

Percutaneous Placement of Permanent Inferior Vena Cava (IVC) Filters

2009 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for medical procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement when placing or retrieving an optional Cook inferior vena cava (IVC) filter.

Coverage

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (<http://www.cms.hhs.gov/mcd/search.asp?>), and contact their carrier's medical director (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

Placement of a percutaneous (IVC) filter, if performed in conjunction with an IVC venography, typically involves coding for access, device placement, and imaging procedures. If the device is deployed in a hospital outpatient setting, facilities will also report applicable C-codes for the device.

| | |
|----------|--|
| 37620 | Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular, (umbrella device) |
| 36010 | Introduction of catheter, superior or inferior vena cava |
| 75825-26 | Venography, caval, inferior, with serialography, radiological supervision and interpretation |

Diagnostic venography (radiological supervision and interpretation) codes should NOT be used with interventional procedures for contrast injections, venography, roadmapping, and/or fluoroscopic guidance for the intervention, vessel measurement, and post-angioplasty/stent venography; as this work is captured in the radiological supervision and interpretation code(s)

Diagnostic venography performed at the time of an interventional procedure is separately reportable if no prior catheter-based venographic study is available and a full diagnostic study is performed, and decision to intervene is based on the diagnostic study, OR a prior study is available, but as documented in the medical record: the patient's condition with respect to the clinical indication has changed since the prior study, there is inadequate visualization of the anatomy and/or pathology, or there is a clinical change during the procedure that requires new evaluation outside the target area of intervention.

Diagnostic venography performed at a separate setting from an interventional procedure is separately reported.

| | |
|----------|---|
| 75940-26 | Percutaneous placement of IVC filter, radiological supervision and interpretation |
|----------|---|

CPT © 2008 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.



Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which may include, but are not limited to, the CPT, ICD-9 and MS-DRG 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.

Medicare requires hospitals to report, if applicable, device(s) used in the hospital outpatient setting by using Level II HCPCS codes or "C-codes". When reporting placement of a permanent percutaneous IVC filter in a hospital outpatient hospital setting, we recommend the following C-code(s):

- C1880 Vena Cava Filter
- C1894 Introducer/Sheath
- C1769 Guide Wire

Payment

2009 Medicare Reimbursement for Percutaneous IVC Filter Placement (if performed in conjunction with IVC venography)

| Code | Procedure Description | Ambulatory Surgery Center | Outpatient Hospital | | Physician Services | |
|----------|--|--|---------------------|---|--|---|
| | | Facility Payment ¹ | APC | Facility Payment (National Medicare Avg ²) | Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg ³) | Fee When Procedure Is Performed in Office (National Medicare Avg ³) |
| 37620 | Interruption, partial or complete, of inferior vena cava by suture ligation, plication, clip, extravascular, intravascular (umbrella device) | This service is not included on Medicare's list of approved procedures | 0091 | \$2,892.88 | \$655.69 | \$655.69 |
| 36010-51 | Introduction of catheter, superior or inferior vena cava | There is no additional facility payment for this service | | There is no additional facility payment for this service | \$62.58 Multiple procedure reduction applied | \$282.76 Multiple procedure reduction applied |
| 75825 | Venography, caval, inferior, with serialography, radiological supervision and interpretation | Imaging is included in the payment allowance for filter placement | | Imaging is included in the payment allowance for filter placement | \$58.43 | \$264.01 |
| 75940-26 | Percutaneous placement of IVC filter, radiological supervision and interpretation | There is no additional facility payment for this service | | Imaging is included in the payment allowance for filter placement | \$27.77 | Carrier priced procedure |

1. 2009 Medicare Ambulatory Surgery Center Fee Schedule
2. 2009 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule
3. 2009 Medicare Physician Fee Schedule

CPT © 2008 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

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>



Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which may include, but are not limited to, the CPT, ICD-9 and MS-DRG 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.