

2007 Procedural Reimbursement Guide

Select Boston Scientific Radiology/Oncology Interventions

		2007 Medicare Reimbursement (National Average)			
CPT® Code	CPT Code Description	Physician ¹		Facility	
		MD In-office Payment	MD In-facility Payment	Hospital Outpatient Payment ²	ASC Payment ³
Venous Access Procedures					
Non-tunneled Venous Access					
36555	Insertion of non-tunneled centrally inserted CVC, under 5 yrs	\$298	\$124	\$540	\$333
36556	Insertion of non-tunneled centrally inserted CVC, 5 years or older	\$279	\$119	\$540	\$333
36580	Replacement, complete, of a non-tunneled centrally inserted CVC, w/o subcutaneous port or pump, through same venous access site	\$285	\$67	\$540	\$333
Tunneled Venous Access					
36557	Insertion of tunneled centrally inserted CVC, without reservoir, under 5 years	\$932	\$292	\$1,393	\$446
36558	Insertion of tunneled centrally inserted CVC, without reservoir, 5 years or older	\$920	\$279	\$1,393	\$446
36581	Replacement, complete, of a tunneled centrally inserted CVC, w/o subcutaneous port or pump, through same venous access site	\$819	\$194	\$1,393	\$446
Chest Port Procedures					
36560	Insertion of tunneled centrally inserted CVAD, with subcutaneous port, under 5 years	\$1,275	\$345	\$1,752	\$510
36561	Insertion of tunneled centrally inserted CVAD, with subcutaneous port, 5 years or older	\$1,274	\$334	\$1,752	\$510
36582	Replacement, complete, of a tunneled centrally inserted CVAD, w/subcutaneous port, through same venous access site	\$1,114	\$287	\$1,752	\$510
PICC Procedures					
36568	Insertion of peripherally inserted CVC, w/o port, under 5 yrs	\$336	\$91	\$540	\$333
36569	Insertion of peripherally inserted CVC, w/o port, 5 years or older	\$317	\$91	\$540	\$333
36584	Replacement, complete, of a peripherally inserted CVC, w/o subcutaneous port or pump, through same venous access	\$282	\$69	\$540	\$333
Arm Port Procedures					
36570	Insertion of peripherally inserted CVAD, w/port, under 5 years	\$1,358	\$302	\$1,393	\$510
36571	Insertion of peripherally inserted CVAD, w/port, 5 years or older	\$1,377	\$302	\$1,393	\$510
36585	Replacement, complete, of a peripherally inserted CVAD, w/subcutaneous port, through same venous access	\$1,167	\$269	\$1,393	\$510
Repair, Removal and Partial Replacement Procedures					
36575	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site	\$176	\$40	\$540	\$446
36576	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$368	\$183	\$540	\$446
36578	Replacement, catheter only , of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	\$526	\$209	\$1,393	\$446
36589	Removal of tunneled central venous catheter, without subcutaneous port or pump	\$167	\$137	\$540	\$333
36590	Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion	\$259	\$194	\$540	\$333
Ultrasound Guidance for Vascular Access Insertion					
76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting	\$34	\$15	NA	NA

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.

	CPT® Code	CPT Code Description	Physician ¹		Facility		
			MD In-office Payment	MD In-facility Payment	Hospital Outpatient Payment ²	ASC Payment ³	
Embolization (Hypervascular Tumors)							
	UFE	37210	Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete procedure	\$2,128	\$503	\$2,642	NA
	Non-Head or Neck	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	\$891	\$891	\$1,796	NA
	Head or Neck	61626	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck	\$816	\$816	\$2,639	NA
Radiofrequency Ablation							
Liver Tumor Ablation							
	Percutaneous	47382	Ablation, one or more liver tumor(s), percutaneous, radiofrequency	\$775	\$775	\$2,296	NA
	Open	47380	Ablation, open, of one or more liver tumor(s); radiofrequency	\$1,288	\$1,288	NA	NA
	Laparoscopic	47370	Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency	\$1,105	\$1,105	\$4,334	NA
Supervision & Interpretation							
	CT Scan	77013	Computerized axial tomographic guidance for, and monitoring of, parenchymal tissue ablation	\$191	\$191	\$298	NA
	MRI	77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation	\$204	\$204	\$280	NA
	Ultrasound	76940	Ultrasound guidance for, and monitoring of, parenchymal tissue ablation	\$104	\$104	\$73	NA
Biopsy Needle							
	Lung	32405	Biopsy, lung or mediastinum, percutaneous needle	\$94	\$93	\$377	\$333
	Liver	47000	Biopsy of liver, needle; percutaneous	\$225	\$93	\$377	\$333
	Kidney	50200	Renal biopsy; percutaneous, by trocar or needle	\$143	\$143	\$377	\$333
	Thyroid	60100	Biopsy thyroid, percutaneous core needle	\$108	\$76	\$127	NA
	Prostate	55700	Biopsy, prostate; needle or punch, single or multiple, any approach	\$245	\$123	\$346	\$346
	Breast	19100	Biopsy of breast; percutaneous, needle core, not using imaging guidance (separate procedure)	\$127	\$65	\$240	\$240
		19102	Biopsy of breast; percutaneous, needle core, using imaging guidance	\$213	\$98	\$240	\$240
Drainage							
	Biliary	47510	Introduction of percutaneous transhepatic catheter for biliary drainage	\$468	\$468	\$1,246	\$446
		47511	Introduction of percutaneous transhepatic stent for internal and external biliary drainage	\$574	\$574	\$1,246	\$1,246
		47525	Change of percutaneous biliary drainage catheter	\$763	\$303	\$717	\$333
		47530	Revision and/or reinsertion of transhepatic tube	\$1,451	\$351	\$717	\$333
		49420	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary	\$126	\$126	\$1,816	\$333
		49421	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent	\$348	\$348	\$1,816	\$333
		50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	\$178	\$178	\$1,182	\$333
	Abscess	49423	Exchange of previously placed abscess or cyst drainage catheter under radiological guidance (separate procedure)	\$571	\$73	\$717	NA

NA in the "2007 Hospital Outpatient Payment" column means the code is on Medicare's inpatient only list and will not be reimbursed by Medicare in the hospital outpatient setting.

¹ 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.

² Hospital Outpatient payments are 2007 Medicare national averages. Source: November 24, 2006 Federal Register. Actual rates will vary geographically.

³ ASC payments are from the 2007 Update to the Ambulatory Surgical Center Covered Procedures List. Source: November 24, 2006 Federal Register.

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