Transcatheter Peripheral Embolization or Occlusion Services

2019 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 embolization or occlusion procedures. If you have any questions, please contact our reimbursement team at 800.468.1379 or by e-mail at Reimbursement@cookmedical.com.

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 carriers' medical directors (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

The following CPT® codes are bundled codes, which include all radiological supervision and interpretation; intra-procedural guidance and roadmapping; and imaging to document the completion of the procedure.

- Codes for vessel selection, non-selective/selective (if used consistent with coding guidelines) catheter placement, and ultrasound guidance for vascular access should be reported in addition to the code(s) for the therapeutic aspect of the procedure.[1]
- Only one embolization code should be reported for each surgical field (ie, the area immediately surrounding and directly involved in a treatment/procedure).[1]
- Diagnostic angiography may also be separately reported when performed according to coding guidelines for diagnostic angiography during endovascular procedures. This service should be reported with an appropriate modifier (eg, modifier 59).[1]

Embolization or Occlusion

37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)
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
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

- When a stent is placed for the purpose of providing a latticework for deployment of embolization coils, such as for embolization of an aneurysm, the embolization code (37241-37244) is reported and not the stent code (37236-37239). If a stent is deployed as the sole management of an aneurysm, pseudoaneurysm, or vascular extravasation, then the stent deployment code should be reported and not the embolization code.[1]
- Separate CPT® codes exist for central nervous system (61624) and non-central nervous system head or neck (61626).

[1] American Medical Association. Vascular Embolization and Occlusion. In: *CPT 2019 Professional Edition*. Chicago, IL: American Medical Association; 2018:286-287.

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Payment

2019 Medicare Reimbursement for Transcatheter Embolization or Occlusion Services

		Ambulatory Surgery Center	*Outpatient Hospital*		*Physician Services*	
CPT Code	Procedure Description	Facility Payment (National Medicare Avg[2])	APC	Facility Payment (National Medicare Avg[3])	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg[4])	Fee When Procedure Is Performed in Office (National Medicare Avg[4])
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	$4,056.12	5193	$9,669.04	$463.46	$4,949.61
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	$5,786.97	5193	$9,669.04	$499.50	$7,622.27
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	$4,056.12	5193	$9,669.04	$588.52	$9,860.66
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	This service is not included on Medicare's list of approved procedures	5193	$9,669.04	$695.92	$7,051.77

[2] 2019 Medicare Ambulatory Surgery Center (ASC) Fee Schedule
[3] 2019 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule
[4] 2019 Medicare Physician Fee Schedule

2019 physician fees for your local area can be found at the following CMS links:

https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

or

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

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