## ANGIOGRAM

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>APC</th>
<th>Status Indicator</th>
<th>Hospital Outpatient</th>
<th>Ambulatory Surgery Center</th>
<th>Physician Services Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>75726</td>
<td>Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation</td>
<td>5184</td>
<td>Q2</td>
<td>$4,376.52</td>
<td>N1</td>
<td>$147.04</td>
</tr>
<tr>
<td>+75774</td>
<td>Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)</td>
<td>-</td>
<td>N</td>
<td>N/A</td>
<td>-</td>
<td>$83.97</td>
</tr>
</tbody>
</table>

## CATHETER ACCESS

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>36245</td>
<td>Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family</td>
<td>-</td>
<td>N</td>
<td>-</td>
<td>N1</td>
<td>$1,348.94</td>
</tr>
<tr>
<td>36246</td>
<td>Initial second order abdominal, pelvic</td>
<td>-</td>
<td>N</td>
<td>-</td>
<td>N1</td>
<td>$857.73</td>
</tr>
<tr>
<td>36247</td>
<td>Initial third order abdominal, pelvic</td>
<td>-</td>
<td>N</td>
<td>-</td>
<td>N1</td>
<td>$1,535.27</td>
</tr>
<tr>
<td>36248</td>
<td>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)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>$148.12</td>
</tr>
</tbody>
</table>

## EMBOLIZATION PROCEDURES

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>37243</td>
<td>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</td>
<td>5193</td>
<td>J1</td>
<td>$9,669.04</td>
<td>N1</td>
<td>$9,861.02</td>
</tr>
<tr>
<td>75894*</td>
<td>Transcatheter therapy, embolization, any method, radiological supervision and interpretation</td>
<td>-</td>
<td>N</td>
<td>-</td>
<td>N1</td>
<td>$74.24</td>
</tr>
<tr>
<td>75898*</td>
<td>Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis</td>
<td>5182</td>
<td>Q2</td>
<td>$1,093.63</td>
<td>N1</td>
<td>$92.62</td>
</tr>
</tbody>
</table>

*Do not report in the same operative field.

APC=Ambulatory Payment Classification. Status indicator: Q2 is paid under OPPS when services are separately payable and packaged if there is a status T procedure on the same claim. S is a significant procedure. T separate payment but multiple procedure reduction applies. Effective January 1, 2015, Medicare implemented the packaged code classification: Status Code J1. This is a comprehensive APC (C-APC). All associated services are to be packaged within the primary code (assigned as J1 status indicator). All pretreatment and mapping services will be packaged when billed on the same day as CPT code 37243 (J1). Physician payment is not impacted by APC status indicators.
HOSPITAL INPATIENT

ICD-10-CM Diagnosis Code | Description
-------------------------|---------------------
N40.0                    | Benign prostatic hyperplasia without lower urinary tract symptoms
N40.1                    | Benign prostatic hyperplasia with lower urinary tract symptoms
N13.8                    | Urinary obstruction
R33.8                    | Other retention of urine
R33.9                    | Retention of urine, unspecified
R34                      | Anuria and oliguria
R35.1                    | Nocturia
R39.12                   | Weak urinary stream
R39.14                   | Incomplete bladder emptying

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

Possible MS-DRG Assignment | Description | FY2018 Medicare National Average Payment Rate
---------------------------|-------------|---------------------
MS-DRG 726                | Benign prostate hypertrophy without MCC | $5,875.31
MS-DRG 725                | Benign prostate hypertrophy with MCC | $9,332.11

ICD-10-CM Diagnosis Code

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N13.8 Urinary obstruction
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R33.9 Retention of urine, unspecified
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Possible MS-DRG Assignment

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MS-DRG 725 Benign prostate hypertrophy with MCC $9,332.11

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

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2. Source: December 13, 2018 release date December 20, 2018 Medicare physician relative value scale conversion factor $36.0391. Rates are effective from January 1, 2019 – April 1, 2019. 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 using modifier 26. If the procedure was done in an ASC and the ASC bills separately, then the ASC may receive the technical component payment. HYPERLINK “http://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf”.

3. CMS 2019 Hospital Outpatient Prospective Payment System Ambulatory Payment Classification Addendum B effective January 01, 2019.

4. CMS October 1, 2018 ICD-10-PCS, CDC 2018 ICD-10-CM.

5. FY 2018-19 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 may vary depending on the admitting diagnosis, surgical procedures provided.

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