

### 2009 CODING & REIMBURSEMENT QUICK REFERENCE

#### BACKGROUND

- This guide covers the coding and reimbursement information for procedures utilizing the PolarCath Peripheral Dilatation System.
- 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.

#### MEDICARE PHYSICIAN AND HOSPITAL OUTPATIENT

**Please note:** Decisions about peripheral interventions procedures and site of service should always be based on clinical considerations in the best interest of the patient and the labeled indications for approved products for the procedures being performed.

CPT® <sup>1</sup> Code	CPT Description <sup>1</sup>	Physician		Outpatient
		2009 Medicare National Average Physician Payment <sup>2</sup>		APC Category and 2009 National Average Payment <sup>3</sup>
		In-Facility	In-Office	
<b>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>
35471	Transluminal balloon angioplasty, percutaneous; renal or visceral artery	\$552	\$3,019	
35473	Transluminal balloon angioplasty, percutaneous; iliac	\$370	\$2,095	
35474	Transluminal balloon angioplasty, percutaneous, femoral-popliteal	\$328	\$2,001	
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	\$494	\$2,157	
35476	Transluminal balloon angioplasty, percutaneous, venous	\$315	\$1,628	
G0392	Transluminal balloon angioplasty, percutaneous; hemodialysis access fistula or graft; arterial	\$449	\$2,157	
G0393	Transluminal balloon angioplasty, percutaneous; hemodialysis access fistula or graft; venous	\$315	\$1,628	

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<sup>2</sup>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](http://www.access.gpo.gov/su_docs/fedreg/a081119c.html).

<sup>3</sup>Source: November 18, 2008 Federal Register. [http://www.access.gpo.gov/su\\_docs/fedreg/a081118c.html](http://www.access.gpo.gov/su_docs/fedreg/a081118c.html).

**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.

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CPT® <sup>4</sup> Code	CPT Description <sup>4</sup>	Physician		Outpatient
		2009 Medicare National Average Physician Payment <sup>5</sup>		APC Category and 2009 National Average Payment <sup>6</sup>
		In-Facility	In-Office	
<b>Radiological S&amp;I Codes - Billed in conjunction with Procedure Code (Use physician modifier -26 as appropriate)</b>				
75962*	Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation  *Note: Code assigned to APC 83, however not paid separately in addition to the PTA procedure, as does not meet OPPS criteria for separate payment	\$28	\$286	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>
75964	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation	\$19	\$168	Status N, items and services packaged into APC rate. No separate payment
75966*	Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation  *Note: Code assigned to APC 83, however not paid separately in addition to the PTA procedure, as does not meet OPPS criteria for separate payment	\$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	\$19	\$169	Status N, items and services packaged into APC rate. No separate payment
75978*	Transluminal balloon angioplasty, venous (e.g. subclavian stenosis), radiological supervision and interpretation  *Note: Code assigned to APC 83, however not paid separately in addition to the PTA procedure, as does not meet OPPS criteria for separate payment	\$27	\$282	<b>83:</b> Coronary or non-coronary angioplasty and percutaneous valvuloplasty <b>\$3,195</b>
<b>Catheter Access</b>				
36140	Introduction of needle or intracatheter, extremity artery	\$104	\$471	Status N, items and services packaged into APC rate. No separate payment
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>Angiography</b>				
75710	Angiography unilateral extremity	\$59	\$289	<b>279:</b> Level II Angiography and Venography except extremity <b>\$1,954</b>
75716	Angiography bilateral extremity	\$68	\$321	
75722	Angiography unilateral renal	\$60	\$285	
75724	Angiography bilateral renal	\$81	\$331	
75726	Angiography visceral	\$59	\$286	
75731	Angiography adrenal unilateral	\$62	\$295	
75733	Angiography bilateral adrenal pelvic	\$72	\$334	
75736	Angiography pelvic	\$60	\$288	

<sup>4</sup> Common Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

<sup>5</sup> 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](http://www.access.gpo.gov/su_docs/fedreg/a081119c.html).

<sup>6</sup> Source: November 18, 2008 Federal Register. [http://www.access.gpo.gov/su\\_docs/fedreg/a081118c.html](http://www.access.gpo.gov/su_docs/fedreg/a081118c.html).

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CPT® Code	CPT Description <sup>7</sup>	Physician		Outpatient
		2009 Medicare National Average Physician Payment <sup>8</sup>		APC Category and 2009 National Average Payment <sup>9</sup>
		In-Facility	In-Office	
<b>Catheter Placement</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
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	

#### MEDICARE HOSPITAL INPATIENT

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Resultant MS- DRG <sup>10</sup>	2009 Medicare National Average Payment Rate <sup>11</sup> (Effective Oct 01, 2008 – Sept 30, 2009)
<b>39.50</b> Angioplasty or atherectomy of non-coronary vessel	<b>440.2X*</b> Atherosclerosis of native arteries of extremities	<b>MS-DRG 252</b> Other vascular procedures with MCC	\$16,408
		<b>MS-DRG 253</b> Other vascular procedures with CC	\$12,518
		<b>MS-DRG 254</b> Other vascular procedures w/o CC/MCC	\$8,565

\*Diagnosis code 440.2X: fifth digit required to further specify patient's condition.

<sup>7</sup> Common Procedural Terminology (CPT) © 2008 American Medical Association. All rights reserved.

<sup>8</sup> 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](http://www.access.gpo.gov/su_docs/fedreg/a081119c.html).

<sup>9</sup> Source: November 18, 2008 Federal Register. [http://www.access.gpo.gov/su\\_docs/fedreg/a081118c.html](http://www.access.gpo.gov/su_docs/fedreg/a081118c.html).

<sup>10</sup> MS-DRG grouping based on a combination of ICD-9 procedure codes and diagnosis codes.

Diagnosis codes not provided due to large number of possibilities that exist.

<sup>11</sup> 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). [http://www.access.gpo.gov/su\\_docs/fedreg/a081003c.html](http://www.access.gpo.gov/su_docs/fedreg/a081003c.html).

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