

# Endovascular Repair of Thoracic Aortic Aneurysm

## Coverage, Coding and Reimbursement Overview – Physician

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

#### PROCEDURE<sup>A</sup>

	CPT <sup>®</sup> CODE	TOTAL RVU (facility site)	PHYSICIAN MODIFIER			COMMENTS
			-50	-80	-62	
<b>Open Arterial Exposure for Delivery of Aortic Endoprosthesis (code also the catheter placement)</b>						
Open femoral artery exposure by groin incision, unilateral	34812	10.62	1	2	2	
Placement fem-fem prosthetic during aortic aneurysm repair	+34813	7.50	0	2	2	Add-on for 34812.
Open Iliac artery exposure by abdominal or retroperitoneal incision, unilateral	34820	15.31	1	2	2	
Open Iliac artery exposure with creation of conduit by abdominal or retroperitoneal incision, unilateral	34833	19.25	1	2	2	Do not report with 34820 for same side.
Open brachial artery exposure to assist in deployment of aortic or iliac endoprosthesis, unilateral	34834	8.70	1	2	2	
<b>Percutaneous Catheter Placements (as commonly used with Thoracic Aorta Endoprosthesis Delivery / Deployment)</b>						
Introduction of catheter, aorta, non-selective	36200	4.80	1	1	0	Example: Thoracic aortic arch.
Selective catheter placement, arterial, first order thoracic / brachiocephalic branch	36215	7.54	0	1	0	Example: Left subclavian.
Selective catheter placement, arterial, second order	36216	8.53	0	1	0	Example: Left vertebral.
Selective catheter placement, arterial, first order abdominal	36245	7.68	1	1	0	Example: Celiac trunk.
<b>Delivery and Deployment Thoracic Aorta Endoprosthesis</b>						
Endo repair of descending TA; involving coverage of L subclavian, initial endoprosthesis plus descending extensions, if required, to level of celiac origin (S&I 75956)	33880	56.62	2	2	2	
Endo repair of descending TA; not involving coverage of L subclavian, initial endoprosthesis plus descending extensions, if required, to level of celiac origin (S&I 75957)	33881	48.71	2	2	2	
Placement of proximal extension for endo repair of descending TA, initial extension (S&I 75958)	33883	35.31	0	2	2	If proximal extension covers left subclavian, case converts to 33880.
Placement of proximal extension for endo repair of descending TA, each additional extension (S&I 75958)	+33884	12.87	0	2	2	Use with 33883.
Placement of distal extension(s), delayed after initial endo repair (S&I 75959)	33886	30.65	0	2	2	Do not use with 33880, 33881 Report once, not per extension.
Transcatheter placement of wireless pressure sensor during endo repair	+34806	3.25	0	2	2	Add-on for 33880, 33881, 33886.
Radiologic supervision and interpretation (S&I) for 33880	75956	10.98	0	0	0	Report physician with -26.
Radiologic S&I for 33881	75957	9.39	0	0	0	Report physician with -26.
Radiologic S&I for 33883, +33884,	75958	6.24	0	0	0	Report physician with -26.
Radiologic S&I for 33886	75959	5.52	0	0	0	Report physician with -26.
Place access occlusive device, post procedure	G0269	—	—	—	—	Bundled – no extra payment.
Transcatheter occlusion or embolization	37204	27.65	0	1	0	
Radiologic S&I for 37204	75894	2.01	0	0	0	

#### MODIFIERS (Selected modifiers shown – Always consult MPFSDB for all modifiers – See CPT<sup>®</sup> Appendix A for description)

-50 Bilateral Procedure	-80 Assistant Surgeon	-62 Two Surgeons
0 = pay lesser of charge or 100% of one code	0 = pay restriction, documentation required	0 = not permitted
1 = 150% pay adjustment applies for two codes	1 = not permitted	1 = pay restriction, documentation required
2 = not applicable, already bilateral	2 = may be paid	2 = may be paid, no documentation if two specialties

<sup>A</sup> Abbreviated CPT<sup>®</sup> code descriptions. See CPT<sup>®</sup> codebook for full descriptions.

**PROCEDURE<sup>A</sup>**

	CPT <sup>®</sup> CODE	TOTAL RVU (facility site)	PHYSICIAN MODIFIER			COMMENTS
			-50	-80	-62	
<b>Ancillary Procedures</b>						
Open subclavian to carotid transposition in conjunction with endo repair of descending TA, by neck incision, unilateral	33889	25.19	1	2	2	Do not report with 35694.
Bypass graft, other than vein, transcervical retropharyngeal carotid-carotid, in conjunction with endo repair TA	33891	31.11	1	2	2	Do not use with 35509, 35601.
Transcatheter placement of wireless pressure sensor during endo repair	+34806	3.25	0	2	2	
Study (non-invasive) of pressure sensor recording; complete	93982	—	0	0	0	<b>Payable only in non-facility.</b>

**ENDOVASCULAR TAA REPAIR: POTENTIAL ANCILLARY SERVICES**

PROCEDURE <sup>A</sup>	CPT <sup>®</sup> CODE	COMMENTS
<b>Three-Day Rule Applies to Diagnostic Services</b>		
<b>Contrast Angiography — Typical Pre-Procedural Work-up Services</b>		
Non-selective catheter placement in aorta only	36200	• Do not code for intra-procedure “roadmapping.”
RS&I, thoracic aortogram	75605	! Caution: CMS will not cover co-occurring use of CA and MRA on routine basis (NCD Manual, Chapter 1, Part 4, Section 220.3).
RS&I, abdominal aortogram	75625	
RS&I, bilateral extremity arteriogram	75716	
<b>CT, CT Angiography</b>		
CT chest, without contrast	71250	• Do not code for intra-procedure “roadmapping.”
CT chest, with contrast	71260	
CT chest without contrast, followed with contrast	71270	
CT abdomen, without contrast	74150	
CT abdomen, with contrast	74160	
CT abdomen without contrast, followed with contrast	74170	
CT angiography, chest	71275	
CT angiography, aorta with iliofemoral runoff	75635	
<b>MR, MR Angiography</b>		
MR chest, without contrast	71550	• Do not code for intra-procedure “roadmapping.”
MR chest, with contrast	71551	! Caution: CMS will not cover co-occurring use of CA and MRA on routine basis (NCD Manual, Chapter 1, Part 4, Section 220.3).
MR chest, without contrast followed with contrast	71552	• Hospitals report C8909, C8910, or C8911 for MRA of the chest.
MR abdomen, without contrast	74181	
MR abdomen, with contrast	74182	
MR abdomen, without contrast, followed with contrast	74183	
MR angiography abdomen, with or without contrast	74185	• Hospitals report C8900, C8901, or C8902 for MRA of the abdomen.
<b>3D Image Reconstruction</b>		
3D rendering with interpretation and reporting, not requiring image post-processing on an independent workstation	76376	! Caution: Do not report reconstruction with CTA or MRA.
3D rendering, requiring post-processing on independent workstation	76377	
G0288 reconstruction, CTA Aorta for surgical planning	G0288	! Caution: Technical fee only for hospital or IDTF.
<b>Ultrasound / IVUS</b>		
US chest	76604	• Do not code for intra-procedure “roadmapping.”
IVUS non-coronary during therapy, initial	+ 37250	• Report IVUS Codes once for each vessel studied.
IVUS additional vessel	+ 37251	
RS&I, IVUS initial vessel	75945	
RS&I, IVUS additional vessel	+ 75946	

<sup>A</sup> Abbreviated CPT<sup>®</sup> code descriptions. See CPT<sup>®</sup> codebook for full descriptions.

## PHYSICIAN CASE EXAMPLES

### PHYSICIAN REIMBURSEMENT

Appropriate physician reimbursement relies on thorough documentation supporting accurate coding. The endovascular repair of a thoracic aortic aneurysm can be very complex, requiring many component steps, and often involving two physicians as either co-surgeons or assistant surgeons. The following cases are illustrative only, demonstrating the range of potential circumstances. Modifier conventions and Relative Value Units (RVU) are those used by Medicare payers; other payers may differ. Consult all professional coding resources available for complete discussion of component coding practice. Confirm practices and requirements with local carriers, and always utilize a current CPT® Professional edition for complete definitions of codes, terminology, and modifiers.

### MODIFIERS

<b>-50 Bilateral Procedure</b> (RVU x 150%)	<b>-51 Multiple Procedures</b> (RVU x 50%)	<b>-62 Two Surgeons</b> (RVU x 62.5%)	<b>-80 Assistant Surgeon</b> (RVU x 16%)	<b>-26 Professional</b>
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Modifier -51 has been used in this guide to indicate those procedures that are subject to multiple procedure payment reductions. It is not typically necessary to apply this modifier on the claim for professional services, as the payment reduction will be applied automatically by the payor.

### CASE 1: INITIAL DEVICE WITH PROXIMAL EXTENSION, NO SUBCLAVIAN COVERAGE; ASSIST SURGEON

Physician 1 performs right femoral artery exposure. Physician 2 performs left femoral puncture and places catheters from both sides in thoracic aorta to arch. After angio, Physician 2 delivers / deploys the initial device, with Physician 1 assisting. Physician 2 then extends repair proximally with second device, landing distal to the subclavian; Physician 1 assists. Physician 2 performs touch-up ballooning to seat the devices, followed by confirmatory angiography. Physician 1 closes the access with suture.

PHYSICIAN 1 CODES	PROCEDURE	RVU	WITH MODIFIER	NATIONAL MEDICARE RATE <sup>A</sup>
33881-80-51	Main Operation	48.71	3.90	
33883-80-51	Proximal Extension	35.31	2.82	
34812-RT	Exposure	10.62	10.62	
<b>Physician 1 Total</b>			<b>17.34</b>	<b>\$589</b>
PHYSICIAN 2 CODES				
33881	Main Operation	48.71	48.71	
33883-51	Proximal Extension	35.31	17.66	
36200-50-51	Bilateral Catheter	4.80	3.60	
75957-26	Radiologic S&I Main	9.39	9.39	
75958-26	Radiologic S&I Extension	6.24	6.24	
<b>Physician 2 Total</b>			<b>85.60</b>	<b>\$2,908</b>

### CASE 2: RETROPERITONEAL ACCESS; INITIAL DEVICE WITH DISTAL EXTENSIONS; ASSIST SURGEON

Physician 1 provides cut-down of left femoral artery; Physician 2 performs right femoral percutaneous access, and performs bilateral catheterization of the thoracic aorta. Physician 2 attempts delivery of GORE® TAG® Device via left side, but is unsuccessful due to tortuous Iliac artery. Physician 1 performs right side retroperitoneal incision and sews graft to left common Iliac. Using the graft, Physician 2 catheterizes the aorta and delivers initial device distal to subclavian, and then places two distal extensions with Physician 1 assisting. Physician 1 ligates the graft conduit and closes all incisions.

PHYSICIAN 1 CODES	PROCEDURE	RVU	WITH MODIFIER	NATIONAL MEDICARE RATE <sup>A</sup>
33881-80-51	Main Operation	48.71	3.90	
34812-51-LT	Exposure	10.62	5.31	
34833-RT	Exposure	19.25	19.25	
<b>Physician 1 Total</b>			<b>28.46</b>	<b>\$967</b>
PHYSICIAN 2 CODES				
33881	Main Operation	48.71	48.71	
36200-50-51	Bilateral Catheter	4.80	3.60	
36200-59-51	Catheter	4.80	2.40	
75957-26	Radiologic S&I Main	9.39	9.39	
<b>Physician 2 Total</b>			<b>64.10</b>	<b>\$2,178</b>

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

**CASE 3: INITIAL DEVICE, PROXIMAL EXTENSION WITH SUBCLAVIAN COVERAGE; EMBOLIZATION; CO-SURGEON**

Physician 1 performs right femoral artery exposure and catheterizes thoracic aorta. Physician 2 performs left femoral puncture and catheterizes thoracic aorta. Physician 1 and 2 both deploy initial endoprosthesis distal to subclavian. Imaging shows inadequate proximal seal; decision is made to coil embolize left subclavian and place proximal extension. Physician 2 performs embolization; Physicians 1 and 2 deploy extension covering subclavian. Angiogram confirms good result; Physician 1 closes femoral exposure with suture.

PHYSICIAN 1 CODES	PROCEDURE	RVU	WITH MODIFIER	NATIONAL MEDICARE RATE <sup>A</sup>
33880-62	Main Operation	56.62	35.39	
34812-51-RT	Exposure	10.62	5.31	
36200-51-RT	Catheter	4.80	2.40	
<b>Physician 1 Total</b>			<b>43.10</b>	<b>\$1,464</b>
PHYSICIAN 2 CODES				
33880-62	Main Operation	56.62	35.39	
36215-51	Catheter	7.54	3.77	
37204-51	Embolize	27.65	13.83	
75956-26	Radiologic S&I Main	10.98	10.98	
75894-26	Radiologic S&I Embolize	2.01	2.01	
<b>Physician 2 Total</b>			<b>66.98</b>	<b>\$2,242</b>

**CASE 4: INITIAL DEVICE WITH SUBCLAVIAN COVERAGE, SUBCLAVIAN-CAROTID TRANSPOSITION; DISTAL EXT; CO-SURGEON**

Physician 1 performs subclavian-carotid transposition. Physician 1 performs left femoral cutdown, Physician 2 performs right femoral puncture, placing catheters bilaterally in the thoracic aorta. Physician 1 and 2 deploy initial device crossing the subclavian artery, then place two distal extensions terminating proximal to celiac artery. After touch-up ballooning, confirmation angiography performed; Physician 1 closes left femoral cutdown, Physician 2 closes right femoral exposure with closure device.

PHYSICIAN 1 CODES	PROCEDURE	RVU	WITH MODIFIER	NATIONAL MEDICARE RATE <sup>A</sup>
33880-62	Main Operation	56.62	35.39	
33889-51	Transposition	25.19	12.60	
34812-51-LT	Exposure	10.62	5.31	
<b>Physician 1 Total</b>			<b>53.30</b>	<b>\$1,811</b>
PHYSICIAN 2 CODES				
33880-62	Main Operation	56.62	35.39	
36200-50-51	Bilateral Catheter	4.80	3.60	
75956-26	Radiologic S&I	10.98	10.98	
G0269	Closure Device	0.00	0.00	
<b>Physician 2 Total</b>			<b>49.97</b>	<b>\$1,698</b>

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

**CASE 5: DELAYED DISTAL EXTENSION, WITH IVUS IMAGING, SOLO PHYSICIAN**

Angiographic finding of type 1B endoleak is made at six-month follow-up of patient with previously placed thoracic endoprosthesis. Physician 1 gains access via cutdown to right side of previously placed aorto-femoral graft; and places catheter. Physician 1 then uses IVUS via left femoral puncture to confirm position of previous device relative to celiac trunk. Physician 1 deploys distal extension terminating proximal to celiac origin. Angiography confirms result; cutdown exposure is closed with suture.

PHYSICIAN 1 CODES	PROCEDURE	RVU	WITH MODIFIER	NATIONAL MEDICARE RATE <sup>A</sup>
33886	Main Operation	30.65	30.65	
34812-51-RT	Exposure	10.62	5.31	
36200-50-51	Bilateral Catheter	4.80	3.60	
37250	IVUS	3.39	3.39	
75959-26	Radiologic S&I	5.52	5.52	
75945-26	Radiologic S&I IVUS	0.61	0.61	
<b>Physician 1 Total</b>			<b>49.08</b>	<b>\$1,668</b>

**CASE 6: INITIAL DEVICE, NO SUBCLAVIAN COVERAGE, 2X PROXIMAL EXTENSIONS; ANCILLARY STENT; CO-SURGEON**

Physician 1 performs left femoral artery exposure, Physician 2 provides right femoral puncture and places bilateral catheters. Physician 1 and 2 place initial device distal to subclavian, followed by a proximal extension. Despite repeated ballooning at proximal end, seal is not satisfactory. Physician 1 performs right brachial artery cutdown, advances catheter to the arch, and places a wire in the left subclavian. Physician 2 then deploys a second proximal extension, just distal to the left subclavian. Via the brachial access, Physician 1 places stent at the origin of the left subclavian. Physician 1 closes incisions.

PHYSICIAN 1 CODES	PROCEDURE	RVU	WITH MODIFIER	NATIONAL MEDICARE RATE <sup>A</sup>
33881-62	Main Operation	48.71	30.44	
33883-62-51	Proximal Extension	35.31	11.03	
37205-51	Stent	13.47	6.73	
34812-51-LT	Exposure	10.62	5.31	
34834-51-LT	Exposure Brachial	8.70	4.35	
36215-51-LT	Catheter	7.54	3.77	
75960-26	Radiologic S&I Stent	1.21	1.21	
<b>Physician 1 Total</b>			<b>62.84</b>	<b>\$2,135</b>
PHYSICIAN 2 CODES				
33881-62	Main Operation	48.71	30.44	
33883-62-51	Proximal Extension	35.31	11.03	
33884	Proximal Extension	12.87	12.87	
36200-50-51	Bilateral Catheter	4.80	3.60	
75957-26	Radiologic S&I	9.39	9.39	
75958-26	Radiologic S&I Extension 1	6.24	6.24	
75958-26	Radiologic S&I Extension 2	6.24	6.24	
<b>Physician 2 Total</b>			<b>79.81</b>	<b>\$2,712</b>

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

## 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.

## 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.

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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