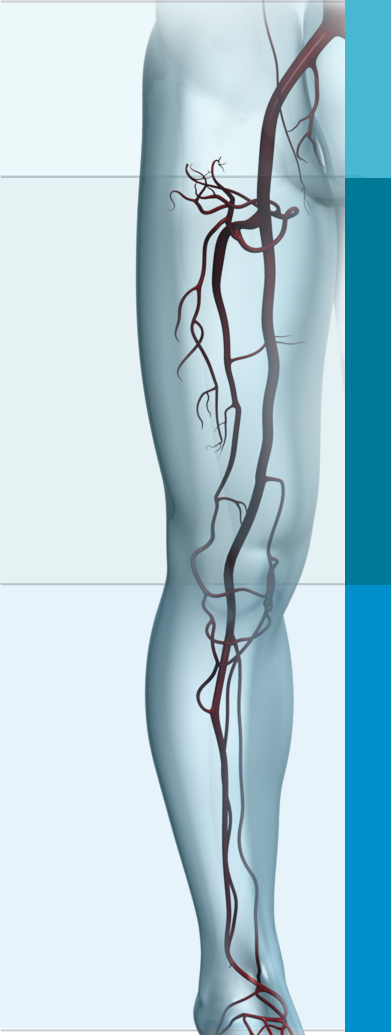


LE ARTERIAL REIMBURSEMENT REFERENCE GUIDE

2019 Medicare National Average Payments



Lower Extremity (LE) PI Procedure Abbreviated Description		CPT®	APC	Hospital Outpatient Pay	ASC Pay	DRG	Hospital Inpatient Pay	MD In Office Pay	MD In Hospital Pay
Iliac	PTA	37220 + 37222	5192	\$4,679	\$2,002	<ul style="list-style-type: none"> • 252 • 253 254 	\$19,915	\$3,019 \$816	\$421 \$195
	PTA and Stent	37221 + 37223	5193	\$9,669	\$5,834			\$4,284 \$2,256	\$520 \$223
Femoral / Popliteal	PTA	37224	5192	\$4,679	\$2,887			\$3,628	\$466
	PTA and Atherectomy	37225	5193	\$9,669	\$6,411			\$12,444	\$635
	PTA and Stent	37226			\$6,223			\$10,793	\$547
	PTA, Stent and Atherectomy	37227	5194	\$15,355	\$10,354			\$16,033	\$763
Tibial / Peroneal	PTA	37228 + 37232	5193	\$9,669	\$5,484			\$5,260 \$1,122	\$570 \$211
	PTA and Atherectomy	37229 + 37233	5194	\$15,355	\$9,787			\$12,451 \$1,367	\$741 \$343
	PTA and Stent	37230 + 37234			\$9,604			\$10,600 \$3,955	\$735 \$300
	PTA, Stent and Atherectomy	37231 + 37235			\$9,851			\$15,230 \$4,291	\$799 \$421

+ symbol denotes add-on codes relevant for other recognized vessels within Iliac and Tib-Per territories

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

Hospital in-patient payment rates are based on services rendered as reported with ICD-10 codes and documented diagnosis codes. 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

DRG Payments –Updated on Fiscal Year Basis Oct 1 – Sep 30

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

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

www.bostonscientific.com/en-US/reimbursement/peripheral-interventions.html

For additional PI coding, see the 2019 Procedural Payment Guide

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