

PHYSICIAN AND OUTPATIENT BILLING CODES

Clinicians and outpatient facilities use Current Procedural Terminology (CPT¹) codes to bill for procedures and services. Each CPT code is assigned unique relative value units (RVUs), which are used to determine payment by the Centers for Medicare & Medicaid Services (CMS). Some commonly billed CPT codes used to describe procedures related to Edwards Lifesciences' Vascular technologies (e.g. Fogarty catheters) are listed below.² This list may not be comprehensive or complete. These procedures may be subject to the CMS multiple procedure reduction rule. When applicable, a payment reduction of 50% is applied to all payment amounts except the procedure with the greatest RVUs, which is paid at 100% unless exempt by CPT instructions or payer policy. This rule does not normally apply to radiologic procedures.

Procedures related to the use of Edwards Lifesciences' technologies (e.g. Fogarty catheters) are often performed in a facility setting, including an outpatient hospital department (HOPPS, Place of Service (POS) code 22), Ambulatory Surgery Center (POS code 24), or a Vascular Access Center (which can be licensed as POS 11, 22 or 24). Reimbursement is determined based upon services rendered and varies by place of service. The following are commonly billed codes and associated national average Medicare payment amounts. This list may not be comprehensive and complete.

Interventional Procedures ³	CPT Code	Description	Medicare National Average Physician Payment ⁴		Medicare National Average Facility Payment		
			Facility Setting (Various POSs)	Non-Facility Setting (Including POS 11)	Outpatient Hospital ⁵ (POS 22)	ASC (POS 24)	
	36147 ⁶	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including 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 entire venous outflow including the inferior or superior vena cava)	\$192	\$827	APC 676	\$162	\$91
	36148 ⁷	Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure).	\$51	\$261	n/a	n/a (packaged)	n/a (packaged)



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CPT Code	Description	Facility Setting (Various POSs)	Non-Facility Setting (Including POS 11)	Outpatient Hospital ⁵ (POS 22)		ASC (POS 24)
				APC	Rate	
36831	Thrombectomy, open, arteriovenous fistula without revision, autogenous or non-autogenous dialysis graft (separate procedure)	\$482	Facility Only	APC 0088	\$2,874	\$1,616
36833	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or non-autogenous dialysis graft (separate procedure)	\$692	Facility Only	APC 0088	\$2,874	\$1,616
36870	Thrombectomy, percutaneous, arteriovenous fistula; autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	\$314	\$1,890	APC 0653	\$3,106	\$1,747
37201	Transcatheter therapy, infusion for thrombolysis other than coronary	\$289	Facility Only	APC 0103	\$1,318	Non-covered

INPATIENT HOSPITAL BILLING CODES

Medicare inpatient hospital reimbursement is based upon the Medicare Severity-Diagnostic Related Group (MS-DRG) classification system, which assigns MS-DRGs based on ICD-9-CM diagnosis and procedure codes. The following codes generally describe procedures associated with the use of Edwards Lifesciences' Vascular technologies (e.g. Fogarty catheters).

ICD9-CM Procedure Code ⁸	Description
39.42	Revision of arteriovenous shunt for renal dialysis
39.49	Other revisions of vascular procedure

REVENUE CODES⁹ AND HCPCS CODES

Revenue codes help hospitals categorize services provided by revenue center. Medicare utilizes revenue codes for cost reporting purposes. It may be appropriate for hospitals to capture the cost of products used for these procedures for payer reporting or cost accounting purposes as expenses within Revenue Code 0278 (Medical/Surgical Supply – Other Implants) on the hospital UB-04 billing form. CMS uses C-codes under the Outpatient Prospective Payment System (OPPS) to track device cost information for future APC rate-setting purposes. No additional facility payment is associated with these codes. CMS may reject hospital claims if the appropriate C codes used to report device costs are not identified on the claim. Edwards Lifesciences' Vascular technologies can be used in both the inpatient and outpatient setting. C codes which may apply to the use of these products in the outpatient setting are listed below. Procedure codes associated with these products are not necessarily included within this document.

C Code	Description	Edwards Product Examples
C1757	Thrombectomy/Embolectomy Catheter	Fogarty and Fogarty Fortis thrombectomy and embolectomy catheters: 120403F-120807F, 12A0403F-12A1004F, NL2EMB40-NL7EMB80, 12TLW403F-12TLW807F, 140806-1408010, 160245F-320808F
C2628	Catheter, occlusion	620403F, 620404F, 620405F, 62080814F, 62080822F

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² Not all codes provided are applicable for the clinical scenarios in which Edwards Lifesciences' Vascular technologies are used. The provider is responsible for selecting the most appropriate code(s) for the patient's clinical presentation. When radiologic guidance is used for catheter placement, it may be appropriate to add applicable codes according to the service provided following correct coding guidelines. Services that are considered a component of another procedure may not always be coded and billed separately.

³ Where applicable, a physician may be required to report CPT codes for radiological supervision and interpretation with CPT codes for interventional procedures. The use of modifier-26 may be required with various radiological supervision and interpretation CPT codes unless radiological equipment is owned by the physician performing these services. Radiological services are often packaged and do not qualify for separate payment by Medicare when performed in conjunction with interventional procedures. Consult with coding and billing staff, as well as payer policy for further guidance.

⁴ For all Medicare Payments for physician, hospital outpatient, and ASC services, the multiple procedure reduction rule may apply. Consult with coding and billing staff, and payer policy for further guidance. National average Medicare payment is calculated using the Conversion Factor of \$33.9764. Federal Register Volume 75, Number 228, November 29, 2010.

⁵ Various radiological services are often packaged in APC payments and do not qualify for separate payment by Medicare when performed in conjunction with the interventional procedure. For Medicare claims submission and processing, applicable device-related C codes must also be reported.

⁶ CPT code 36147 should not be used in conjunction with 75791.

⁷ CPT code 36148 may be used in conjunction with 36147.

⁸ International Classification of Diseases, 9th Revision, Clinical Modification 6th Edition, 2011 ICD-9-CM for hospitals, volume 1, 2, & 3.

⁹ National Uniform Billing Committee, American Hospital Association.

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