

# Reimbursement Guide

## Indigo® System Percutaneous Mechanical Thrombectomy and Peripheral Coil Embolization

EFFECTIVE OCTOBER 2019

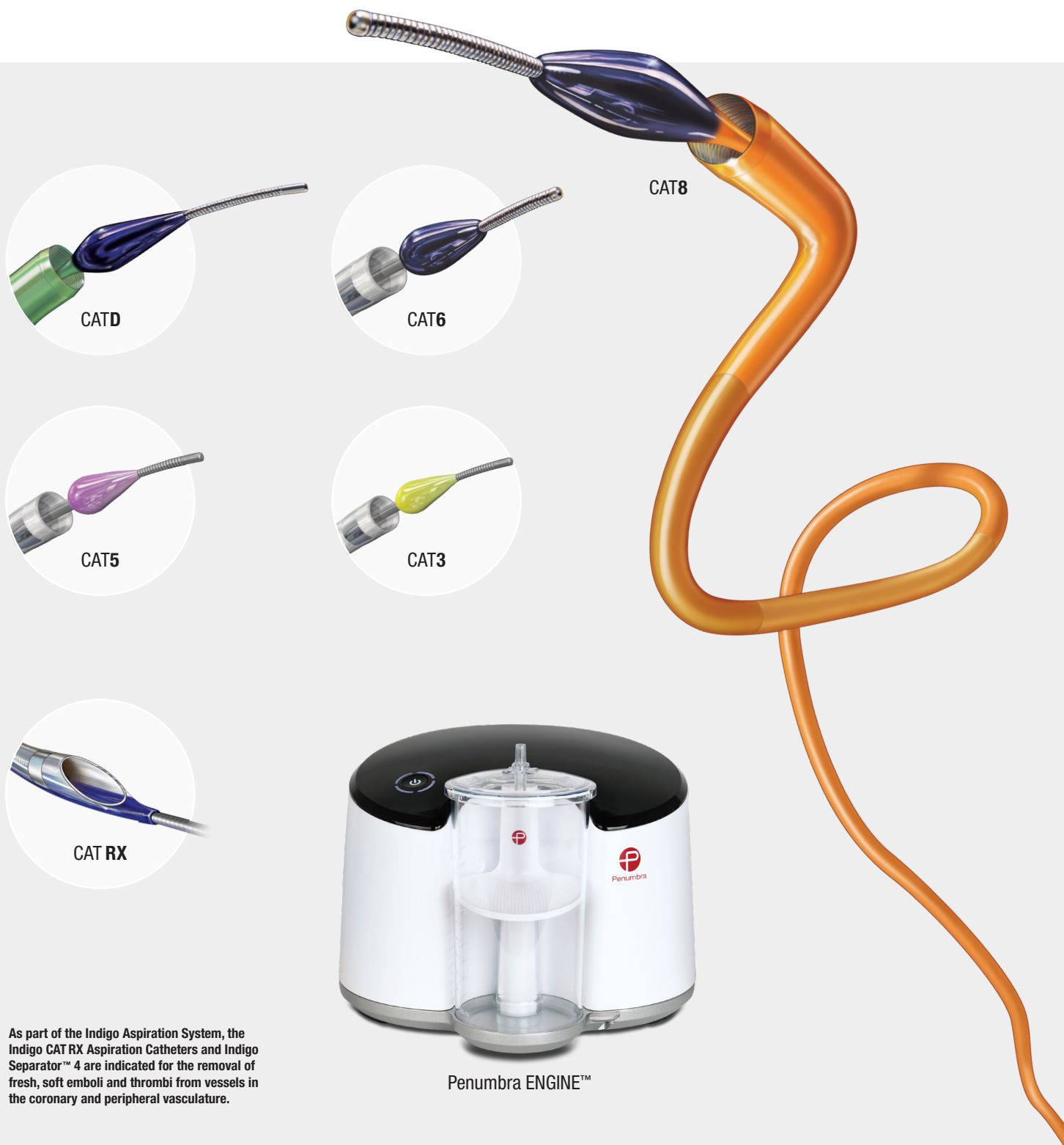
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As part of the Indigo Aspiration System, the Indigo CAT RX Aspiration Catheters and Indigo Separator™ 4 are indicated for the removal of fresh, soft emboli and thrombi from vessels in the coronary and peripheral vasculature.

## Physician and Outpatient Coding and Payment

### Coverage

Medicare carriers issue local coverage decisions (LCDs) listing coverage criteria for certain procedures. Physicians are urged to review their local carrier coverage policies (<http://www.cms.hhs.gov/mcd/search.asp?>) and/or contact their local carrier medical directors (<http://www.cms.hhs.gov/apps/contacts/>).

### Coding

#### Mechanical Thrombectomy Coding Tips

- Code(s) for catheter placement(s), diagnostic studies, and other percutaneous interventions (e.g., transluminal balloon angioplasty, stent placement) provided are separately reportable, unless for lower extremity revascularization.
- Current Procedural Terminology (CPT®) codes 37184–37188 and 37211–37214 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for guidance of the procedure.
- Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of a thrombolytic is not an included service.
- Effective January 1, 2017, prior moderate sedation codes CPT 99143–99150 have been deleted and moderate sedation service have been unbundled from many interventional services. To receive full payment, providers performing moderate sedation for mechanical thrombectomy (CPT 37184–37188) should now separately report new moderate sedation codes (CPT 99151–99157) with proper medical documentation.

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## Physician and Outpatient Coding and Payment

CPT® Code <sup>1</sup>	Description
<b>Arterial Mechanical Thrombectomy Codes</b>	
<b>37184</b>	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel
<b>(+) 37185</b>	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)
<b>(+) 37186</b>	Secondary percutaneous transluminal thrombectomy (e.g., nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)
<b>37211*</b>	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day
<b>Venous Mechanical Thrombectomy Codes</b>	
<b>37187</b>	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance
<b>37188</b>	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy
<b>37212</b>	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day
<b>37213</b>	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
<b>37214</b>	Transcatheter therapy, cessation of thrombolysis including removal of catheter and vessel closure, by any method
<b>Dialysis Circuit Mechanical Thrombectomy Codes</b>	
<b>36904</b>	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)
<b>36905</b>	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty
<b>36906</b>	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit
<b>(+) 36909</b>	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)
<b>Manual Aspiration Codes</b>	
<b>37799</b>	Unlisted procedure, vascular surgery

(+) in front of a procedure code denotes an add-on code. Add-on codes allow reporting of additional work associated with a primary procedure(s) and must never be reported alone. In addition, physician add-on codes are exempt from multiple procedure reduction.

\* For continued transcatheter therapy (arterial infusion for thrombolysis other than coronary or intracranial) beyond the initial treatment day, please report CPT 37213.  
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## Physician and Outpatient Coding and Payment

### Venous Mechanical Thrombectomy Coding Tips

- CPT® 37187 is used to report venous mechanical thrombectomy, either by itself or in conjunction with other percutaneous interventions. In certain circumstances, it may be necessary to repeat venous mechanical thrombectomy during the course of thrombolytic therapy. CPT code 37188 is used to report “repeat” venous mechanical thrombectomy on a subsequent day during the course of pharmacological thrombolysis. Any additional percutaneous interventions provided to treat underlying pathology(ies) are separately reportable.
- Fluoroscopy is considered an inclusive service in arterial and venous thrombectomy. Therefore, **DO NOT** report CPT 37187-37188 in conjunction with CPT 76000, 76001, or 96375.
- Report CPT 37212-37214 once per date of treatment
- **DO NOT** report CPT 37212-37214 in conjunction with 75898.

### Arterial Mechanical Thrombectomy Coding Tips

- Primary mechanical thrombectomy is reported per vascular family using CPT 37184 for the initial vessel treated and CPT 37185 for second or all subsequent vessel(s) within the same vascular family. To report mechanical thrombectomy of an additional vascular family treated through a separate access site, use modifier 51 in conjunction with CPT 37184–37185.
- **DO NOT** report CPT 37184–37185 for mechanical thrombectomy performed for the retrieval of short segments of thrombus or embolus evident during other percutaneous interventional procedures. See CPT 37186 for these procedures.
- Secondary mechanical thrombectomy is reported using CPT 37186.  
**DO NOT** report CPT 37186 in conjunction with CPT 37184–37185.

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## Physician and Outpatient Coding and Payment

		Ambulatory Surgery Center (ASC)	Hospital Outpatient Department (HOPD)		Physician Services	
CPT® Code¹	Description	Facility Payment²	APC	Facility Payment³	Fee When Service is Performed in the HOPD or Inpatient Setting⁴	Fee When Service is Performed in the Physician Office⁴
Medicare Reimbursement for Arterial Percutaneous Mechanical Thrombectomy						
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	\$2,912.48	5192	\$4,678.53	\$469.68	\$2,193.42
(+) 37185	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)	\$ – (Packaged service/item; no separate payment made)	\$ – (Items and services are packaged into APC rate)	\$ – (Items and services are packaged into APC rate)	\$175.91	\$675.15
(+) 37186	Secondary percutaneous transluminal thrombectomy (e.g., nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)	\$ – (Packaged service/item; no separate payment made)	\$ – (Items and services are packaged into APC rate)	\$ – (Items and services are packaged into APC rate)	\$257.37	\$1,362.19
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	\$3,046.10	5184	\$4,376.52	\$406.24	\$ – (Surgical procedure not performed in office setting)

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2. 2019 Medicare Ambulatory Surgical Center (ASC) Payment System.

3. 2019 Medicare Outpatient Prospective Payment System (OPPS).

4. 2019 Medicare Physician Fee Schedule (MPFS).

a. The 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. 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.

Physician fees for your local area can be found at the following CMS link: <https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

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Medicare Reimbursement for Venous Percutaneous Mechanical Thrombectomy						
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	\$2,721.19	5192	\$4,678.53	\$413.09	\$2,027.24
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	\$1,305.43	5183	\$2,641.52	\$291.61	\$1,703.91
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	\$1,720.56	5183	\$2,641.52	\$354.70	\$ – (Surgical procedure not performed in office setting)
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	\$ – (Surgical procedure excluded from payment in ASCs)	5182	\$1,093.63	\$244.39	\$ – (Surgical procedure not performed in office setting)
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	\$ – (Surgical procedure excluded from payment in ASCs)	5182	\$1,093.63	\$128.69	\$ – (Surgical procedure not performed in office setting)

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## Physician and Outpatient Coding and Payment

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Medicare Reimbursement for Dialysis Circuit Mechanical Thrombectomy (continued)						
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report	\$522.21	5181	\$1,093.63	\$177.71	\$672.62

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Medicare Reimbursement for Dialysis Circuit Mechanical Thrombectomy (continued)						
36902	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	\$2,002.23	5192	\$4,678.53	\$253.41	\$1,325.42
36903	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	\$6,001.75	5193	\$9,669.04	\$335.23	\$5,431.82

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Medicare Reimbursement for Dialysis Circuit Mechanical Thrombectomy (continued)						
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	\$2,662.89	5192	\$4,678.53	\$390.74	\$1,947.94
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	\$4,056.12	5193	\$9,669.04	\$468.96	\$2,452.95
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of an intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation to perform the stenting and all angioplasty within the peripheral dialysis circuit	\$9,724.07	5194	\$15,354.50	\$542.14	\$6,698.12
(+) 36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	\$ – (Packaged service/ item; no separate payment made)	\$ – (Items and services are packaged into APC rate)	\$ – (Items and services are packaged into APC rate)	\$212.67	\$2,016.79

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Medicare Reimbursement for Manual Aspiration						
37799	Unlisted procedure, vascular surgery	\$ – (Surgical procedure excluded from payment under ASC)	5181	\$612.53	Carrier Priced	Carrier Priced
Medicare Reimbursement for Percutaneous Transluminal Coronary Mechanical Thrombectomy*						
(+)92973	Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure)  Notes: (Use 92973 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454-93461, 93563, 93564)  (Do not report 92973 for non-mechanical aspiration thrombectomy)	\$ – (Packaged service/ item; no separate payment made)	(Items and services are packaged into APC rate)	\$ – (Items and services are packaged into APC rate)	\$186.36	\$ – (Surgical procedure not performed in office setting)
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	\$ – (Surgical procedure excluded from payment under ASC)	5192	\$4,679	\$559.81	\$559.81
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	\$ – (Surgical procedure excluded from payment under ASC)	5193	\$9,669	\$623.24	\$623.24
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	\$ – (Surgical procedure excluded from payment under ASC)	5193	\$9,669	\$667.94	\$667.94
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	\$ – (Surgical procedure excluded from payment under ASC)	5194	\$15,355	\$698.58	\$698.58
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	\$ – (Surgical procedure excluded from payment under ASC)	5193	\$9,669	\$623.24	\$623.24
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	\$ – (Surgical procedure excluded from payment under ASC)	5194	\$9,669	\$700.38	\$700.38

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Medicare Reimbursement for Percutaneous Transluminal Coronary Mechanical Thrombectomy* (continued)						
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	\$ – (Surgical procedure excluded from payment under ASC)	5191	\$2,810	\$253.05	\$900.80
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	\$ – (Surgical procedure excluded from payment under ASC)	5191	\$2,810	\$294.86	\$1,037.77
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	\$ – (Surgical procedure excluded from payment under ASC)	5191	\$2,810	\$328.74	\$1,140.87
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	\$ – (Surgical procedure excluded from payment under ASC)	5191	\$2,810	\$370.56	\$1,276.04
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	\$ – (Surgical procedure excluded from payment under ASC)	5191	\$2,810	\$312.88	\$1,069.85
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	\$ – (Surgical procedure excluded from payment under ASC)	5191	\$2,810	\$355.06	\$1,175.11

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## Physician and Outpatient Coding and Payment

		Ambulatory Surgery Center (ASC)	Hospital Outpatient Department (HOPD)		Physician Services	
CPT® Code¹	Description	Facility Payment²	APC	Facility Payment³	Fee When Service is Performed in the HOPD or Inpatient Setting⁴	Fee When Service is Performed in the Physician Office⁴
Medicare Reimbursement for Percutaneous Transluminal Coronary Mechanical Thrombectomy* (continued)						
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	\$ – (Surgical procedure excluded from payment under ASC)	5191	\$2,810	\$395.43	\$1,282.89
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	\$ – (Surgical procedure excluded from payment under ASC)	5191	\$2,810	\$437.96	\$1,452.31

\*As part of the Indigo Aspiration System, the Indigo CAT RX Aspiration Catheters and Indigo Separator™ 4 are indicated for the removal of fresh, soft emboli and thrombi from vessels in the coronary and peripheral vasculature.

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2. 2019 Medicare Ambulatory Surgical Center (ASC) Payment System.

3. 2019 Medicare Outpatient Prospective Payment System (OPPS).

4. 2019 Medicare Physician Fee Schedule (MPFS).

a. The 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. 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.

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# Hospital Inpatient Coding and Payment

## ICD-10-PCS Arteriovenous Fistula Procedural Coding

03WY3JZ	Revision of Synthetic Substitute of Upper Artery, Percutaneous Approach
03WY37Z	Revision of Autologous Tissue Substitute of Upper Artery, Percutaneous Approach
03WY3KZ	Revision of Non-Autologous Tissue Substitute of Upper Artery, Percutaneous Approach

## ICD-10-PCS Arterial Procedure Coding

03C33ZZ	Extirpation of Matter from Right Subclavian Artery, Percutaneous Approach
03C43ZZ	Extirpation of Matter from Left Subclavian Artery, Percutaneous Approach
03C53Z6	Extirpation of Matter from Right Axillary Artery, Bifurcation, Percutaneous Approach
03C53ZZ	Extirpation of Matter from Right Axillary Artery, Percutaneous Approach
03C63Z6	Extirpation of Matter from Left Axillary Artery, Bifurcation, Percutaneous Approach
03C63ZZ	Extirpation of Matter from Left Axillary Artery, Percutaneous Approach
03C73Z6	Extirpation of Matter from Right Brachial Artery, Bifurcation, Percutaneous Approach
03C73ZZ	Extirpation of Matter from Right Brachial Artery, Percutaneous Approach
03C83Z6	Extirpation of Matter from Left Brachial Artery, Bifurcation, Percutaneous Approach
03C83ZZ	Extirpation of Matter from Left Brachial Artery, Percutaneous Approach
03C93Z6	Extirpation of Matter from Right Ulnar Artery, Bifurcation, Percutaneous Approach
03C93ZZ	Extirpation of Matter from Right Ulnar Artery, Percutaneous Approach
03CA3Z6	Extirpation of Matter from Left Ulnar Artery, Bifurcation, Percutaneous Approach
03CA3ZZ	Extirpation of Matter from Left Ulnar Artery, Percutaneous Approach
03CB3Z6	Extirpation of Matter from Right Radial Artery, Bifurcation, Percutaneous Approach
03CB3ZZ	Extirpation of Matter from Right Radial Artery, Percutaneous Approach
03CC3Z6	Extirpation of Matter from Left Radial Artery, Bifurcation, Percutaneous Approach
03CC3ZZ	Extirpation of Matter from Left Radial Artery, Percutaneous Approach
03CY3ZZ	Extirpation of Matter from Upper Artery, Percutaneous Approach
04C53Z6	Extirpation of Matter from Superior Mesenteric Artery, Bifurcation, Percutaneous Approach
04C53ZZ	Extirpation of Matter from Superior Mesenteric Artery, Percutaneous Approach
04C93Z6	Extirpation of Matter from Right Renal Artery, Bifurcation, Percutaneous Approach
04C93ZZ	Extirpation of Matter from Right Renal Artery, Percutaneous Approach
04CA3Z6	Extirpation of Matter from Left Renal Artery, Bifurcation, Percutaneous Approach
04CA3ZZ	Extirpation of Matter from Left Renal Artery, Percutaneous Approach
04CB3Z6	Extirpation of Matter from Inferior Mesenteric Artery, Bifurcation, Percutaneous Approach
04CB3ZZ	Extirpation of Matter from Inferior Mesenteric Artery, Percutaneous Approach
04CC3Z6	Extirpation of Matter from Right Common Iliac Artery, Bifurcation, Percutaneous Approach
04CC3ZZ	Extirpation of Matter from Right Common Iliac Artery, Percutaneous Approach
04CD3Z6	Extirpation of Matter from Left Common Iliac Artery, Bifurcation, Percutaneous Approach
04CD3ZZ	Extirpation of Matter from Left Common Iliac Artery, Percutaneous Approach
04CE3Z6	Extirpation of Matter from Right Internal Iliac Artery, Bifurcation, Percutaneous Approach
04CE3ZZ	Extirpation of Matter from Right Internal Iliac Artery, Percutaneous Approach
04CF3Z6	Extirpation of Matter from Left Internal Iliac Artery, Bifurcation, Percutaneous Approach
04CF3ZZ	Extirpation of Matter from Left Internal Iliac Artery, Percutaneous Approach



# Hospital Inpatient Coding and Payment

## ICD-10-PCS Arterial Procedure Coding (continued)

04CH3Z6	Extirpation of Matter from Right External Iliac Artery, Bifurcation, Percutaneous Approach
04CH3ZZ	Extirpation of Matter from Right External Iliac Artery, Percutaneous Approach
04CJ3Z6	Extirpation of Matter from Left External Iliac Artery, Bifurcation, Percutaneous Approach
04CJ3ZZ	Extirpation of Matter from Left External Iliac Artery, Percutaneous Approach
04CK3Z6	Extirpation of Matter from Right Femoral Artery, Bifurcation, Percutaneous Approach
04CK3ZZ	Extirpation of Matter from Right Femoral Artery, Percutaneous Approach
04CL3Z6	Extirpation of Matter from Left Femoral Artery, Bifurcation, Percutaneous Approach
04CL3ZZ	Extirpation of Matter from Left Femoral Artery, Percutaneous Approach
04CM3Z6	Extirpation of Matter from Right Popliteal Artery, Bifurcation, Percutaneous Approach
04CM3ZZ	Extirpation of Matter from Right Popliteal Artery, Percutaneous Approach
04CN3Z6	Extirpation of Matter from Left Popliteal Artery, Bifurcation, Percutaneous Approach
04CN3ZZ	Extirpation of Matter from Left Popliteal Artery, Percutaneous Approach
04CP3Z6	Extirpation of Matter from Right Anterior Tibial Artery, Bifurcation, Percutaneous Approach
04CP3ZZ	Extirpation of Matter from Right Anterior Tibial Artery, Percutaneous Approach
04CQ3Z6	Extirpation of Matter from Left Anterior Tibial Artery, Bifurcation, Percutaneous Approach
04CQ3ZZ	Extirpation of Matter from Left Anterior Tibial Artery, Percutaneous Approach
04CR3Z6	Extirpation of Matter from Right Posterior Tibial Artery, Bifurcation, Percutaneous Approach
04CR3ZZ	Extirpation of Matter from Right Posterior Tibial Artery, Percutaneous Approach
04CS3Z6	Extirpation of Matter from Left Posterior Tibial Artery, Bifurcation, Percutaneous Approach
04CS3ZZ	Extirpation of Matter from Left Posterior Tibial Artery, Percutaneous Approach
04CT3Z6	Extirpation of Matter from Right Peroneal Artery, Bifurcation, Percutaneous Approach
04CT3ZZ	Extirpation of Matter from Right Peroneal Artery, Percutaneous Approach
04CU3Z6	Extirpation of Matter from Left Peroneal Artery, Bifurcation, Percutaneous Approach
04CU3ZZ	Extirpation of Matter from Left Peroneal Artery, Percutaneous Approach
04CV3Z6	Extirpation of Matter from Right Foot Artery, Bifurcation, Percutaneous Approach
04CV3ZZ	Extirpation of Matter from Right Foot Artery, Percutaneous Approach
04CW3Z6	Extirpation of Matter from Left Foot Artery, Bifurcation, Percutaneous Approach
04CW3ZZ	Extirpation of Matter from Left Foot Artery, Percutaneous Approach
04CY3Z6	Extirpation of Matter from Lower Artery, Bifurcation, Percutaneous Approach
04CY3ZZ	Extirpation of Matter from Lower Artery, Percutaneous Approach

## ICD-10-PCS Venous Procedure Coding

05C53ZZ	Extirpation of Matter from Right Subclavian Vein, Percutaneous Approach
05C63ZZ	Extirpation of Matter from Left Subclavian Vein, Percutaneous Approach
05C73ZZ	Extirpation of Matter from Right Axillary Vein, Percutaneous Approach
05C83ZZ	Extirpation of Matter from Left Axillary Vein, Percutaneous Approach
05C93ZZ	Extirpation of Matter from Right Brachial Vein, Percutaneous Approach
05CA3ZZ	Extirpation of Matter from Left Brachial Vein, Percutaneous Approach
05CB3ZZ	Extirpation of Matter from Right Basilic Vein, Percutaneous Approach
05CC3ZZ	Extirpation of Matter from Left Basilic Vein, Percutaneous Approach
05CD3ZZ	Extirpation of Matter from Right Cephalic Vein, Percutaneous Approach
05CF3ZZ	Extirpation of Matter from Left Cephalic Vein, Percutaneous Approach
06C93ZZ	Extirpation of Matter from Right Renal Vein, Percutaneous Approach
06CB3ZZ	Extirpation of Matter from Left Renal Vein, Percutaneous Approach
06CC3ZZ	Extirpation of Matter from Right Common Iliac Vein, Percutaneous Approach
06CD3ZZ	Extirpation of Matter from Left Common Iliac Vein, Percutaneous Approach
06CF3ZZ	Extirpation of Matter from Right External Iliac Vein, Percutaneous Approach
06CG3ZZ	Extirpation of Matter from Left External Iliac Vein, Percutaneous Approach
06CH3ZZ	Extirpation of Matter from Right Hypogastric Vein, Percutaneous Approach
06CJ3ZZ	Extirpation of Matter from Left Hypogastric Vein, Percutaneous Approach
06CM3ZZ	Extirpation of Matter from Right Femoral Vein, Percutaneous Approach
06CN3ZZ	Extirpation of Matter from Left Femoral Vein, Percutaneous Approach
06CP3ZZ	Extirpation of Matter from Right Greater Saphenous Vein, Percutaneous Approach
06CQ3ZZ	Extirpation of Matter from Left Greater Saphenous Vein, Percutaneous Approach
06CR3ZZ	Extirpation of Matter from Right Lesser Saphenous Vein, Percutaneous Approach
06CS3ZZ	Extirpation of Matter from Left Lesser Saphenous Vein, Percutaneous Approach
06CT3ZZ	Extirpation of Matter from Right Foot Vein, Percutaneous Approach
06CV3ZZ	Extirpation of Matter from Left Foot Vein, Percutaneous Approach
06CY3ZZ	Extirpation of Matter from Lower Vein, Percutaneous Approach



# Hospital Inpatient Coding and Payment

## MS-DRG and 2020 Payment Rates: Arterial/Venous Procedure Reimbursement

MS-DRG	Description	2020 National Medicare Payment
252	Other Vascular Procedures w/ MCC	\$20,548
253	Other Vascular Procedures w/ CC	\$16,327
254	Other Vascular Procedures w/o CC/MCC	\$11,401
270	Other Major Cardiovascular Procedures w/ MCC	\$32,009
271	Other Major Cardiovascular Procedures w/ CC	\$22,224
272	Other Major Cardiovascular Procedures w/o CC/MCC	\$16,294

2020 Inpatient rates in effect from October 1, 2019 – September 30, 2020  
 (M)CC = (major) complications and/or comorbidities. Complete list available at: <http://www.cms.hhs.gov/AcuteInpatientPPS>  
 Rates reflect FY 2020 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.

## Charges for the Indigo System may be assigned to the following revenue codes:

- **0270** Medical/surgical supply
- **0272** Sterile supply
- **0279** Other supplies/devices

## HCPSC

Product	Suggested HCPSC
Penumbra Aspiration Catheters	<b>C1887</b> - Catheter, guiding (may include infusion/perfusion capability)
Penumbra Separators	<b>C1757</b> - Catheter, thrombectomy/embolectomy
Sterile Aspiration Tubing	NONE
Non-Sterile System Supplies	NONE

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

## References & Sources

- HIPPS (Inpatient) Federal Register / Vol. 84, No. 159 / Friday, August 16, 2019.
- OPPS/ASC (Outpatient) Federal Register / Vol 83, No. 225 / Wednesday, November 21, 2018.
- MPFS (Physician) Federal Register / Vol 83, No. 226 / Friday, November 23, 2018.
- ICD-10-PCS 2019 ICD-10-PCS Complete Official Codebook. American Medical Association. Copyright ©2019 Optum360, LLC.
- HCPSC 2019 Level II Professional Edition. American Medical Association. Copyright ©2019 Optum360, LLC.

# Hospital Inpatient Reimbursement

## DRG and 2020 Payment Rates: Percutaneous Coronary Intervention (PCI) Procedures

DRG	Description	2020 National Medicare Payment
246	Percutaneous Cardiovascular Procedure w/ Drug-Eluting Stent w/ MCC or 4+ Vessls/Stents	\$19,874
247	Percutaneous Cardiovascular Procedure w/ Drug-Eluting Stent w/o MCC	\$12,745
248	Percutaneous Cardiovascular Procedure w/ Non-Drug-Eluting Stent w/ MCC or 4+ Vessls/Stents	\$19,396
249	Percutaneous Cardiovascular Procedure w/ Non-Drug-Eluting Stent w/o MCC	\$12,005
250	Percutaneous Cardiovascular Procedure w/o Coronary Artery Stent w/ MCC	\$15,973
251	Percutaneous Cardiovascular Procedure w/o Coronary Artery Stent w/o MCC	\$10,542

2020 inpatient rates in effect from October 1, 2019 - September 30, 2020

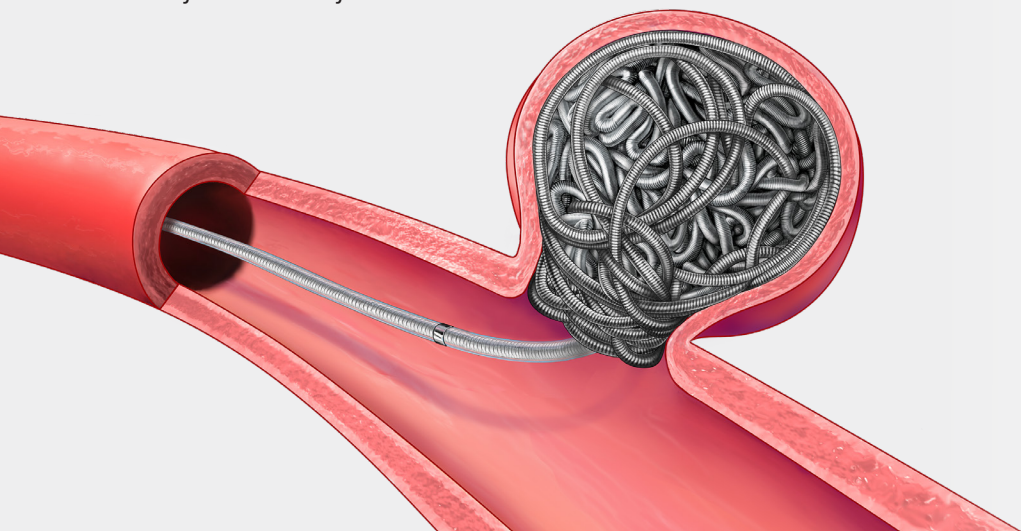
(M)CC = (major) complications and/or comorbidities. Complete list available at: <http://www.cms.hhs.gov/AcuteInpatientPPS>

Rates reflect FY 2020 National Medicare payment rates for hospitals submitting quality data and meaningful EHR users.

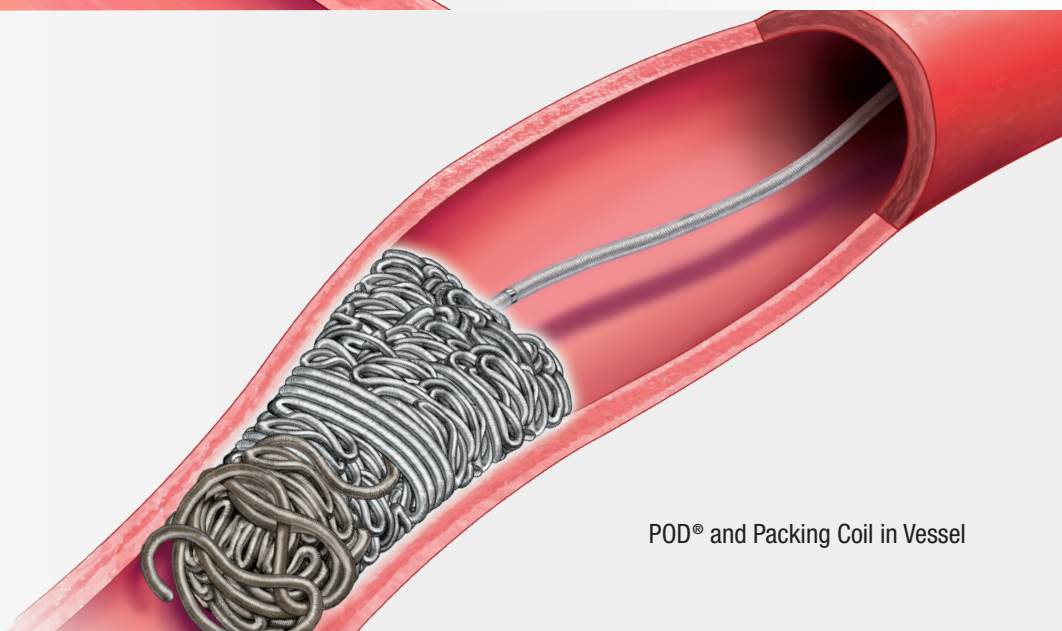
Hospitals that do not submit quality data or are not meaningful EHR users may see decreased payment rates.

# Peripheral Coil Embolization

Ruby® Coil in Aneurysm



POD® and Packing Coil in Vessel



LANTERN® Microcatheter



## Physician and Outpatient Coding and Payment

Coverage, coding, and reimbursement for medical procedures and devices can be confusing. This guide was developed to assist you in correctly reporting and obtaining appropriate Medicare reimbursement for peripheral coil embolization procedures. If you have any questions, please contact our reimbursement team at 1.866.808.1645 or by email at [penumbra@navigant.com](mailto:penumbra@navigant.com).

### Coverage

Medicare carriers issue local coverage decisions (LCDs) listing coverage criteria for certain procedures. Physicians are urged to review their local carrier coverage policies (<http://www.cms.hhs.gov/mcd/search.asp?>) and/or contact their local carrier medical directors (<http://www.cms.hhs.gov/apps/contacts/>).

### Coding Tips for Vascular Embolization

Effective January 1, 2017, prior moderate sedation codes CPT® 99143-99150 have been deleted and moderate sedation services have been unbundled from many interventional services. To receive full payment, providers performing moderate sedation for vascular embolization (CPT 37241-37244) should now separately report new moderate sedation codes (CPT 99151-99157) with proper medical documentation.

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## Physician and Outpatient Coding and Payment

Embolization		Physician Services		Hospital Outpatient Department (HOPD)		Ambulatory Surgical Center (ASC)
CPT® Code <sup>1</sup>	Description	Fee When Service is Performed in the HOPD or Inpatient Setting <sup>4</sup>	Fee When Service is Performed in the Physician Office <sup>4</sup>	APC	Facility Payment <sup>3</sup>	Facility Payment <sup>2</sup>
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (e.g., congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	\$468.96	\$5,055.13	5193	\$9,669.04	\$4,056.12
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (e.g., congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	\$501.76	\$7,715.35	5193	\$9,669.04	\$5,786.97
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	\$591.16	\$10,014.02	5193	\$9,669.04	\$4,056.12
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	\$696.00	\$7053.00	5193	\$9669.04	\$— (Service not covered in ASC setting)

Catheter Access		Physician Services		Hospital Outpatient Department (HOPD)	
CPT Code <sup>1</sup>	Description	Fee When Service is Performed in the HOPD or Inpatient Setting <sup>4</sup>	Fee When Service is Performed in the Physician Office <sup>4</sup>	APC	Facility Payment <sup>3</sup>
36140	Introduction of needle or intracatheter, extremity artery	\$94.08	\$462.11	\$— (Items and services are packaged into APC Rate)	\$— (Items and services are packaged into APC Rate)
36160	Introduction of needle or intracatheter, aortic, translumbar	\$129.05	\$532.04	\$— (Items and services are packaged into APC Rate)	\$— (Items and services are packaged into APC Rate)
36200	Introduction of catheter, aorta	\$147.43	\$590.08	\$— (Items and services are packaged into APC Rate)	\$— (Items and services are packaged into APC Rate)

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3. 2019 Medicare Outpatient Prospective Payment System (OPPS).

4. 2019 Medicare Physician Fee Schedule (MPFS).

"TC" refers to the technical component of the procedure.

"26" is a modifier for the professional component of the procedure.

a. The 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. 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.

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## Physician and Outpatient Coding and Payment

Catheter Placement		Physician Services		Hospital Outpatient Department (HOPD)	
CPT® Code <sup>1</sup>	Description	Fee When Service is Performed in the HOPD or Inpatient Setting <sup>4</sup>	Fee When Service is Performed in the Physician Office <sup>4</sup>	APC	Facility Payment <sup>3</sup>
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	\$224.57	\$1,080.67	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)
36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	\$287.65	\$1,154.92	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	\$344.60	\$1,937.85	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)
(+) 36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	\$54.07	\$251.24	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$250.16	\$1,362.91	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$267.46	\$865.11	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$317.57	\$1,549.99	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)
(+) 36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (list in addition to code for initial second or third order vessel as appropriate)	\$51.55	\$149.95	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)

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"TC" refers to the technical component of the procedure.

"26" is a modifier for the professional component of the procedure.

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(+) in front of a procedure code denotes an add-on code. Add-on codes allow reporting of additional work associated with a primary procedure(s) and must never be reported alone. In addition, physician add-on codes are exempt from multiple procedure reduction.

## Physician and Outpatient Coding and Payment

Catheter Placement (continued)		Physician Services		Hospital Outpatient Department (HOPD)	
CPT® Code <sup>1</sup>	Description	Fee When Service is Performed in the HOPD or Inpatient Setting <sup>4</sup>	Fee When Service is Performed in the Physician Office <sup>4</sup>	APC	Facility Payment <sup>3</sup>
36251	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	\$273.23	\$1,425.63	5183	\$2,641.52
36252	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	\$379.93	\$1,539.18	5183	\$2,641.52
36253	Superselective catheter placement (one or more second order or higher renal artery branches), renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	\$376.32	\$2,286.78	5184	\$4,376.52
36254	Superselective catheter placement (one or more second order or higher renal artery branches), renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	\$439.40	\$2,208.20	5183	\$2,641.52

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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.

Physician fees for your local area can be found at the following CMS link: <https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

(+) in front of a procedure code denotes an add-on code. Add-on codes allow reporting of additional work associated with a primary procedure(s) and must never be reported alone. In addition, physician add-on codes are exempt from multiple procedure reduction.

## Physician and Outpatient Coding and Payment

Imaging			Physician Services		Hospital Outpatient Department (HOPD)		a
CPT® Code <sup>1</sup>	Modifier	Description	Fee When Service is Performed in the HOPD or Inpatient Setting <sup>4</sup>	Fee When Service is Performed in the Physician Office <sup>4</sup>	APC	Facility Payment <sup>3</sup>	
75710		Angiography, extremity, unilateral, radiological supervision and interpretation	NA	\$171.58	5183	\$2,641.52	
	TC		NA	\$83.27			
	26		\$88.31	\$88.31			
75716		Angiography, extremity, bilateral, radiological supervision and interpretation	NA	\$181.31	5183	\$2,641.52	
	TC		NA	\$83.99			
	26		\$97.33	\$97.33			
75726		Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	NA	\$148.15	5184	\$4,376.52	
	TC		NA	\$92.28			
	26		\$55.87	\$55.87			
75731		Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	NA	\$171.22	5181	\$1,093.63	
	TC		NA	\$113.19			
	26		\$58.03	\$58.03			
75733		Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	NA	\$182.75	5183	\$2,641.52	
	TC		NA	\$118.23			
	26		\$64.52	\$64.52			
75736		Angiography, pelvic, selective or supraseductive, radiological supervision and interpretation	NA	\$159.32	5184	\$4,376.52	
	TC		NA	\$102.73			
	26		\$56.59	\$56.59			
(+ 75774		Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	NA	\$84.35	\$– (Items and services are packaged into APC Rate)	\$– (Items and services are packaged into APC Rate)	
	TC		NA	\$67.05			
	26		\$17.30	\$17.30			

1. CPT® 2019. American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

2. 2019 Medicare Ambulatory Surgical Center (ASC) Payment System.

3. 2019 Medicare Outpatient Prospective Payment System (OPPS).

4. 2019 Medicare Physician Fee Schedule (MPFS).

"TC" refers to the technical component of the procedure.

"26" is a modifier for the professional component of the procedure.

a. The 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. 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.

Physician fees for your local area can be found at the following CMS link: <https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>



# Hospital Inpatient Coding and Payment

## ICD-10-PCS Arterial Procedure Coding

03V03DZ	Restriction of Right Internal Mammary Artery with Intraluminal Device, Percutaneous Approach
03V13DZ	Restriction of Left Internal Mammary Artery with Intraluminal Device, Percutaneous Approach
03V23DZ	Restriction of Innominate Artery with Intraluminal Device, Percutaneous Approach
03V33DZ	Restriction of Right Subclavian Artery with Intraluminal Device, Percutaneous Approach
03V43DZ	Restriction of Left Subclavian Artery with Intraluminal Device, Percutaneous Approach
03V53DZ	Restriction of Right Axillary Artery with Intraluminal Device, Percutaneous Approach
03V63DZ	Restriction of Left Axillary Artery with Intraluminal Device, Percutaneous Approach
03V73DZ	Restriction of Right Brachial Artery with Intraluminal Device, Percutaneous Approach
03V83DZ	Restriction of Left Brachial Artery with Intraluminal Device, Percutaneous Approach
03V93DZ	Restriction of Right Ulnar Artery with Intraluminal Device, Percutaneous Approach
03VA3DZ	Restriction of Left Ulnar Artery with Intraluminal Device, Percutaneous Approach
03VB3DZ	Restriction of Right Radial Artery with Intraluminal Device, Percutaneous Approach
03VC3DZ	Restriction of Left Radial Artery with Intraluminal Device, Percutaneous Approach
03VD3DZ	Restriction of Right Hand Artery with Intraluminal Device, Percutaneous Approach
03VF3DZ	Restriction of Left Hand Artery with Intraluminal Device, Percutaneous Approach
03VR3DZ	Restriction of Face Artery with Intraluminal Device, Percutaneous Approach
03VS3DZ	Restriction of Right Temporal Artery with Intraluminal Device, Percutaneous Approach
03VT3DZ	Restriction of Left Temporal Artery with Intraluminal Device, Percutaneous Approach
03VU3DZ	Restriction of Right Thyroid Artery with Intraluminal Device, Percutaneous Approach
03VV3DZ	Restriction of Left Thyroid Artery with Intraluminal Device, Percutaneous Approach
03VY3DZ	Restriction of Upper Artery with Intraluminal Device, Percutaneous Approach
03L03DZ	Occlusion of Right Internal Mammary Artery with Intraluminal Device, Percutaneous Approach
03L13DZ	Occlusion of Left Internal Mammary Artery with Intraluminal Device, Percutaneous Approach
03L23DZ	Occlusion of Innominate Artery with Intraluminal Device, Percutaneous Approach
03L33DZ	Occlusion of Right Subclavian Artery with Intraluminal Device, Percutaneous Approach
03L43DZ	Occlusion of Left Subclavian Artery with Intraluminal Device, Percutaneous Approach
03L53DZ	Occlusion of Right Axillary Artery with Intraluminal Device, Percutaneous Approach
03L63DZ	Occlusion of Left Axillary Artery with Intraluminal Device, Percutaneous Approach
03L73DZ	Occlusion of Right Brachial Artery with Intraluminal Device, Percutaneous Approach
03L83DZ	Occlusion of Left Brachial Artery with Intraluminal Device, Percutaneous Approach
03L93DZ	Occlusion of Right Ulnar Artery with Intraluminal Device, Percutaneous Approach
03LA3DZ	Occlusion of Left Ulnar Artery with Intraluminal Device, Percutaneous Approach
03LB3DZ	Occlusion of Right Radial Artery with Intraluminal Device, Percutaneous Approach
03LC3DZ	Occlusion of Left Radial Artery with Intraluminal Device, Percutaneous Approach
03LD3DZ	Occlusion of Right Hand Artery with Intraluminal Device, Percutaneous Approach
03LF3DZ	Occlusion of Left Hand Artery with Intraluminal Device, Percutaneous Approach
03LR3DZ	Occlusion of Face Artery with Intraluminal Device, Percutaneous Approach
03LS3DZ	Occlusion of Right Temporal Artery with Intraluminal Device, Percutaneous Approach
03LT3DZ	Occlusion of Left Temporal Artery with Intraluminal Device, Percutaneous Approach
03LU3DZ	Occlusion of Right Thyroid Artery with Intraluminal Device, Percutaneous Approach
03LV3DZ	Occlusion of Left Thyroid Artery with Intraluminal Device, Percutaneous Approach
03LY3DZ	Occlusion of Upper Artery with Intraluminal Device, Percutaneous Approach

# Hospital Inpatient Coding and Payment

## ICD-10-PCS Arterial Procedure Coding

04V03DZ	Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach
04V13DZ	Restriction of Celiac Artery with Intraluminal Device, Percutaneous Approach
04V23DZ	Restriction of Gastric Artery with Intraluminal Device, Percutaneous Approach
04V33DZ	Restriction of Hepatic Artery with Intraluminal Device, Percutaneous Approach
04V43DZ	Restriction of Splenic Artery with Intraluminal Device, Percutaneous Approach
04V53DZ	Restriction of Superior Mesenteric Artery with Intraluminal Device, Percutaneous Approach
04V63DZ	Restriction of Right Colic Artery with Intraluminal Device, Percutaneous Approach
04V73DZ	Restriction of Left Colic Artery with Intraluminal Device, Percutaneous Approach
04V83DZ	Restriction of Middle Colic Artery with Intraluminal Device, Percutaneous Approach
04V93DZ	Restriction of Right Renal Artery with Intraluminal Device, Percutaneous Approach
04VA3DZ	Restriction of Left Renal Artery with Intraluminal Device, Percutaneous Approach
04VB3DZ	Restriction of Inferior Mesenteric Artery with Intraluminal Device, Percutaneous Approach
04VC3DZ	Restriction of Right Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04VD3DZ	Restriction of Left Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04VE3DZ	Restriction of Right Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04VF3DZ	Restriction of Left Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04VH3DZ	Restriction of Right External Iliac Artery with Intraluminal Device, Percutaneous Approach
04VJ3DZ	Restriction of Left External Iliac Artery with Intraluminal Device, Percutaneous Approach
04VK3DZ	Restriction of Right Femoral Artery with Intraluminal Device, Percutaneous Approach
04VL3DZ	Restriction of Left Femoral Artery with Intraluminal Device, Percutaneous Approach
04VM3DZ	Restriction of Right Popliteal Artery with Intraluminal Device, Percutaneous Approach
04VN3DZ	Restriction of Left Popliteal Artery with Intraluminal Device, Percutaneous Approach
04VP3DZ	Restriction of Right Anterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04VQ3DZ	Restriction of Left Anterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04VR3DZ	Restriction of Right Posterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04VS3DZ	Restriction of Left Posterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04VT3DZ	Restriction of Right Peroneal Artery with Intraluminal Device, Percutaneous Approach
04VU3DZ	Restriction of Left Peroneal Artery with Intraluminal Device, Percutaneous Approach
04VV3DZ	Restriction of Right Foot Artery with Intraluminal Device, Percutaneous Approach
04VW3DZ	Restriction of Left Foot Artery with Intraluminal Device, Percutaneous Approach
04VY3DZ	Restriction of Lower Artery with Intraluminal Device, Percutaneous Approach
04L13DZ	Occlusion of Celiac Artery with Intraluminal Device, Percutaneous Approach
04L23DZ	Occlusion of Gastric Artery with Intraluminal Device, Percutaneous Approach
04L33DZ	Occlusion of Hepatic Artery with Intraluminal Device, Percutaneous Approach
04L43DZ	Occlusion of Splenic Artery with Intraluminal Device, Percutaneous Approach
04L53DZ	Occlusion of Superior Mesenteric Artery with Intraluminal Device, Percutaneous Approach
04L63DZ	Occlusion of Right Colic Artery with Intraluminal Device, Percutaneous Approach
04L73DZ	Occlusion of Left Colic Artery with Intraluminal Device, Percutaneous Approach
04L83DZ	Occlusion of Middle Colic Artery with Intraluminal Device, Percutaneous Approach
04L93DZ	Occlusion of Right Renal Artery with Intraluminal Device, Percutaneous Approach
04LA3DZ	Occlusion of Left Renal Artery with Intraluminal Device, Percutaneous Approach
04LB3DZ	Occlusion of Inferior Mesenteric Artery with Intraluminal Device, Percutaneous Approach
04LC3DZ	Occlusion of Right Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04LD3DZ	Occlusion of Left Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04LE3DZ	Occlusion of Right Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04LF3DZ	Occlusion of Left Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04LH3DZ	Occlusion of Right External Iliac Artery with Intraluminal Device, Percutaneous Approach
04LJ3DZ	Occlusion of Left External Iliac Artery with Intraluminal Device, Percutaneous Approach
04LK3DZ	Occlusion of Right Femoral Artery with Intraluminal Device, Percutaneous Approach
04LL3DZ	Occlusion of Left Femoral Artery with Intraluminal Device, Percutaneous Approach

# Hospital Inpatient Coding and Payment

## ICD-10-PCS Arterial Procedure Coding

04LM3DZ	Occlusion of Right Popliteal Artery with Intraluminal Device, Percutaneous Approach
04LN3DZ	Occlusion of Left Popliteal Artery with Intraluminal Device, Percutaneous Approach
04LP3DZ	Occlusion of Right Anterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04LQ3DZ	Occlusion of Left Anterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04LR3DZ	Occlusion of Right Posterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04LS3DZ	Occlusion of Left Posterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04LT3DZ	Occlusion of Right Peroneal Artery with Intraluminal Device, Percutaneous Approach
04LU3DZ	Occlusion of Left Peroneal Artery with Intraluminal Device, Percutaneous Approach
04LV3DZ	Occlusion of Right Foot Artery with Intraluminal Device, Percutaneous Approach
04LW3DZ	Occlusion of Left Foot Artery with Intraluminal Device, Percutaneous Approach
04LY3DZ	Occlusion of Lower Artery with Intraluminal Device, Percutaneous Approach

## ICD-10-PCS Venous Procedure Coding

06L13DZ	Occlusion of Splenic Vein with Intraluminal Device, Percutaneous Approach
06L23DZ	Occlusion of Gastric Vein with Intraluminal Device, Percutaneous Approach
06L33DZ	Occlusion of Esophageal Vein with Intraluminal Device, Percutaneous Approach
06L43DZ	Occlusion of Hepatic Vein with Intraluminal Device, Percutaneous Approach
06L53DZ	Occlusion of Superior Mesenteric Vein with Intraluminal Device, Percutaneous Approach
06L63DZ	Occlusion of Inferior Mesenteric Vein with Intraluminal Device, Percutaneous Approach
06L73DZ	Occlusion of Colic Vein with Intraluminal Device, Percutaneous Approach
06L83DZ	Occlusion of Portal Vein with Intraluminal Device, Percutaneous Approach
06L93DZ	Occlusion of Right Renal Vein with Intraluminal Device, Percutaneous Approach
06LB3DZ	Occlusion of Left Renal Vein with Intraluminal Device, Percutaneous Approach
06LC3DZ	Occlusion of Right Common Iliac Vein with Intraluminal Device, Percutaneous Approach
06LD3DZ	Occlusion of Left Common Iliac Vein with Intraluminal Device, Percutaneous Approach
06LF3DZ	Occlusion of Right External Iliac Vein with Intraluminal Device, Percutaneous Approach
06LG3DZ	Occlusion of Left External Iliac Vein with Intraluminal Device, Percutaneous Approach
06LH3DZ	Occlusion of Right Hypogastric Vein with Intraluminal Device, Percutaneous Approach
06LY3DZ	Occlusion of Lower Vein with Intraluminal Device, Percutaneous Approach
06LJ3DZ	Occlusion of Left Hypogastric Vein with Intraluminal Device, Percutaneous Approach
06LM3DZ	Occlusion of Right Femoral Vein with Intraluminal Device, Percutaneous Approach
06LN3DZ	Occlusion of Left Femoral Vein with Intraluminal Device, Percutaneous Approach
06LP3DZ	Occlusion of Right Greater Saphenous Vein with Intraluminal Device, Percutaneous Approach
06LQ3DZ	Occlusion of Left Greater Saphenous Vein with Intraluminal Device, Percutaneous Approach
06LR3DZ	Occlusion of Right Lesser Saphenous Vein with Intraluminal Device, Percutaneous Approach
06LS3DZ	Occlusion of Left Lesser Saphenous Vein with Intraluminal Device, Percutaneous Approach
06LT3DZ	Occlusion of Right Foot Vein with Intraluminal Device, Percutaneous Approach
06LV3DZ	Occlusion of Left Foot Vein with Intraluminal Device, Percutaneous Approach
06V13DZ	Restriction of Splenic Vein with Intraluminal Device, Percutaneous Approach
06V23DZ	Restriction of Gastric Vein with Intraluminal Device, Percutaneous Approach
06V33DZ	Restriction of Esophageal Vein with Intraluminal Device, Percutaneous Approach
06V43DZ	Restriction of Hepatic Vein with Intraluminal Device, Percutaneous Approach
06V53DZ	Restriction of Superior Mesenteric Vein with Intraluminal Device, Percutaneous Approach
06V63DZ	Restriction of Inferior Mesenteric Vein with Intraluminal Device, Percutaneous Approach
06V73DZ	Restriction of Colic Vein with Intraluminal Device, Percutaneous Approach
06V83DZ	Restriction of Portal Vein with Intraluminal Device, Percutaneous Approach
06V93DZ	Restriction of Right Renal Vein with Intraluminal Device, Percutaneous Approach
06VB3DZ	Restriction of Left Renal Vein with Intraluminal Device, Percutaneous Approach

# Hospital Inpatient Coding and Payment

## ICD-10-PCS Venous Procedure Coding

06VC3DZ	Restriction of Right Common Iliac Vein with Intraluminal Device, Percutaneous Approach
06VD3DZ	Restriction of Left Common Iliac Vein with Intraluminal Device, Percutaneous Approach
06VF3DZ	Restriction of Right External Iliac Vein with Intraluminal Device, Percutaneous Approach
06VG3DZ	Restriction of Left External Iliac Vein with Intraluminal Device, Percutaneous Approach
06VH3DZ	Restriction of Right Hypogastric Vein with Intraluminal Device, Percutaneous Approach
06VY3DZ	Restriction of Lower Vein with Intraluminal Device, Percutaneous Approach
06VJ3DZ	Restriction of Left Hypogastric Vein with Intraluminal Device, Percutaneous Approach
06VM3DZ	Restriction of Right Femoral Vein with Intraluminal Device, Percutaneous Approach
06VN3DZ	Restriction of Left Femoral Vein with Intraluminal Device, Percutaneous Approach
06VP3DZ	Restriction of Right Greater Saphenous Vein with Intraluminal Device, Percutaneous Approach
06VQ3DZ	Restriction of Left Greater Saphenous Vein with Intraluminal Device, Percutaneous Approach
06VR3DZ	Restriction of Right Lesser Saphenous Vein with Intraluminal Device, Percutaneous Approach
06VS3DZ	Restriction of Left Lesser Saphenous Vein with Intraluminal Device, Percutaneous Approach
06VT3DZ	Restriction of Right Foot Vein with Intraluminal Device, Percutaneous Approach
06VV3DZ	Restriction of Left Foot Vein with Intraluminal Device, Percutaneous Approach

## MS-DRG and 2020 Payment Rates: Arterial/Venous Procedure Reimbursement

MS-DRG	Description	2020 National Medicare Payment
270	Other Major Cardiovascular Procedures w/ MCC	\$32,009
271	Other Major Cardiovascular Procedures w/ CC	\$22,224
272	Other Major Cardiovascular Procedures w/o CC/MCC	\$16,294
252	Other Vascular Procedures w/ MCC	\$20,548
253	Other Vascular Procedures w/ CC	\$16,327
254	Other Vascular Procedures w/o CC/MCC	\$11,401

Because MS-DRG reimbursement may vary based on actual procedures performed, this table does not represent all possible MS-DRG assignments. 2020 Inpatient rates in effect from October 1, 2019 – September 30, 2020.

(M)CC = (major) complications and/or comorbidities. Complete list available at: <http://www.cms.hhs.gov/AcuteInpatientPPS>

Rates reflect FY 2020 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.

## Costs for the Ruby® Coil, POD® Embolization System, and LANTERN® Microcatheter can be categorized into the following revenue codes:

- 0270 Medical/surgical supply
- 0272 Sterile supply
- 0279 Other supplies/devices

**There are currently no applicable Medicare C-codes for peripheral embolization coils.**

## References & Sources

- HIPPS (Inpatient) Federal Register / Vol. 84, No. 159 / Friday, August 16, 2019.
- OPPI/ASC (Outpatient) Federal Register / Vol. 83, No. 225 / Wednesday, November 21, 2018.
- MPFS (Physician) Federal Register / Vol. 83, No. 226 / Friday, November 23, 2018.
- ICD-10-PCS 2019 ICD-10-PCS Complete Official Codebook. American Medical Association. Copyright ©2019 Optum360, LLC.



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