UTERINE FIBROID EMBOLIZATION

Coding & Reimbursement Information 2018

ANGIOGRAM

CPT Code	Description[1]	APC	Status Indicator	Hospital Outpatient[2]	Ambulatory Surgery Center[2]	Physician Services Fee	
						Performed in Office[3]	Performed in Hospital or ASC[3]
75726	Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	5184	Q2	$4,264.96	N1	$151.92	$56.52
+75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	-	N	N/A	N1	$88.20	$17.64

CATHETER ACCESS

CPT Code	Description[1]	APC	Status Indicator	Hospital Outpatient[2]	Ambulatory Surgery Center[2]	Physician Services Fee	
						Performed in Office[3]	Performed in Hospital or ASC[3]
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	-	N	-	N1	$1,337.03	$249.48
36246	Initial second order abdominal, pelvic	-	N	-	N1	$839.51	$266.76
36247	Initial third order abdominal, pelvic	-	N	-	N1	$1,530.34	$313.16
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	-	N	-	N1	$155.88	$51.12

EMBOLIZATION PROCEDURES

CPT Code	Description[1]	APC	Status Indicator	Hospital Outpatient[2]	Ambulatory Surgery Center[2]	Physician Services Fee	
						Performed in Office[3]	Performed in Hospital or ASC[3]
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intrap-rocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	5193	J1	$10,510.46	$4,480.05	$9,900.25	$589.67
75894*	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	-	N	-	N1	$73.80	$73.80
75898*	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	5182	Q2	$982.97	N1	$92.16	$92.16

*Do not report in the same operative field.

APC=Ambulatory Payment Classification. S=significant procedure. T=multiple procedure reduction applies. Status indicator Q2 is paid when services are separately payable or packaged if there is a status T or S procedure on the same claim. Status Code J1 is a comprehensive APC. All associated services are packaged within the primary code with J1 status indicator. Physician payment is not impacted by APC payment or status indicators.

CONTINUED

UTERINE FIBROID EMBOLIZATION

Coding & Reimbursement Information 2018

HOSPITAL INPATIENT

ICD-10-CM Diagnosis Codes[4]	Description
D25.0	Submucous leiomyoma of uterus
D25.1	Intramural leiomyoma of uterus
D25.2	Subserosal leiomyoma of uterus
D25.9	Leiomyoma of uterus, unspecified
N92.0	Excessive and frequent menstruation with regular cycle
N92.1	Excessive and frequent menstruation with regular cycle
N92.2	Excessive menstruation at puberty
N92.3	Ovulation bleeding
N92.4	Excessive bleeding in the premenopausal period
N92.5	Other specified irregular menstruation
N92.6	Irregular menstruation, unspecified

ICD-10-CM Diagnosis Codes[4]	Description
04LE3DT	Occlusion of right uterine artery with intraluminal device, percutaneous approach
04LE3ZT	Occlusion of right uterine artery, percutaneous approach
04LF3DU	Occlusion of left uterine artery with intraluminal device, percutaneous approach
04LF3ZU	Occlusion of left uterine artery, percutaneous approach

Possible MS-DRG Assignment	Description	FY 2017 Medicare National Average Payment Rate[5]
MS-DRG 761	Menstrual and other female reproductive system disorders without CC/MCC	$4,687.51
MS-DRG 760	Menstrual and other female reproductive system disorders with CC/MCC	$6,264.12
MS-DRG 743	Uterine and adnexa procedures for non-malignancy without CC/MCC	$7,839.27
MS-DRG 742	Uterine and adnexa procedures for non-malignancy with CC/MCC	$11,956.99

Reimbursement Helpline
serviced by the Institute for Quality Resource Management
phone: (888) 447-1211 email: embo@IQRM.info

1. CPT ©2018 American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AMA. Applicable FARS/DFARS restrictions apply to government use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of the CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
2. CY 2018 Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Final Rule; Correction Notice (Federal Register, Vol. 82, No.247 CMS-1678-CN; 12/27/2017. Ambulatory Payment Classification Addendum B effective January 01, 2018 and ASC Addendum AA and BB effective January 01,2018.
3. Source: January 1, 2018 Medicare physician relative value scale conversion factor $35.9996. Rates are effective from January 1, 2018 - April 1, 2018. When an Angiography procedure is performed in an office-based setting, the physician may bill for a global (professional and technical payment). When a procedure is performed in a hospital based or ambulatory surgical center (ASC), the physician may bill the professional payment signified by the place of service code on the CMS 1500 form. If the physician is only performing the supervision and interpretation of an imaging study, the physician may bill the appropriate code with modifier 26. If the procedure was done in an ASC and the ASC bills separately, then the ASC may receive the technical component payment. https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf.
4. CMS 2018 ICD-10-PCS, CDC 2018 ICD-10-CM.
5. FY 2017 Hospital Inpatient Final Rule, Correction Notice. MS-DRG estimated payments National average (wage index greater than 1) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts reflecting an average community hospital reporting quality data. MS-DRG assignment will depend on the admitting diagnosis and surgical procedure codes.