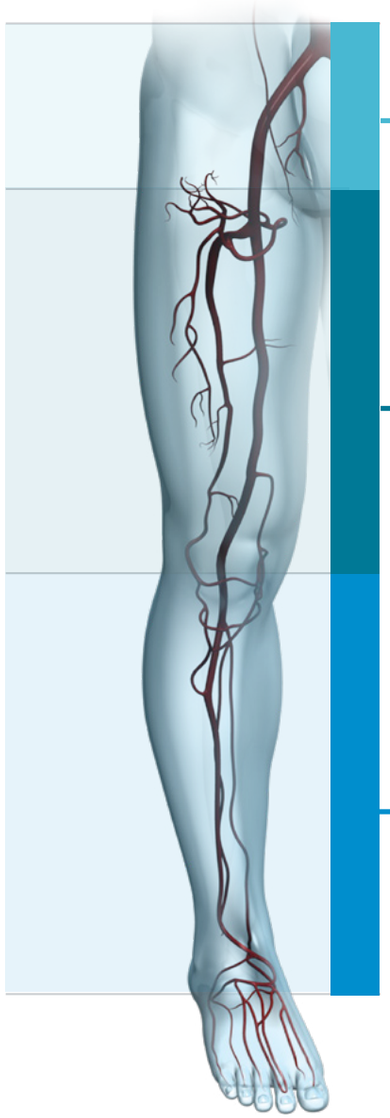
LE ARTERIAL REIMBURSEMENT REFERENCE GUIDE

Boston Scientific

2018 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	$5,085	$2,525	• 252 • 253 254	$19,492 $15,281 $10,928	$3,122 $877	$422 $196
	PTA and Stent	37221 + 37223	5193	$10,510	$6,402			$4,631 $2,595	$521 $224
Femoral / Popliteal	PTA	37224	5192	$5,085	$2,525			$3,790	$467
	PTA and Atherectomy	37225	5193	$10,510	$7,024			$11,130	$637
	PTA and Stent	37226			$6,749			$9,100	$549
	PTA, Stent and Atherectomy	37227	5194	$16,019	$10,864			$15,062	$765
Tibial / Peroneal	PTA	37228 + 37232	5193	$10,510	$4,481			$5,424 $1,210	$572 $212
	PTA and Atherectomy	37229 + 37233	5194	$16,019	$10,228			$10,976 $1,464	$742 $346
	PTA and Stent	37230 + 37234			$10,207			$8,389 $3,969	$735 $300
	PTA, Stent and Atherectomy	37231 + 37235			$10,276			$13,605 $4,194	$798 $420

+ 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 2018 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 2018 Procedural Payment Guide

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