

### 2008 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

CPT® Code <sup>1</sup>	CPT Description	Physician		Outpatient
		2008 Medicare National Average Physician Payment <sup>2</sup>		APC Category and 2008 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	\$445	\$3,174	<b>83:</b> Coronary / Non-coronary PTA & Valvuloplasty <b>\$2,891</b>
35471	Transluminal balloon angioplasty, percutaneous; renal or visceral artery	\$527	\$3,531	
35473	Transluminal balloon angioplasty, percutaneous; iliac	\$315	\$2,249	
35474	Transluminal balloon angioplasty, percutaneous, femoral-popliteal	\$380	\$3,091	
35475	Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	\$474	\$2,338	
35476	Transluminal balloon angioplasty, percutaneous, venous	\$302	\$1,775	
G0392	Transluminal balloon angioplasty, percutaneous; hemodialysis access fistula or graft; arterial	\$474	\$2,338	
G0393	Transluminal balloon angioplasty, percutaneous; hemodialysis access fistula or graft; venous	\$302	\$1,775	

#### 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	\$27	\$421	<b>83:</b> Coronary / Non-coronary PTA & Valvuloplasty <b>\$2,891</b>
75964	Transluminal balloon angioplasty, each additional peripheral artery, radiological supervision and interpretation	\$18	\$237	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	\$66	\$466	<b>83:</b> Coronary / Non-coronary PTA & Valvuloplasty <b>\$2,891</b>
75968	Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation	\$18	\$237	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	\$26	\$416	<b>83:</b> Coronary / Non-coronary PTA & Valvuloplasty <b>\$2,891</b>

See footnotes on page 3

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		2008 Medicare National Average Physician Payment <sup>2</sup>		APC Category and 2008 Payment <sup>3</sup>
		In-Facility	In-Office	
<b>Catheter Access</b>				
36140	Introduction of needle or intracatheter, extremity artery	\$99	\$516	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)	\$97	\$507	
36160	Introduction of needle or intracatheter, aortic, translumbar	\$131	\$571	
36200	Introduction of catheter, aorta	\$149	\$686	
<b>Angiography</b>				
75710	Angiography unilateral extremity	\$56	\$388	<b>279:</b> Level II Angiography and Venography except extremity <b>\$1,839</b>
75716	Angiography bilateral extremity	\$64	\$413	
75722	Angiography unilateral renal	\$57	\$386	
75724	Angiography bilateral renal	\$77	\$425	
75726	Angiography visceral	\$55	\$384	
75731	Angiography adrenal unilateral	\$57	\$390	
75736	Angiography pelvic	\$56	\$387	
75733	Angiography bilateral adrenal	\$67	\$424	
<b>Catheter Placement</b>				
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	\$233	\$1,177	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	\$262	\$1,277	
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	\$315	\$2,158	
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)	\$50	\$205	
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$241	\$1,328	
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$264	\$1,285	
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$315	\$2,033	
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)	\$50	\$174	

See footnotes on page 3

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#### MEDICARE HOSPITAL INPATIENT

ICD-9-CM Procedure Code	ICD-9-CM Diagnosis Code	Resultant MS- DRG <sup>4</sup>	2008 Medicare National Average Payment Rate <sup>5</sup> (Effective 10/1/07-9/30/08)
39.50 Angioplasty or atherectomy of non-coronary vessel	440.2X* Atherosclerosis of native arteries of extremities	MS-DRG 252 Other vascular procedures with MCC	\$14,930
		MS-DRG 253 Other vascular procedures with CC	\$12,207
		MS-DRG 254 Other vascular procedures w/o CC/MCC	\$9,092

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

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\*Note: Code assigned to APC 83, however not paid separately in addition to the PTA procedure, as does not meet OPFS criteria for separate payment

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<sup>2</sup> Source: Medicare, Medicaid, and SCHIP Act of 2007, 2007 Federal Register, PFS 2008 Addendum B revised December 4, 2007 and Federal Register Jan 15, 2008 corrections. MD payments calculated using the 2008 conversion factor of 38.0870 and mandated budget neutrality work adjustor of .8806, MD rates are effective through June 30, 2008.

<sup>3</sup> Source: November 27, 2007 Federal Register. [http://www.access.gpo.gov/su\\_docs/fedreg/a071127c.html](http://www.access.gpo.gov/su_docs/fedreg/a071127c.html)

<sup>4</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>5</sup> 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). Source: October 10, 2007 Federal Register (update). [http://www.access.gpo.gov/su\\_docs/fedreg/a071010c.html](http://www.access.gpo.gov/su_docs/fedreg/a071010c.html)



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