

# Peripheral Vascular Stenting Procedures

## 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 performing transcatheter peripheral vascular stenting procedures.

### 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 local carrier's medical director ([www.cms.hhs.gov/apps/contacts](http://www.cms.hhs.gov/apps/contacts)) or commercial insurers to determine if a procedure is covered.

### Coding

**Placement of peripheral vascular stent(s) typically involves separate coding for vascular access, stent placement and imaging procedures. There may be separate coding for angioplasty as well; for this reason we encourage you to check with your local payers. The following CPT® codes are used to report transcatheter peripheral vascular stent placement:**

37205	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel
+37206	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure)
37207	Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; initial vessel
+37208	Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure)

### Imaging

75960	Transcatheter introduction of intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel
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### Outpatient Hospital

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 use of Cook peripheral vascular stent(s) in an outpatient hospital setting, we recommend the following C-code(s):

C1876	Stent, non-coated/non-covered, with delivery system
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## Inpatient Hospital

Hospitals use ICD-9-PCS codes to describe procedures performed during hospital admissions. Following are examples of procedure codes that may be pertinent for a given hospital admission.

### Facilities coding for transcatheter peripheral stent placement should consider:

39.50	Angioplasty or atherectomy of other non-coronary vessel(s)
39.90	Insertion of non-drug-eluting peripheral (non-coronary) vessel stent(s)
00.55	Insertion of drug-eluting peripheral vessel stent(s)
00.40	Procedure on single vessel
00.41	Procedure on two vessels
00.42	Procedure on three vessels
00.43	Procedure on four or more vessels
00.44	Procedure on vessel bifurcation
00.45	Insertion of one vascular stent
00.46	Insertion of two vascular stents
00.47	Insertion of three vascular stents
00.48	Insertion of four or more vascular stents

Submitting a claim using one of the following primary diagnoses (listed for illustrative purposes only) with the above procedure code(s) will typically group into one of the following DRGs:

### Primary Diagnosis Codes (ICD-9-CM)

Atherosclerosis of the Extremities	440.20, 440.21, 440.22, 440.23, 440.24
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MS-DRG	2009 Medicare Inpatient Reimbursement Description	Inpatient Facility Payment (National Medicare Avg) <sup>1,2</sup>
DRG 252	Other Vascular Procedures with Major Complication or Comorbidity	\$15,143.07
DRG 253	Other Vascular Procedures with Complication or Comorbidity	\$11,550.76
DRG 254	Other Vascular Procedures without Comorbidity or Complication or Major Comorbidity or Complication	\$7,902.07

- Hart A, ed. Appendix E. In: *DRG Expert: A Comprehensive Guidebook to the DRG Classification System*. 25th ed. Eden Prairie, MN: Ingenix; 2009.
- Individual hospital payment levels differ based on, but not limited to, geographic location, bed size, teaching status and the percentage of low-income patients.

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## Payment

### 2009 Medicare Reimbursement for Peripheral Stent Placement - Physician and Outpatient Facilities

Code	Procedure Description	Ambulatory Surgery Center	Outpatient Hospital	Physician Services		
		Facility Payment <sup>1</sup>	APC	Facility Payment (National Medicare Avg <sup>2</sup> )	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg <sup>3</sup> )	Fee When Procedure Is Performed in Office (National Medicare Avg <sup>3</sup> )
37205	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel	<i>This service is not included on Medicare's list of approved procedures</i>	0229	\$6,093.99	\$444.70	\$4,112.31
+37206	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous; each additional vessel (List separately in addition to code for primary procedure)	<i>This service is not included on Medicare's list of approved procedures</i>	0229	\$3,047.00 <i>Multiple procedure reduction applied</i>	\$216.76	\$2,477.41
37207	Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; initial vessel	<i>This service is not included on Medicare's list of approved procedures</i>	0229	\$6,093.99	\$437.85	\$437.85
+37208	Transcatheter placement of an intravascular stent(s) (non-coronary vessel), open; each additional vessel (List separately in addition to code for primary procedure)	<i>This service is not included on Medicare's list of approved procedures</i>	0229	\$3,047.00 <i>Multiple procedure reduction applied</i>	\$212.07	\$212.07
75960	Transcatheter placement of an intravascular stent(s) (except coronary, carotid, and vertebral vessel), percutaneous and/or open, radiological supervision and interpretation, each vessel	<i>This service is not included on Medicare's list of approved procedures</i>		<i>Imaging is included in the payment allowance for stent placement</i>	\$42.92	\$267.97

**NOTE:** Additional codes exist for vascular access.

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

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

[http://www.cms.hhs.gov/PFSlookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/PFSlookup/02_PFSsearch.asp)

or

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



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