

# 2009 Procedural Reimbursement Guide

## Select Percutaneous Cardiovascular Interventions



***This Procedural Reimbursement Guide for percutaneous coronary and peripheral interventional procedures provides coding and reimbursement information for physicians and facilities.***

The codes included in this guide are intended to represent typical percutaneous cardiovascular (coronary and peripheral) 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 and peripheral interventional procedures, the FDA-approved/cleared labeling for all products will 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, and/or proportion of low-income patients. Please feel free to contact the Boston Scientific reimbursement department at 1-800-553-5878 ext. 2801 if you have any questions about the information in these materials. You can also find reimbursement updates on our website, [www.bostonscientific.com/reimbursement](http://www.bostonscientific.com/reimbursement).

**Important – Please Note:** Reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice. Boston Scientific makes no representation or warranty regarding this information or its completeness, accuracy, timeliness, or applicability with a particular patient. Boston Scientific specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. Boston Scientific encourages providers to submit accurate and appropriate claims for services. Laws, regulations and payer policies concerning reimbursement are complex and change frequently. Providers are responsible for making appropriate decisions relating to coding and reimbursement submissions. Accordingly, Boston Scientific recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.

If reimbursement is requested for the use of a device that could be inconsistent with (or not expressly specified in) the FDA cleared or approved labeling, please carefully consult with your billing advisors or payers for advice as some payers may have policies that make it inappropriate to submit claims for such items or related services. Boston Scientific does not promote the off-label use of our devices.

**Boston  
Scientific**

## DESCRIPTION OF PAYMENT METHODS

**Physician Billing and Payment:** Medicare and most other insurers typically reimburse physicians based on fee schedules tied to Current Procedural Terminology<sup>1</sup> (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.

**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 a procedure to an APC based on the billed CPT/HCPCS (Healthcare Common Procedural Code 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.

Medicare has identified a small subset of APCs where hospitals are required to report C-Codes with edits applied at a CPT/HCPCS code level. 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/>). See page 20 for a list of applicable Boston Scientific device-related C-Codes.

**Hospital Inpatient Billing and Payment:** Many insurers, including Medicare, define a 24-hour or longer length of stay as inpatient hospital care. A Medicare Severity Diagnosis Related Group (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 Center (ASCs). Payments made to ASCs from private insurers depend on the contract the facility has with the payer. In 2009, CMS enters the second year of a four year transition to align ASC payment rates at approximately 65% of Medicare APC hospital rates for the same procedure. 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/>.

<sup>1</sup>2008 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Coronary Interventions**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹ CPT Description¹

Physician	Facility	
	Outpatient	Inpatient
2009 Medicare National Average Physician Payment² (In-Facility)	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁴
	ICD-9-CM Procedure Codes⁴	

**Diagnostic Cardiac Catheterization (Possible Hospital Device Revenue Code: 480, 481)**

Use physician modifier -26 as appropriate

	CPT Code	CPT Description	Physician Payment	Outpatient Payment	Inpatient Payment
Right	93501	Right heart catheterization	\$170	<b>80:</b> Diagnostic cardiac catheterization <b>\$2,594</b>	<b>37.21:</b> Right heart cardiac catheterization <b>37.22:</b> Left heart cardiac catheterization <b>37.23:</b> Combined right and left heart cardiac catheterization <b>38.91:</b> Arterial catheterization  <b>216:</b> Cardiac valve & other major cardiothoracic procedures with cardiac catheterization with MCC <b>\$56,049</b> <b>217:</b> Cardiac valve & other major cardiothoracic procedures with cardiac catheterization with CC <b>\$38,812</b> <b>218:</b> Cardiac valve & other major cardiothoracic procedures with cardiac catheterization without CC/MCC <b>\$30,101</b> <b>222:</b> Cardiac defibrillator implant with cardiac cath with AMI/HF/Shock with MCC⁶ <b>\$48,011</b> <b>223:</b> Cardiac defibrillator implant with cardiac cath with AMI/HF/Shock without MCC⁶ <b>\$34,906</b> <b>224:</b> Cardiac defibrillator implant with cardiac cath without AMI/HF/Shock with MCC⁶ <b>\$44,155</b> <b>225:</b> Cardiac defibrillator implant with cardiac cath without AMI/HF/Shock without MCC⁶ <b>\$32,764</b> <b>233:</b> Coronary bypass with cardiac cath with MCC <b>\$38,948</b> <b>234:</b> Coronary bypass with cardiac cath without MCC <b>\$25,583</b> <b>286:</b> Circulatory disorders except AMI, with cardiac catheterization with MCC <b>\$10,977</b> <b>287:</b> Circulatory disorders except AMI, with cardiac catheterization without MCC <b>\$5,693</b>
	93508	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization	\$236		
	93530	Right heart catheterization, for congenital cardiac anomalies	\$234		
Left	93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous	\$249		
	93511	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; by cutdown	\$289		
	93514	Left heart catheterization by left ventricular puncture	\$397		
Combined	93524	Combined transseptal and retrograde left heart catheterization	\$398		
	93526	Combined right heart catheterization and retrograde left heart catheterization	\$343		
	93527	Combined right heart catheterization and transseptal left heart catheterization through intact septum (with or without retrograde left heart catheterization)	\$415		
	93528	Combined right heart catheterization with left ventricular puncture (with or without retrograde left heart catheterization)	\$493		
	93529	Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)	\$275		
	93531	Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies	\$459		
	93532	Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies	\$544		
	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	\$366		

See Page 7 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Coronary Interventions**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT®  
Code¹ CPT Description¹

Physician	Facility		
	Outpatient	Inpatient	
2009 Medicare National Average Physician Payment² (In-Facility)	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁴	
		ICD-9-CM Procedure Codes⁴	

**Injection with Diagnostic Cardiac Catheterization (Possible Hospital Device Revenue Code: 480, 481)**

Each site may be injected multiple times, only report each code once

CPT Code	CPT Description	Physician Payment	Outpatient Hospital Payment	ICD-9-CM Procedure Codes	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment
93539	Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (e.g., internal mammary), whether native or used for bypass	\$22	Status N, items and services packaged into the primary procedure APC rate. No separate payment.	<b>88.52:</b> Angiocardiology of: pulmonary valve, right atrium, right ventricle (outflow tract)  <b>88.53:</b> Angiocardiology of: aortic valve, left atrium, left ventricle (outflow tract)  <b>88.54:</b> Combined right and left heart angiocardiology  <b>88.55:</b> Coronary arteriography using a single catheter  <b>88.56:</b> Coronary arteriography using two catheters  <b>88.57:</b> Coronary arteriography NOS	N/A⁸
93540	Injection procedure during cardiac catheterization; for selective opacification of aortocoronary venous bypass grafts, one or more coronary arteries	\$24			
93541	Injection procedure during cardiac catheterization; for pulmonary angiography	\$16			
93542	Injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography	\$16			
93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography	\$16			
93544	Injection procedure during cardiac catheterization; for aortography	\$14			
93545	Injection procedure during cardiac catheterization; for selective coronary angiography (injection of radiopaque material may be by hand)	\$22			

**Radiological S&I Following Injection with Diagnostic Cardiac Catheterization (Possible Hospital Device Revenue Code: 480, 481)**

Billed in conjunction with Procedure Code. Use physician modifier -26 as appropriate

CPT Code	CPT Description	Physician Payment	Outpatient Hospital Payment	ICD-9-CM Procedure Codes	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment
93555	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; ventricular and/or atrial angiography	\$45	Status N, items and services packaged into the primary procedure APC rate. No separate payment.	N/A⁷	N/A⁸
93556	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)	\$46			

**Coronary Angioplasty (PTCA), Percutaneous (Possible Hospital Device Revenue Code: 272)**

CPT Code	CPT Description	Physician Payment	Outpatient Hospital Payment	ICD-9-CM Procedure Codes	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment
92982	Percutaneous transluminal coronary balloon angioplasty; single vessel	\$629	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>	<b>00.66:</b> Percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy	<b>250:</b> Percutaneous cardiovascular procedures without coronary artery stent with MCC <b>\$16,610</b>  <b>251:</b> Percutaneous cardiovascular procedures without coronary artery stent without MCC <b>\$8,905</b>
92984	Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)	\$168			

**Coronary Atherectomy, Percutaneous (Possible Hospital Device Revenue Code: 272)**

CPT Code	CPT Description	Physician Payment	Outpatient Hospital Payment	ICD-9-CM Procedure Codes	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment
92995	Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel	\$693	<b>82:</b> Coronary or non-coronary atherectomy <b>\$5,962</b>	<b>00.66:</b> Percutaneous transluminal coronary angioplasty (PTCA) or coronary atherectomy	<b>250:</b> Percutaneous cardiovascular procedures without coronary artery stent or AMI with MCC <b>\$16,610</b>  <b>251:</b> Percutaneous cardiovascular procedures without coronary artery stent or AMI without MCC <b>\$8,905</b>
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)	\$180			

See Page 7 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Coronary Interventions**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

		Physician	Facility		
			Outpatient	Inpatient	
CPT® Code¹	CPT Description¹	2009 Medicare National Average Physician Payment² (In-Facility)	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Coronary Stent Placement, Percutaneous (Possible Hospital Device Revenue Code: 278)</b>					
92980	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	\$848	<b>104:</b> Transcatheter placement of intracoronary stents <b>\$5,638</b>	<b>36.06:</b> Insertion of non-drug-eluting coronary artery stent(s)  <b>Select additional appropriate codes:</b>  <b>00.40:</b> Procedure on single vessel  <b>00.41:</b> Procedure on two vessels  <b>00.42:</b> Procedure on three vessels  <b>00.43:</b> Procedure on four or more vessels  <b>00.44:</b> Procedure on vessel/bifurcation  <b>00.45:</b> Insertion of one vascular stent  <b>00.46:</b> Insertion of two vascular stents  <b>00.47:</b> Insertion of three vascular stents  <b>00.48:</b> Insertion of four or more vascular stents	<b>248:</b> Percutaneous cardiovascular proc with non-drug-eluting stent with MCC or 4+ ves/stent <b>\$15,573</b>  <b>249:</b> Percutaneous cardiovascular proc with non-drug-eluting stent without MCC <b>\$9,104</b>
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)	\$236			
<b>Coronary Drug-Eluting Stent Placement, Percutaneous (Possible Hospital Device Revenue Code: 278)</b>					
G0290	Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel	NA Physicians use 92980 - see coronary stent	<b>656:</b> Transcatheter placement of intracoronary drug-eluting stents <b>\$7,669</b>	<b>36.07:</b> Insertion of drug-eluting coronary artery stent(s)  <b>Select additional appropriate codes:</b>  <b>00.40:</b> Procedure on single vessel  <b>00.41:</b> Procedure on two vessels  <b>00.42:</b> Procedure on three vessels  <b>00.43:</b> Procedure on four or more vessels  <b>00.44:</b> Procedure on vessel/bifurcation  <b>00.45:</b> Insertion of one vascular stent  <b>00.46:</b> Insertion of two vascular stents  <b>00.47:</b> Insertion of three vascular stents  <b>00.48:</b> Insertion of four or more vascular stents	<b>246:</b> Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents <b>\$17,473</b>  <b>247:</b> Percutaneous cardiovascular proc with drug-eluting stent without MCC <b>\$10,620</b>
G0291	Transcatheter placement of a drug-eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel	NA Physicians use 92981 - see coronary stent			

See Page 7 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Coronary Interventions**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT®  
Code¹ CPT Description¹

Physician	Facility		
	Outpatient	Inpatient	
2009 Medicare National Average Physician Payment² (In-Facility)	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵

**Intravascular Ultrasound (Possible Hospital Device Revenue Code: 272)**

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	Status N, items and services packaged into the primary procedure APC rate. No separate payment.	<p><b>00.24:</b> Intravascular imaging of coronary vessels</p> <p><b>00.28:</b> Intravascular imaging, other specified vessel(s)</p> <p><b>00.29:</b> Intravascular imaging unspecified vessel(s)</p>	<p><b>231:</b> Coronary bypass with PTCA with MCC <b>\$42,443</b></p> <p><b>232:</b> Coronary bypass with PTCA without MCC <b>\$30,701</b></p> <p><b>246:</b> Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents <b>\$17,473</b></p> <p><b>247:</b> Percutaneous cardiovascular proc with drug-eluting stent without MCC <b>\$10,620</b></p> <p><b>248:</b> Percutaneous cardiovascular proc with non-drug-eluting stent with MCC or 4+ vessels/stents <b>\$15,573</b></p> <p><b>249:</b> Percutaneous cardiovascular proc with non-drug-eluting stent without MCC <b>\$9,104</b></p> <p><b>250:</b> Percutaneous cardiovascular procedure without coronary artery stent with MCC <b>\$16,610</b></p> <p><b>251:</b> Percutaneous cardiovascular procedures without coronary artery stent without MCC <b>\$8,905</b></p> <p><b>286:</b> Circulatory disorders except AMI, with cardiac catheterization with MCC <b>\$10,977</b></p> <p><b>287:</b> Circulatory disorders except AMI, with cardiac catheterization without MCC <b>\$5,693</b></p>
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			

**Endomyocardial Biopsy (Possible Hospital Device Revenue Code: 272)**

Use physician modifier -26 as appropriate

93505	Endomyocardial biopsy	\$246	<p><b>103:</b> Miscellaneous vascular procedures <b>\$1,039</b></p>	<p><b>37.25:</b> Biopsy of heart</p>	<p><b>001:</b> Heart transplant or implant of heart assist system with MCC <b>\$131,430</b></p> <p><b>002:</b> Heart transplant or implant of heart assist system without MCC <b>\$71,160</b></p>
-------	-----------------------	-------	---	--	---

**Embolic Protection Device (Possible Hospital Device Revenue Code: 272)**

93799	Unlisted cardiovascular service or procedure	Carrier priced	<p><b>97:</b> Cardic and ambulatory blood pressure monitoring <b>\$66</b></p>	N/A⁷	N/A⁸
-------	--	----------------	---	------	------

See Page 7 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Coronary Interventions**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

		Physician	Facility		
			Outpatient	Inpatient	
CPT® Code¹	CPT Description¹	2009 Medicare National Average Physician Payment² (In-Facility)	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Aortic and Pulmonary Valvuloplasty, Percutaneous (Possible Hospital Device Revenue Code: 272)</b>					
92986	Percutaneous balloon valvuloplasty; aortic valve	\$1,391	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>	<b>35.96:</b> Percutaneous valvuloplasty	<b>231:</b> Coronary bypass with PTCA with MCC <b>\$42,443</b>  <b>232:</b> Coronary bypass with PTCA without MCC <b>\$30,701</b>  <b>246:</b> Percutaneous cardiovascular proc with drug-eluting stent with MCC or 4+ vessels/stents <b>\$17,473</b>  <b>247:</b> Percutaneous cardiovascular proc with drug-eluting stent without MCC <b>\$10,620</b>  <b>248:</b> Percutaneous cardiovascular proc with non-drug-eluting stent with MCC or 4+ vessels/stents <b>\$15,573</b>  <b>249:</b> Percutaneous cardiovascular proc with non-drug-eluting stent without MCC <b>\$9,104</b>  <b>250:</b> Percutaneous cardiovascular procedures without coronary artery stent with MCC <b>\$16,610</b>  <b>251:</b> Percutaneous cardiovascular procedures without coronary artery stent without MCC <b>\$8,905</b>
92990	Percutaneous balloon valvuloplasty; pulmonary valve	\$1,108			

1. Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.  
 2. Sources: November 19, 2008 Federal Register. MD payments calculated using the 2009 conversion factor of \$36.0666. MD rates are effective through December 31, 2009.  
 3. Source: November 18, 2008 Federal Register.  
 4. Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2008. Craig D. Puckett, Fifth Edition.  
 5. Source: October 3, 2008 Federal Register (update). National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,552.58). (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.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description¹	Physician		Facility		
		2009 Medicare National Average Physician Payment²		Outpatient	Inpatient	
		In-Facility	In-Office	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Percutaneous Transluminal Angioplasty (Possible Hospital Device Revenue Code: 272)</b>						
35470	Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel	\$463	\$2,748	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>	<b>39.50:</b> Angioplasty or atherectomy of non-coronary vessel	<b>252:</b> Other vascular procedures with MCC <b>\$16,408</b> <b>253:</b> Other vascular procedures with CC <b>\$12,518</b> <b>254:</b> Other vascular procedures without CC/MCC <b>\$8,565</b>
35471	Transluminal balloon angioplasty, percutaneous; renal or visceral artery	\$552	\$3,019			
35472	Transluminal balloon angioplasty, percutaneous; aortic	\$370	\$2,095			
35473	Transluminal balloon angioplasty, percutaneous; iliac	\$328	\$2,001			
35474	Transluminal balloon angioplasty, percutaneous; femoral-popliteal	\$396	\$2,667			
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	\$494	\$2,157			
35476*	Transluminal balloon angioplasty, percutaneous; venous <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$1,952</b></i>	\$315	\$1,628			
G0392*	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC) <b>\$1,629</b></i>	\$449	\$2,157			
G0393*	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC) <b>\$1,629</b></i>	\$315	\$1,628			

Radiological S&I Codes - Billed in conjunction with Procedure Code. Use physician modifier -26 as appropriate

75962*	Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation <i>*CPT code assigned to APC 83, however, not paid separately in addition to the PTA procedure as it does not meet OPPS criteria for separate payment</i>	\$28	\$286	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>	N/A⁶	N/A⁷
75964	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)	\$19	\$168	Status N, items and services packaged into the primary procedure APC rate. No separate payment.		
75966*	Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation <i>*CPT code assigned to APC 83, however, not paid separately in addition to the PTA procedure as it does not meet OPPS criteria for separate payment</i>	\$69	\$335	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>		
75968	Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)	\$19	\$169	Status N, items and services packaged into the primary procedure APC rate. No separate payment.		
75978*	Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation <i>*CPT code assigned to APC 83, however, not paid separately in addition to the PTA procedure as it does not meet OPPS criteria for separate payment</i>	\$27	\$282	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>		

See Page 19 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description¹	Physician		Facility			
		2009 Medicare National Average Physician Payment²	In-Facility	In-Office	Outpatient	Inpatient	
					APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Biliary Stenting (Possible Hospital Device Revenue Code: 278)</b>							
47556	Biliary endoscopy, percutaneous via T-Tube or other tract; with dilation of biliary duct stricture(s) with stent	\$445	NA	<b>152:</b> Level I percutaneous abdominal and biliary procedures <b>\$2,009</b>	<b>51.98:</b> Other percutaneous procedures on biliary tract	<b>420:</b> Hepatobiliary diagnostic procedure with MCC <b>\$22,814</b>  <b>421:</b> Hepatobiliary diagnostic procedures with CC <b>\$10,527</b>  <b>422:</b> Hepatobiliary diagnostic procedure without CC/MCC <b>\$6,821</b>  <b>435:</b> Malignancy of hepatobiliary system or pancreas with MCC <b>\$9,553</b>  <b>436:</b> Malignancy of hepatobiliary system or pancreas with CC <b>\$6,619</b>  <b>437:</b> Malignancy of hepatobiliary system or pancreas without CC/MCC <b>\$5,292</b>  <b>444:</b> Disorders of the biliary tract with MCC <b>\$8,653</b>  <b>445:</b> Disorders of the biliary tract with CC <b>\$5,768</b>  <b>446:</b> Disorders of the biliary tract without CC/MCC <b>\$4,015</b>	

Radiological S&I Codes - Billed in conjunction with Procedure Code. Use physician modifier -26 as appropriate

74363	Percutaneous transhepatic dilation of biliary duct stricture with or without placement of stent, radiological supervision and interpretation	\$45	NA	Status N, items and services packaged into the primary procedure APC rate. No separate payment.	N/A⁶	N/A⁷
-------	--	------	----	---	------	------

See Page 19 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description¹	Physician		Facility		
		2009 Medicare National Average Physician Payment²		Outpatient	Inpatient	
		In-Facility	In-Office	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Transcatheter Placement of Carotid Stents (Possible Hospital Device Revenue Code: 278)</b>						
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection	\$1,101	NA	N/A	<b>00.61:</b> Percutaneous angioplasty or atherectomy of precerebral, extracranial vessel(s)	<b>034:</b> Carotid artery stent procedure with MCC <b>\$17,891</b>
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection	\$1,010			<b>00.63:</b> Percutaneous insertion of carotid artery stent(s)	<b>035:</b> Carotid artery stent procedure with CC <b>\$11,231</b> <b>036:</b> Carotid artery stent procedure without CC/MCC <b>\$8,702</b> <b>037:</b> Extracranial procedures with MCC <b>\$16,804</b> <b>038:</b> Extracranial procedures with CC <b>\$8,621</b> <b>039:</b> Extracranial procedures without CC/MCC <b>\$5,555</b>
<b>Transcatheter Placement of Intravascular Stents (Possible Hospital Device Revenue Code: 278)</b>						
37205*	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel	\$445	\$4,112*	<b>229:</b> Transvascular placement of intravascular shunts <b>\$6,094</b>	<b>39.90:</b> Insertion of non-drug-eluting non-coronary artery stent(s)	<b>252:</b> Other vascular procedures with MCC <b>\$16,408</b> <b>253:</b> Other vascular procedures with CC <b>\$12,518</b> <b>254:</b> Other vascular procedures without CC/MCC <b>\$8,565</b>
37206*	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	\$217	\$2,477*			
37207	Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; initial vessel	\$438	NA			
37208	Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure)	\$212				
<i>Radiological S&amp;I Codes - Billed in conjunction with Procedure Code. Use physician modifier -26 as appropriate</i>						
75960	Transcatheter introduction of intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel	\$43	\$268	Status N, items and services packaged into the primary procedure APC rate. No separate payment.	N/A⁶	N/A⁷

See Page 19 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

\*Please Note: Source December 31, 2008 Federal Register. MD payments calculated using the 2009 conversion factor of \$36.0666. MD rates are effective through December 31, 2009.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code <sup>1</sup>	CPT Description <sup>1</sup>	Physician		Facility		
		2009 Medicare National Average Physician Payment <sup>2</sup>		Outpatient	Inpatient	
		In-Facility	In-Office	APC Category and 2009 Medicare National Average Outpatient Hospital Payment <sup>3</sup>	ICD-9-CM Procedure Codes <sup>4</sup>	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment <sup>5</sup>
<b>Atherectomy, Percutaneous, Non-Coronary (Possible Hospital Device Revenue Code: 272)</b>						
35490*	Transluminal peripheral atherectomy, percutaneous; renal or other visceral artery	\$615	NA	<b>82:</b> Coronary or non-coronary atherectomy <b>\$5,962</b>	<b>39.50:</b> Angioplasty or atherectomy of non-coronary stent	<b>252:</b> Other vascular procedures with MCC <b>\$16,408</b>  <b>253:</b> Other vascular procedures with CC <b>\$12,518</b>  <b>254:</b> Other vascular procedures without CC/MCC <b>\$8,565</b>
35491*	Transluminal peripheral atherectomy, percutaneous; aortic	\$416				
35492*	Transluminal peripheral atherectomy, percutaneous; iliac	\$374				
35493*	Transluminal peripheral atherectomy, percutaneous; femoral-popliteal	\$457				
35494*	Transluminal peripheral atherectomy, percutaneous; brachiocephalic trunk or branches, each vessel	\$577				
35495*	Transluminal peripheral atherectomy, percutaneous; tibioperoneal trunk and branches	\$529				

Radiological S&I Codes - Billed in conjunction with Procedure Code. Use physician modifier -26 as appropriate

75992	Transluminal atherectomy, peripheral artery, radiological supervision and interpretation	\$28	Carrier priced	Status N, items and services packaged into the primary procedure APC rate. No separate payment.	N/A <sup>6</sup>	N/A <sup>7</sup>
75993	Transluminal atherectomy, each additional peripheral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)	\$19	NA			
75994	Transluminal atherectomy, renal, radiological supervision and interpretation	\$63				
75995	Transluminal atherectomy, visceral, radiological supervision and interpretation	\$66				
75996	Transluminal atherectomy, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)	\$18				

**Vena Cava Procedure (Possible Hospital Device Revenue Code: 278)**

37620	Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)	\$656	NA	<b>91:</b> Level II vascular ligation <b>\$2,893</b>	<b>38.7:</b> Interruption of the vena cava	<b>252:</b> Other vascular procedures with MCC <b>\$16,408</b>  <b>253:</b> Other vascular procedures with CC <b>\$12,518</b>  <b>254:</b> Other vascular procedures without CC/MCC <b>\$8,565</b>
-------	---	-------	----	--	---	--

See Page 19 for Sources and Footnotes.

<sup>1</sup>Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

\*Please Note: Boston Scientific Corporation does not have an atherectomy device that is FDA-approved for the peripheral vasculature.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code <sup>1</sup>	CPT Description <sup>1</sup>	Physician		Facility			
		2009 Medicare National Average Physician Payment <sup>2</sup>	In-Facility	In-Office	Outpatient	Inpatient	
					APC Category and 2009 Medicare National Average Outpatient Hospital Payment <sup>3</sup>	ICD-9-CM Procedure Codes <sup>4</sup>	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment <sup>5</sup>
<b>Intravascular Ultrasound (Possible Hospital Device Revenue Code: 272)</b>							
37250	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)	\$111	NA	Status N, items and services packaged into the primary procedure APC rate. No separate payment.	<b>00.21:</b> Intravascular imaging of extracranial cerebral vessels  <b>00.22:</b> Intravascular imaging of intrathoracic vessels  <b>00.23:</b> Intravascular imaging of peripheral vessels  <b>00.28:</b> Intravascular imaging, other specified vessel(s)  <b>00.29:</b> Intravascular imaging, unspecified vessel(s)	<b>252:</b> Other vascular procedures with MCC <b>\$16,408</b>  <b>253:</b> Other vascular procedures with CC <b>\$12,518</b>  <b>254:</b> Other vascular procedures without CC/MCC <b>\$8,565</b>  <b>299:</b> Peripheral vascular disorders with MCC <b>\$7,979</b>  <b>300:</b> Peripheral vascular disorders with CC <b>\$5,156</b>  <b>301:</b> Peripheral vascular disorders without CC/MCC <b>\$3,668</b>	
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					

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  *CPT code assigned to APC 267, however, not paid separately in addition to the PTA procedure as it does not meet OPPI criteria for separate payment.	\$21	NA	<b>267:</b> Level III diagnostic and screening ultrasound <b>\$153</b>	N/A <sup>6</sup>	N/A <sup>7</sup>
75946	Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)	\$21	NA	Status N, items and services packaged into the primary procedure APC rate. No separate payment.		

**Thrombectomy (Possible Hospital Device Revenue Code: 272)**

36870*	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)  *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$1,598</b>	\$303	\$1,770	<b>653:</b> Vascular reconstruction/fistula repair with device <b>\$3,095</b>  <b>88:</b> Thrombectomy <b>\$2,663</b>	<b>39.49:</b> Other revision of vascular procedure  <b>38.03:</b> Incision of upper limb vessels  <b>38.05:</b> Incision of other thoracic vessels  <b>38.91:</b> Arterial catheterization	<b>252:</b> Other vascular procedures with MCC <b>\$16,408</b>  <b>253:</b> Other vascular procedures with CC <b>\$12,518</b>  <b>254:</b> Other vascular procedures without CC/MCC <b>\$8,565</b>
34101	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision	\$611	NA			
34111	Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision	\$611				
34201	Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision	\$985				
34490*	Embolectomy or thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision  *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$1,627</b>	\$614				

See Page 19 for Sources and Footnotes.

<sup>1</sup>Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description¹	Physician		Facility		
		2009 Medicare National Average Physician Payment²		Outpatient	Inpatient	
		In-Facility	In-Office	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Catheter Access (Possible Hospital Device Revenue Code: 272)</b>						
36140	Introduction of needle or intracatheter; extremity artery	\$104	\$471	Status N, items and services packaged into APC rate. No separate payment.	N/A⁶	N/A⁷
36145	Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)	\$101	\$466			
36160	Introduction of needle or intracatheter, aortic, translumbar	\$136	\$520			
36200	Introduction of catheter, aorta	\$156	\$630			
<b>Catheter Placement (Possible Hospital Device Revenue Code: 272)</b>						
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	\$246	\$1,109	Status N, items and services packaged into APC rate. No separate payment.	N/A⁶	N/A⁷
36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	\$277	\$1,212			
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	\$333	\$1,974			
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)	\$53	\$186			
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$254	\$1,223			
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$277	\$1,202			
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$330	\$1,887			
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)	\$53	\$160			

See Page 19 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description¹	Physician		Facility		
		2009 Medicare National Average Physician Payment²		Outpatient	Inpatient	
		In-Facility	In-Office	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Angiography (Possible Hospital Device Revenue Code: 272 or 278)</b>						
75710*	Angiography, extremity, unilateral, radiological supervision and interpretation *CPT codes assigned to APC 279, however, not paid separately in addition to primary procedure as it does not meet OPPS criteria for separate payment	\$59	\$289	<b>279:</b> Level II angiography and venography <b>\$1,954</b>	<b>88.45:</b> Arteriography of renal arteries  <b>88.47:</b> Arteriography of other intra-abdominal arteries  <b>88.48:</b> Arteriography of femoral and other lower extremity arteries  <b>88.49:</b> Arteriography of other specified sites	N/A⁷
75716*	Angiography, extremity, bilateral, radiological supervision and interpretation *CPT codes assigned to APC 279, however, not paid separately in addition to primary procedure as it does not meet OPPS criteria for separate payment	\$68	\$321			
75722*	Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation *CPT codes assigned to APC 279, however, not paid separately in addition to primary procedure as it does not meet OPPS criteria for separate payment	\$60	\$285			
75724*	Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation *CPT codes assigned to APC 279, however, not paid separately in addition to primary procedure as it does not meet OPPS criteria for separate payment	\$81	\$331			
75726*	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation *CPT codes assigned to APC 279, however, not paid separately in addition to primary procedure as it does not meet OPPS criteria for separate payment	\$59	\$286			
75731*	Angiography, adrenal, unilateral, selective, radiological supervision and interpretation *CPT codes assigned to APC 279, however, not paid separately in addition to primary procedure as it does not meet OPPS criteria for separate payment	\$62	\$295			
75733*	Angiography, adrenal, bilateral, selective, radiological supervision and interpretation *CPT codes assigned to APC 279, however, not paid separately in addition to primary procedure as it does not meet OPPS criteria for separate payment	\$72	\$334			
75736*	Angiography, pelvic, selective or supraseductive, radiological supervision and interpretation *CPT codes assigned to APC 279, however, not paid separately in addition to primary procedure as it does not meet OPPS criteria for separate payment	\$60	\$288			
<b>Bronchoscopy (Possible Hospital Device Revenue Code: 278)</b>						
31631*	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with placement of tracheal stent(s) (includes tracheal/bronchial dilation as required) *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$725</b>	\$225	NA	<b>415:</b> Level II endoscopy lower airway <b>\$1,662</b>	<b>31.93:</b> Replacement of laryngeal or tracheal stent  <b>31.99:</b> Other operations on trachea	N/A⁷

See Page 19 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code <sup>1</sup>	CPT Description <sup>1</sup>	Physician		Facility			
		2009 Medicare National Average Physician Payment <sup>2</sup>	In-Facility	In-Office	Outpatient	Inpatient	
					APC Category and 2009 Medicare National Average Outpatient Hospital Payment <sup>3</sup>	ICD-9-CM Procedure Codes <sup>4</sup>	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment <sup>5</sup>
<b>Transhepatic Shunts (TIPS) (Possible Hospital Device Revenue Code: 278)</b>							
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)	\$894	NA	N/A	<b>39.1:</b> Intra-abdominal venous shunt	<b>237:</b> Major cardiovascular procedures with MCC or thoracic aortic aneurysm repair <b>\$28,174</b>	
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)	\$425		<b>229:</b> Transcatheter placement of intravascular shunts <b>\$6,094</b>		<b>238:</b> Major cardiovascular procedures without MCC <b>\$16,032</b>	
<b>Procedures on Arteriovenous Fistula (Possible Hospital Device Revenue Code: 278)</b>							
36830*	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft) <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC); \$1,121</i>	\$657	NA	<b>88:</b> Thrombectomy <b>\$2,663</b>	<b>38.03:</b> Incision of upper limb vessels <b>39.27:</b> Arteriovenostomy for renal dialysis <b>39.42:</b> Revision of arteriovenous shunt for renal dialysis <b>39.49:</b> Other revision of vascular procedure <b>39.94:</b> Replacement of vessel-to-vessel cannula	<b>252:</b> Other vascular procedures with MCC <b>\$16,408</b> <b>253:</b> Other vascular procedures with CC <b>\$12,518</b> <b>254:</b> Other vascular procedures without CC/MCC <b>\$8,565</b> <b>264:</b> Other circulatory system O.R. procedures <b>\$14,064</b>	
36831*	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure) <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC); \$1,466</i>	\$453					
36832*	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure) <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC); \$1,121</i>	\$579					
36833*	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure) <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC); \$1,121</i>	\$655					
G0392*	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; arterial <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC); \$1,629</i>	\$449	\$2,157	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>	<b>39.50:</b> Angioplasty or atherectomy of non-coronary vessel	<b>252:</b> Other vascular procedures with MCC <b>\$16,408</b> <b>253:</b> Other vascular procedures with CC <b>\$12,518</b> <b>254:</b> Other vascular procedures without CC/MCC <b>\$8,565</b>	
G0393*	Transluminal balloon angioplasty, percutaneous; for maintenance of hemodialysis access, arteriovenous fistula or graft; venous <i>*Eligible for reimbursement in the Ambulatory Surgical Center (ASC); \$1,629</i>	\$315	\$1,628				
<b>Uterine Fibroid Embolization (Possible Hospital Device Revenue Code: 272)</b>							
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	\$562	\$3,399	<b>229:</b> Transcatheter placement of intravascular shunts <b>\$6,094</b>	<b>99.29:</b> Injection or infusion of other therapeutic or prophylactic substance	<b>760:</b> Menstrual & other female reproductive system disorders with CC/MCC <b>\$4,406</b> <b>761:</b> Menstrual & other female reproductive system disorders without CC/MCC <b>\$2,789</b>	

See Page 19 for Sources and Footnotes.

<sup>1</sup>Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description¹	Physician		Facility		
		In-Facility	In-Office	Outpatient	Inpatient	
				APC Category and 2009 Medicare National Average Outpatient Hospital Payment²	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Chemoembolization of Liver Tumors (Possible Hospital Device Revenue Code: 272)</b>						
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	\$947	NA	<b>82:</b> Coronary or non-coronary atherectomy <b>\$5,962</b>	<b>99.25:</b> Injection or infusion of cancer chemotherapeutic substance	<b>435:</b> Malignancy of hepatobiliary system or pancreas with MCC <b>\$9,553</b>
96420	Chemotherapy administration, intra-arterial; push technique	\$108		<b>439:</b> Level IV drug administration <b>\$129</b>	<b>38.91:</b> Arterial catheterization  <b>88.47:</b> Arteriography of other intra-abdominal arteries	<b>436:</b> Malignancy of hepatobiliary system or pancreas with CC <b>\$6,619</b>  <b>437:</b> Malignancy of hepatobiliary system or pancreas without CC/MCC <b>\$5,292</b>  <b>846:</b> Chemotherapy without acute leukemia as secondary diagnosis with MCC <b>\$11,811</b>  <b>847:</b> Chemotherapy without acute leukemia as secondary diagnosis with CC <b>\$5,231</b>  <b>848:</b> Chemotherapy without acute leukemia as secondary diagnosis without CC/MCC <b>\$4,425</b>

Radiological S&I Codes - Billed in conjunction with Procedure Code. Use physician modifier -26 as appropriate

75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	\$68	NA	Status N, items and services packaged into primary procedure APC rate. No separate payment.	N/A⁶	N/A⁷
75898*	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion  *CPT code assigned to APC 263, however, not paid separately in addition to the embolization procedure as it does not meet OPSS criteria for separate payment	\$85		<b>263:</b> Level I miscellaneous radiology procedures <b>\$200</b>		

See Page 19 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description¹	Physician		Facility		
		2009 Medicare National Average Physician Payment²		Outpatient	Inpatient	
		In-Facility	In-Office	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Biopsy (Possible Hospital Device Revenue Code: 272)</b>						
19100*	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure) *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$207</b>	\$65	\$126	<b>04:</b> Level I needle biopsy/aspiration except bone marrow <b>\$295</b>	<b>85.11:</b> Closed (percutaneous) (needle) biopsy of breast <b>85.12:</b> Open biopsy of breast <b>87.37:</b> Other mammography	<b>584:</b> Breast biopsy, local excision and other breast procedures with CC/MCC <b>\$7,956</b> <b>585:</b> Breast biopsy, local excision and other breast procedures without CC/MCC <b>\$4,462</b>
19102*	Biopsy of breast; percutaneous, needle core, using imaging guidance *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$266</b>	\$104	\$206	<b>05:</b> Level II needle biopsy/aspiration except bone marrow <b>\$488</b>	<b>85.11:</b> Closed (percutaneous) (needle) biopsy of breast <b>85.12:</b> Open biopsy of breast <b>87.37:</b> Other mammography	N/A⁷
32405*	Biopsy, lung or mediastinum, percutaneous needle *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$356</b>	\$100	\$100	<b>685:</b> Level III needle biopsy/aspiration except bone marrow <b>\$633</b>	<b>33.26:</b> Closed (percutaneous) (needle) biopsy of lung <b>34.25:</b> Closed (percutaneous) (needle) biopsy of mediastinum	
47000*	Biopsy of liver, needle; percutaneous *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$356</b>	\$99	\$307		<b>50.11:</b> Closed (percutaneous) (needle) biopsy of liver <b>50.12:</b> Open biopsy of liver	<b>264:</b> Other circulatory system O.R. procedures <b>\$14,064</b>
50200*	Renal biopsy; percutaneous, by trocar or needle *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$356</b>	\$146	NA		<b>55.23:</b> Closed (percutaneous) (needle) biopsy of kidney <b>55.24:</b> Open biopsy of kidney	N/A⁷
55700*	Biopsy, prostate; needle or punch, single or multiple, any approach *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$402</b>	\$141	\$236	<b>184:</b> Prostate biopsy <b>\$763</b>	<b>60.11:</b> Closed (percutaneous) (needle) biopsy of prostate <b>60.12:</b> Open biopsy of prostate <b>60.91:</b> Percutaneous aspiration of prostate	
60100*	Biopsy thyroid, percutaneous core needle *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$49</b>	\$80	\$109	<b>04:</b> Level I needle biopsy/aspiration except bone marrow <b>\$295</b>	<b>6.11:</b> Closed (percutaneous) (needle) biopsy of thyroid gland	

See Page 19 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description¹	Physician		Facility			
		2009 Medicare National Average Physician Payment²	In-Facility	In-Office	Outpatient	Inpatient	
					APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵
<b>Drainage (Possible Hospital Device Revenue Code: 272)</b>							
47510*	Introduction of percutaneous transhepatic catheter for biliary drainage *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$831</b>	\$481		NA	<b>152:</b> Level I Percutaneous abdominal and biliary procedures <b>\$2,009</b>	<b>51.43:</b> Insertion of choledochohepatic tube for decompression  <b>51.98:</b> Other percutaneous procedures on biliary tract  <b>51.99:</b> Other operations on biliary tract	<b>405:</b> Pancreas, liver and shunt procedures with MCC <b>\$31,319</b> <b>406:</b> Pancreas, liver and shunt procedures with CC <b>\$15,468</b> <b>407:</b> Pancreas, liver and shunt procedures without CC/MCC <b>\$10,210</b> <b>408:</b> Biliary tract procedures except only cholecystectomy with or without C.D.E. with MCC <b>\$23,645</b> <b>409:</b> Biliary tract procedures except only cholecystectomy with or without C.D.E. with CC <b>\$14,242</b> <b>410:</b> Biliary tract procedures except only cholecystectomy with or without C.D.E. without CC/MCC <b>\$9,143</b>
47511*	Introduction of percutaneous transhepatic stent for internal and external biliary drainage *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$1,221</b>	\$604					
47525*	Change of percutaneous biliary drainage catheter *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$477</b>	\$128	\$567		<b>427:</b> Level II tube or catheter changes or repositioning <b>\$1,030</b>	<b>97.05:</b> Replacement of stent (tube) in biliary or pancreatic duct	N/A⁶
47530*	Revision and/or reinsertion of transhepatic tube *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$477</b>	\$362	\$1,363				
49420*	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$765</b>	\$130		NA	<b>652:</b> Insertion of intraperitoneal and pleural catheters <b>\$1,973</b>	<b>51.94:</b> Percutaneous abdominal drainage	
49421*	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$765</b>	\$354					
49423*	Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure) *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$630</b>	\$78	\$537		<b>427:</b> Level II tube or catheter changes or repositioning <b>\$1,030</b>	<b>97.15:</b> Replacement of wound catheter	
50392*	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous *Eligible for reimbursement in the Ambulatory Surgical Center (ASC); <b>\$542</b>	\$187		NA	<b>161:</b> Level II Cystourethroscopy and other genitourinary procedures <b>\$1,241</b>	<b>55.29:</b> Other diagnostic procedures on kidney	<b>656:</b> Kidney and ureter procedures for neoplasm with MCC <b>\$18,203</b> <b>657:</b> Kidney and ureter procedures for neoplasm with CC <b>\$10,342</b> <b>658:</b> Kidney and ureter procedures for neoplasm without CC/MCC <b>\$7,643</b> <b>659:</b> Kidney and ureter procedures for non-neoplasm with MCC <b>\$18,518</b> <b>660:</b> Kidney and ureter procedures for non-neoplasm with CC <b>\$10,505</b> <b>661:</b> Kidney and ureter procedures for non-neoplasm without CC/MCC <b>\$6,976</b>

See Page 19 for Sources and Footnotes.

¹Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

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

**PROCEDURAL REIMBURSEMENT GUIDE**

**Select Peripheral Vascular and other Interventional Procedures**

Inpatient information effective through Sept 30, 2009.  
All other information effective through Dec 31, 2009.

CPT® Code¹	CPT Description	Physician		Facility		
		2009 Medicare National Average Physician Payment²		Outpatient	Inpatient	
		In-Facility	In-Office	APC Category and 2009 Medicare National Average Outpatient Hospital Payment³	ICD-9-CM Procedure Codes⁴	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment⁵

**Drainage (Possible Hospital Device Revenue Code: 272)**

Radiological S&I Codes - Billed in conjunction with Procedure Code. Use physician modifier -26 as appropriate

CPT Code	CPT Description	In-Facility	In-Office	APC Category and 2009 Medicare National Average Outpatient Hospital Payment	ICD-9-CM Procedure Codes	Possible MS-DRG Assignments and 2009 Medicare National Average Inpatient Hospital Payment
75980	Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation	\$74	NA	Status N, items and services packaged into primary procedure APC rate. No separate payment.	N/A⁶	N/A⁷
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	\$74	NA			
75984	Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation	\$37	\$114			

1. Current Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.  
 2. Sources: November 19, 2008 Federal Register. MD payments calculated using the 2009 conversion factor of \$36.0666. MD rates are effective through December 31, 2009.  
 3. Source: November 18, 2008 Federal Register.  
 4. Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2008. Craig D. Puckett, Fifth Edition.  
 5. Source: October 3, 2008 Federal Register (update). National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5,552.58). (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. Procedure codes do not exist for this procedure because it does not drive the MS-DRG grouping.  
 7. MS-DRG grouping is driven by other primary procedures that are performed in conjunction with this procedure.

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

## CATEGORY C-CODE REFERENCE GUIDE 2009

### Interventional Cardiology and Peripheral Interventions

Effective as of October 1, 2008 with quarterly updates.

**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 certain C-Codes for device categories with edits mapped to corresponding CPT 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-Code <sup>1</sup>	Category C-Code Description <sup>1</sup>	Edit Effective Date	APC <sup>2</sup>
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, laser	April 1, 2005	82, 83
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, nonlaser	October 1, 2005	84

Peripheral			
Category C-Code <sup>1</sup>	Category C-Code Description <sup>1</sup>	Edit Effective Date	APC <sup>2</sup>
C1724	Catheter, transluminal atherectomy, rotational	April 1, 2005	82
C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	October 1, 2005	83
C1753	Catheter, intravascular ultrasound		
C1757	Catheter, thrombectomy, embolectomy	January 1, 2006	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
C1877	Stent, noncoated/noncovered, without delivery system	October 1, 2005	104
C1880	Vena Cava Filter		
C1884	Embolization protective system		
C1887	Catheter, guiding (may include infusion/perfusion capability)	April 1, 2005	82
		October 1, 2005	229
C2617	Stent, noncoronary, temporary, without delivery system	October 1, 2005	229
C2625	Stent, non-coronary, temporary, with delivery system	April 1, 2005	83
		October 1, 2005	229
C2628	Catheter, occlusion	April 1, 2005	82

<sup>1</sup>Source: [http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/DeviceCats\\_OPSPUpdate.pdf](http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/DeviceCats_OPSPUpdate.pdf)

<sup>2</sup>Source: Device Edits, [http://www.cms.hhs.gov/HospitalOutpatientPPS/02\\_device\\_procedure.asp#TopOfPage](http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage).  
October 2008 procedure-to-Device Edits

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



Boston Scientific Corporation  
One Boston Scientific Place  
Natick, MA 01760-1537  
[www.bostonscientific.com](http://www.bostonscientific.com)

© 2009 Boston Scientific Corporation  
or its affiliates. All rights reserved.

USPG5446.141.1 FEB09