

Dialysis Vascular Access

Coverage, Coding and Reimbursement Overview – Physician / Hospital / ASC

2011 Edition† – All Reimbursement Amounts are Listed at National Medicare Rates



PHYSICIAN OVERVIEW

Physician rates effective January 1, 2011 through December 31, 2011.

COVERAGE

Medicare	Carrier LCD (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

CREATION	CODING	REIMBURSEMENT ^A	
		CPT® Codes	Professional or Facility
Vascular Access			
Procedure			
Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	36818	\$706	—
Arteriovenous anastomosis, open; by upper arm basilic vein transposition	36819	\$842	—
Arteriovenous anastomosis, open; by forearm vein transposition	36820	\$848	—
Arteriovenous anastomosis, open; direct, any site (e.g., Cimino type) (separate procedure)	36821	\$722	—
Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	36825	\$857	—
Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (e.g., biological collagen, thermoplastic graft)	36830	\$694	—
Imaging^B			
Injection procedure for extremity venography (including introduction of needle or intracatheter)	36005	\$51	\$349
Venography, extremity, unilateral, radiological supervision and interpretation	75820	\$35	\$91
Venography, extremity, bilateral, radiological supervision and interpretation	75822	\$53	\$102
Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	93971	\$23	\$147
MAINTENANCE	CODING	REIMBURSEMENT ^A	
Procedure Revisions			
Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	35475	\$512	\$2,322
Transluminal balloon angioplasty, percutaneous; venous	35476	\$325	\$1,755
Introduction of needle and / or catheter, arteriovenous shunt created for dialysis (graft / fistula); initial access with complete radiological evaluation of dialysis access, using fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through the entire venous outflow including the inferior or superior vena cava)	36147	\$192	\$827
Additional access for therapeutic intervention (List separately in addition to code for primary procedure)	+36148	\$51	\$260
Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	36831	\$482	—
Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	36832	\$612	—
Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	36833	\$692	—
Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	36838	\$1,228	—
Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intragraft thrombolysis)	36870	\$314	\$1,890
Transcatheter therapy, infusion for thrombolysis other than coronary	37201	\$289	—
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel	37205	\$458	\$4,349
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	37206	\$226	\$2,616
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel	37207	\$455	—
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)	37208	\$220	—
Imaging^B			
Angiography, arteriovenous shunt (e.g., dialysis patient fistula / graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including inferior or superior vena cava), radiological supervision and interpretation	75791	\$83	\$246
Transcatheter therapy, infusion, any method (e.g., thrombolysis other than coronary), radiological supervision and interpretation	75896	\$69	Carrier Determined
Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel	75960	\$41	\$153
Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation	75962	\$27	\$186
Transluminal balloon angioplasty, venous (e.g., subclavian stenosis), radiological supervision and interpretation	75978	\$27	\$187
Other			
Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method	90940	\$0	\$0
Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	93990	\$13	\$198

^A Conversion factor used for this Overview is \$33.9764, as published in CMS Change Request 7330.

^B For imaging services (excluding screening and diagnostic mammograms), the DRA of 2005 caps the physician technical component rate at the payment level established for the OPFS fee schedule.

HOSPITAL (FACILITY) INPATIENT OVERVIEW

Hospital Inpatient rates effective October 1, 2010 through September 30, 2011.

COVERAGE

Medicare	Fiscal Intermediary (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

CREATION	CODING ICD-9 Procedure Code ^A	REIMBURSEMENT	
		Inpatient (IPPS) MS-DRG ^B Rate	
Arteriovenostomy for renal dialysis	39.27	264, 673, 674, 675	\$14,131, \$16,339, \$11,690, \$7,471

MAINTENANCE	CODING	REIMBURSEMENT	
		Inpatient (IPPS) MS-DRG ^B Rate	
Revision of arteriovenous shunt for renal dialysis	39.42	264, 673, 674, 675	\$14,131, \$16,339, \$11,690, \$7,471
Removal of arteriovenous shunt for renal dialysis	39.43	↓	↓
Other revision of vascular procedure	39.49		
Angioplasty or atherectomy of other non-coronary vessel(s)	39.50		
Insertion of non-drug-eluting peripheral vessel stents(s)	39.90		
Replacement of vessel-to-vessel cannula	39.94		
Injection or infusion of therapeutic or prophylactic substance	99.10		

^AListed are common primary procedures. Code additional procedures in accordance to coding guidelines.

^BMS-DRG assignment is determined by the patient ICD-9 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs.

MS-DRG Descriptions

- 264 - Other circulatory system O.R. procedures
- 673 - Other kidney and urinary tract procedures with MCC
- 674 - Other kidney and urinary tract procedures with CC
- 675 - Other kidney and urinary tract procedures without CC / MCC

HOSPITAL (FACILITY) OUTPATIENT OVERVIEW

Hospital Outpatient rates effective January 1, 2011 through December 31, 2011.

COVERAGE

Medicare	Fiscal Intermediary (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

	CODING		REIMBURSEMENT	
	HCPCS / CPT® Code	APC	SI ^A	Rate
Device Code*				Required for Medicare Outpatient claims
Graft, vascular	C1768	—	N	—
Stent, coated / covered with delivery system	C1874	—	N	—

Procedure	CODING		REIMBURSEMENT	
	HCPCS / CPT® Code	APC	SI ^A	Rate
Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	36818	0088	T	\$2,874
Arteriovenous anastomosis, open; by upper arm basilic vein transposition	36819	0088	T	\$2,874
Arteriovenous anastomosis, open; by forearm vein transposition	36820	0088	T	\$2,874
Arteriovenous anastomosis, open; direct, any site (e.g., Cimino type) (separate procedure)	36821	0088	T	\$2,874
Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	36825	0088	T	\$2,874
Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (e.g., biological collagen, thermoplastic graft)	36830	0088	T	\$2,874
Imaging				
Injection procedure for extremity venography (including introduction of needle or intracatheter)	36005	—	N	—
Venography, extremity, unilateral, radiological supervision and interpretation	75820	0668	Q2	\$719
Venography, extremity, bilateral, radiological supervision and interpretation	75822	0668	Q2	\$719
Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	93971	0266	S	\$96

Procedure	CODING		REIMBURSEMENT	
	HCPCS / CPT® Code	APC	SI ^A	Rate
Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	35475	0083	T	\$3,780
Transluminal balloon angioplasty, percutaneous; venous	35476	0083	T	\$3,780
Introduction of needle and / or catheter, arteriovenous shunt created for dialysis (graft / fistula); initial access with complete radiological evaluation of dialysis access, using fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through the entire venous outflow including the inferior or superior vena cava)	36147	0676	T	\$162
Additional access for therapeutic intervention (List separately in addition to code for primary procedure)	+36148	—	N	—
Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	36831	0088	T	\$2,874
Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	36832	0088	T	\$2,874
Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	36833	0088	T	\$2,874
Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	36838	0088	T	\$2,874
Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intragraft thrombolysis)	36870	0653	T	\$3,106
Transcatheter therapy, infusion for thrombolysis other than coronary	37201	0103	T	\$1,318
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel	37205	0229	T	\$8,025
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	37206	0229	T	\$8,025
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel	37207	0229	T	\$8,025
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)	37208	0229	T	\$8,025
Imaging				
Angiography, arteriovenous shunt (e.g., dialysis patient fistula / graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including inferior or superior vena cava), radiological supervision and interpretation	75791	0676	Q2	\$162
Transcatheter therapy, infusion, any method (e.g., thrombolysis other than coronary), radiological supervision and interpretation	75896	—	N	—
Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel	75960	—	N	—
Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation	75962	0083	Q2	\$3,780
Transluminal balloon angioplasty, venous (e.g., subclavian stenosis), radiological supervision and interpretation	75978	0093	Q2	\$2,513
Other				
Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method	90940	—	N	—
Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	93990	0266	S	\$96

^A Status Indicators: C—Inpatient Procedures; N—Items & Services Packaged into APC Rates; Q1—STVX-Packaged Codes; Q2—T-Packaged Codes; S—Significant Procedure, Not Discounted When Multiple;
T—Significant Procedure, Multiple Reduction Applies

* Medicare OPSS billing instructions require the reporting of device C-codes for certain APCs. Refer to the CMS website: http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedures.asp

AMBULATORY SURGERY CENTER (ASC) OVERVIEW^A

ASC rates effective January 1, 2011 through December 31, 2011.

COVERAGE

Medicare	Carrier LCD (Local Coverage Determination)
Medicaid	State Policies
Commercial Insurance	Plan Design, Medical Policies, Patient Eligibility

CREATION	CODING CPT® Code	REIMBURSEMENT Rate
Procedure		
Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	36818	\$1,616
Arteriovenous anastomosis, open; by upper arm basilic vein transposition	36819	\$1,616
Arteriovenous anastomosis, open; by forearm vein transposition	36820	\$1,616
Arteriovenous anastomosis, open; direct, any site (e.g., Cimino type) (separate procedure)	36821	\$1,616
Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	36825	\$1,616
Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (e.g., biological collagen, thermoplastic graft)	36830	\$1,616
Imaging		
Injection procedure for extremity venography (including introduction of needle or intracatheter)	36005	Packaged
Venography, extremity, unilateral, radiological supervision and interpretation	75820	Packaged
Venography, extremity, bilateral, radiological supervision and interpretation	75822	Packaged
Duplex scan of extremity veins...limited study	93971	Non-covered
MAINTENANCE	CODING	REIMBURSEMENT
Procedure		
Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel	35475	\$2,126
Transluminal balloon angioplasty, percutaneous; venous	35476	\$2,126
Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, using fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through the entire venous outflow including the inferior or superior vena cava)	36147	\$91
Additional access for therapeutic intervention (List separately in addition to code for primary procedure)	+36148	Packaged
Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	36831	\$1,616
Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	36832	\$1,616
Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	36833	\$1,616
Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	36838	Non-covered
Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intragraft thrombolysis)	36870	\$1,747
Transcatheter therapy, infusion for thrombolysis other than coronary	37201	Non-covered
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel	37205	\$3,035
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	37206	\$1,850
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel	37207	Non-covered
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)	37208	Non-covered
Imaging		
Angiography, arteriovenous shunt (e.g., dialysis patient fistula / graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including inferior or superior vena cava), radiological supervision and interpretation	75791	Packaged
Transcatheter therapy, infusion, any method (e.g., thrombolysis other than coronary), radiological supervision and interpretation	75896	Packaged
Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel	75960	Packaged
Transluminal balloon angioplasty, peripheral artery other than cervical carotid, renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation	75962	Packaged
Transluminal balloon angioplasty, venous (e.g., subclavian stenosis), radiological supervision and interpretation	75978	Packaged
Hemodialysis access flow study to determine blood flow in grafts and AV fistulae by an indicator dilution method	90940	Non-covered
Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	93990	Non-covered

^A Refer to Addendum AA and BB of CMS - 1504 - FC for covered ASC procedures: [www.cms.hhs.gov/ASCPayment/04f_CMS-1504-FC\(ASC\).asp](http://www.cms.hhs.gov/ASCPayment/04f_CMS-1504-FC(ASC).asp)

EXAMPLE CASES

CASE 1: ACCESS CREATION – OUTPATIENT SURGICAL CREATION OF PTFE GRAFT FOR AV ACCESS

Procedure	HCPCS / CPT® Codes ^A	Physician		Hospital Outpatient			ASC Rate
		Technical or Non-Facility Extension of Practice	Professional or Facility	APC	SI ^B	Rate	
Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (e.g., biological collagen, thermoplastic graft)	36830	—	\$694	0088	T	\$2,874	\$1,616
Case Total		—	\$694			\$2,874	\$1,616

CASE 2: FISTULA REVISION – OUTPATIENT THROMBECTOMY WITH VENOUS PTA AND STENT

Access	HCPCS / CPT® Codes ^A	Physician		Hospital Outpatient			ASC Rate
		Technical or Non-Facility Extension of Practice	Professional or Facility	APC	SI ^B	Rate	
Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft / fistula); initial access with complete radiological evaluation of dialysis access, using fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through the entire venous outflow including the inferior or superior vena cava)	36147	\$414 (50%)	\$96 (50%)	0676	T	\$81 (50%)	—
Additional access for therapeutic intervention (List separately in addition to code for primary procedure)	+36148	\$260 (100%)	\$51 (100%)	—	N	Packaged	Non-covered
Procedure							
Transluminal balloon angioplasty, percutaneous; venous	35476	\$878 (50%)	\$163 (50%)	0083	T	\$1,890 (50%)	—
Device code required	CXXXX	—	—	—	N	—	—
Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intragraft thrombolysis)	36870	\$945 (50%)	\$157 (50%)	0653	T	\$1,553 (50%)	—
Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel	37205	\$4,349 (100%)	\$458 (100%)	0229	T	\$8,025 (100%)	Non-covered
Stent, coated / covered with delivery system	C1874	—	—	—	N	—	—
Imaging							
Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel	75960	\$153 + Pro Fee	\$41	—	N	Packaged	Packaged
Transluminal balloon angioplasty, venous (e.g., subclavian stenosis), radiological supervision and interpretation	75978	\$187 + Pro Fee	\$27	0093	Q2	\$2,513 (100%)	Packaged
Case Total		\$7,186 + Pro Fees (\$68)	\$993			\$14,062	—

CASE 3: FISTULA REVISION – OUTPATIENT BALLOON THROMBECTOMY WITH PTA

Access	HCPCS / CPT® Codes ^A	Physician		Hospital Outpatient			ASC Rate
		Technical or Non-Facility Extension of Practice	Professional or Facility	APC	SI ^B	Rate	
Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft / fistula); initial access with complete radiological evaluation of dialysis access, using fluoroscopy, image documentation and report (includes access of shunt, injection(s) of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through the entire venous outflow including the inferior or superior vena cava)	36147	\$414 (50%)	\$96 (50%)	0676	T	\$81 (50%)	\$45 (50%)
Procedure							
Transluminal balloon angioplasty, percutaneous; venous	35476	\$878 (50%)	\$325 (100%)	0083	T	\$3,780 (100%)	\$2,126 (100%)
Device code required for PTA	CXXXXs	—	—	—	N	—	—
Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intragraft thrombolysis)	36870	\$1,890 (100%)	\$157 (50%)	0653	T	\$1,553 (50%)	\$874 (50%)
Imaging							
Transluminal balloon angioplasty, venous (e.g., subclavian stenosis), radiological supervision and interpretation	75978	\$187 + Pro Fee	\$27	0083	Q	Packaged	Packaged
Case Total		\$3,369 + Pro Fees (\$27)	\$605			\$5,414	\$3,045

^A Review CPT® Coding Guideline, modifiers and NCCI Edits for these codes.

^B Status Indicators: C—Inpatient Procedures; N—Items & Services Packaged into APC Rates; Q1—STVX-Packaged Codes; Q2—T-Packaged Codes; S—Significant Procedure, Not Discounted When Multiple; T—Significant Procedure, Multiple Reduction Applies

TERMINOLOGY AND ACRONYMS

ABN: Advance Beneficiary Notice. A legal, written notice to a Medicare beneficiary from a physician or hospital informing the patient that the health service or item that the physician has prescribed is not or may not be a covered service under Medicare, and that the patient will be responsible for payment if denied.

Anesthesia Guidelines: The rules for coding and charging are complex. Variable circumstances can include duration, method of anesthesia / sedation, the physician or specialist administering services, and the site of service. Local Medicare Policies, and the AMA CPT® coding book, professional edition, should be consulted for questions regarding the proper coding and billing for anesthesia services.

APC: Ambulatory Payment Classification. These are numeric classifications used by Medicare to reimburse services performed in a hospital outpatient setting. An APC will contain multiple HCPCS Codes that are similar both clinically and in terms of resources used by the hospital. The APC rate is set prospectively by CMS based on historic claims data.

APC Status Indicator: Alpha characters are used to designate the APC payment calculation method. For multiple APCs on a single claim with Status Indicator “T” the first APC will be paid at 100% and all others at 50%. For all APCs with Status Indicator “S” each APC will be paid at 100%, no discounting.

ASC: Ambulatory Surgery Center. When used by Medicare, this designation describes a legal licensing status establishing a site of service distinct from a physician’s office or hospital-based facility.

Bundled: Certain supplies / procedures provided by a physician as described by CPT® Codes / HCPCS Codes may be included (“Bundled”) with another service for reimbursement purposes.

Carrier: A Medicare contractor responsible for physician and ASC medical policies, adjudication of claims and other administrative functions.

CC: Complications and Comorbidities. Patient conditions utilized as two of several factors in MS-DRG Groupers.

CCI: Correct Coding Initiative. A listing of CPT® Codes that are designated as comprehensive or component codes. If comprehensive and component codes are submitted on the same bill, only the comprehensive code will be paid unless a modifier is submitted. Medicare uses these as NCCI (National Correct Coding Initiative) edits.

CPT® Code: Current Procedural Terminology Code. These 5-digit numeric codes are the property of the American Medical Association and are used to describe physician services. Additionally, Medicare licenses these codes from the AMA and uses them to describe physician, hospital outpatient, ASC services, and other outpatient services.

DRG: Diagnosis Related Group. A numeric classification system used by Medicare and some commercial payers to reimburse for hospital inpatient services. The DRG is assigned by software that considers the ICD-9 procedure and diagnosis codes submitted on a claim.

DME: Durable Medical Equipment. Certified supplies, prosthetics, equipment, etc., provided to patients in other than a hospital inpatient setting.

DMERC: Durable Medical Equipment Regional Contractor. Medicare contractor that adjudicates claims for DME providers.

Facility / Non-Facility: For some physician procedures, the reimbursement is determined by the site of service. If the fee is designated as “Facility,” the procedure is performed in a site of service other than a physician office. If the fee is designated as “Non-Facility,” the procedure is performed in a physician office.

FI: Fiscal Intermediary. A Medicare contractor responsible for hospital inpatient and outpatient medical policies, adjudication of claims and other administrative functions.

HCPCS: Healthcare Common Procedure Coding System. The name of a coding system established by Medicare to describe services and supplies. The base (Level I) codes are CPT® Codes.

ICD-9: International Classification of Diseases. Numeric codes used by essentially all payers to describe diagnosis and procedures. The combination of procedure and diagnosis codes determines DRG assignment for inpatient reimbursement.

ICD-9 procedure 4-digit codes (e.g., 39.90 Insertion of non-drug-eluting peripheral vessel artery stent(s)) Abbrev: Px.

ICD-9 diagnosis 3, 4 or 5-digit codes (e.g., 586 Renal failure, unspecified) Abbrev: Dx.

Inpatient: The status used to describe a patient who has been admitted to the hospital. Usually involves multi-day stay.

IPPS: Inpatient Prospective Payment System. Medicare (CMS) per case (see “DRG” and “MS-DRG”) methodology for hospital inpatient services.

LCD / LMRP: Local Coverage Determination / Local Medical Review Policy. The written policies produced by Medicare contractors applicable to geographic areas. A CMS national policy (see NCD) supersedes a LCD.

MCC: Major Complications and Comorbidities. Patient conditions utilized as two of several factors in MS-DRG Groupers. MCC are typically significant acute manifestations or advanced stages of chronic conditions that would result in higher resource utilization in the course of treatment.

MS-DRG: Medicare Severity Diagnosis Related Group. A numeric classification system effective October 1, 2007 used by Medicare to reimburse for hospital inpatient services. The MS-DRG is assigned by the combination of ICD-9 procedure codes, diagnosis codes and the presence or absence of MCC / CCs as derived from the medical record documentation. The MS-DRG system was designed to more accurately pay hospitals based on patient severity of illness.

Modifier: A 2-digit alphanumeric code that is appended to a CPT® Code for further specificity.

NCD: National Coverage Determination. The written policies from Medicare that have a national jurisdiction (supersede any LCD).

Observation: Hospital outpatient services to monitor and assess a patient for determination of hospital admission or discharge.

OPPS: Outpatient Prospective Payment System. Medicare (CMS) per group (see “APC”) methodology for hospital outpatient services.

Outpatient: A patient admitted to a hospital to receive treatment but not admitted as an inpatient (see “Observation”).

Packaged: Certain supplies / procedures provided by a facility as described by CPT® Codes / HCPCS Codes may be included (“Packaged”) with another service for reimbursement purposes.

Prospective: A predetermined reimbursement rate, regardless of the cost of that service.

Pro / Tech: Professional / Technical. For some diagnostic tests, the physician reimbursement is established in two components. The “Professional” component is for the physician supervision, interpretation and other personal service. The “Technical” component is for the equipment, supplies, staff and other costs related to the test.

S&I: Supervision and Interpretation. This term is sometimes used to differentiate the imaging service (professional reading / interpretation) from other components of the procedure, such as introduction and placement of catheters.

Unadjusted Rate: The prospective reimbursement rate before it is adjusted for local factors such as the wage index, graduate medical education, outlier cases, disproportionate share and other factors. This is sometimes called the “national average” rate. All Medicare reimbursement will have local adjustment factors.

RESOURCES

Suggested Resources: Coding and reimbursement is complex, specific to case documentation and variable by geographic location. Always consult current physician, hospital and ASC resources.

1. Medicare national (NCD) and local policies (LCD / LMRP): <http://www.cms.hhs.gov/mcd/search.asp>
2. *SIR Interventional Radiology Coding User’s Guide*, Society of Interventional Radiology, available at: <http://directory.sirweb.org/store>
3. *Current Procedural Terminology CPT®, 2011*, American Medical Association: <http://www.ama-assn.org>
4. *ICD-9-CM 2011*
5. *CSI Navigator For: Interventional Radiology / Procedures 2011 ed.*; Coding Strategies, Inc.: <http://www.codingstrategies.com>
6. Coding Terminology and Acronyms and additional resource: <http://goremedical.com/coding/>

* **Disclaimer:** The payment amounts listed in this guide are national averages. Actual payment will vary based on several factors including the site of the service, geographic location, patient population mix, and hospital teaching status. References to particular applications and procedures listed in this Coding Overview do not represent the appropriateness or market availability of any Gore Medical Product. The information contained in this Overview is provided for general information purposes only and should NOT be relied on for submission purposes. Consult your professional resources and the patient’s insurer for situation-specific information.

Physicians and hospitals are responsible for selecting and reporting the code(s) that most accurately describe the procedure(s) performed, the products used and the patient’s condition. The basis for accurate coding is clear and complete documentation in the medical record, precisely describing the procedures performed and products used.

Providers should follow coding guidelines from the patient’s insurer, and should also review the complete coding authorities (e.g., CPT®, HCPCS, ICD-9-CM) used by the insurer.

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