

# **Diagnostic and Interventional Arterial Procedures (Lower Extremity)**

2016 Coding and Medicare Payment Guide

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Hospitals are reimbursed by Medicare for inpatient procedures and services under the Inpatient Prospective Payment System (IPPS), which utilizes the Medicare Severity Diagnosis Related Group (MS-DRG) system.

## 1.1 Hospital Inpatient Procedure Codes

Not an all-inclusive list. Refer to ICD-10-PCS 2016: The Complete Official Codebook for additional codes. Depending upon procedure performed, multiple codes may be reported.

ICD-10-PCS	DESCRIPTOR
<b>B44GZZ3</b>	Ultrasonography of left lower extremity arteries, intravascular
<b>B44FZZ3</b>	Ultrasonography of right lower extremity arteries, intravascular
<b>B44LZZ3</b>	Ultrasonography of femoral artery, intravascular
<b>047K3ZZ</b>	Dilation of right femoral artery, percutaneous approach
<b>047K3DZ</b>	Dilation of right femoral artery with intraluminal device, percutaneous approach
<b>047K34Z</b>	Dilation of right femoral artery with drug-eluting intraluminal device, percutaneous approach
<b>047K3Z1</b>	Dilation of right femoral artery using drug-coated balloon, percutaneous approach
<b>04CK3ZZ</b>	Extirpation of matter from right femoral artery, percutaneous approach
<b>047L3ZZ</b>	Dilation of left femoral artery, percutaneous approach
<b>047L3DZ</b>	Dilation of left femoral artery with intraluminal device, percutaneous approach
<b>047L34Z</b>	Dilation of left femoral artery with drug-eluting intraluminal device, percutaneous approach
<b>047L341</b>	Dilation of left femoral artery with drug-eluting intraluminal device, using drug-coated balloon, percutaneous approach
<b>04CL3ZZ</b>	Extirpation of matter from left femoral artery, percutaneous approach
<b>047M3ZZ</b>	Dilation of right popliteal artery, percutaneous approach
<b>047M3DZ</b>	Dilation of right popliteal artery with intraluminal device, percutaneous approach
<b>047N3ZZ</b>	Dilation of left popliteal artery, percutaneous approach
<b>047N3DZ</b>	Dilation of left popliteal artery with intraluminal device, percutaneous approach
<b>047T3ZZ</b>	Dilation of right peroneal artery, percutaneous approach
<b>04CT3ZZ</b>	Extirpation of matter from right peroneal artery, percutaneous approach
<b>047U3ZZ</b>	Dilation of left peroneal artery, percutaneous approach
<b>04CU3ZZ</b>	Extirpation of matter from left peroneal artery, percutaneous approach
<b>047P3ZZ</b>	Dilation of right anterior tibial artery, percutaneous approach
<b>04CP3ZZ</b>	Extirpation of matter from right anterior tibial artery, percutaneous approach
<b>047Q3ZZ</b>	Dilation of left anterior tibial artery, percutaneous approach

continued from **1.1 Hospital Inpatient Procedure Codes**

ICD-10-PCS	DESCRIPTOR
<b>04CS3ZZ</b>	Extirpation of matter from left posterior tibial artery, percutaneous approach
<b>047E3ZZ</b>	Dilation of right internal iliac artery, percutaneous approach
<b>047E3DZ</b>	Dilation of right internal iliac artery with intraluminal device, percutaneous approach
<b>047F3ZZ</b>	Dilation of left internal iliac artery, percutaneous approach
<b>047F3DZ</b>	Dilation of left internal iliac artery with intraluminal device, percutaneous approach
<b>047H3ZZ</b>	Dilation of right external iliac artery, percutaneous approach
<b>047H3DZ</b>	Dilation of right external iliac artery with intraluminal device, percutaneous approach
<b>047J3ZZ</b>	Dilation of left external iliac artery, percutaneous approach
<b>047J3DZ</b>	Dilation of left external iliac artery with intraluminal device, percutaneous approach
<b>047C3ZZ</b>	Dilation of right common iliac artery, percutaneous approach
<b>047C3DZ</b>	Dilation of right common iliac artery with intraluminal device, percutaneous approach
<b>047D3ZZ</b>	Dilation of left common iliac artery, percutaneous approach
<b>047D3DZ</b>	Dilation of left common iliac artery with intraluminal device, percutaneous approach
<b>04HC3ZZ</b>	Insertion of infusion device into right common iliac artery, percutaneous approach
<b>04HD3ZZ</b>	Insertion of infusion device into left common iliac artery, percutaneous approach
<b>B41FYZZ</b>	Fluoroscopy of right lower extremity arteries using other contrast
<b>B41GYZZ</b>	Fluoroscopy of left lower extremity arteries using other contrast

## 1.2 Hospital Inpatient Diagnosis Related Groups

For arterial primary interventional procedures; assignment varies based on patient condition.

DRG	DESCRIPTOR	PAYMENT <sup>1</sup>
<b>252</b>	Other vascular procedures with MCC <sup>2</sup>	\$19,410
<b>253</b>	Other vascular procedures with CC <sup>3</sup>	\$15,367
<b>254</b>	Other vascular procedures without CC/MCC	\$10,175

## 2.1 Hospital Outpatient Procedure Codes

CPT	DESCRIPTOR	APC / STATUS INDICATOR	PAYMENT
<b>ENDOASCULAR REVASCULARIZATION-ILIAC</b>			
<b>37220</b>	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	5191 <sup>4</sup>	\$4,592
<b>37221</b>	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	5192 <sup>4</sup>	\$9,542
<b>+37222</b>	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (list separately in addition to code for primary procedure)	<b>Status: N<sup>5</sup></b>	0
<b>+37223</b>	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)	<b>Status: N<sup>5</sup></b>	0
<b>ENDOASCULAR REVASCULARIZATION-FEMORAL/POPLITEAL</b>			
<b>37224</b>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	5191 <sup>4</sup>	\$4,592
<b>37225</b>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	5192 <sup>4</sup>	\$9,542
<b>37226</b>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	5193 <sup>4</sup>	\$14,612
<b>37227</b>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	5193 <sup>4</sup>	\$14,612

CPT	DESCRIPTOR	APC / STATUS INDICATOR	PAYMENT
<b>ENDOVASCULAR REVASCULARIZATION-TIBIAL/PERONEAL</b>			
<b>37228</b>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	5192 <sup>4</sup>	\$9,542
<b>37229</b>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	5193 <sup>4</sup>	\$14,612
<b>37230</b>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	5193 <sup>4</sup>	\$14,612
<b>37231</b>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	5193 <sup>4</sup>	\$14,612
<b>+37232</b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (list separately in addition to code for primary procedure)	<b>Status:</b> N <sup>5</sup>	0
<b>+37233</b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)	<b>Status:</b> N <sup>5</sup>	0
<b>+37234</b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)	<b>Status:</b> N <sup>5</sup>	0
<b>+37235</b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)	<b>Status:</b> N <sup>5</sup>	0
<b>INTRAVASCULAR ULTRASOUND (IVUS)</b>			
<b>+37252</b>	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial non-coronary vessel (list separately in addition to code for primary procedure)	<b>Status:</b> N <sup>5</sup>	0
<b>+37253</b>	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional non-coronary vessel (list separately in addition to code for primary procedure)	<b>Status:</b> N <sup>5</sup>	0

continued from 2.1 Hospital Outpatient Procedure Codes

CPT	DESCRIPTOR	APC / STATUS INDICATOR	PAYMENT
<b>DIAGNOSTIC ANGIOGRAPHY</b>			
<b>75710</b>	Angiography, extremity, unilateral, radiological supervision and interpretation	5526 <sup>6</sup>	\$2,719
<b>75716</b>	Angiography, extremity, bilateral, radiological supervision and interpretation	5526 <sup>6</sup>	\$2,719
<b>+75774</b>	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (list separately in addition to code for primary procedure)	5526 <sup>6</sup>	\$2,719
<b>SELECTIVE CATHETER PLACEMENT</b>			
<b>36245</b>	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	<b>Status:</b> N <sup>5</sup>	0
<b>36246</b>	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	<b>Status:</b> N <sup>5</sup>	0
<b>36247</b>	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	<b>Status:</b> N <sup>5</sup>	0
<b>+36248</b>	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)	<b>Status:</b> N <sup>5</sup>	0

## 2.2 HCPCS Supply Code

In the outpatient setting, when devices are used in combination with device-related procedures, hospitals report C codes. While the supply codes are not paid separately from the procedure, the assignment of charges and reporting these supply codes identify device-related costs. This information is important for future rate-setting by Medicare. Private payers' policies vary if they accept the use of these C codes.

HCPCS	DESCRIPTOR	APC / STATUS INDICATOR	PAYMENT
<b>ATHERECTOMY AND IVUS</b>			
<b>C1724</b>	Catheter, transluminal atherectomy, rotational	<b>Status:</b> N <sup>5</sup>	0
<b>C1753</b>	Catheter, intravascular ultrasound	<b>Status:</b> N <sup>5</sup>	0

# 3 Physician

Physicians services are paid by Medicare based on the Physician Fee Schedule.

## 3.1 Physician Procedure Codes – Inpatient, Outpatient and Office

		IN HOSPITAL FACILITY <sup>7</sup>		IN OFFICE NON-FACILITY <sup>8</sup>	
CPT	DESCRIPTOR	PAYMENT	RVU <sup>9</sup>	PAYMENT	GLOBAL RVU
ENDOVASCULAR REVASCULARIZATION-ILIAC					
37220 <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	\$437.53	8.15	\$3,225.97	90.10
37221 <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	\$537.78	10.00	\$4,755.89	120.72
+37222 <sup>11</sup>	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (list separately in addition to code for primary procedure)	\$197.28	3.73	\$906.21	25.31
+37223 <sup>11</sup>	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)	\$226.28	4.25	\$2,644.86	73.87
ENDOVASCULAR REVASCULARIZATION-FEMORAL/POPLITEAL					
37224 <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	\$481.57	9.00	\$3,914.13	109.32
37225 <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	\$653.07	12.00	\$11,244.34	314.05
37226 <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	\$566.07	10.49	\$9,247.53	258.28



CPT	DESCRIPTOR	IN HOSPITAL FACILITY <sup>7</sup>		IN OFFICE NON-FACILITY <sup>8</sup>	
		PAYMENT	RVU <sup>9</sup>	PAYMENT	GLOBAL RVU
<b>37227</b> <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	\$785.19	14.50	\$15,186.39	424.15
<b>ENDOASCULAR REVASCULARIZATION-TIBIAL/PERONEAL</b>					
<b>37228</b> <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	\$588.26	11.00	\$5,561.48	155.33
<b>37229</b> <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	\$761.56	14.05	\$11,084.65	309.59
<b>37230</b> <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	\$750.10	13.80	\$8,473.45	236.66
<b>37231</b> <sup>10,11</sup>	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	\$815.98	15.00	\$13,638.57	380.92
<b>+37232</b> <sup>11</sup>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (list separately in addition to code for primary procedure)	\$213.75	4.00	\$1,238.47	34.59
<b>+37233</b> <sup>11</sup>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)	\$348.02	6.50	\$1,496.26	41.79

CPT	DESCRIPTOR	IN HOSPITAL FACILITY <sup>7</sup>		IN OFFICE NON-FACILITY <sup>8</sup>	
		PAYMENT	RVU <sup>9</sup>	PAYMENT	GLOBAL RVU
<b>+37234<sup>11</sup></b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)	\$299.68	5.50	\$3,958.52	110.56
<b>+37235<sup>11</sup></b>	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)	\$426.43	7.80	\$4,169.05	116.44
<b>INTRAVASCULAR ULTRASOUND (IVUS)</b>					
<b>+37252</b>	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial non-coronary vessel (list separately in addition to code for primary procedure)	\$496.67	1.80	\$1,425.73	39.82
<b>+37253</b>	Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional non-coronary vessel (list separately in addition to code for primary procedure)	\$77.34	1.44	\$221.63	6.19

## 3.2 Diagnostic Angiography and Selective Catheterization

(Only reportable at the time of lower extremity arterial revascularization in certain circumstances; refer to CPT manual for guidance.)

		IN HOSPITAL FACILITY <sup>7</sup>		IN OFFICE NON-FACILITY <sup>8</sup>	
CPT	DESCRIPTOR	PAYMENT	RVU <sup>9</sup>	PAYMENT	GLOBAL RVU
DIAGNOSTIC ANGIOGRAPHY					
75710 <sup>12</sup>	Angiography, extremity, unilateral, radiological supervision and interpretation	\$57.64	1.61	\$165.77	5.31
75716 <sup>12</sup>	Angiography, extremity, bilateral, radiological supervision and interpretation	\$65.88	1.84	\$190.12	4.63
+75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (list separately in addition to code for primary procedure)	\$17.90	0.50	\$88.79	2.48
SELECTIVE CATHETER PLACEMENT					
36245 <sup>10,11</sup>	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$264.24	4.90	\$1,397.80	39.04
36246 <sup>10,11</sup>	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$281.42	5.27	\$910.15	25.42
36247 <sup>10,11</sup>	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$332.62	6.29	\$1,611.19	45.00
+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)	\$51.92	1.01	\$156.46	4.37

# Highlights

For complete guidance, refer to CPT Medicare and private payer edits and rules.

## ANGIOGRAPHY

Angiography/venography is included in the description of the interventional codes unless it meets the following criteria for diagnostic angiogram/venogram.

- » No prior or recent angiogram/venogram is available to guide therapy
- » The patient's condition has changed
- » The treatment plan may be affected
- » Other vessels may be identified for treatment

*CPT Assistant Archives, 2011 – Coding Communication: Lower Extremity Revascularization*

## INTRAVASCULAR ULTRASOUND

- » Services described by the IVUS CPT codes include all transducer manipulations and repositioning within the specific vessel being examined during a diagnostic procedure or before, during, and/or after therapeutic intervention (e.g., stent or stent graft placement, angioplasty, atherectomy, embolization, thrombolysis, transcatheter biopsy).

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*CPT Changes: An Insider's View, Surgery, 2016*

- » IVUS is designated as an add-on procedure and is always performed in conjunction with a primary procedure.

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*CPT Changes: An Insider's view, Surgery, 2016*

- » The catheter supply cost is packaged into the facility payment for the primary procedure. IVUS codes 37252, 37253 are designated as status "N" in the facility setting by Medicare, which means the payment for IVUS has been packaged into other services and there is no separate payment

*Medicare Claims Processing Manual Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS): 10.4*

- » If a lesion extending across the margins of one vessel into another is imaged with IVUS, report using only 37252 (first vessel) despite imaging more than one vessel.

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*CPT Changes: An Insiders View, Surgery, 2016*

## ARTERIAL INTERVENTIONS

- » The lower extremity arterial system is considered 3 separate territories for interventional coding purposes; Iliac, Femoral/Popliteal and Tibial/Peroneal.

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*CPT Changes: An Insider's View: Cardiovascular System, 2011*

- » Use modifier 59 (or applicable distinct procedural modifiers) to denote that different legs are being treated, even if the mode of therapy is different.

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- » The intervention should be reported only once (first vessel CPT code) if a lesion extends across the margins of one vessel into another, but can be treated with a single therapy.

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- » When treating multiple vessels within a territory report each additional vessel using an add-on code as applicable. Select the base code that represents the most complex service.

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- » When treating multiple lesions within the same vessel report one service that reflects the combined procedures whether done on one lesion or different lesions using the same hierarchy.

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*CPT Changes: An Insider's View: Cardiovascular System, 2011*

## THIRD-PARTY SOURCES

- » Medicare Physician Fee Schedule 2016 Final Rule (CMS-1631-FC) Federal Register Vol 80 No. 220, November 16, 2015 Update January 5, 2016
- » Medicare Inpatient Prospective Payment System 2016 Final Rule (CMS-1632-F) Federal Register Vol 80 No. 158, August 17, 2015
- » Medicare Outpatient Prospective Payment System 2016 Final Rule (CMS-1633-FC) Federal Register Vol 80 No. 219, November 13, 2015 Update December 14, 2015
- » 2016 CPT Professional Edition
- » 2016 CPT Changes, An Insider's View
- » CPT Assistant
- » 2016 ICD-10-CM and ICD-10-PCS

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<sup>1</sup> Payment rates assume full update amount for hospitals which have submitted quality data and that hospitals have a wage index greater than 1. Actual payment rates will vary by locality.

<sup>2</sup> Major Complications and Comorbidities

<sup>3</sup> Complications and Comorbidities

<sup>4</sup> Status J1: Comprehensive APC – accounts for all costs and component services typically involved in the provision of the complete primary procedure

<sup>5</sup> Status N: No separate APC payment. Packaged into payment for other services.

<sup>6</sup> Status Q2: T-Packaged Codes. Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "T." (2) In other circumstances, payment is made through a separate APC payment.

<sup>7</sup> Procedures performed in the hospital inpatient or hospital outpatient setting are reimbursed at the Medicare facility rate. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.

<sup>8</sup> Procedures performed in the physician office are reimbursed at the Medicare non-facility rate. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.

<sup>9</sup> RVU-Relative Value Units assigned under the Physician Fee Schedule. For each CPT code, RVUs are assigned to account for the relative resource costs used to provide the service.

<sup>10</sup> Multiple Procedure payment adjustment Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. (Modifier -51)

<sup>11</sup> 150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

<sup>12</sup> Diagnostic Cardiovascular Services Subject to 25% reduction of the second highest and subsequent procedures to the TC of diagnostic cardiovascular services, effective for services January 1, 2013, and thereafter. (Modifier -51)

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