PROSTATIC ARTERY EMBOLIZATION

Coding & Reimbursement Information 2019

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	$4,376.52	N1	$147.04	$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	-	$83.97	$17.66

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	$1,348.94	$248.31
36246	Initial second order abdominal, pelvic	-	N	-	N1	$857.73	$266.33
36247	Initial third order abdominal, pelvic	-	N	-	N1	$1,535.27	$316.42
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)	-	-	-	-	$148.12	$51.18

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	$9,669.04	N1	$9,861.02	$588.52
75894*	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	-	N	-	N1	$74.24	$74.24
75898*	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	5182	Q2	$1,093.63	N1	$92.62	$92.62

*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.

CONTINUED

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HOSPITAL INPATIENT

ICD-10-CM Diagnosis Code[4]	Description
N40.0	Benign prostatic hyperplasia without lower urinary
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[4]	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[5]
MS-DRG 726	Benign prostate hypertrophy without MCC	$5,875.31
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

1. CPT ©2019 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: 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"https://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.