

# Chemoembolization of Liver Tumors

## Reimbursement Information

### 2007 CODING & PAYMENT QUICK REFERENCE

#### BACKGROUND

- Boston Scientific Corporation has compiled this reimbursement information 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 rates shown are 2007 Medicare national averages; actual rates will vary.
- For physicians, CPT® Code 37204 is the primary procedure in a typical chemoembolization of liver tumors procedure. Medicare physician payments shown for 36247 and 96420 have been reduced by 50% to reflect Medicare's multiple procedure discounting. Medicare APC payments for the secondary procedures are paid at 100% because they have a status indicator of "S."
- For radiological supervision and interpretation codes, only the professional component of the physician's payment is shown.

#### MEDICARE HOSPITAL OUTPATIENT, ASC and PHYSICIAN PAYMENTS

| CPT Code   | Code Description   | Hospital Outpatient Payment <sup>1</sup> | MD Payment <sup>2</sup> |
|--|--|--|-------------------------|
| <b>Hepatic Angiogram</b>   |  |  |                         |
| 75726  | Angiography, visceral, selective or supraseductive, (with or without flush aortogram), radiological supervision and interpretation   | \$1,280                                  | \$55                    |
| 75774  | Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)                | \$584                                    | \$18                    |
| <b>Access Celiac Trunk (right or left, track catheter to site)</b> |  |  |                         |
| 36247  | Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family                                     | NA                                       | \$157                   |
| <b>Embolization Procedures</b>                                     |  |  |                         |
| 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 | \$1,796                                  | \$891                   |
| 75894  | Transcatheter therapy, embolization, any method, radiological supervision and interpretation   | \$516                                    | \$64                    |
| 96420  | Chemotherapy administration, intra-arterial; push technique  | \$97                                     | \$55                    |
| <b>Angiographic Run</b>  |  |  |                         |
| 75898  | Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion  | \$104                                    | \$76                    |
| <b>Total reimbursement for a typical procedure</b>                 |  | <b>\$4,377</b>                           | <b>\$1,320</b>          |

**Important - Please Note:** Reimbursement information provided by Boston Scientific Corporation (BSC) is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice, and BSC makes no representation or warranty regarding this information or its completeness, accuracy or timeliness. Laws, regulations and payer policies concerning reimbursement are complex and change frequently, and service providers are responsible for all decisions relating to coding and reimbursement submissions. Accordingly, BSC strongly recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.

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Effective 1/1/07  
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(DRG rates expire on 9/30/07)  
ONCM430/125/12/05

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#### MEDICARE HOSPITAL INPATIENT

- The DRG assignment will depend on the circumstances of the admission and will vary depending on the patient's principal diagnosis.
- DRG payment rates shown are CY2007 final urban base rates using national conversion factor of \$5,302. Actual payments will vary by hospital.

| ICD-9-CM Diagnosis Code   | ICD-9-CM Procedure Code  | Possible DRG Assignment <sup>3</sup>   |
|---|--|--|
| V58.1 - Chemotherapy, encounter or admission for chemotherapy     | 99.25 - Injection or infusion of cancer chemotherapeutic substance | DRG 410 - Chemotherapy without acute leukemia as secondary diagnosis - \$5,783 |
| 155.0 - Carcinoma of liver, primary                               | 38.91 - Arterial catheterization                                   |  |
| 155.2 - Carcinoma of liver, not specified as primary or secondary | 88.47 - Arteriography of other intra-abdominal arteries            | DRG 203 - Malignancy of hepatobiliary system or pancreas - \$7,248             |
| 197.7 - Carcinoma of liver, secondary                             |  |  |

<sup>1</sup> Hospital Outpatient payments are 2007 Medicare national averages. Source: November 24, 2006 Federal Register. Actual rates will vary geographically.

<sup>2</sup> MD payments calculated using the 2007 conversion factor of \$37.8975 and mandated budget neutrality work adjuster of 0.8994. Source: December 1, 2006 Federal Register.

<sup>3</sup> National average (wage index greater than one) DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5301.52). Source: October 11, 2006 Federal Register (update).

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