838** **249:** Percutaneous cardiovascular proc w non-drug-eluting stent without MCC **$11,032**
+ 92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	**$0.00**	0.00	**N/A**		
Drug-Eluting Stent with Angioplasty (PTCA) ***(See page 10 for APC Complexity Adjustment Code Combinations)***						
C9600	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	**NA Physicians Use 92928**	NA	**229:** Level II Endovascular procedures **$9,624**	**36.07:** Insertion of drug-eluting coronary artery stent(s) **00.66:** Percutaneous transluminal coronary angioplasty Code Also: **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	**246:** Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents **$18,985** **247:** Percutaneous cardiovascular proc with drug eluting stent without MCC **$12,075**
+ C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	**NA Physicians Use +92929**	NA	**N/A**		

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Non-Drug-Eluting Stent with Atherectomy						
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	**$700**	12.54	**319:** Level III endovascular procedures **$14,841**	**36.06:** Insertion of non-drug-eluting coronary artery stent(s) **17.55:** Transluminal coronary atherectomy Code Also: **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	**248:** Percutaneous cardiovascular proc w non-drug-eluting stent with MCC or 4+ vessels/stents **$17,838** **249:** Percutaneous cardiovascular proc w non-drug-eluting stent without MCC **$11,032**
+ 92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure	**$0.00**	0.00	**N/A**		
Drug-Eluting Stent with Atherectomy						
C9602	Percutaneous transluminal coronary atherectomy, with drug-eluting coronary intracoronary stent, angioplasty when performed; single major coronary artery or branch	**NA Physicians Use 92933**	NA	**319:** Level III Endovascular procedures **$14,841**	**36.07:** Insertion of drug-eluting coronary artery stent(s) **17.55** Transluminal coronary atherectomy Code Also **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	**246:** Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents **$18,985** **247:** Percutaneous cardiovascular proc with drug eluting stent without MCC **$12,075**
+C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure	**NA Physicians Use 92934**	NA	**N/A**		

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Non-Drug-Eluting Stent Coronary Revascularization						
Bypass Graft						
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	**$626**	11.20	**229:** Level II Endovascular procedures **$9,624**	**36.06:** Insertion of non-drug-eluting coronary artery stent(s) **00.66:** Percutaneous transluminal coronary angioplasty **17.55** **T**ransluminal coronary atherectomy **Code Also:** **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	**248:** Percutaneous cardiovascular proc with non-drug-eluting stent with MCC or 4+ vessels/stents **$17,838** **249:** Percutaneous cardiovascular proc with non-drug-eluting stent without MCC **$11,032**
+ 92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)	**$0.00**	0.00	**N/A**		
Acute Myocardial Infarction						
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	**$702**	12.56	**229:** Level II Endovascular procedures **$9,624**		
Chronic Total Occlusion						
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	**$701**	12.56	**229:** Level II Endovascular procedures **$9,624**		
+ 92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	**$0.00**	0.00	**N/A**		
Drug-Eluting Stent Coronary Revascularization						
Bypass Graft *(See page 10 for APC Complexity Adjustment Code Combinations)*						
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	**NA Physicians Use 92937**	NA	**229:** Level II Endovascular procedures **$9,624**	**36.07:** Insertion of drug-eluting coronary artery stent(s) **00.66:** Percutaneous transluminal coronary angioplasty **17.55** Transluminal coronary atherectomy **Code Also** **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	**246:** Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents **$18,985** **247:** Percutaneous cardiovascular proc with drug eluting stent without MCC **$12,075**
+ C9605	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)	**NA Physicians Use 92938**	NA	**N/A**		
Acute Myocardial Infarction						
C9606	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	**NA Physicians Use 92941**	NA	**319:** Level III Endovascular procedures **$14,841**		
Chronic Total Occlusion						
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	**NA Physicians Use 92943**	NA	**319:** Level III Endovascular procedures **$14,841**		
+ C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	**NA Physicians Use 92944**	NA	**N/A**		

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		Physician		*Hospital*		
				Outpatient	*Inpatient*	
CPT®[1] Code	**CPT Description[1]**	**2015 Medicare National Average Physician Payment[2] In-Facility**	**Work RVUs**	**APC Category and 2015 Medicare National Average Outpatient Hospital Payment[3]**	**ICD-9-CM Procedure Codes[4]**	**Possible MS-DRG Assignments and 2015 Medicare National Average Inpatient Hospital Payment[5]**
Intravascular Ultrasound						
Use physician modifier -26 as appropriate						
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)	**$100**	1.80	Status N, Items and Services Packaged Into the primary procedure APC Rate. No Separate Payment.	**00.24:** Intravascular imaging of coronary vessels **00.28:** Intravascular imaging, other specified vessel(s) **00.29:** Intravascular imaging unspecified vessel(s)	**231:** Coronary bypass with PTCA with MCC **$45,309** **232:** Coronary bypass with PTCA without MCC **$32,833** **246:** Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents **$18,985** **247:** Percutaneous cardiovascular proc with drug-eluting stent without MCC **$12,075** **248:** Percutaneous cardiovascular proc with non-drug-eluting stent with MCC or 4+ vessels/stents **$17,838** **249:** Percutaneous cardiovascular proc with non-drug eluting stent without MCC **$11,032** **250:** Percutaneous cardiovascular procedure without coronary artery stent with MCC **$17,529** **251:** Percutaneous cardiovascular procedures without coronary artery stent without MCC **$11,965** **286:** Circulatory disorders except AMI, with cardiac catheterization with MCC **$12,458** **287:** Circulatory disorders except AMI, with cardiac catheterization without MCC **$6,622**
92979	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)	**$80**	1.44			
Fractional Flow Reserve (FFR)						
Use physician modifier -26 as appropriate						
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)	**$100**	1.80	Status N, Items and Services Packaged Into the primary procedure APC Rate. No Separate Payment.	**00.59:** Intravascular pressure measurement of coronary arteries **00.69:** Intravascular pressure measurement, other specified and unspecified vessels	
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)	**$80**	1.44			
Intravascular Ultrasound (Peripheral Interventions)						
Use physician modifier -26 as appropriate						
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**	2.10	Status N, items and services packaged into APC rate. No separate payment.	**00.21**: Intravascular imaging of extracranial cerebral vessels **00.22:** Intravascular imaging of intrathoracic vessels **00.23:** Intravascular imaging of peripheral vessels **00.28:** Intravascular imaging, other specified vessel(s) **00.29**: Intravascular imaging, unspecified vessel(s)	**252:** Other vascular procedures w\ MCC **$19,148** **253:** Other vascular procedures w\CC **$14,976** **254:** Other vascular procedures without CC/MCC **$10,150** **299:** Peripheral vascular disorders with MCC **$8,267** **300:** Peripheral vascular disorders w\CC **$5,731** **301:** Peripheral vascular disorders without CC/MCC **$3,974**
75945*	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel	**$20**	0.40	*Items and services packaged into primary procedure APC rate if same date. Otherwise APC 267 applies		
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)	**$83**	1.60	Status N, items and services packaged into APC rate. No separate payment.		
75946	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)	**$20**	0.40			

See Page 9 for Sources and Footnotes.

See page 1 for important information about the uses and limitations of this document.

Inpatient information effective through Sept 30, 2015.
APC information effective through Dec 31, 2015.
Physician fee information effective through Mar 31, 2015.
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 sources for appropriate coding options.

***National Average Medicare physician payment rates calculated using the 2015 conversion factor of $35.8013 and CY2015 Final Rule Addendum B**

		Physician		***Hospital***		
				Outpatient	***Inpatient***	
CPT®[1] Code	**CPT Description[1]**	**2015 Medicare National Average Physician Payment[2] In-Facility**	**Work RVUs**	**APC Category and 2015 Medicare National Average Outpatient Hospital Payment[3]**	**ICD-9-CM Procedure Codes[4]**	**Possible MS-DRG Assignments and 2015 Medicare National Average Inpatient Hospital Payment[5]**
Thrombectomy						
+92973	Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)	**$183**	3.28	**N/A**	**36.09** Other removal of coronary obstruction	**246:** Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents **$18,985** **247:** Percutaneous cardiovascular proc with drug-eluting stent without MCC **$12,075** **248:** Percutaneous cardiovascular proc with non-drug-eluting stent with MCC or 4+ vessels/stents **$17,838** **249:** Percutaneous cardiovascular proc with non-drug eluting stent without MCC **$11,032** **250:** Percutaneous cardiovascular procedure without coronary artery stent with MCC **$17,529** **251:** Percutaneous cardiovascular procedures without coronary artery stent w/o MCC **$11,965**
Percutaneous Balloon Valvuloplasty; Aortic Valve						
92986	Percutaneous balloon valvuloplasty; aortic valve	**$1,377**	22.85	**83:** Coronary angioplasty, valvuloplasty and Level I endovascular revascularization of the lower extremity **$4,537**	**35.96:** Percutaneous balloon valvuloplasty	**231:** Coronary bypass with PTCA with MCC **$45,309** **232:** Coronary bypass with PTCA without MCC **$32,833** **246:** Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents **$18,985** **247:** Percutaneous cardiovascular proc with drug-eluting stent without MCC **$12,075** **248:** Percutaneous cardiovascular proc with non-drug-eluting stent with MCC or 4+ vessels/stents **$17,838** **249:** Percutaneous cardiovascular proc with non-drug eluting stent without MCC **$11,032** **250:** Percutaneous cardiovascular procedure without coronary artery stent with MCC **$17,529** **251:** Percutaneous cardiovascular procedures without coronary artery stent without MCC **$11,965**
92987	Percutaneous balloon valvuloplasty; mitral valve	**$1,420**	23.63	**229:** Level II Endovascular procedures **$9,624**		
92990	Percutaneous balloon valvuloplasty; pulmonary valve	**$1,123**	18.27	**229:** Level II Endovascular procedures **$9,624**		

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***National Average Medicare physician payment rates calculated using the 2015 conversion factor of $35.8013 and CY2015 Final Rule Addendum B**

	CPT®[1] Code	CPT Description[1]	Physician: 2015 Medicare National Average Physician Payment[2] In-Facility	Physician: Work RVUs	Hospital: Outpatient: APC Category and 2015 Medicare National Average Outpatient Hospital Payment[3]	Hospital: Inpatient: ICD-9-CM Procedure Codes[4]	Hospital: Inpatient: Possible MS-DRG Assignments and 2015 Medicare National Average Inpatient Hospital Payment[5]
Endovascular or Transthoracic Valves							
Aortic	**33361**	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; percutaneous femoral artery approach	**$1,408**	25.13	**N/A** **Inpatient Only Procedure**	**35.05** Endovascular replacement of aortic valve **35.09** Endovascular Replacement of unspecified heart valve	**266:** Endovascular cardiac valve replacement with MCC **$52,742** **267:** Endovascular cardiac valve replacement without MCC **$39,602**
	33362	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open femoral artery approach	**$1,539**	27.52			
	33363	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open axillary artery approach	**$1,617**	28.50			
	33364	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open iliac artery approach	**$1,676**	30.00			
	33365	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; transaortic approach (e.g., median sternotomy, mediastinotomy)	**$1,845**	33.12			
	33366	Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transapical exposure (eg. left thoracotomy)	**$2,011**	35.88		**39.61** Extracorporeal circulation auxiliary to open heart surgery	
	+ 33367	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (e.g., femoral vessels) (list separately in addition to code for primary procedure)	**$647**	11.88			
	+ 33368	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (e.g., femoral, iliac, axillary vessels) (list separately in addition to code for primary procedure)	**$777**	14.39			
	+ 33369	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (e.g., aorta, right atrium, pulmonary artery) (list separately in addition to code for primary procedure)	**$1,026**	19.00		**35.06** Transapical replacement of aortic valve	
Pulmonary	**0262T**	Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach	**Carrier Priced**	NA		**35.07** Endovascular replacement of pulmonary valve 35.09 Endovascular Replacement of unspecified heart valve	
	33999	Unlisted cardiac surgery	**Carrier Priced**		**70:** Thoracentesis/ Lavage Procedures **$489**	**35.08** Transapical replacement of pulmonary valve **35.09** Endovascular Replacement of unspecified heart valve	
Mitral	**93799**	Unlisted cardiovascular service or procedure	**Carrier Priced**	0.00	**97:** Level I noninvasive physiologic studies **$70**	**35.97** Percutaneous mitral valve repair with implant **35.09** Endovascular Replacement of unspecified heart valve	**250:** Percutaneous cardiovascular procedures without coronary artery stent with MCC **$17,529** **251:** Percutaneous cardiovascular procedures without coronary artery stent without MCC **$11,965**

1. *Current Procedural Terminology (CPT)* © 2014 American Medical Association. All Rights Reserved. All rights reserved. CPT is a registered trademark of the American Medical Association.

2. Sources: CMS Physician Fee Schedule CY2015 Final Rule (CMS-1612-FC) Addendum B found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html. Rates subject to change and do not reflect the projected 2015 Sustainable Growth Rate (SGR) reduction or 21..2% 2015 National Average Medicare physician payment rates calculated using a conversion factor $35.8013 and are effective through March 31, 2015.

3. Source: CMS website. CY2015 OPPS Final Rule (CMS-1613-FC) Addendum B http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html?DLPage=1&DLSort=2&DLSortDir=descending.

4. Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2013. Craig D. Puckett, Fifth Edition.

5.Source: August 1, 2014 updated data tables (FY2015 IPPS Final Rule--CMS-1607-F). 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 ($5,865.48). 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). http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Final-Rule-Home-Page.html.

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.

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2015 Complexity Adjustment Interventional Cardiology Code Combinations for Comprehensive APCs (c-APCs) 83, 229, and 319

APC	Description		CY 2015 Final Payment
Interventional Cardiology PCI Base APCs and National Average Payment			
83	Level I Endovascular Procedures		$4,537
229	Level II Endovascular Procedures		$9,624
319	Level III Endovascular Procedures		$14,841

Complexity Adjustment CPT® Combinations (83 base code plus second CPT equals APC 229 payment)

Primary HCPCS Code	Primary Short Descriptor	Primary SI	Primary Code Base APC Assignment	Secondary or Device Add-on HCPCS Code	Secondary Short Descriptor	Secondary SI	Secondary Code Base APC Assignment	Complexity Adjusted APC Assignment
92920	Prq cardiac angioplast 1 art	J1	0083	**92920**	Prq cardiac angioplast 1 art	J1	0083	**0229**
92920	Prq cardiac angioplast 1 art	J1	0083	**92921**	Prq cardiac angio addl art	N		**0229**

Complexity Adjustment CPT Combinations (229 base code plus second CPT equals APC 319 payment)

Primary HCPCS Code	Primary Short Descriptor	Primary SI	Primary Code Base APC Assignment	Secondary or Device Add-on HCPCS Code	Secondary Short Descriptor	Secondary SI	Secondary Code Base APC Assignment	Complexity Adjusted APC Assignment
92928	Prq card stent w/angio 1 vsl	J1	0229	**C9601**	Perc drug-el cor stent bran	N		**0319**
C9600	Perc drug-el cor stent sing	J1	0229	**33208**	Insrt heart pm atrial & vent	J1	0089	**0319**
C9600	Perc drug-el cor stent sing	J1	0229	**33210**	Insert electrd/pm cath sngl	J1	0090	**0319**
C9600	Perc drug-el cor stent sing	J1	0229	**37221**	Iliac revasc w/stent	J1	0229	**0319**
C9600	Perc drug-el cor stent sing	J1	0229	**37236**	Open/perq place stent 1st	J1	0229	**0319**
C9600	Perc drug-el cor stent sing	J1	0229	**92924**	Prq card angio/athrect 1 art	J1	0229	**0319**
C9600	Perc drug-el cor stent sing	J1	0229	**C9600**	Perc drug-el cor stent sing	J1	0229	**0319**
C9600	Perc drug-el cor stent sing	J1	0229	**C9601**	Perc drug-el cor stent bran	N		**0319**
C9600	Perc drug-el cor stent sing	J1	0229	**C9605**	Perc d-e cor revasc t cabg b	N		**0319**
C9604	Perc d-e cor revasc t cabg s	J1	0229	**C9600**	Perc drug-el cor stent sing	J1	0229	**0319**
C9604	Perc d-e cor revasc t cabg s	J1	0229	**C9601**	Perc drug-el cor stent bran	N		**0319**
C9604	Perc d-e cor revasc t cabg s	J1	0229	**C9604**	Perc d-e cor revasc t cabg s	J1	0229	**0319**
C9604	Perc d-e cor revasc t cabg s	J1	0229	**C9605**	Perc d-e cor revasc t cabg b	N		**0319**

APC 319 is Highest Level in the Vascular family, payment is capped at the 319 level

Complexity Adjustment Combinations (CMS Defined Combination based on Cost) are Two CPT combinations identified that high cost results in next highest APC vascular family payment when billed together

Note:

1. All complexity adjustment stay in the same "Comprehensive" family
2. IC and PI APCs 83, 229 and 319 are in the same Comprehensive family defined as Vascular (VASCX)
3. Status indicator J1 identifies c-APC and corresponding base codes
   In 2014 T or S result in additional multiple procedure payment, in 2015 one bundled c-APC payment
4. 2015 payment adjustments are two CPT code combinations (complexity adjustments) pre-defined by CMS based on cost
5. The highest payment, even with Complexity Adjustments is APC 319
6. Base codes in APC 319 are at the highest vascular family c-APC payment level, no additional complexity adjustments apply.

[2] *Source: CMS website. CY2015 OPPS Final Rule (CMS-1613-FC) Addendum J http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1613-FC.html?DLPage=1&DLSort=2&DLSortDir=descending.*

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Category C-Code Reference Guide 2015
Interventional Cardiology

Quarterly updates can be found on the Medicare website (http://www.cms.hhs.gov/HospitalOutpatientPPS/).

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.

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-Code[2]	**Category C-Code Description[2]**
C1724	**Catheter, transluminal atherectomy, rotational**
C1725	**Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)**
C1753	**Catheter, intravascular ultrasound**
C1757	**Catheter, Embolectomy/thrombectomy**
C1769	**Guide Wire**
C1874	**Stent, coated/covered, with delivery system**
C1876	**Stent, noncoated/noncovered, with delivery system**
C1884	**Embolization protective system**
C1887	**Catheter, guiding (may include infusion/perfusion capability)**
C1894	**Introducer/sheath, other than guiding, other than intracardiac electrophysiological, nonlaser**

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. Health economics and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules and policies. This information is provided for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges, and modifiers for services that are rendered. Boston Scientific recommends that you consult with your payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

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We welcome your feedback. Please send comments to lorenzd@bsci.com

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[2] *Source: Device Edits; http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/device_procedure.html*

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