

2008 Medicare Payment to Physicians and Hospitals for Carotid Artery Stenting (CAS)

Physician Payment

- The payment rates described below represent the National Average Medicare allowance for physicians according to the latest available Medicare Physician Fee Schedule; actual payments will vary by numerous factors.
- Private payers often use the Medicare Physician Fee Schedule as a benchmark for establishing their own physician payment rates, yet payment rates may be higher or lower than those published by Medicare. Moreover, non-Medicare, payers' physician payment rates vary by payer, so it is important to confirm specific payers' payment rates.

CPT® Code ¹	Code Description	2008 MD In-Facility Transitional National Average Payment ² (Effective 1/1/08-06/30/08)
37215	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection	\$1,061
37216	Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; without distal embolic protection (Note: Medicare does not cover this procedure)	\$950

Hospital Payment

- Payments for hospital inpatient services under Medicare are determined by assignment to CMS' Medicare Severity Diagnosis Related Group (MS-DRGs). All DRG assignments described in the following table are based only on reporting of the occlusion and stenosis diagnosis codes and the procedure codes for PTA and stenting of the carotid artery listed below. Final MS-DRG grouping may be impacted by the reporting of other ICD-9-CM diagnosis or procedure codes in addition to those provided below.
- MS-DRG payment amounts are Medicare national averages; actual payments will vary by numerous factors.
- Private payers often pay for inpatient hospital services on a per diem or case rate basis. Non-Medicare, private payers' hospital payment rates vary by hospital and by payer, so it is important to confirm specific payers' payment rates.
- A facility's ability to bill separately for carotid stent and embolic protection devices for patients insured by non-Medicare, private payers using revenue code 0278 or other codes, will depend on the facility's contractual arrangements. Consult with your payer or reimbursement specialist to confirm the payer's coding requirements.

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²Sources: Medicare, Medicaid, and SCHIP Act of 2007, November 27, 2007 Federal Register, and PFS 2008 Addendum B revised December 4, 2007. MD payments calculated using the 2008 conversion factor of \$38.0870 and mandated budget neutrality work adjuster of 0.8806. MD rates are effective through June 30, 2008

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MS-DRG ³ (Primary Procedure)	2008 Medicare National Average Payment ² (Effective 10/01/07-09/30/08)
034: Carotid artery stent procedure with MCC*	\$13,779
035: Carotid artery stent procedure with CC**	\$10,290
036: Carotid artery stent procedure without CC/MCC	\$9,196

*Major Complication and Comorbidity

**Complication and Comorbidity

³2008 MS-DRG Expert. Ingenix 2008.

³Source: October 10, 2007 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 (\$5,416.74). *(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)*

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