Penumbra

Reimbursement Guide

Artemis™ Neuro Evacuation Device

EFFECTIVE JANUARY 2025

Reimbursement Inquiries: reimbursement@penumbrainc.com

For USA only.

Table of Contents

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Penumbra Pump MAX® with Artemis Neuro Evacuation Device

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The reimbursement information is provided for illustrative purposes only and does not constitute reimbursement or legal advice. Providers are responsible for consulting payers and reimbursement specialists regarding coding, coverage and reimbursement and for submitting appropriate coding and information for services provided.

Facility Coding and Payment

ICD-10-PCS Procedure Codes

00C03ZZ Extirpation of Matter from Brain, Percutaneous Approach
00C00ZZ Extirpation of Matter from Brain, Open Approach
00C63ZZ Extirpation of Matter from Cerebral Ventricle, Percutaneous Approach
00C60ZZ Extirpation of Matter from Cerebral Ventricle, Open Approach
00C73ZZ Extirpation of Matter from Cerebral Hemisphere, Percutaneous Approach
00C70ZZ Extirpation of Matter from Cerebral Hemisphere, Open Approach
00C83ZZ Extirpation of Matter from Basal Ganglia, Percutaneous Approach
00C80ZZ Extirpation of Matter from Basal Ganglia, Open Approach
00C93ZZ Extirpation of Matter from Thalamus, Percutaneous Approach
00C90ZZ Extirpation of Matter from Thalamus, Open Approach 00H033Z
Insertion of Infusion Device into Brain, Percutaneous Approach

Charge for the Artemis Neuro Evacuation Device may be assigned to the following revenue codes:

0270	Medical/surgical supply
0272	Sterile supply
0279	Other supplies/device

DRG and 2025 Payment Rates

Medicare pays hospitals for inpatient services under a prospective payment system using Medicare Severity Diagnosis Related Groups (MS-DRGs). Each MS-DRG is associated with a payment rate; however, the actual payment may vary considerably depending on the specifics of the patient encounter (i.e., patient diagnosis and procedures performed and coded). Medicare's algorithm determines the appropriate MS-DRG assignment that best reflects the charges from a given patient's entire admission. Final MS-DRG payments are adjusted to the specific facility, taking into consideration locality and other adjustments.

Private insurers use a variety of reimbursement algorithms for inpatient hospital services and similarly, payments will vary on a case-by-case basis.

MS–DRG and 2025 Payment Rates

MS-DRG	Description	2025 National DRG Payment*
23	Craniotomy w/ Major Device Implant or Acute CNS PDX With MCC Or Chemotherapy Implant or Epilepsy w/Neurostimulator	$40,600
24	Craniotomy With Major Device Implant or Acute Complex CNS PDX w/o MCC	$27,055
25	Craniotomy and Endovascular Intracranial Procedures w/ MCC	$31,827
26	Craniotomy and Endovascular Intracranial Procedures w/ CC	$21,767
27	Craniotomy and Endovascular Intracranial Procedures w/o MCC or CC	$17,562

2025 Inpatient rates in effect from October 1, 2024 – September 30, 2025
(M)CC (major) complications and/or comorbidities. Complete list available at: http://www.cms.hhs.gov/AcuteInpatientPPS
* Rates reflect FY 2025 National Medicare payment rates for hospitals submitting quality data and meaningful EHR users. Hospitals that do not submit quality data or are not meaningful EHR users may see decreased payment.

References & Sources

- HIPPS (Inpatient) Federal Register / Vol. 89, No. 192 / Thursday, October 3, 2024
- ICD-10-CM 2025 ICD-10-CM Complete Official Codebook. American Medical Association. Copyright ©2025 Optum360, LLC.
- ICD-10-PCS 2025 ICD-10-PCS Complete Official Codebook. American Medical Association. Copyright ©2025 Optum360, LLC.

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Physician Coding and Payment

Physician Payment

- Based on RBRVS relative weights per CPT® code × $ conversion factor
- Payments vary based on geographic location

CPT Code	Code Descriptor	2025 National Average Payment[a]	Work RVU[a]
61105	Twist drill hole for subdural or ventricular puncture	**$466.49**	**5.45**
61108	Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma	**$903.21**	**11.64**
61150	Burr hole(s) or trephine; with drainage of brain abscess or cyst	**$1,341.23**	**18.90**
61151	Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cyst	**$989.26**	**13.49**
61154	Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural	**$1,271.68**	**17.07**
61156	Burr hole(s); with aspiration of hematoma or cyst, intracerebral	**$1,232.21**	**17.45**
61312	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	**$2,044.52**	**30.17**
61313	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral	**$1,965.91**	**28.09**
61314	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural	**$1,808.37**	**25.90**
61315	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar	**$2,044.52**	**29.65**
61781	Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)	**$230.01**	**3.75**

a. The 2025 physician payment rates are reflective of the Calendar Year 2025 Medicare Physician Fee Schedule (MPFS) Final Rule, which was published in Federal Register, Vol. 89, No. 236, Monday, December 9, 2024. Payments listed are national unadjusted fee schedule rates and are subject to change due to CMS' quarterly fee schedule updates and correction notices. Actual payments to physicians may also vary based on locality.

This list may not be comprehensive or complete. These procedures may be subject to the CMS multiple procedure reduction rule. When applicable, a payment reduction of 50% is applied to all payment amounts except the procedure with the greatest RVUs, which is paid at 100% unless exempt by CPT instructions or payer policy.

Modifier 62 — Two Surgeons, Different Specialties

Under Medicare, modifier 62 is used to identify when two surgeons (each in a different specialty) are required to perform a specific procedure. Each surgeon bills the same CPT procedure code, and both surgeons must append the CPT procedure code with modifier 62 to report they both operated on the same case. This modifier can be used only when the co-surgeons have different specialties and are working simultaneously. Reimbursement will be 125% of the established fee, divided equally between the co-surgeons (payment for each of two co-surgeons is 62.5% of the global surgery fee).

Claims including modifier 62 for surgical procedure codes must include an operative report that supports the need for co-surgeons. If the surgical procedures performed by each physician can be clearly identified, and each surgeon's role is explicitly described within the operative report, only one operative report is necessary.

Commercial payer policies on co-surgeons vary, and payment rates will depend on contractual agreements. Providers should contact individual payers to confirm.

References & Sources

- Modifier 62 — Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Rev.10869 July 14, 2021, Chapter 4, Section 250.10: Coding Co-surgeon Services Rendered in a Method II CAH, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf.

Indications for Use:

For the complete Penumbra IFU Summary Statements, please scan QR code or visit http://www.peninc.info/risks

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Caution: Federal (USA) law restricts these devices to sale by or on the order of a physician. Prior to use, please refer to the Instructions for Use for complete product indications, contraindications, warnings, precautions, potential adverse events, and detailed instructions for use.

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