

ANGIOGRAM

CPT® Code	Description¹	APC	Status Indicator	Hospital Outpatient²	Ambulatory Surgery Center	Physician Services Fee	
						Performed in Office²	Performed in Hospital or ASC²
75726	Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation	5184	Q2	\$5,405.70	N1	\$165.61	\$90.57
+75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	-	N	-	N1	\$92.83	\$43.99

CATHETER ACCESS

CPT Code	Description¹	APC	Status Indicator	Hospital Outpatient³	Ambulatory Surgery Center	Physician Services Fee	
						Performed in Office²	Performed in Hospital or ASC²
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	-	N	-	N1	\$1,144.10	\$224.16
36246	Initial second order abdominal, pelvic	-	N	-	N1	\$769.52	\$238.72
36247	Initial third order abdominal, pelvic	-	N	-	N1	\$1,309.71	\$281.74
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	\$109.65	\$45.93

EMBOLIZATION PROCEDURES

CPT Code	Description¹	APC	Status Indicator	Hospital Outpatient³	Ambulatory Surgery Center	Physician Services Fee	
						Performed in Office³	Performed in Hospital or ASC²
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	5193	J1	\$11,340.57	\$6,530.20	\$7,841.12	\$530.48
75894*	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	-	N	-	N1	\$69.22	\$69.22
75898*	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	5183	J1	\$3,147.50	\$1,588.69 (Z2)	\$87.66	\$87.66

*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. ASC = Ambulatory surgical center. Z2 = Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight. G2= Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.

CONTINUED

UTERINE FIBROID EMBOLIZATION

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 Procedure 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 742	Uterine and adnexa procedures for non-malignancy with CC/MCC	\$15,773.63
MS-DRG 743	Uterine and adnexa procedures for non-malignancy	\$10,658.78
MS-DRG 760	Menstrual and other female reproductive system disorders with CC/MCC	\$8,923.15
MS-DRG 761	Menstrual and other female reproductive system disorders without CC/MCC	\$6,058.67

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2. CMS FY 2025 Hospital Outpatient Prospective Payment System Ambulatory Payment Classification Addendum B effective January 01, 2025.
3. CMS Final ASC Covered Surgical Procedures for CY 2025 Addenda AA and BB effective January 01, 2025.
4. Source: January 01, 2025 Medicare physician relative value scale conversion factor \$32.3465. Rates are effective from January 01, 2025 – April 01, 2025. 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>.
5. CMS FY 2025 ICD-10-PCS and CDC FY 2025 ICD-10-CM.
6. FY 2025 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.

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