Penumbra

# Reimbursement Guide

## Artemis™ Neuro Evacuation Device

EFFECTIVE JANUARY 2019

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# Penumbra Pump MAX™ with Artemis Neuro Evacuation Device

# 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 |



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## DRG and 2019 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 2019 Payment Rates

| MS-DRG | Description | 2019 National DRG Payment* |
|---|---|---|
| 23 | Craniotomy With Major Device Implant Or Acute CNS PDX With MCC Or Chemotherapy Implant Or Epilepsy With Neurostimulator | $33,357 |
| 24 | Craniotomy With Major Device Implant Or Acute Complex CNS PDX w/o MCC | $23,945 |
| 25 | Craniotomy and Endovascular Intracranial Procedures w/ MCC | $26,132 |
| 26 | Craniotomy and Endovascular Intracranial Procedures w/ CC | $18,424 |
| 27 | Craniotomy and Endovascular Intracranial Procedures w/o MCC or CC | $14,697 |

2019 Inpatient rates in effect from October 1, 2018 – September 30, 2019
(M)CC = (major) complications and/or comorbidities. Complete list available at: http://www.cms.hhs.gov/AcuteInpatientPPS
*Rates reflect FY 2019 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 rates.

### References & Sources


- HIPPS (Inpatient) — Federal Register / FR 38514 / CMS-1688-F / August 17, 2018.
- ICD-10-CM — 2019 ICD-10-CM Complete Official Codebook. American Medical Association. Copyright ©2019 Optum360, LLC.
- ICD-10-PCS — 2019 ICD-10-PCS Complete Official Codebook. American Medical Association. Copyright ©2019 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 | 2019 National Average Payment[a] |
|---|---|---|
| 61105 | Twist drill hole for subdural or ventricular puncture | $493.11 |
| 61108 | Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma | $950.18 |
| | | |
| 61150 | Burr hole(s) or trephine; with drainage of brain abscess or cyst | $1,452.31 |
| 61151 | Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cyst | $1,064.81 |
| 61154 | Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural | $1,356.06 |
| 61156 | Burr hole(s); with aspiration of hematoma or cyst, intracerebral | $1,333.35 |
| | | |
| 61312 | Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural | $2,217.21 |
| 61313 | Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral | $2,114.84 |
| 61314 | Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural | $1,941.09 |
| 61315 | Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar | $2,200.27 |
| | | |
| 61781 | Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure) | $254.13 |

a. The following 2019 physician payment rates are reflective of the Calendar Year 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, which was published in Federal Register, Vol. 83, No. 226, Friday, November 23, 2018. Fee schedule rates and are subject to change due to CMS' quarterly fee schedule updates. 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.

## HCPCS Codes

| Product | Suggested HCPCS Code |
|---|---|
| Artemis Neuro Evacuation Device | **A4649**, Surgical supply; miscellaneous |
| Aspiration Tubing | **A7002**, Tubing, used with suction pump, each |
| Collection Canister | **A7000**, Canister, disposable, used with suction pump, each |

HCPCS Codes are not separately reimbursed for hospital inpatient procedures. However, they may be used for tracking or other administration processes.

### References & Sources

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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 | 2019 Work RVUs[a] |
|---|---|---|
| 61105 | Twist drill hole for subdural or ventricular puncture | 5.45 |
| 61108 | Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for evacuation and/or drainage of subdural hematoma | 11.64 |
| | | |
| 61150 | Burr hole(s) or trephine; with drainage of brain abscess or cyst | 18.9 |
| 61151 | Burr hole(s) or trephine; with subsequent tapping (aspiration) of intracranial abscess or cyst | 13.49 |
| 61154 | Burr hole(s); with evacuation and/or drainage of hematoma, extradural or subdural | 17.07 |
| 61156 | Burr hole(s); with aspiration of hematoma or cyst, intracerebral | 17.45 |
| | | |
| 61312 | Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural | 30.17 |
| 61313 | Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral | 28.09 |
| 61314 | Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural | 25.9 |
| 61315 | Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar | 29.65 |
| | | |
| 61781 | Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure) | 3.75 |

a. The following 2019 physician payment rates are reflective of the Calendar Year 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, which was published in Federal Register, Vol. 83, No. 226, Friday, November 23, 2018. Fee schedule rates and are subject to change due to CMS' quarterly fee schedule updates. Actual payments to physicians may also vary based on locality.

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## 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 — MLN Matters, SE 1322, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1322.pdf. Released: June 27, 2013. Accessed: September 19, 2018.




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