

Intravascular Ultrasound (IVUS) Peripheral

Reimbursement Information



2008 CODING & PAYMENT QUICK REFERENCE

BACKGROUND

- This guide reviews possible coding options for peripheral IVUS procedures.
- All payment amounts are Medicare national averages; actual payments may vary depending on numerous factors, including geographic location.

MEDICARE PHYSICIAN PAYMENT

CPT ^{®1} Code	Code Description	2008 MD National Average Payment ² (Effective 1/1/08-6/30/08)
+37250*	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)	\$107
+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)	\$81
75945 -26**	Intravascular ultrasound (non-coronary vessel), radiologic supervision and interpretation; initial vessel	\$20
75946 -26**	Intravascular ultrasound (non-coronary vessel), radiologic supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)	\$20

*Add-on codes (denoted by +) are always performed in addition to the primary service/procedure, and are not reimbursed as a stand-alone code. Check with your local Medicare contractors and third party payers to determine which interventions will be accepted as the primary procedure. Note: IVUS is typically not recognized as an add-on to diagnostic catheterization.

**26: Professional or physician component may be reported separately for image interpretation.

MEDICARE HOSPITAL OUTPATIENT

CPT ¹ Code	Code Description	APC Group	2008 APC Payment ³ (Effective 1/1/08-12/31/08)	Pass-through C-Code
37250	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)	Status N, items and services packaged into primary procedure. No separate payment.		C1753* Catheter Intravascular Ultrasound
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)			
75945**	Intravascular ultrasound (non-coronary vessel), radiologic supervision and interpretation; initial vessel	267-Level III diagnostic ultrasound	\$152	
75946	Intravascular ultrasound (non-coronary vessel), radiologic supervision and interpretation; each additional vessel (List separately in addition to code for primary procedure)	Status N, items and services packaged into primary procedure. No separate payment.		

*C1753 is for data tracking and will not trigger additional pass-through payment

**75945 – Status Q, packaged service subject to separate payment under OPSS payment criteria

See page 2 for footnotes

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2008 CODING & PAYMENT QUICK REFERENCE

MEDICARE HOSPITAL INPATIENT

ICD-9-CM Procedure Code ⁴	MS-DRG ⁵ (Primary Procedure)	2008 Medicare National Average Payment Rate ⁶ (Effective 10/1/07-9/30/08)
00.21: Intravascular imaging of extracranial cerebral vessels	MS-DRG 252 -Other vascular procedures with MCC*	\$14,930
00.22: Intravascular imaging of intrathoracic vessels	MS-DRG 253 -Other vascular procedures with CC**	\$12,207
00.23: Intravascular imaging of peripheral vessels	MS-DRG 254 -Other vascular procedures without CC/MCC	\$9,092
00.28: Intravascular imaging, other specified vessels(s)	MS-DRG 299 -Peripheral vascular disorders with MCC	\$6,619
00.28: Intravascular imaging, other specified vessels(s)	MS-DRG 300 -Peripheral vascular disorders with CC	\$5,119
00.29: Intravascular imaging, unspecified vessel(s)	MS-DRG 301 -Peripheral vascular disorders without CC/MCC	\$3,891

*MCC: Major Complication or Comorbidity

**CC: Complication or Comorbidity

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²Source: 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.

³Source: November 27, 2007 Federal Register

⁴Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2007. Craig D. Puckett, Fifth Edition.

⁵MS-DRG grouping is based on combination of ICD-9 procedure codes and diagnosis codes. Diagnosis codes not provided due to large number of possibilities that exist.

⁶Source: 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).

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