EKOS™ ENDOVASCULAR SYSTEM
2021 CODING & PAYMENT GUIDE

The procedure codes listed below are applicable to EkoSonic (EKOS) Endovascular System.

HOSPITAL INPATIENT CODING & REIMBURSEMENT

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)[1] is the system of codes used by facilities to report procedures and services provided in the inpatient setting. ICD-10-PCS alphanumeric codes are composed of seven characters that identify the general procedure type, body system, procedure objective, specific body part, procedure approach and device use.

Claims must contain the appropriate CPT/HCPCS/ICD-10-PCS code(s) for the specific site of service to indicate the items and services that are furnished. The tables below contain a list of possible CPT/HCPCS/ICD-10-PCS codes that may be used to bill for the EKOS™ Endovascular System. Providers should select the most appropriate code(s) and modifier(s] with the highest level of detail to describe the service(s) actually rendered.

Effective for dates of service beginning October 1, 2020, the following ICD-10-PCS codes are appropriate for describing ultrasonic fragmentation procedures utilizing the EKOS™ Endovascular System:

ICD-10-PCS (0 =ZERO)	ICD-10-PCS DESCRIPTION	HEART & GREAT VESSELS	
02F_ 3Z0*	Fragmentation of ___, Percutaneous Approach, Ultrasonic	P Pulmonary Trunk Q Right Pulmonary Artery R Left Pulmonary Artery	S Right Pulmonary Vein T Left Pulmonary Artery
		UPPER ARTERIES	
03F_3Z0*	Fragmentation of ___, Percutaneous Approach, Ultrasonic	2 Innominate Artery 3 Right Subclavian Artery 4 Left Subclavian Artery 5 Right Axillary Artery 6 Left Axillary Artery 7 Right Brachial Artery	8 Left Brachial Artery 9 Right Ulnar Artery A Left Ulnar Artery B Right Radial Artery C Left Radial Artery Y Upper Artery
		LOWER ARTERIES	
04F_3Z0*	Fragmentation of ___, Percutaneous Approach, Ultrasonic	C Right Common Iliac Artery D Left Common Iliac Artery E Right Internal Iliac Artery F Left Internal Iliac Artery H Right External Iliac Artery J Left External Iliac Artery K Right Femoral Artery L Left Femoral Artery M Right Popliteal Artery	N Left Popliteal Artery P Right Anterior Tibial Artery Q Left Anterior Tibial Artery R Right Posterior Tibial Artery S Left Posterior Tibial Artery T Right Peroneal Artery U Left Peroneal Artery Y Lower Artery
		UPPER VEINS	
05F_3Z0*	Fragmentation of___, Percutaneous Approach, Ultrasonic	3 Right Innominate Vein 4 Left Innominate Vein 5 Right Subclavian Vein 6 Left Subclavian Vein 7 Right Axillary Vein 8 Left Axillary Vein	9 Right Brachial Vein A Left Brachial Vein B Right Basilic Vein C Left Basilic Vein D Right Cephalic Vein F Left Cephalic Vein Y Upper Vein

See important notes on the uses and limitations of this information on page 6.

		LOWER VEINS	
06F_3Z0*	Fragmentation of ___, Percutaneous Approach, Ultrasonic	C Right Common Iliac Vein D Left Common Iliac Vein F Right External Iliac Vein G Left External Iliac Vein H Right Hypogastric Vein J Left Hypogastric Vein	M Right Femoral Vein N Left Femoral Vein P Right Saphenous Vein Q Left Saphenous Vein Y Lower Vein

*The underline is for the fourth character that identifies the body part

ICD-10-PCS (0 =ZERO)	ICD-10-PCS DESCRIPTION	VEIN/ARTERY	
3E0_317	Introduction of Other Thrombolytic into ___, Percutaneous Approach	3 Peripheral Vein 4 Central Vein	5 Peripheral Artery 6 Central Artery

Medicare reimburses facilities for inpatient stays based on the Medicare Severity Diagnosis Related Group (MS-DRG). The MS-DRG is a system of classifying patients based on principal diagnosis, complications and comorbidities managed and the procedures performed during an inpatient stay. A single MS-DRG payment is intended to cover all hospital costs associated with treating a patient for a hospital stay. Private payers may use MS-DRG based systems or other payer-specific systems.

The Medicare reimbursement values for each MS-DRG, while specific to your hospital, do not include pass-through payments or New Technology Add-On Payment (NTAP) as these are calculated on a case-by-case basis.

The following MS-DRGs are associated with procedures involving the EKOS™ ® Endovascular System:

MS-DRG	MS-DRG DESCRIPTION	MS-DRG FY 2021 NATIONAL AVERAGE PAYMENT[1]
Pulmonary Embolism		
166	Other Respiratory System O.R. Procedures with MCC	$24,394
167	Other Respiratory System O.R. Procedures with CC	$12,010
168	Other Respiratory System O.R. Procedures without CC/MCC	$8,842
Peripheral Vascular (Venous & Arterial)		
252	Other Vascular Procedures with MCC	$21,420
253	Other Vascular Procedures with CC	$17,145
254	Other Vascular Procedures without CC/MCC	$11,710

HOSPITAL OUTPATIENT& ASC CODING & REIMBURSEMENT

Hospital Outpatient Departments and Ambulatory Surgical Centers (ASCs) report procedures with CPT® codes. Medicare reimburses hospitals for outpatient stays under the Ambulatory Payment Classification (APC) system. Each CPT code is assigned to an APC based on similar clinical characteristics and costs and each APC has an assigned rate on the fee schedule.

Transcatheter thrombolysis therapy codes (37211-37214) are assigned by CMS to Comprehensive APCs (C-APCs). C-APCs are utilized to identify device intensive outpatient procedures and will receive a single C-APC payment. Most services performed for that patient on that date of service are packaged into the primary service on the claim.

Medicare reimburses Ambulatory Surgical Centers (ASCs) according to a fee schedule assigned to each CPT code. Not all procedures that Medicare covers in the hospital outpatient setting are eligible for payment in an ASC.

Commercial payers reimburse hospital outpatient departments and ambulatory surgical centers at contracted and/or negotiated amounts.

See important notes on the uses and limitations of this information on page 6.

CPT	DESCRIPTION	CY 2021 HOSPITAL OUTPATIENT[2]		CY 2021 ASC NATIONAL AVERAGE PAYMENT[3]
		NATIONAL AVERAGE PAYMENT	APC	
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	$4,770	5184	$2,381
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	$2,862	5183	$1,372
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;	$1,406	5182	NA
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	$1,406	5182	NA
+37252	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)	Packaged		Packaged
+37253	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)	Packaged		Packaged

- Report CPT codes 37211-37214 only once per date of treatment; 37211 or 37212 for the initial day, 37213 for subsequent treatment days and 37214 on the final treatment day (only if on a different date than the date reported for 37211 or 37212).
- When initiation and completion occur on the same day, report only 37211 or 37212.
- Hospital Outpatient Department: Bilateral thrombolytic infusions through separate access sites is reported using modifier -50 in conjunction with 37211 or 37212. Medicare requires a single line billing format and a unit of 1 for bilateral procedures. Please consult commercial payer guidelines for their billing format requirements.
- Ambulatory Surgical Center: It is not appropriate to append modifier -50 for bilateral thrombolytic infusions performed in an ASC. Bilateral procedures are reported as two procedures, either as a single unit on two separate billing lines or two units on one billing line.
- C-codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. C-codes only apply to Medicare hospital outpatient claims. They do not trigger additional payment to the facility today. It is very important that hospitals report C-codes as well as the associated device costs. This will help inform future outpatient hospital payment rates.

See important notes on the uses and limitations of this information on page 6.

HCPCS device category codes appropriate for reporting EKOS™ Endovascular System therapy procedures include:

HCPCS[4]	HCPCS DESCRIPTION
C1887	Catheter, guiding (may include infusion/perfusion capability)
C1889	Implantable/insertable device, not otherwise classified

PHYSICIAN CODING & REIMBURSEMENT

CPT Codes are used to report medical services and procedures performed by or under the direction of physicians in the office or facility setting.

The Medicare Physician Fee Schedule (MPFS) is based on Relative Value Units (RVUs) assigned to each CPT code. RVUs represent the physician work, practice expenses and malpractice costs associated with each procedure or service. Reimbursement for commercial payers may be based on the Medicare RVUs or by a contractually negotiated rate.

CPT	DESCRIPTION	CY 2021 RVU[5]	CY 2021 NATIONAL AVERAGE PAYMENT[5]
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	Work 7.75 Total 11.27	$365
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	Work 6.81 Total 9.83	$319
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;	Work 4.75 Total 6.74	$218
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	Work 2.49 Total 3.54	$159
+37252	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)	Work 1.80 Total 2.63	$85
+37253	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)	Work 1.44 Total 2.08	$67

See the CPT® 2021 Professional Edition Codebook for important instructions regarding the use of the codes shown above.

See important notes on the uses and limitations of this information on page 6.

CAUTION: Federal law (USA) restricts this device to sale by or on the order of a physician. Rx only. Prior to use, please see the complete "Directions for Use" for more information on Indications, Contraindications, Warnings, Precautions, Adverse Events, and Operator's Instructions.

INDICATIONS FOR USE:

The EkoSonic Endovascular System is indicated for the:

- Ultrasound facilitated, controlled and selective infusion of physician-specified fluids, including thrombolytics, into the vasculature for the treatment of pulmonary embolism.
- Infusion of solutions into the pulmonary arteries.
- Controlled and selective infusion of physician-specified fluids, including thrombolytics, into the peripheral vasculature. All therapeutic agents utilized with the EkoSonic Endovascular System should be fully prepared and used according to the instruction for use of the specific therapeutic agent.

CONTRAINDICATIONS:

- Not designed for peripheral vasculature dilation purposes.
- This system is contraindicated when, in the medical judgment of the physician, such a procedure may compromise the patient's condition.

POTENTIAL COMPLICATIONS:

Vessel perforation or rupture • Distal embolization of blood clots • Vessel spasm • Hemorrhage • Hematoma • Pain and tenderness • Sepsis/Infection • Thrombophlebitis • Tricuspid and pulmonic valve damage • Pulmonary infarct due to tip migration and spontaneous wedging, air embolism, and/or thromboembolism • Right bundle branch block and complete heart block • Intimal disruption • Arterial dissection • Vascular thrombosis • Drug reactions • Allergic reaction to contrast medium • Arteriovenous fistula • Thromboembolic episodes • Amputation • Pneumothorax • Perforation of the pulmonary artery. • Cardiac Arrhythmias – most frequently occurring during placement, removal or following displacement into the right ventricle.

The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

Sources:

1. 2021 IPPS Payment. CMS-1735-FC https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page#Data
2. 2021 OPPS Payment. CMS-1736-FC. https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-fc
3. 2021 ASC Payment. CMS-1736-FC ASC. https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1736-fc
4. HCPCS C Code Device Category Codes https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Complet-list-DeviceCats-OPPS.pdf
5. 2021 Physician Fee Schedule. CMS-1734-F. https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f 2021 Conversion Factor of $34.8931.
   FY 2021 (10/1/2020-09/30/2021)
   CMS ICD-10-CM/PCS
   https://www.cms.gov/medicare/icd-10/2021-icd-10-cm
   https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs
   MS-DRG V38.1:https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software

See important notes on the uses and limitations of this information on page 6.

IMPORTANT INFORMATION

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