



Reimbursement Guide

Zenith® Fenestrated AAA Endovascular Graft

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 coding system; 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, 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.

The FDA approval of the Zenith® Fenestrated AAA Endovascular Graft enables physicians to use an FDA-approved endovascular procedure for treating abdominal aortic aneurysms in patients with shorter infrarenal aortic necks unsuitable for standard endovascular graft repair. However, as with many new procedures in medicine, reimbursement may present certain challenges, and the Zenith Fenestrated AAA Endovascular Graft is no exception.

COVERAGE

Medicare carriers may issue Local Coverage Decisions 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. Also, you may contact the Cook Medical Reimbursement department with questions concerning coverage and your local Medicare carrier.

PHYSICIAN CODING AND REIMBURSEMENT

AAA Fenestrated Endovascular Planning and Sizing

Effective January 1, 2016, physician planning and sizing for a patient-specific visceral aortic endograft has been bundled into the primary procedure and will not be reimbursed separately. Code 34839 is reported on the date that planning work is complete and may not include time spent on the day before or the day of the fenestrated endovascular repair procedure (34841-34848).¹

34839	Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time
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AAA Fenestrated Endovascular procedures

Repair performed using a Zenith Fenestrated AAA graft is reported with one of the following Category I CPT codes below (34845 - 34848). These codes are considered inclusive or bundled codes, so the following are NOT separately reportable when performed in conjunction with a fenestrated repair: a) introduction of guide wires and catheters in the aorta and visceral and/or renal arteries; b) balloon angioplasty within the target treatment zone, before or after endograft deployment; and c) fluoroscopic guidance and radiological S&I (includes angiographic diagnostic imaging of the aorta and branches prior to deployment of the endovascular device; fluoroscopic guidance in the delivery of the fenestrated components; and intraprocedural arterial angiography [eg, confirm position, detect endoleak, evaluate runoff]).

Note: The number of branch vessels receiving covered stents is a major factor in determining the correct CPT code.

Adjunctive Procedure codes and physician reimbursement rates are provided in table A.

34845	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)
34846	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])
34847	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])
34848	Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

*Do not report 34845-34848 in conjunction with 34701-34706, 34841-34844, 35081, 35102

*Do not report 34845-34848 in conjunction with 37236, 37637 for bare metal or covered stents placed into the visceral branches within the endoprosthesis target zone

*For placement of distal extension prosthesis[es]terminating in the internal iliac, external iliac, or common femoral artery[s], see 34709, 34710, 34711, 0254T

*Use 34845-34848 in conjunction with 37220-37223, only when 37220-37223 are performed outside the target treatment zone of the endoprosthesis

1. American Medical Association. Fenestrated Endovascular Repair of the Visceral and Infrarenal Aorta. In: *CPT 2022 Professional Edition* American Medical Association; 2021:291-292.

Table A

2022 Physician Medicare Reimbursement for Procedures Adjunctive to a Zenith Fenestrated AAA Endovascular Graft Procedure

CPT Code	Description	Physician Fees (National Medicare Avg ²)
+34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (34709 may only be reported once per vessel treated [ie, multiple endograft extensions placed in a single vessel may only be reported once])	\$326.34
+34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12French or larger), including ultrasound guidance, when performed, unilateral (34713 may only be reported once per side. For bilateral procedure, report 34713 twice) (Do not report ultrasound guidance [ie, 76937] for percutaneous vascular access in conjunction with 34713 for the same access)	\$124.93
+34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (34812 may only be reported once per side. For bilateral procedure, report 34812 twice)	\$208.68
+34714	Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (34714 may only be reported once per side. For bilateral procedure, report 34714 twice)	\$272.20
+34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (34820 may only be reported once per side. For bilateral procedure, report 34820 twice)	\$340.87
+34833	Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (34833 may only be reported once per side. For bilateral procedure, report 34833 twice)	\$397.63
+34834	Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (34834 may only be reported once per side. For bilateral procedure, report 34834 twice)	\$130.81
+34715	Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (34715 may only be reported once per side. For bilateral procedure, report 34715 twice)	\$303.15
+34716	Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (34716 may only be reported once per side. For bilateral procedure, report 34716 twice)	\$375.82
+34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (Use 34813 in conjunction with 34812)	\$239.13
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	\$1,786.03
34831	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis	\$1,951.44
34832	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis	\$1,920.30
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery	\$446.42
+37237	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery	\$213.52

²2022 Medicare Physician Fee Schedule.

2022 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 <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>

Establishing a Value for CPT Codes 34845-34848

Even though Category I codes were created, there are currently no relative value units (RVUs) associated with these codes. Since RVUs were not created, Medicare payment rates have not been pre-established. Physicians will have to work with their local insurance carriers to establish payment rates. Some of Medicare's local contractors have established a payment rate which may or may not be published on their respective fee schedules.

NOTE: The creation of these Category I codes will not necessarily result in coverage of fenestrated procedures.

When establishing a value for fenestrated procedures, the use of a building block methodology to capture all the steps included in these complex procedures can capture component work performed. Physicians are encouraged to contact their medical society and/or Medicare's local contractor for assistance to value CPT codes 34845-34848.

Contesting Non-Coverage

If the procedure is denied by Medicare or another payer after your initial submission of the claim, you may need to further educate the payer regarding medical necessity, FDA approval and/or the efficacy of the procedure. If reimbursement is denied, the reason should be listed under the explanation of benefits (EOB), and we encourage the operating physician to contact the local health plan's medical directors to discuss the medical merits of this procedure.

Influencing Payer Decision Making

If Medicare is a dominant payer and you plan to do the procedure on a regular basis, we advise you to check your local Medicare carrier's local coverage determination (LCD) to verify coverage of the procedure.

Private-payer coverage determinations are usually made by the payer's technology or medical device group. As with Medicare, we encourage you to contact your other local commercial health plans to discuss coverage of this procedure, whether for a specific case or for overall approval of the Zenith Fenestrated AAA Endovascular Graft.

Commercial Insurance

Unlike Medicare, commercial insurers have not established a consistent national payment methodology, so arrangements between insurers and hospitals vary considerably. Because of this, it's not possible for Cook Medical to offer guidance to hospitals regarding any individual plan. We encourage you to work closely with your local hospital management and insurance plans to understand the contracted payment arrangements between them. A coordinated effort between the physician and the hospital can be quite effective in obtaining appropriate reimbursement.

If you have any questions, please contact our reimbursement team at:

800.468.1379

Or

By e-mail at:

reimbursement@cookmedical.com

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