### 2019 Medicare National Average Payments

<table>
<thead>
<tr>
<th>Lower Extremity (LE) PI Procedure Abbreviated Description</th>
<th>CPT®</th>
<th>APC</th>
<th>ASC Pay</th>
<th>Hospital Inpatient Pay</th>
<th>MD In Office Pay</th>
<th>MD In Hospital Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iliac PTA</td>
<td>37220 + 37222</td>
<td>5192</td>
<td>$4,679</td>
<td>$2,002</td>
<td>$3,019</td>
<td>$421</td>
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<tr>
<td>PTA and Stent</td>
<td>37221 + 37223</td>
<td>5193</td>
<td>$9,669</td>
<td>$5,834</td>
<td>$4,284</td>
<td>$520</td>
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<tr>
<td>Femoral / Popliteal PTA</td>
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<td>$2,887</td>
<td>$3,628</td>
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<td>PTA and Atherectomy</td>
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<td>$12,444</td>
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<td>PTA, Stent and Atherectomy</td>
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<tr>
<td>Tibial / Peroneal PTA</td>
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<td>PTA and Stent</td>
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<td>$9,604</td>
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<tr>
<td>PTA, Stent and Atherectomy</td>
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<td>$9,851</td>
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<td>$15,230</td>
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</tr>
</tbody>
</table>

- Denotes DRG assigned to patient w. MCC (major complications or comorbidities)
- Denotes DRG assigned to patient w. CC (complications or comorbidities)

For Hospital in-patient payment rates, see Boston Scientific Procedural Payment Guide for common procedure codes.
CMS – Centers for Medicare and Medicaid Services
– Largest payer in the US. Annually releases PPS – Prospective Payment System (Fee Schedule). Fee Schedules pay differently for doctors, hospitals, and other facilities. Private Insurance payers (UnitedHealth, Blue Cross Blue Shield, etc.) pay approximately 120-150% on average of rates paid by CMS fee schedules

**Hospital Outpatient**

HOPPS – Hospital Outpatient Prospective Payment System
– Payment rate based on APC–Ambulatory Payment Classification
– Services grouped by ICD 10 diagnosis, CPT, HCPCS Level II codes

**C-Code** – Used to identify devices used during outpatient procedures
– Required for claims processing, no impact on payment

**Hospital Inpatient**

HIPPS – Hospital Inpatient Prospective Payment System
– Payment rates grouped by

**MS DRG- Medical Severity - Diagnosis Related Group**
– Higher paying DRGs associated with cases involving patients dx with

**MCC – Major Complication or Comorbidity or CC – Complication or Comorbidity** - CMS classifies which ICD 10 dx codes are CCs and MCCs

**ICD 10- International Classification of Diseases**
– Encompassing diagnosis and procedural codes

New for FY2014 – Inpatient admission requires anticipated stay of at least 2 midnights

**Physician**

PFS – Physician Fee Schedule – Sets CPT payment rates

**CPT – Current Procedural Terminology**
– CPT payment dependent on:
  - Place of Service – (Facility or Non-Facility)
  - RVU – Relative Value Unit

**HCPCS–Healthcare Common Procedural Coding System**
Codes for services equipment and supplies
  - Level I HCPCS – Contain numeric CPT codes
  - Level II HCPCS - Contain alphanumeric non-CPT codes

**ASC**

ASC – Ambulatory Surgery Center
– Same day surgery center, only certain procedures allowed in ASCs.
– Facility payment based on HOPPS fee schedule, ASC rate is typically lower than outpatient hospital

**Bundled LE CPT Codes**
Includes:

• Accessing the Vessel
• Vessel Catheterization
• Crossing the Lesion
• Radiological S&I
• Arterial Closure
• Post Procedure Imaging

**CPT, APC and ASC Payments** – Updated on Calendar Year Basis
For additional Pt coding, see the 2019 Procedural Payment Guide


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For additional PI coding, see the 2019 Procedural Payment Guide

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