Percutaneous Placement, Repositioning, or Retrieval of Inferior Vena Cava (IVC) Filters

2022 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 for use of the Word catheter in the treatment of a Bartholin gland cyst or abscess. 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 encouraged to contact their local carrier medical directors (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

Placement

37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

Repositioning

37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed (Do not report 37192 in conjunction with 37191)

Retrieval

37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed (Do not report 37193 in conjunction with 37197)

In the event filter repositioning or retrieval is abandoned because the initial venography reveals a thrombus in the filter, we suggest you contact your carrier(s) to determine appropriate codes.

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

C1880	Vena cava filter

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Payment

2022 Medicare Reimbursement for IVC Filter Placement, Repositioning, or Retrieval

		Ambulatory Surgery Center	***Outpatient Hospital***		***Physician Services***	
CPT Code	Procedure Description	Facility Payment (National Medicare Avg)[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]
Placement						
37191	Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	*Not payable in ASC setting*	5184	$4,870.25	$222.52	$2,199.22
Repositioning						
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	*Not payable in ASC setting*	5183	$2,923.63	$349.18	$1,367.64
Retrieval						
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	*Not payable in ASC setting*	5183	$2,923.63	$348.83	$1,600.88

[1] 2022 Medicare Ambulatory Surgery Center Fee Schedule
[2] 2022 Medicare Outpatient Hospital Fee Schedule
[3] 2022 Medicare Physician Services Fee Schedule

2022 Physician fees for your local area can be found at the following CMS links:
http://www.cms.hhs.gov/PFSlookup/
or
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

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***Disclaimer**: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources that may 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 you are 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.*