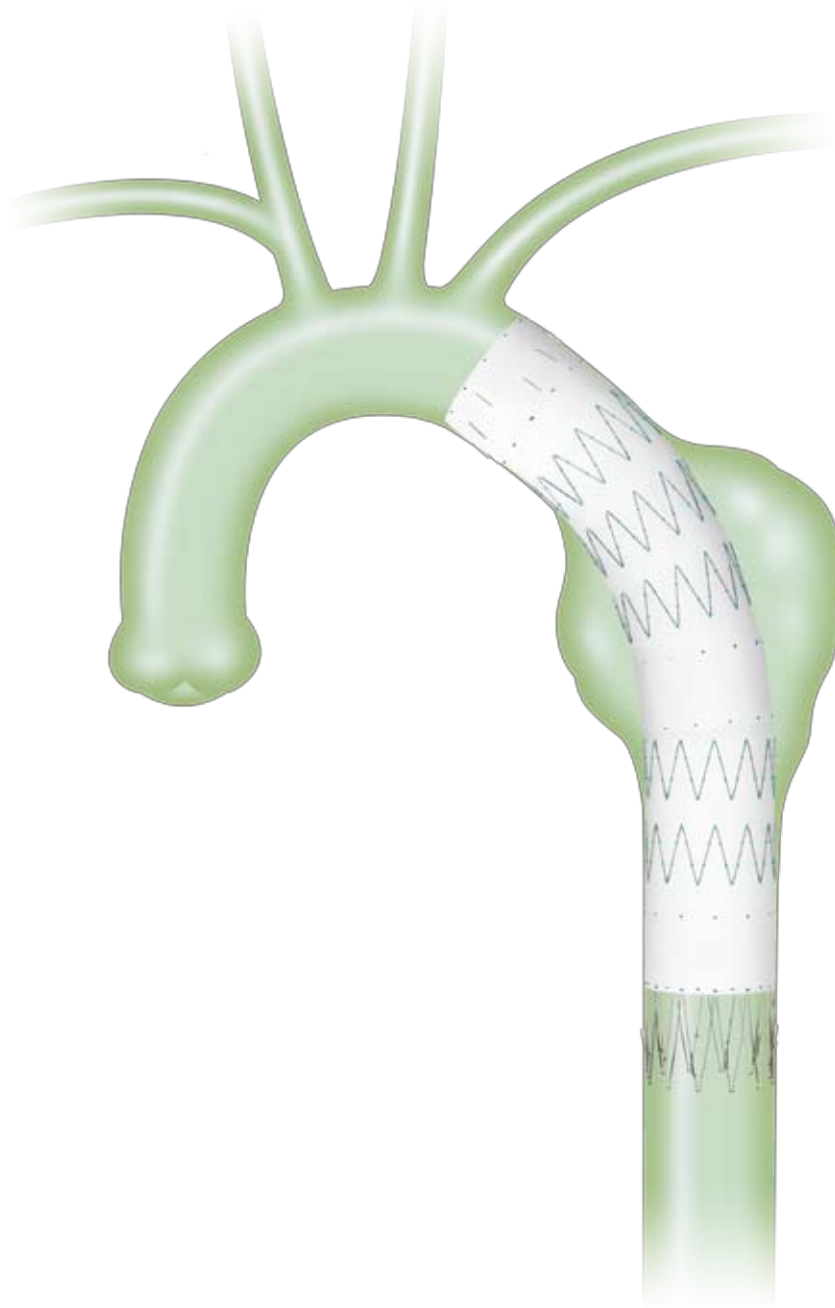




Zenith® TX2®

TAA ENDOVASCULAR GRAFT

REIMBURSEMENT GUIDE



Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which include, but are not limited to, the CPT, ICD-9, DRG and ASC coding systems; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, AHA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.

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INTRODUCTION

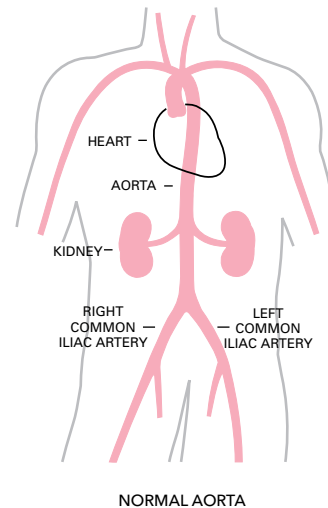
This guide was developed to assist physicians and hospital coding and reimbursement staff with Medicare coding and reimbursement when placing the Zenith TX2 TAA Endovascular Graft.

What Is a Thoracic Aortic Aneurysm?

The aorta is the largest artery in the body and is responsible for carrying blood from the heart to the rest of the body. It extends upward from the heart through the chest and then arches and descends into the abdomen. Sometimes, with aging or other changes, a section of the aorta weakens and begins to bulge. This bulge can enlarge over time as the walls of the aorta become thinner and stretch. This bulge in the aorta is called an aneurysm.

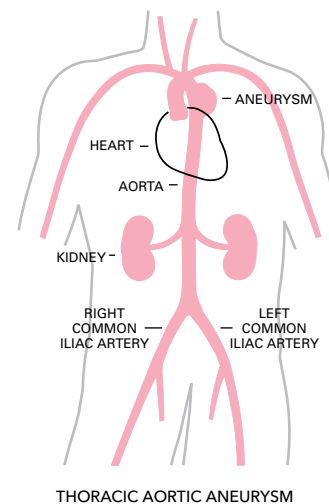
When an aneurysm occurs in the part of the aorta that runs through the chest, it is called a thoracic aortic aneurysm, or TAA. Thoracic aortic aneurysms occur most often in the descending thoracic aorta (50 percent of the time) followed by the ascending aorta (25 percent of the time) and the aortic arch (25 percent of the time).

In the early stages, when a TAA is small, it may not pose an immediate health risk. If the TAA continues to grow, the aorta's walls become thin and lose their ability to stretch. The weakened sections of the aortic wall may become unable to support the force of blood flow. The aneurysm could rupture, causing serious internal bleeding.



How Is a Typical TAA Endograft Procedure Performed?

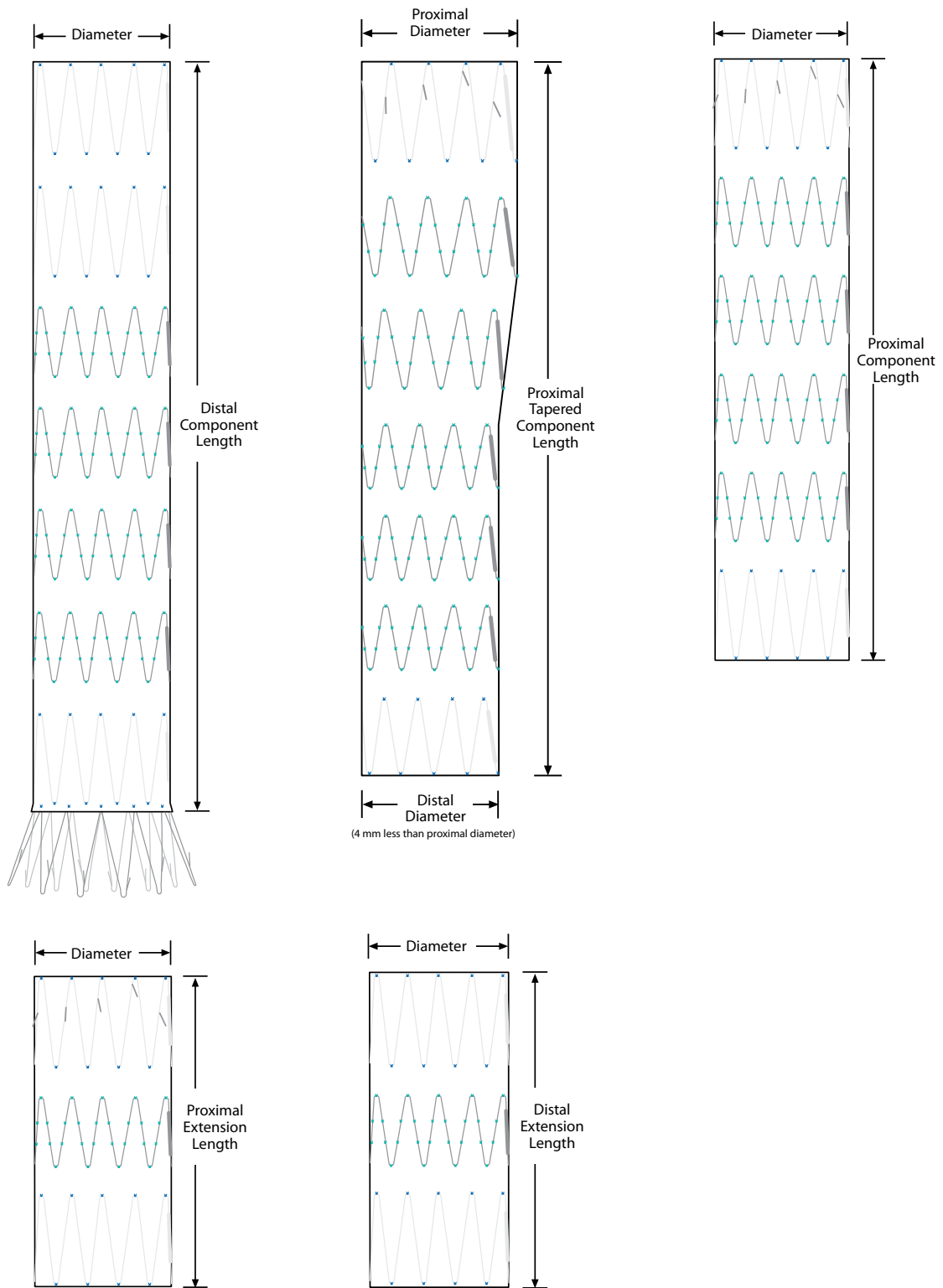
The patient is typically placed under general anesthesia and prepped for the procedure. The physician performs a cutdown of a femoral or iliac artery to expose the blood vessel. Wires, introducer sheaths, catheters and the TX2 device are introduced and placed under fluoroscopy into the thoracic aorta where the TX2 endograft is deployed. The TX2 main body has both proximal and distal components. These are two separate device components with two separate delivery systems; they are designed to overlap each other for part of their length. Together they make up the "main body" of the TX2 device. In some procedures both proximal and distal components will be used; in other procedures, particularly for short aneurysms, only the proximal component will be required. Distal and proximal extensions may be added to the main body component(s) to accommodate the patient's anatomy. Additional steps may be required and could include use of balloons, stents or other devices. Embolization may also be needed prior to graft placement if the subclavian is covered by the endograft and a carotid-subclavian bypass is needed for adequate circulation. Once the procedure is complete, the physician repairs all cutdowns and closes.



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COVERAGE

Medicare sometimes issues coverage policies indicating under what circumstances they will/will not cover a particular medical service or procedure. On occasion, these policies are issued as national coverage policies affecting all Medicare patients. Other times they are issued by local Medicare contractors as local coverage decisions (LCDs) affecting only those Medicare beneficiaries in a given contractor's jurisdiction. At this point in time, Medicare has not issued a national coverage decision about endovascular treatment of thoracic aortic aneurysms. However, we encourage physicians to periodically check with their local Medicare carrier(s) for coverage policies on this topic to see if they have issued an LCD. LCDs can be searched at the CMS coverage database: <http://www.cms.hhs.gov/mcd/search.asp?>, and if you need to contact your local contractors' Medical Directors, their contact information is accessible at www.cms.hhs.gov/apps/contacts/.

CODING

Facility Coding

Facilities should report the following ICD-9 procedure code for deployment of the Zenith TX2 endograft to treat TAA:

39.73	Endovascular implantation of graft in thoracic aorta
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In their final rule for the fiscal year 2008 (effective October 1, 2007) Hospital Inpatient Prospective Payment System, Medicare determined that all patients admitted to hospitals for endovascular repair of TAA will be assigned to:

		Relative Weight
DRG 237	Major Cardiovascular Procedures with Major Complications and Comorbidities or Thoracic Aortic Aneurysm Repair	5.0741

Physician Coding

CPT Coding Conventions for Endovascular Repairs

The work described by the TAA repair code(s) includes the pre-, intra- and postoperative care involved in placement of the endograft.

Preoperative work includes:

- measurement of preoperative imaging studies
- redetermination of candidacy for endovascular TAA repair
- selection of type and size of graft
- final discussions with patient and family regarding risks and benefits of the procedure
- preoperative supervision of OR setup
- selection of appropriate equipment such as catheters, wire guides, etc.
- direction of the OR and x-ray personnel

Intraoperative work includes:

- introduction of the device into the vessel(s), positioning the device, and ballooning of the anastomotic hooks and graft
- all angioplasty, stenting and ballooning performed within the target treatment zone of the graft before, during and after endograft placement
- placement of distal extensions (during initial procedure)
- any additional ballooning, stents, or components used within the graft to seat and open the endograft

Postoperative care includes:

- routine care and outpatient or inpatient visits related to TAA repair for a period of 90 days

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Steps of an Endovascular Repair–Thoracic Aortic Aneurysm

Step 1:

Surgical Exposure of Artery for Endograft Delivery

The codes used to describe open exposure of access vessels, i.e., femoral or iliac artery(s), include both the work of exposing the vessel and closing of the exposure site(s). The code(s) used to report access are:

34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (For bilateral procedure, use modifier '-50')
34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (For bilateral procedure, use modifier '-50')
34833	Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral (Do not report 34833 in addition to 34820) (For bilateral procedure, use modifier '-50')
34834	Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral (For bilateral procedure, use modifier '-50')

In some cases, the iliac arteries are too small to allow introduction of the endograft device, and a conduit (34833) is required to permit delivery of the endograft into the aorta. The conduit may be permanently attached to the iliac or femoral artery or it may be removed. Once 34833 is reported, correct coding convention dictates procedure code 34820 should not be reported, because 34833 includes the work of iliac artery exposure.

Step 2:

Placement of Wires/Catheters/Sheaths

Once access has been established, wire guides, catheters, and/or sheaths are introduced either percutaneously or through arterial exposure(s) to deliver and correctly place the endograft. At least one catheterization code is reported for each vessel accessed, and quite often bilateral catheters are introduced into the aorta and reported with the -50 modifier. The code(s) to report are:

36200	Introduction of catheter, aorta
36200-50	Introduction of catheter, aorta - bilaterally

Physicians should code selective catheter placement according

to established guidelines.

Step 3:

Placement and Deployment of Thoracic Endograft

The endograft is introduced into the abdominal aorta and advanced to the target treatment area in the descending thoracic aorta (33880-33881). Once the endograft is deployed, the work associated with “seating” by fully opening the endograft using balloon dilatations, stents or endograft module(s) is included in the CPT procedure description and should not be separately reported. Physicians should report one of the following procedure codes when a Cook Zenith TX2 device is placed (Note: These codes apply whether just the proximal component or both the proximal and distal components of a Zenith TX2 device are used in the procedure):

33880	Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (For radiological supervision and interpretation, use 75956 in conjunction with 33880)
33881	Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (For radiological supervision and interpretation, use 75957 in conjunction with 33881)

Physicians should also report the appropriate radiological supervision and interpretation code along with the professional component modifier -26.

75956-26	Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation
75957-26	Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation



CPT codes 75956 and 75957 include all work associated with imaging during endograft placement, the aortogram performed at the beginning of the procedure, fluoroscopic guidance, road-mapping and completion angiography. All supervision and interpretation services involving angioplasty, balloon expansion of the endograft or "seating," and stenting performed within the endograft zone during the procedure are included in these codes.

Step 4:

Placement of Extensions

Extensions are devices used to elongate the target treatment area and help custom fit the device to each patient's anatomy. Proximal extensions deployed during initial thoracic endograft placement are separately reported, and coding choice will vary depending on whether there is coverage of the subclavian artery origin. Proximal extension(s) resulting in noncoverage of the left subclavian origin are reported with the following code(s):

33883	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension (For radiological supervision and interpretation, use 75958 in conjunction with 33883) (Do not report 33881, 33883 when extension placement converts repair to cover left subclavian origin. Use only 33880)
+33884	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure) (For radiological supervision and interpretation, use 75958 in conjunction with 33884)

Do not report 33881, 33883 when proximal extension placement converts the repair to one covering the left subclavian artery origin. Instead, use only 33880.

The placement of a distal extension(s) during initial thoracic endograft deployment is considered inherent or is included in the work associated with placement of the thoracic endograft and is not separately reported.

Distal extensions placed at a later operative date are reported with the following code:

33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta (Do not report 33886 in conjunction with 33880, 33881) (Report 33886 once, regardless of number of modules deployed) (For radiological supervision and interpretation, use 75959 in conjunction with 33886)
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Physicians should also report the radiological supervision and interpretation for extension placement along with the physician professional component modifier -26:

75958-26	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation
75959-26	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation



Ancillary Procedures

Bypass Grafts/Transpositions

33889	Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral (Do not report 33889 in conjunction with 35694)
33891	Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision (Do not report 33891 in conjunction with 35509, 35601)

Embolization

37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck (For radiological supervision and interpretation, use 75894)
75894-26	Transcatheter therapy, embolization, any method, radiological supervision and interpretation

Modifiers

Modifiers provide the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.¹ Correct coding includes the appropriate use of modifiers and may affect the physician payment rate of the CPT reported. Some of the more common modifiers used in TAA repairs include:

Modifier	Description	% Allowed of the Medicare Physician Fee Schedule
-24	Unrelated evaluation and management service by the same physician during a postoperative period	100%
-26	Professional component	100% For the physician's component of a two-component service
-50	Bilateral procedure	150%
-51	Multiple procedures	50% For the second through fifth highest valued procedures
-52	Reduced services	Carrier discretion
-53	Discontinued procedure	Carrier discretion
-59*	Distinct procedural service	100%
-62	Two surgeons (co-surgeons)	125% Split equally between both physicians
-78	Return to the operating room for a related procedure during the postoperative period	Carrier discretion
-79	Unrelated procedure or service by the same physician during the postoperative period	100%
-80	Assistant surgeon	16%

*CMS issued a special edition article discussing the proper use of the -59 modifier. Providers are encouraged to view this article on MLN Matters (Number: SE0715) or follow the link:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0715.pdf>

¹American Medical Association. *CPT 2009 Professional Edition*. Chicago, IL: American Medical Association; 2009: xv.

PAYMENT

Physician Reimbursement for TX2 Placement

Physician Fees
(National Medicare Avg)¹

CPT Code

Procedure Description

Arterial Exposure

CPT Code	Procedure Description	Physician Fees
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral	\$354.53
34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral	\$506.74
34833	Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral	\$628.64
34834	Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral	\$284.93

Catheter Placement

CPT Code	Procedure Description	Physician Fees
36200	Introduction of catheter, aorta	\$155.81
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	\$245.97

Main Body

CPT Code	Procedure Description	Physician Fees
33880	Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (For radiological supervision and interpretation use 75956 in conjunction with 33880)	\$1,787.10
33881	Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (For radiological supervision and interpretation use 75957 in conjunction with 33881)	\$1,533.91
75956-26	Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation	\$358.50
75957-26	Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin radiological supervision and interpretation	\$306.93

¹2009 Medicare Physician Fee Schedule

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**CPT
Code**

Procedure Description

Extensions

33883	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension (For radiological supervision and interpretation, use 75958 in conjunction with 33883)	\$1,125.64
+33884	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure) (For radiological supervision and interpretation, use 75958 in conjunction with 33884)	\$412.24
75958-26	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation	\$202.69
33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta (For radiological supervision and interpretation, use 75959 in conjunction with 33886)	\$966.95
75959-26	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	\$178.17

Bypass Grafts

33889	Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral	\$815.47
33891	Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	\$1,019.96

Embolization

37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	\$947.47
75894-26	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	\$67.81

¹2009 Medicare Physician Fee Schedule

2009 physician fees for your local area can be found at the following CMS links:

http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp#TopOfPage

or

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSNPAF/list.asp#TopOfPage>



PHYSICIAN CODING SCENARIOS

(Note: The following coding recommendations apply whether a physician uses both the proximal and distal components of the Zenith TX2 device or the proximal component only.)

Scenario #1

The physician performs a left open femoral artery exposure. Catheters are placed bilaterally in the aorta. The Zenith TX2 device is introduced into the thoracic aorta and deployed covering the left subclavian artery.

34812	Open femoral artery exposure
36200-50	Catheter in the aorta, bilateral
33880	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (covering the left subclavian)
75956-26	TAA with subclavian coverage (Radiological S&I)

Scenario #2

Physician performs a left open femoral artery exposure. Catheters are placed bilaterally in the aorta. The Zenith TX2 device is introduced into the thoracic aorta and deployed and does not cover the left subclavian artery. The operator then places two distal extensions for adequate coverage of the target area.

34812	Open femoral artery exposure
36200-50	Catheter in aorta, bilateral
33881	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (not covering the left subclavian)
75957-26	TAA without subclavian coverage (Radiological S&I)

Scenario #3

The physician performs an open subclavian to carotid artery transposition and left open femoral artery exposure. Catheters are placed bilaterally in the aorta. The Zenith TX2 device is introduced into the thoracic aorta and deployed covering the left subclavian artery.

33889	Open subclavian to carotid artery transposition
34812	Open femoral artery exposure
36200-50	Catheter in aorta, bilateral
33880	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (covering the left subclavian)
75956-26	TAA with subclavian coverage (Radiological S&I)

Scenario #4

The physician performs a left open iliac exposure with creation of conduit for delivery of endograft. Catheters are placed bilaterally in the aorta. The Zenith TX2 device is introduced into the thoracic aorta and deployed covering the left subclavian artery. The physician then places two distal and one proximal extensions for adequate coverage of the target area.

34833	Open iliac artery exposure
36200-50	Catheter in the aorta, bilateral
33880	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (covering the left subclavian)
33883	Initial proximal extension
75956-26	TAA with subclavian coverage (Radiological S&I)
75958-26	Proximal extension (Radiological S&I)



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Scenario #5

Physician 1 performs an open right femoral artery exposure. Physician 2 places catheters bilaterally into the thoracic aorta to the arch. Physician 2 moves the Zenith TX2 device into place and deploys the device with Physician 1 assisting. Physician 2 decides to extend the graft proximally with an extension, not allowing the extension to cover the subclavian artery. Physician 1 closes the open right femoral artery access.

Physician 1

34812	Open femoral artery exposure
33881-80	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (not covering the left subclavian)

Physician 2

36200-50	Catheter in aorta, bilateral
33881	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (not covering the left subclavian)
33883	Initial proximal extension
75957-26	TAA without subclavian coverage (Radiological S&I)
75958-26	Proximal extension (Radiological S&I)

Scenario #6

Physician 1 performs the open left femoral artery exposure. Physician 2 places catheters bilaterally into the thoracic aortic arch. The Zenith TX2 device is unsuccessfully delivered due to a narrow left iliac artery. Physician 1 performs a right retroperitoneal incision and sews a graft to the right common iliac. Physician 2 catheterizes the aorta and delivers the Zenith TX2 device to the target area with Physician 1 assisting deployment. The Zenith TX2 device is delivered distal to the subclavian, and one distal extension is placed to the level of the celiac artery origin by Physician 2. Physician 1 ties off the graft conduit and closes.

Physician 1

34812	Open femoral artery exposure
34833	Open iliac artery exposure with creation of conduit
33881-80	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (not covering the left subclavian)

Physician 2

36200-50	Catheter in aorta, bilateral
36200-59	Percutaneous femoral artery access
33881	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (not covering the left subclavian)
75957-26	TAA with subclavian coverage (Radiological S&I)

Scenario #7

Physician 1 performs open subclavian to carotid artery transposition and left femoral artery exposure. Physician 2 places catheters bilaterally into the thoracic aortic arch. The Zenith TX2 device is introduced and deployed across the left subclavian origin by both physicians. Physician 1 closes all incisions.

Physician 1

33889	Open subclavian to carotid artery transposition
34812	Open femoral artery exposure
33880-62	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (covering the left subclavian)

Physician 2

36200-50	Catheter in aorta, bilateral
33880-62	Placement of thoracic endograft plus descending thoracic aortic extension(s), if required, to level of celiac artery origin (covering the left subclavian)
75956-26	TAA with subclavian coverage (Radiological S&I)



FREQUENTLY ASKED QUESTIONS

What services can we bill separately during endovascular TAA repair?

- vascular access
- placement of catheter(s) into aorta
- placement of the endograft
- proximal extensions
- radiological supervision and interpretation services
- bypass grafts or transpositions
- intravascular ultrasound
- angioplasty or stenting performed **outside** the target treatment zone of the graft
- embolization

What services can we bill separately after endovascular TAA repair?

- placement of distal and proximal extensions, starting the day after endograft placement
- unrelated E/M services
- follow-up imaging services (i.e., CT, US, angiography, Doppler)

We initially placed proximal and distal components of a Zenith TX2 device without covering the left subclavian artery, and then placed a distal extension graft during the same procedure. Can we report the placement of the distal extension?

No. All distal extension grafts placed during the initial deployment of the thoracic endograft are included and are not reported separately.

We initially placed the thoracic endograft without covering the left subclavian artery, and used a second graft to extend the repair proximally, resulting in coverage of the subclavian. Should we use 33883 to report the placement of the proximal graft?

No. The placement of the proximal extension resulted in coverage of the left subclavian artery, and the entire repair 'converts' to 33880. Any subsequent proximal extensions would be coded with 33883.

Will Medicare allow payment for three different specialty physicians (i.e., vascular surgeon, interventional radiologist, and thoracic surgeon) involved in a TAA repair?

No. Medicare will only pay for two physicians regardless of medical specialty. This includes services as a co-surgeon (-62) or as an assisting surgeon (-80).

COOK MEDICAL REIMBURSEMENT CONTACT INFORMATION

Call this toll-free number:

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or e-mail us at

Reimbursement@cookmedical.com



Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which include, but are not limited to, the CPT, ICD-9, DRG and ASC coding systems; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Cook does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, AHA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Cook does not promote the off-label use of its devices.



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