PROSTATIC ARTERY 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, intra-procedural 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

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HOSPITAL INPATIENT

ICD-10-CM Diagnosis Codes[4]	Description
N400	Benign prostatic hyperplasia without lower urinary tract symptoms
N401	Benign prostatic hyperplasia with lower urinary tract symptoms

ICD-10-CM Procedure Codes[4]	Description
0V503ZZ	Destruction of Prostate, Percutaneous Approach
0VH433Z	Insert infusion device into prostate/seminal vesicles

Possible MS-DRG Assignment	Description	FY2017 Medicare National Average Payment Rate[5]
MS-DRG 726	Benign prostate hypertrophy without MCC	$5,379.88
MS-DRG 725	Benign prostate hypertrophy with MCC	$9,292.59

Place of Service Code Set [6]

Listed below are place of service codes and descriptions. These codes should be used to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes.

Place of Service Code(s)	Place of Service Name	Place of Service Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
24	Ambulatory Surgery Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

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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.
6. https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html