PHILIPS

Coding and Medicare national payment guide

2018

Diagnostic and interventional venous procedures (lower extremity)

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1 Hospital inpatient

Hospitals are reimbursed by Medicare for inpatient procedures and services under the FY2018 Inpatient Prospective Payment System (IPPS), which utilizes the Medicare Severity Diagnosis Related Group (MS-DRG) system.

1.1 Hospital inpatient diagnosis codes

Not an all-inclusive list. Refer to ICD-10-CM 2018: The Complete Official Codebook for additional codes. Depending on procedure performed, multiple codes may be reported.

ICD-10-CM[1]	Descriptor
I70.401	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities, right leg
I70.402	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities, left leg
I70.403	Unspecified atherosclerosis of autologous vein bypass graft(s) of the extremities, bilateral legs
I70.411	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, right leg
I70.412	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, left leg
I70.413	Atherosclerosis of autologous vein bypass graft(s) of the extremities with intermittent claudication, bilateral legs
I70.421	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain, right leg
I70.422	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain, left leg
I70.423	Atherosclerosis of autologous vein bypass graft(s) of the extremities with rest pain, bilateral legs
I70.461	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, right leg
I70.462	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, left leg
I70.463	Atherosclerosis of autologous vein bypass graft(s) of the extremities with gangrene, bilateral legs
I70.491	Other atherosclerosis of autologous vein bypass graft(s) of the extremities, right leg
I70.492	Other atherosclerosis of autologous vein bypass graft(s) of the extremities, left leg
I70.493	Other atherosclerosis of autologous vein bypass graft(s) of the extremities, bilateral legs
I80.10	Phlebitis and thrombophlebitis of unspecified femoral vein
I80.11	Phlebitis and thrombophlebitis of right femoral vein
I80.12	Phlebitis and thrombophlebitis of left femoral vein
I80.13	Phlebitis and thrombophlebitis of femoral vein, bilateral
I80.211	Phlebitis and thrombophlebitis of right iliac vein
I80.212	Phlebitis and thrombophlebitis of left iliac vein
I80.213	Phlebitis and thrombophlebitis of iliac vein, bilateral
I80.219	Phlebitis and thrombophlebitis of unspecified iliac vein
I80.221	Phlebitis and thrombophlebitis of right popliteal vein
I80.222	Phlebitis and thrombophlebitis of left popliteal vein
I80.223	Phlebitis and thrombophlebitis of popliteal vein, bilateral

continued from **1.1 Hospital inpatient diagnosis codes**

ICD-10-CM[1]	Descriptor
I80.229	Phlebitis and thrombophlebitis of unspecified popliteal vein
I80.231	Phlebitis and thrombophlebitis of right tibial vein
I80.232	Phlebitis and thrombophlebitis of left tibial vein
I80.233	Phlebitis and thrombophlebitis of tibial vein, bilateral
I80.239	Phlebitis and thrombophlebitis of unspecified tibial vein
187.2	Venous insufficiency (chronic) (peripheral)

1.2 Hospital inpatient procedure codes

Not an all-inclusive list. Refer to ICD-10-PCS 2018: The Complete Official Codebook for additional codes. Depending on procedure performed, multiple codes may be reported.

ICD-10-PCS[2]	Descriptor
Non-coronary intravascular ultrasound (IVUS)	
B543ZZ3	Ultrasonography of Right Jugular Veins, Intravascular
B544ZZ3	Ultrasonography of Left Jugular Veins, Intravascular
B546ZZ3	Ultrasonography of Right Subclavian Vein, Intravascular
B547ZZ3	Ultrasonography of Left Subclavian Vein, Intravascular
B548ZZ3	Ultrasonography of Superior Vena Cava, Intravascular
B549ZZ3	Ultrasonography of Inferior Vena Cava, Intravascular
B54BZZ3	Ultrasonography of Right Lower Extremity Veins, Intravascular
B54CZZ3	Ultrasonography of Left Lower Extremity Veins, Intravascular
B54DZZ3	Ultrasonography of Bilateral Lower Extremity Veins, Intravascular
B54JZZ3	Ultrasonography of Right Renal Vein, Intravascular
B54KZZ3	Ultrasonography of Left Renal Vein, Intravascular
B54LZZ3	Ultrasonography of Bilateral Renal Veins, Intravascular
B54MZZ3	Ultrasonography of Right Upper Extremity Veins, Intravascular
B54NZZ3	Ultrasonography of Left Upper Extremity Veins, Intravascular
B54PZZ3	Ultrasonography of Bilateral Upper Extremity Veins, Intravascular
B54TZZ3	Ultrasonography of Portal and Splanchnic Veins, Intravascular

continued from **1.2 Hospital inpatient procedure codes**

ICD-10-PCS[2]	Descriptor
Venous stent	
067C3DZ	Dilation of Right Common Iliac Vein with Intraluminal Device, Percutaneous Approach
067C4DZ	Dilation of Right Common Iliac Vein with Intraluminal Device, Percutaneous Endoscopic Approach
067D3DZ	Dilation of Left Common Iliac Vein with Intraluminal Device, Percutaneous Approach
067D4DZ	Dilation of Left Common Iliac Vein with Intraluminal Device, Percutaneous Endoscopic Approach
067F3DZ	Dilation of Right External Iliac Vein with Intraluminal Device, Percutaneous Approach
067F4DZ	Dilation of Right External Iliac Vein with Intraluminal Device, Percutaneous Endoscopic Approach
067G3DZ	Dilation of Left External Iliac Vein with Intraluminal Device, Percutaneous Approach
067G4DZ	Dilation of Left External Iliac Vein with Intraluminal Device, Percutaneous Endoscopic Approach
067M3DZ	Dilation of Right Femoral Vein with Intraluminal Device, Percutaneous Approach
067M4DZ	Dilation of Right Femoral Vein with Intraluminal Device, Percutaneous Endoscopic Approach
067N0DZ	Dilation of Left Femoral Vein with Intraluminal Device, Open Approach
067N3DZ	Dilation of Left Femoral Vein with Intraluminal Device, Percutaneous Approach
067N4DZ	Dilation of Left Femoral Vein with Intraluminal Device, Percutaneous Endoscopic Approach
067P3DZ	Dilation of Right Saphenous Vein with Intraluminal Device, Percutaneous Approach
067P4DZ	Dilation of Right Saphenous Vein with Intraluminal Device, Percutaneous Endoscopic Approach
067Q3DZ	Dilation of Left Saphenous Vein with Intraluminal Device, Percutaneous Approach
067Q4DZ	Dilation of Left Saphenous Vein with Intraluminal Device, Percutaneous Endoscopic Approach

1.3 FY2018 Hospital inpatient diagnosis related groups (DRG)

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

DRG	Descriptor	Payment[3]
299	Peripheral vascular disorders with MCC[4]	**$8,505**
300	Peripheral vascular disorders with CC[5]	**$6,137**
301	Peripheral vascular disorders without CC/MCC	**$4,370**

2 Hospital outpatient and ambulatory surgery center

Hospitals are reimbursed by Medicare for outpatient procedures and services under the Outpatient Prospective Payment System (OPPS), which utilizes the CY2018 Ambulatory Payment Classification (APC) system. Ambulatory Surgery Centers are reimbursed based on a percentage of the OPPS Payment Rates.

2.1 Hospital outpatient procedure and ASC procedure codes

		Outpatient hospital[6]		ASC[6]
CPT code[7]	Descriptor	APC/Status indicator[8]	Payment	Payment
Selective catheter placement				
36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)	N	$0	$0
36012	; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)	N	$0	$0
Diagnostic venography				
36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)	N	$0	$0
75820	Venography, extremity, unilateral, radiological supervision and interpretation	5181 / Q2	$613	$0
75822	Venography, extremity, bilateral, radiological supervision and interpretation	5182 / Q2	$983	$0
Non-coronary intravascular ultrasound (IVUS)				
+37252	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)	N	$0	$0
+37253	; each additional non-coronary vessel (list separately in addition to code for primary procedure)	N	$0	$0
Venous stent placement				
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	5193 / J1	$10,510	$6,518
+37239	; each additional vein (List separately in addition to code for primary procedure)	N	$0	$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 code	Descriptor	Device name	APC/Status indicator	Payment
C1753	Catheter, intravascular ultrasound	Visions PV Intravascular Ultrasound Catheter	**N**	**$0**

3 Physician

Physician services are paid by Medicare based on the CY2018 Physician Fee Schedule.

3.1 Physician procedure codes - inpatient, outpatient, ASC and office

			Facility[10] (hospital or ASC)		Non-facility[10] (in-office, OBL)	
CPT code[7]	Descriptor	Work RVU[9]	Payment[11,12]	Total RVU[9]	Payment[11,12]	Total RVU[9]
Selective catheter placement						
36011	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	**3.14**	**$164**	**4.56**	**$847**	**23.52**
36012	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	**3.51**	**$181**	**5.04**	**$868**	**24.12**
Diagnostic venography						
36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)	**.95**	**$50**	**1.40**	**$332**	**9.22**
75820	Venography, extremity, unilateral, radiological supervision and interpretation	**.70**	**$36**	**.99**	**$118**	**3.27**
75822	Venography, extremity, bilateral, radiological supervision and interpretation	**1.06**	**$53**	**1.48**	**$138**	**3.84**
Non-coronary intravascular ultrasound (IVUS)						
+37252	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)	**1.80**	**$96**	**2.66**	**$1,398**	**38.83**
+37253	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)	**1.44**	**$77**	**2.14**	**$211**	**5.86**

continued from **3.1 Physician procedure codes - inpatient, outpatient, ASC and office**

CPT code[7]	Descriptor	Work RVU[8]	Facility[10] (hospital or ASC) Payment[11,12]	Facility[10] (hospital or ASC) Total RVU[9]	Non-facility[10] (in-office, OBL) Payment[11,12]	Non-facility[10] (in-office, OBL) Total RVU[9]
Venous stent placement						
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	**6.04**	**$314**	**8.73**	**$4,250**	**118.06**
+37239	; each additional vein (List separately in addition to code for primary procedure)	**2.97**	**$159**	**4.43**	**$2,058**	**57.16**

4 Moderate sedation

Also known as conscious sedation.

Effective January 1, 2017

Moderate sedation was removed from all procedural services it was previously inherently included. CPT codes have been revised to reflect the removal of the moderate sedation CPT symbol indicating which procedure included moderate sedation. Moderate sedation is now separately billed using the new moderate sedation codes. Six new CPT codes CPT 99151-99157 were created. Providers should report the appropriate moderate sedation code(s) in addition to the procedure CPT codes when moderate sedation is performed. For further coding instructions, please refer to the coding guidelines and moderate sedation table in 2018 CPT Professional.

Highlights

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

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).
  - *CPT Copyright© 2017 American Medical Association*
  - *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.
  - *CPT Copyright© 2017 American Medical Association*
  - *CPT Changes: An Insider's View, Surgery, 2016*

Intervention

- 37238, 37239 includes any and all balloon angioplasty(s) performed in the treated vessel, including any predilation (whether performed as a primary or secondary angioplasty), post-dilation following stent placement, treatment of a lesion outside the stented segment but in the same vessel, or use of larger/smaller balloon to achieve therapeutic result. Angioplasty in a separate and distinct vessel may be reported separately. Non-selective and/or selective catheterization(s) is reported separately. Intravascular ultrasound may be reported separately (ie, 37252, 37253).
  - *CPT Changes: An Insider's View: Surgery 2016*

- If a lesion extends across the margins of one vessel into another, but can be treated with a single therapy, the intervention should be reported only once. When additional, different vessels are treated in the same session, report 37239 as appropriate
  - *CPT Copyright© 2017 American Medical Association*
  - *CPT Changes: An Insider's View: Surgery, 2016*

Third-party sources

- 2018 CPT Professional Edition
- 2016 CPT Changes, An Insider's View
- 2017 CPT Changes, An Insider's View
- CPT Assistant
- 2018 ICD-10-CM and ICD-10-PCS: The Complete Official Codebook

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1. Refer to ICD-10-CM 2018: The Complete Official Codebook for a complete list of diagnosis codes and specific character codes.
2. Refer to ICD-10-PCS 2018: The Complete Official Codebook for a complete list of procedure codes and specific character codes.
3. Medicare Inpatient Prospective Payment System 2018 Final Rule (CMS-1677-CN) Federal Register Vol 82 No. 191, October 4, 2017. Table 5 CN. Payment rates assume full update amount for hospitals which have submitted quality data and hospitals have a wage index greater than 1.
4. Major complications and comorbidities
5. Complications and comorbidities
6. Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. 2018 Final Rule (CMS-1678-CN), Published in the Federal Register December 14, 2017, OPPS Addendum B and ASC Addendas AA-EE.
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8. Status J1: Comprehensive APC – accounts for all costs and component services typically involved in the provision of the complete primary procedure; Status N: No separate APC payment. Packaged into payment for other services.
9. RVU: Relative Value Units assigned under the Medicare Physician Fee Schedule, Addendum B. For each CPT code, RVUs are assigned to account for the relative resource costs used to provide the service.
10. Medicare Physician Fee Schedule. Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year 2018, (CMS-1676-F), November 2, 2017. Federal Register Vol. 82, No. 219. Addendum B, 2018 conversion factor 35.9996.
11. Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure (with fee schedule indicator 1, 2, or 3) rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50% and by report). Payment based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. (Modifier -51)
12. 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.

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