

Transvenous Intrahepatic Portosystemic Shunt (TIPS)

Coverage, Coding and Reimbursement Overview — Physician / Hospital

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

	CODING	REIMBURSEMENT ^A	
	CPT [®] Codes	Professional or Facility	Technical or Non-Facility
Procedure			
Insertion of Transvenous Intrahepatic Portosystemic Shunt (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation / dilatation, stent placement and all associated imaging guidance and documentation)	37182	\$880	—
Revision of Transvenous Intrahepatic Portosystemic Shunt (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization / dilatation, stent placement and all associated imaging guidance and documentation)	37183	\$416	\$5,447
Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	37204	\$939	—
Selective catheter placement, venous system; second order or more selective branch (e.g., left adrenal vein, petrosal sinus)	36012	\$186	\$903
Imaging^B			
Transcatheter therapy, embolization, any method, radiological supervision and interpretation	75894	\$68	Carrier Determined
Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	75898	\$87	Carrier Determined

^A Conversion factor used for this Overview is \$33.9764, as published in CMS Change Request 7300.

^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 OPPS fee schedule.

HOSPITAL (FACILITY) OVERVIEW

Hospital Inpatient rates effective October 1, 2010 through September 30, 2011.
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				
	ICD-9 Procedure Codes	HCPCS / CPT® Codes	Inpatient (IPPS) MS-DRG ^A	Rate	Outpatient (OPPS) APC SI ^B Rate		
Device Code*			Required for Medicare Outpatient Claims				
Stent, coated / covered with delivery system		C1874			—	N	—
Procedure							
Intra-abdominal venous shunt	39.1		326	\$32,467			
Insertion of Transvenous Intrahepatic Portosystemic Shunt (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation / dilatation, stent placement and all associated imaging guidance and documentation)		37182	327	\$15,206	—	C	—
			328	\$7,984			
			405	\$31,128			
			406	\$15,519			
			407	\$10,423			
Revision of Transvenous Intrahepatic Portosystemic Shunt (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization / dilatation, stent placement and all associated imaging guidance and documentation)		37183			0229	T	\$8,025
Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck		37204			0082	T	\$6,387
Selective catheter placement, venous system; second order, or more selective, branch (e.g., left adrenal vein, petrosal sinus)		36012			—	N	—
Imaging							
Transcatheter therapy, embolization, any method, radiological supervision and interpretation		75894			—	N	—
Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion		75898			0261	Q1	—

^A MS-DRG assignment is determined by the patient ICD-9 diagnoses and procedure 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

* Medicare OPPS 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

EXAMPLE CASES

CASE 1: INSERTION OF PORTOSYSTEMIC SHUNT

ICD-9 Diagnosis Code: 572.3 Portal Hypertension

	ICD-9 Procedure Code	CPT® Codes ^A	Physician		Hospital Inpatient		Hospital Outpatient		
			Technical or Non-Facility Extension of Practice	Professional or Facility	MS-DRG	Rate	APC	SI ^B	Rate
Intra-abdominal venous shunt	39.1				407	\$10,423			
Insertion of Transvenous Intrahepatic Portosystemic Shunt (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation / dilatation, stent placement and all associated imaging guidance and documentation)		37182	—	\$880			—	C	—
Case Total			—	\$880		\$10,423			—

CASE 2: INSERTION OF PORTOSYSTEMIC SHUNT WITH EMBOLIZATION

ICD-9 Diagnosis Codes: 571.2 Alcoholic Cirrhosis of Liver, 456.20 Esophageal Varices in Diseases Classified Elsewhere with Bleeding

	ICD-9 Procedure Code	CPT® Codes ^A	Physician		Hospital Inpatient				
			Technical or Non-Facility Extension of Practice	Professional or Facility	MS-DRG	Rate			
Intra-abdominal venous shunt	39.1				405				\$31,128
Insertion of Transvenous Intrahepatic Portosystemic Shunt (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation / dilatation, stent placement and all associated imaging guidance and documentation)		37182	—	\$440 (50%)					
Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck		37204	—	\$939 (100%)					
Selective catheter placement, venous system; second order, or more selective, branch (e.g., left adrenal vein, petrosal sinus)		36012-59 ^C	—	\$93 (50%)					
Transcatheter therapy, embolization, any method, radiological supervision and interpretation		75894	—	\$68					
Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion		75898	—	\$87					
Case Total			—	\$1,627					\$31,128

NOTE: Under Medicare regulations, the initial insertion of TIPS is approved for only the inpatient site of service. The physician coding and reimbursement rates listed in Case 1 and Case 2 are only applicable to the TIPS procedure. Other procedures or treatments performed by the physician(s) during the inpatient stay should also be billed. Since the CPT® Code 37182 is designated with zero (000) days for the global surgery period, other services performed during the inpatient stay may be billed by the physician(s). An example of these services is pre- and post-procedure Evaluation and Management (E&M) services, and other services as described in *Interventional Radiology Coding Users' Guide, 15th Edition 2009*, by the Society of Interventional Radiology, the American College of Radiology, the Radiology Business Management Association, and the American Healthcare Radiology Administrators.

CASE 3: REVISION OF PORTOSYSTEMIC SHUNT WITH EMBOLIZATION

ICD-9 Diagnosis Codes: 572.3 Portal Hypertension

	ICD-9 Procedure Code	CPT® Codes ^A	Physician		Hospital Inpatient		Hospital Outpatient		
			Technical or Non-Facility Extension of Practice	Professional or Facility	MS-DRG	Rate	APC	SI ^B	Rate
Intra-abdominal venous shunt	39.1				407	\$10,423			
Revision of Transvenous Intrahepatic Portosystemic Shunt (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization / dilatation, stent placement and all associated imaging guidance and documentation)		37183	—	\$208 (50%)			0229	T	\$8,025 (100%)
Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck		37204	—	\$939 (100%)			0082	T	\$3,194 (50%)
Selective catheter placement, venous system; second order, or more selective, branch (e.g., left adrenal vein, petrosal sinus)		36012-59 ^C	—	\$93 (50%)			—	N	—
Transcatheter therapy, embolization, any method, radiological supervision and interpretation		75894	—	\$68			—	N	—
Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion		75898	—	\$87			0261	Q1	—
Case Total			—	\$1,395		\$10,423			\$11,219

^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

^C NCCI edits require modifier -59 when 36012 is billed on the same claim as 37182, 37183.

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 (supersedes 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.

PHYSICIAN AND HOSPITAL 2011 EDITION

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://goremmedical.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.

The identification of a code in this Coding Overview should not be construed to guarantee coverage for a product or procedure, or payment in any particular amount.



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