GUIDEPOINT Reimbursement Resources

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Deep Vein Thrombosis – Reimbursement Reference Guide

Potential CPT® Codes [1]

	CPT ®	CPT ® Description	Physician Work RVU	Total RVU (In-Facility)	2018 National Avg. Medicare Physician Payment (In-Facility)
Mechanical Thrombectomy	37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	7.78	11.42	$411
	37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	5.46	8.13	$293
	Codes Exclude: Continuous infusion of thrombolytics prior to and after the procedure ([37211, 37212, 37213, 37214]), Diagnostic studies, other interventions performed percutaneously (example, balloon angioplasty), catheter placement, radiological supervision/interpretation can be reported separately.				
Thrombolysis	37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	6.81	9.82	$354
	37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;	4.75	6.79	$244
	37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	2.49	3.56	$128
	Codes Exclude: catheter placement, diagnostic studies, percutaneous interventions, ultrasound guidance				

See important notes on the uses and limitations of this information on page 5.

	CPT ®	CPT ® Description	Physician Work RVU	Total RVU (In-Facility)	2018 National Avg. Medicare Physician Payment (In-Facility)
Angioplasty	37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	6.00	8.68	$312
	37249	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	2.97	4.22	$152
Venography	75820	Venography, extremity, unilateral, radiological supervision and interpretation	0.7	0.99	$36
	75822	Venography, extremity, bilateral, radiological supervision and interpretation	1.06	1.48	$53
	Important: Diagnostic venography codes should NOT be used with interventional procedures for: Contrast injections, venography, road mapping, and/or fluoroscopic guidance for the intervention, vessel measurement and pre and post intervention evaluation. Diagnostic venography performed at the time of an interventional procedure is separately reportable if: A full diagnostic study is performed, and decision to intervene is based on the diagnostic study. Or, a prior study is available, but as documented in the medical record: if the patient's condition has changed, if there is insufficient imaging or if the clinical condition has changed during the procedure, necessitating another examination. A modifier may be required, for example a 59 modifier. Providers should check with payers for specific requirements.			
Catheter Placement	36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)	0.95	1.40	$50
	36010	Introduction of catheter, superior or inferior vena cava	2.18	3.18	$114

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Hospital Inpatient Medicare Reimbursement [2]

MS-DRG assignment is based on procedures performed and documented patient diagnoses. The following information shows potentially applicable MS-DRG assignments for surgical MS-DRGs within MDC 5 when endovascular thrombectomy of the lower limbs is performed.

MS-DRG	Description	FY2018 National Avg. Medicare Reimbursement
270	Other major cardiovascular procedures w/ MCC	$29,782
271	Other major cardiovascular procedures w/ CC	$20,395
272	Other major cardiovascular procedures w/o MCC/CC	$14,792

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Hospital Outpatient Medicare Reimbursement [3]

Ambulatory Payment Classification or APCs are the payment levels assigned by Medicare for Hospital Outpatient services. APC assignment is based on services performed and can vary depending on if thrombectomy is done with or without other percutaneous interventions.

APC	Description	CY2018 National Avg. Medicare Reimbursement
5182	Level 2 Vascular Procedures	$983
5183	Level 3 Vascular Procedures	$2,493
5192	Level 2 Endovascular Procedures	$5,085
5193	Level 3 Endovascular Procedures	$10,510
5194	Level 4 Endovascular Procedures	$16,019

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References:

1. CMS Website. Physician Fee Schedule – CY2018 National Physician Fee Schedule Relative Value File: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-F.html

2. CMS Website. ICD-10-CM/PCS MS-DRG v35 Definitions Manual: https://www.cms.gov/ICD10Manual/version35-fullcode-cms/fullcode_cms/P0001.html

3. CMS Webite. FY2018 Medicare IPPS Final Rule: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

4. CMS website. CY2018 OPPS Addendum B: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1678-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

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Reminder: Treatment setting is based on medical necessity. The decision as to which treatment setting should be determined by the physician and should be based on medical necessity.

See important notes on the uses and limitations of this information on page 5.