

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 supraseductive (with or without flush aortogram), radiological supervision and interpretation	5184	Q2	\$5,241.36	N1	\$166.67	\$90.37
+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	\$94.63	\$44.53

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	\$1,195.16	\$225.28
36246	Initial second order abdominal, pelvic	-	N	-	N1	\$804.85	\$241.65
36247	Initial third order abdominal, pelvic	-	N	-	N1	\$1,367.40	\$284.55
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	\$112.31	\$45.84

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	\$10,492.72	\$4,847.61/G2	\$8,227.96	\$532.42
75894*	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	-	N	-	N1	\$69.09	\$69.09
75898*	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	5183	J1	\$3,040.18	\$1,548.04/Z2	\$88.08	\$88.08

*Do not report in the same operative field.

APC=Ambulatory Payment Classification. Status indicator: Q2 is paid under OPSS 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. ASC=Ambulatory surgical center. Z2= Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPSS relative payment weight. G2= Non office-based surgical procedure added in CY 2008 or later; payment based on OPSS relative payment weight.

CONTINUED

PROSTATIC ARTERY EMBOLIZATION

ICD-10-CM Diagnosis Codes ⁴	Description
N40.0	Benign prostatic hyperplasia without lower urinary
N40.1	Benign prostatic hyperplasia with lower urinary tract symptoms
N40.2	Nodular prostate without lower urinary tract symptoms
N40.3	Nodular prostate with lower urinary tract symptoms
N13.8	Urinary obstruction
R31.0	Gross hematuria
R31.1	Benign essential microscopic hematuria
R31.21	Asymptomatic microscopic hematuria
R31.29	Other microscopic hematuria
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
R94.4	Abnormal results of kidney function studies

ICD-10-CM Procedure Codes ⁴	Description
0V503ZZ	Destruction of Prostate, Percutaneous Approach
0VH433Z	Insert infusion device into prostate/seminal vesicles
0VQ03ZZ	Repair Prostate, Percutaneous Approach

Possible MS-DRG Assignment	Description	FY2024 Medicare National Average Payment Rate ⁵
MS-DRG 726	Benign prostate hypertrophy without MCC	\$8,370.52
MS-DRG 725	Benign prostate hypertrophy with MCC	\$14,005.21

Reimbursement Helpline

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

1. CPT ©2023 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. Source: November 16, 2023 effective January 1, 2024. Medicare physician relative value scale conversion factor \$32.7442. Rates are effective from January 1, 2024 – April 1, 2024. 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. <https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf>.
3. CMS 2024 Hospital Outpatient Prospective Payment System Ambulatory Payment Classification Addendum B effective January 01, 2024.
4. CMS October 1, 2023 ICD-10-PCS, CDC 2023 ICD-10-CM.
5. FY 2024 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.

Merit Medical Systems, Inc. gathers reimbursement information from third-party sources and presents this information for illustrative purposes only. This information does not constitute reimbursement or legal advice and does not guarantee that this information is accurate, complete, without errors, or that use of any of the codes provided will ensure coverage or payment at any particular level. Medicare may implement policies differently in various parts of the country. Physicians and hospitals should confirm with a particular payer or coding authority, such as the American Medical Association or medical specialty society, which codes or combinations of codes are appropriate for a particular procedure or combination of procedures. Reimbursement for a product or procedure can be different depending upon the setting in which the product is used. Coverage and payment policies also change over time and Merit Medical Systems, Inc. assumes no obligation to update the information provided herein.