

2009 CODING & PAYMENT QUICK REFERENCE

Background

- Boston Scientific Corporation has compiled this Reimbursement Guide for coding, billing and reimbursement personnel at medical facilities. As always, the provider is responsible for determining coverage and submitting appropriate codes, modifiers and charges for the services that were rendered. All payment amounts referenced are Medicare national averages; actual payments will vary by numerous factors, including geographic location. Please refer to the actual government publications listed in the footnotes for detailed information about referenced amounts, calculations and other factors.

The set of procedures shown below are not typically performed in a physician office or ASC setting. Payment amounts shown are for physicians performing these procedures in facilities and for outpatient hospital services.

MEDICARE HOSPITAL OUTPATIENT & PHYSICIAN PAYMENT

CPT® ¹ Code	Description ¹	In-Facility M.D Payment ² (Jan 01, 09 – Dec 31, 09)	Hospital Outpatient Payment ³ (Jan 01, 09 – Dec 31, 09)
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	APC 82: Coronary or Non-Coronary Atherectomy \$5,962
96420	Chemotherapy administration, intra-arterial; push technique	\$9	APC 439: Level IV Drug Administration \$129
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	\$68	Status N, items and services packaged into APC rate. No separate payment.
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	\$85	Status Q1, CPT Code assigned to APC 263, however, not paid separately in addition to the embolization procedure as it does not meet OPFS criteria for separate payment

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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. http://www.access.gpo.gov/su_docs/fedreg/a081119c.html.

³Source: November 18, 2008 Federal Register. http://www.access.gpo.gov/su_docs/fedreg/a081118c.html.

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MEDICARE HOSPITAL INPATIENT

CD-9-CM Diagnosis Code ⁴	ICD-9-CM Procedure Code ⁴	Possible MS- DRG Assignment ⁵ (Oct '01, 08 – Sept 30, 09)	2009 Medicare National Average Payment Rate ⁵ (Oct '01, 08 – Sept 30, 09)
V58.1 - Chemotherapy, encounter or admission for chemotherapy	99.25 - Injection or infusion of cancer chemotherapeutic substance	MS-DRG 435: Malignancy of hepatobiliary system or pancreas w MCC	\$9,553
155.0 - Carcinoma of liver, primary	38.91 - Arterial catheterization	MS-DRG 436: Malignancy of hepatobiliary system or pancreas w CC	\$6,619
155.2 - Carcinoma of liver, not specified as primary or secondary	88.47 - Arteriography of other intra-abdominal arteries	MS-DRG 437: Malignancy of hepatobiliary system or pancreas w/o CC/MCC	\$5,292
197.7 - Carcinoma of liver, secondary		MS-DRG 846: Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	\$11,811
		MS-DRG 847: Chemotherapy w/o acute leukemia as secondary diagnosis w CC	\$5,231
		MS-DRG 848: Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/ MCC	\$4,425

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). The MS-DRG assignment will depend on the circumstances of the admission and will vary depending on the patient's principal diagnosis.

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



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