stryker

2019 hospital and physician

Hemorrhagic & acute ischemic stroke inpatient coding and payment guide

StrokEnomics®

StrokEnomics®

Customizing economic solutions. Improving outcomes.

Mission statement

Through StrokEnomics, Stryker is committed to partnering with providers to effectively navigate the increasingly complex healthcare environment. Leveraging our knowledge and experience through collaborative consultation, we develop comprehensive, customized strategies, explore targeted opportunities and deliver proven solutions that drive economic value and outcomes.

Value offerings

- Hospital-specific economic models
- Product-specific costing tool
- ICD-10 coding templates
- New business stroke pro forma
- Physician/hospital business reviews
- Value dossiers
- International centers of excellence and HCPs workshop curriculum
- Budget impact analysis

Important notice: Health economics and reimbursement information provided by Stryker is based on data collected by third parties. The information contained herein is presented for illustrative purposes only. Providers are required to submit accurate and appropriate claims for the services that they provide. It is the provider's responsibility to determine medical necessity, the proper site for delivery of any services and to submit appropriate codes, charges, and modifiers for services that are rendered.

Providers should consult with their payers, reimbursement specialists and or/legal counsel regarding coding, coverage and reimbursement matters.

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Introduction

Hospital inpatient guide

This guide provides a general update of the Centers for Medicare and Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) rule for fiscal year 2019 and relevant information for ischemic stroke intervention and the neuroendovascular treatment of aneurysms for hospital inpatient services. It also provides coding and Medicare payment information for endovascular mechanical thrombectomy/embolectomy for acute ischemic stroke.

Payment update:

On August 2, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that will update Medicare payment policies and rates for inpatient stays in acute care hospitals under the Inpatient Prospective Payment System in fiscal year 2019.

The rule will be effective for discharges occurring on or after October 1, 2018. Under the rule, payment rates for inpatient stays in general acute-care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are Electronic Health Record (EHR) users will be increased by 1.85%. Those that do not successfully participate in the IQR Program and are not meaningful EHR users will receive an approximate 1.55% point reduction.[1]

Background:

- Medicare assigns a hospital inpatient stay to a Medicare Severity-Diagnosis Related Group (MS-DRG) based on the reported ICD-10 diagnoses and procedure codes. Hospitals generally receive a fixed, predetermined payment for each MS-DRG, which includes all costs associated with the patient's hospital stay.
- Hospital MS-DRG payments vary based on teaching status, disproportionate share services, and location in urban versus rural regions.
- MS-DRGs do not include payment for physician services, which are coded and reimbursed separately.
- Many insurers, including Medicare, use a 24+ hour length of stay to define inpatient hospital care.

Payer policies vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We also recommend that providers consult the relevant coding manuals and other resources for appropriate coding options.

1. FY 2019 FINAL IPPS RULE CMS-1694-F: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates page 994, 2433.

See page 17 for important information about the uses and limitations of this document.

Target® Detachable Coils

The following provides coding and Medicare reimbursement information for the neuroendovascular treatment of aneurysms using detachable coils for hospital inpatient services.

Background:

- Medicare assigns a hospital inpatient stay to a Medicare Severity-Diagnosis Related Group (MS-DRG) based on the reported ICD-10 diagnoses and procedure codes. Hospitals generally receive a fixed, predetermined payment for each MS-DRG, which includes all costs associated with the patient's hospital stay.
- Hospital MS-DRG payments vary based on teaching status, disproportionate share services, and location in urban versus rural regions.
- MS-DRGs do not include payment for physician services, which are coded and reimbursed separately.
- Many insurers, including Medicare, use a 24+ hour length of stay to define inpatient hospital care.

Payer policies vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We also recommend that providers consult the relevant coding manuals and other resources for appropriate coding options.

Medicare MS-DRG description[1]	**FY 2019 Medicare base payment rate[1]**	**Average length of stay** (arithmetic mean)[1]
MS-DRG 20 . . . Intracranial vascular procedures with a principal diagnosis of hemorrhage with major complication or comorbidity (MCC)	$63,691	16.5
MS-DRG 21 . . . Intracranial vascular procedures with a principal diagnosis of hemorrhage with complication or comorbidity (CC)	$48,297	13.7
MS-DRG 22 . . . Intracranial vascular procedures with a principal diagnosis of hemorrhage without CC/MCC	$31,508	8.1
MS-DRG 25 . . . Craniotomy & endovascular intracranial procedures with MCC	$26,132	8.8
MS-DRG 26 . . . Craniotomy & endovascular intracranial procedures with CC	$18,424	5.7
MS-DRG 27 . . . Craniotomy & endovascular intracranial procedures without CC/MCC	$14,697	2.7

The 2019 fiscal year began October 1, 2018. Rates shown are the national, unadjusted rates for hospitals with a wage index equal to one and receiving the full update, and do not include adjustments for disproportionate share hospitals, graduate medical education, geographical variations in costs, or other factors.

1. FY 2019 FINAL IPPS RULE CMS-1694-F: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates.

See page 17 for important information about the uses and limitations of this document.

Neuroform EZ® Stent System and Neuroform Atlas® Stent System

The following provides coding and Medicare reimbursement information for the neuroendovascular treatment of aneurysms that involve insertion of the Neuroform EZ Stent System and Neuroform Atlas Stent System, which are approved under a Humanitarian Device Exemption (HDE).[1]

Background:

- Medicare currently maintains a national policy on intracranial Percutaneous Transluminal Angioplasty (PTA) and stenting for treatment of cerebral artery stenosis greater than or equal to 50% in patients with intracranial atherosclerotic disease. PTA with or without stenting is not covered to treat obstructive lesions of the vertebral and cerebral arteries.[2] This national policy does not apply to the placement of stents, including the Neuroform EZ Stent System and Neuroform Atlas Stent System, for treatment of aneurysms. Medicare currently does not have a national policy on use of stents to treat aneurysms. Consult your local contractor to determine if any local coverage determinations apply to this procedure.

Medicare MS-DRG description[3]	FY 2019 Medicare base payment rate[1]	Average length of stay (arithmetic mean)[1]
MS-DRG 20 . . . Intracranial vascular procedure with a principal diagnosis of hemorrhage with major complication or comorbidity (MCC)	$63,691	16.5
MS-DRG 21 . . . Intracranial vascular procedure with a principal diagnosis of hemorrhage with complication or comorbidity (CC)	$48,297	13.7
MS-DRG 22 . . . Intracranial vascular procedure with a principal diagnosis of hemorrhage without CC/MCC	$31,508	8.1
MS-DRG 25 . . . Craniotomy & endovascular intracranial procedures with MCC	$26,132	8.8
MS-DRG 26 . . . Craniotomy & endovascular intracranial procedures with CC	$18,424	5.7
MS-DRG 27 . . . Craniotomy & endovascular intracranial procedures without CC/MCC	$14,697	2.7

The 2019 fiscal year began October 1, 2018. Rates shown are the national, unadjusted rates for hospitals with a wage index equal to one and receiving the full update, and do not include adjustments for disproportionate share hospitals, graduate medical education, geographical variations in costs, or other factors.

The Neuroform EZ Stent System and Neuroform Atlas Stent System are authorized under a Humanitarian Device Exemption (HDE).

IRB approval is required prior to use.

1. Humanitarian Device. The Neuroform EZ Stent System and Neuroform Atlas Stent System are authorized by Federal Law for use with embolic coils for the treatment of wide-neck, intracranial, saccular aneurysms arising from a parent vessel with a diameter of ≥2mm and ≤4.5mm that are not amenable to treatment with surgical clipping. Wide-neck aneurysms are defined as having a neck ≥4mm or a dome-to-neck ratio <2. The effectiveness of this device for this use has not been demonstrated. IRB review required.
2. CMS Manual System, Pub100-03, Medicare National Coverage Determinations, Transmittal 64, January 5, 2007.
3. FY 2019 FINAL IPPS RULE CMS-1694-F: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates.

See page 17 for important information about the uses and limitations of this document.

Surpass Streamline™ Flow Diverter

The following provides coding and Medicare reimbursement information for the neuroendovascular treatment of aneurysms using flow diversion therapy for hospital inpatient services.

Background:

- Medicare assigns a hospital inpatient stay to a Medicare Severity-Diagnosis Related Group (MS-DRG) based on the reported ICD-10 diagnoses and procedure codes. Hospitals generally receive a fixed, predetermined payment for each MS-DRG, which includes all costs associated with the patient's hospital stay.
- Hospital MS-DRG payments vary based on teaching status, disproportionate share services, and location in urban versus rural regions.
- MS-DRGs do not include payment for physician services, which are coded and reimbursed separately.
- Many insurers, including Medicare, use a 24+ hour length of stay to define inpatient hospital care.

Payer policies vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We also recommend that providers consult the relevant coding manuals and other resources for appropriate coding options.

Medicare MS-DRG description[1]	**FY 2019 Medicare base payment rate[1]**	**Average length of stay** (arithmetic mean)[1]
MS-DRG 25 . . . Craniotomy & endovascular intracranial procedures with MCC	$26,132	8.8
MS-DRG 26 . . . Craniotomy & endovascular intracranial procedures with CC	$18,424	5.7
MS-DRG 27 . . . Craniotomy & endovascular intracranial procedures without CC/MCC	$14,697	2.7

The 2019 fiscal year began October 1, 2018. Rates shown are the national, unadjusted rates for hospitals with a wage index equal to one and receiving the full update, and do not include adjustments for disproportionate share hospitals, graduate medical education, geographical variations in costs, or other factors.

1. FY 2019 FINAL IPPS RULE CMS-1694-F: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates.

See page 17 for important information about the uses and limitations of this document.

TransForm® Occlusion Balloon Catheter

The following provides coding and Medicare reimbursement information for the neuroendovascular treatment of aneurysms that involve the use of the TransForm Occlusion Balloon Catheter.

Background:

- Medicare currently maintains a national policy on intracranial Percutaneous Transluminal Angioplasty (PTA) and stenting for treatment of cerebral artery stenosis greater than or equal to 50% in patients with intracranial atherosclerotic disease. PTA with or without stenting is not covered to treat obstructive lesions of the vertebral and cerebral arteries.[1] This national policy does not apply to the use of occlusion balloons, including the TransForm Occlusion Balloon Catheter, for treatment of aneurysms. Medicare currently does not have a national policy on use of occlusion balloons to treat aneurysms. Consult your local contractor to determine if any local coverage determinations apply to this procedure.

Medicare MS-DRG description[2]	**FY 2019 Medicare base payment rate[1]**	**Average length of stay** (arithmetic mean)[1]
MS-DRG 20 . . . Intracranial vascular procedure with a principal diagnosis of hemorrhage with major complication or comorbidity (MCC)	$63,691	16.5
MS-DRG 21 . . . Intracranial vascular procedure with a principal diagnosis of hemorrhage with complication or comorbidity (CC)	$48,297	13.7
MS-DRG 22 . . . Intracranial vascular procedure with a principal diagnosis of hemorrhage without CC/MCC	$31,508	8.1
MS-DRG 25 . . . Craniotomy & endovascular intracranial procedures with MCC	$26,132	8.8
MS-DRG 26 . . . Craniotomy & endovascular intracranial procedures with CC	$18,424	5.7
MS-DRG 27 . . . Craniotomy & endovascular intracranial procedures without CC/MCC	$14,697	2.7

The 2019 fiscal year began October 1, 2018. Rates shown are the national, unadjusted rates for hospitals with a wage index equal to one and receiving the full update, and do not include adjustments for disproportionate share hospitals, graduate medical education, geographical variations in costs, or other factors.

1. CMS Manual System, Pub100-03, Medicare National Coverage Determinations, Transmittal 64, January 5, 2007.
2. FY 2019 FINAL IPPS RULE CMS-1694-F: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates.

See page 17 for important information about the uses and limitations of this document.

Wingspan® Stent System with Gateway® PTA Balloon Catheter

The following provides coding information for the Wingspan Stent System with Gateway PTA Balloon Catheter which is approved under a Humanitarian Device Exemption (HDE).[1] Currently, procedures which involve the Wingspan Stent System and Gateway PTA Balloon Catheter for the HDE-granted indication, remain a noncovered service under Medicare.

Background:

- Medicare patients with 70-99% stenosis and enrolled in any FDA-approved category B IDE trial with use of intracranial stenting will be covered.[2]
- Medicare patients not enrolled in any FDA-approved category B IDE trial with use of intracranial stenting will not be covered.[2]
- Coverage and payment for intracranial angioplasty and stenting may vary by private payers. Some payers may require prior authorization (physicians) or precertification (hospitals) for intracranial angioplasty and stenting procedures. For additional assistance with private payer reimbursement, please contact the Wingspan Stent System reimbursement hotline at 1-877-WS-STENT.
- If a patient's intracranial stenosis is considered to be life-threatening, providers should indicate this status to private payers. When seeking prior authorization or precertification, inquire whether the payer has a special policy for patients with life-threatening illnesses or patients with no other treatment options.

Medicare MS-DRG description[3]	FY 2019 Medicare base payment rate[3]	Average length of stay (arithmetic mean)[3]
MS-DRG 23 . . . Craniotomy with major device implant/acute complex central nervous system principal diagnosis with major complication or comorbidity (MCC) or chemo implant	$33,357	10.2
MS-DRG 24 . . . Craniotomy with major device implant/acute complex central nervous system principal diagnosis without major complication or comorbidity (MCC) or chemo implant	$23,945	5.7
MS-DRG 25 . . . Craniotomy & endovascular intracranial procedures with MCC	$26,132	8.8
MS-DRG 26 . . . Craniotomy & endovascular intracranial procedures with CC	$18,424	5.7
MS-DRG 27 . . . Craniotomy & endovascular intracranial procedures without CC/MCC	$14,697	2.7

The 2019 fiscal year began October 1, 2018. Rates shown are the national, unadjusted rates for hospitals with a wage index equal to one and receiving the full update, and do not include adjustments for disproportionate share hospitals, graduate medical education, geographical variations in costs, or other factors.

Wingspan Stent System with Gateway PTA Balloon Catheter is granted Humanitarian Device Exemption (HDE).

1. The Wingspan Stent System with Gateway PTA Balloon Catheter is indicated for use in improving cerebral artery lumen diameter in patients 22 to 80 years old with recurrent (two or more) strokes refractory to a comprehensive regimen of medical therapy and due to intracranial atherosclerotic disease of intracranial vessels with 70-99% stenosis that are accessible to the system. The most recent stroke must have occurred more than seven days prior to treatment with the Wingspan Stent System. Patients are eligible for treatment with the Wingspan Stent System if their Modified Rankin Score (mRS) is three or less at the time of treatment.
2. May 12th, 2008 Federal Register CAG-00085R5P.
3. FY 2019 FINAL IPPS RULE CMS-1694-F: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates.

See page 17 for important information about the uses and limitations of this document.

Trevo® XP *ProVue Retriever*

The following provides coding and Medicare reimbursement information for the use of retrievers for endovascular mechanical embolectomy/thrombectomy procedures in the inpatient setting. Medicare restricts endovascular mechanical embolectomy/thrombectomy to the inpatient setting; therefore, no category C-code should appear on the inpatient claim when performing mechanical thrombectomy.

Background:

- Medicare assigns a hospital inpatient stay to a Medicare Severity-Diagnosis Related Group (MS-DRG) based on the reported ICD-10 diagnoses and procedure codes. Hospitals generally receive a fixed, predetermined payment for each MS-DRG, which includes all costs associated with the patient's hospital stay.
- Hospital MS-DRG payments vary based on teaching status, disproportionate share services, and location in urban versus rural regions.
- MS-DRGs do not include payment for physician services, which are coded and reimbursed separately.
- Many insurers, including Medicare, use a 24+ hour length of stay to define inpatient hospital care.

Medicare MS-DRG description	FY 2019 Medicare base payment rate[1]	Average length of stay (arithmetic mean)[1]
MS-DRG 23 . . . Craniotomy with major device implant or acute complex CNS PDX with major complication or comorbidity (MCC)	$33,357	10.2
MS-DRG 24 . . . Craniotomy with major device implant or acute complex CNS PDX without MCC	$23,945	5.7

Payer policies vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We also recommend that providers consult the relevant coding manuals and other resources for appropriate coding options.

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See page 17 for important information about the uses and limitations of this document.

FlowGate²™ Balloon Guide Catheter

The following provides coding and Medicare reimbursement information for the use of balloon guide catheters for temporary vascular occlusion during endovascular and neurovascular procedures.

Background:

- Medicare assigns a hospital inpatient stay to a Medicare Severity-Diagnosis Related Group (MS-DRG) based on the reported ICD-10 diagnoses and procedure codes. Hospitals generally receive a fixed, predetermined payment for each MS-DRG, which includes all costs associated with the patient's hospital stay.
- Hospital MS-DRG payments vary based on teaching status, disproportionate share services, and location in urban versus rural regions.
- MS-DRGs do not include payment for physician services, which are coded and reimbursed separately.
- Many insurers, including Medicare, use a 24+ hour length of stay to define inpatient hospital care.

Medicare MS-DRG description	FY 2019 Medicare base payment rate[1]	Average length of stay (arithmetic mean)[1]
MS-DRG 23 . . . Craniotomy with major device implant or acute complex CNS PDX with major complication or comorbidity (MCC)	$33,357	10.2
MS-DRG 24 . . . Craniotomy with major device implant or acute complex CNS PDX without MCC	$23,945	5.7

1. FY 2019 FINAL IPPS RULE CMS-1694-F: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2019 Rates.

See page 17 for important information about the uses and limitations of this document.

2019 physician coding

Physician guide

The following provides coding and Medicare reimbursement information for the neuroendovascular treatment of aneurysms and ischemic stroke intervention for physician services.

Background:

- Medicare typically reimburses physicians according to a fee schedule for each CPT® code, and payment varies by geographic region. Please note that the reimbursement amounts given are specific to Medicare.
- Other health insurers, such as private payers and Medicaid, use a variety of payment mechanisms including fee schedules, percentages of allowable charges, and capitation.

See page 17 for important information about the uses and limitations of this document.

2019 physician coding (cont.)

Intervention

National average Medicare physician payment rates calculated using a 2019 conversion factor of $36.0391. Rates subject to change.

CPT® codes[1]	2019 national average Medicare payment[2]	Physician work RVUs[2]	Total RVUs[2]
Endovascular coiling/flow diversion			
61623 . . . Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post-occlusion	$599	10.0	16.6
61624 . . . Transcatheter permanent occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)	$1,215	20.1	33.7
61626 . . . Transcatheter permanent occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; noncentral nervous system, head or neck (extracranial, brachiocephalic branch)	$922	16.6	25.6

National average rates are not adjusted for geographic variations in costs, and note that multiple procedure payment reductions could apply. Total RVUs = physician work RVUs + facility RVUs + malpractice RVUs.

1. 2019 CPT Professional Edition, USA: American Medical Association page 416.
2. 2019 Final Physician Fee Schedule, CMS Transmittal 1693-F.

See page 17 for important information about the uses and limitations of this document.

2019 physician coding (cont.)

Intervention (cont.)

National average Medicare physician payment rates calculated using a 2019 conversion factor of $36.0391. Rates subject to change.

CPT® codes[1]	2019 national average Medicare payment[3]	Physician work RVUs[3]	Total RVUs[3]
Balloon angioplasty and stenting			
61630* . . . Balloon angioplasty, intracranial (e.g., atherosclerotic stenosis), percutaneous	$1,465	22.1	40.6
61635* . . . Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty if performed	$1,536	24.3	42.6

* These codes include all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family, and all related radiological supervision and interpretation. When diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, 61630 and 61635 are inclusive of these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of 61630 and 61635.

* Do not report 61630 or 61635 in conjunction with 61645 for the same vascular territory.

CPT® codes[2]	2019 national average Medicare payment[3]	Physician work RVUs[3]	Total RVUs[3]
Vasospasm			
61640** . . . Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel	$505	12.3	14.0
61641** . . . Each additional vessel in same vascular family (list separately in addition to code for primary procedure)	$177	4.3	4.9
61642** . . . Each additional vessel in different vascular family (list separately in addition to code for primary procedure)	$355	8.7	9.8

National average rates are not adjusted for geographic variations in costs, and note that multiple procedure payment reductions could apply. Total RVUs = physician work RVUs + facility RVUs + malpractice RVUs.

** Use 61641 and 61642 in conjunction with 61640.

** Do not report 61640 or 61642 in conjunction with 61650 or 61651 for the same vascular territory.

** 61640, 61641 and 61642 include all selective vascular catheterization of the target vessel, contrast injection(s), vessel measurement, roadmapping, post-dilatation angiography, and fluoroscopic guidance for the balloon dilatation.

1. 2019 CPT Professional Edition, USA: American Medical Association page 416.
2. 2019 CPT Professional Edition, USA: American Medical Association page 417.
3. 2019 Final Physician Fee Schedule, CMS Transmittal 1693-F.

See page 17 for important information about the uses and limitations of this document.

2019 physician coding (cont.)

Arterial mechanical thrombectomy

National average Medicare physician payment rates calculated using a 2019 conversion factor of $36.0391. Rates subject to change.

CPT® codes[1]	2019 national average Medicare payment[2]	Physician work RVUs[2]	Total RVUs[2]
61645* . . . Percutaneous arterial transluminal mechanical thrombectomy and/ or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	$876	15.0	24.0
61651* . . . Each additional vascular territory (list separately in addition to code for primary procedure)	$253	4.3	7.0

Infusion coding

National average Medicare physician payment rates calculated using a 2019 conversion factor of $36.0391. Rates subject to change.

If the case requires the infusion of a thrombolytic agent, possible codes are listed below.

CPT® codes[1]	2019 national average Medicare payment[2]	Physician work RVUs[2]	Total RVUs[2]
Thrombolytic infusion			
61645* . . . Percutaneous arterial transluminal mechanical thrombectomy and/ or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	$876	15.0	24.0
61651* . . . Each additional vascular territory (list separately in addition to code for primary procedure)	$253	4.3	7.0

* Do not report 61645, 61650 or 61651 in conjunction with 36221, 36226, 36228, 37184 or 37186 for the treated vascular territory. Do not report 61645 in conjunction with 61650 or 61651 for the same vascular distribution. Diagnostic angiography of a nontreated vascular territory may be reported separately. For example, angiography of the left carotid and/or the vertebral circulations may be reported if the intervention is performed in the right carotid circulation.

National average rates are not adjusted for geographic variations in costs, and note that multiple procedure payment reductions could apply. Total RVUs = physician work RVUs + facility RVUs + malpractice RVUs.

1. 2019 CPT Professional Edition, USA: American Medical Association page 417.
2. 2019 Final Physician Fee Schedule, CMS Transmittal 1693-F.

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2019 physician coding (cont.)

Infusion coding (cont.)

National average Medicare physician payment rates calculated using a 2019 conversion factor of $36.0391. Rates subject to change.

If the case requires the infusion of a thrombolytic agent, possible codes are listed below.

CPT® codes[1]	2019 national average Medicare payment[2]	Physician work RVUs[2]	Total RVUs[2]
Other than thrombolysis			
61650*** . . . Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	$580	10.0	16.1
61651*** . . . Each additional vascular territory (list separately in addition to code for primary procedure)	$253	4.3	7.0

*** Use 61651 in conjunction with 61650.

*** Do not report 61650 or 61651 in conjunction with 36221, 36222, 36223, 36224, 36225, 36226, 61640, 61641, 61642 or 61645 for the same vascular territory.

*** Do not report 61650 or 61651 in conjunction with 96420, 96422, 96423 or 96425 for the same vascular territory.

1. 2019 CPT Professional Edition, USA: American Medical Association page 417.
2. 2019 Final Physician Fee Schedule, CMS Transmittal 1693-F.

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2019 physician coding (cont.)

Catheterization

Identify all catheter introduction sites and all the vessels catheterized within the medical report. Code according to the highest order vascular family catheterized. This means identifying the final destination of catheterization, whether it is a first-order, second-order or third-order in a vascular family. Also, report any additional second- or third-order vessels catheterized in a vascular family.

National average Medicare physician payment rates calculated using a 2019 conversion factor of $36.0391. Rates subject to change.

CPT® codes[1]	2019 national average Medicare payment[2]	Physician work RVUs[2]	Total RVUs[2]
36215 . . . Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	$222	4.2	6.2
36216 . . . Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	$286	5.3	8.0
36217 . . . Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	$343	6.3	9.5
36218 . . . Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family	$54	1.0	1.5

National average rates are not adjusted for geographic variations in costs, and note that multiple procedure payment reductions could apply. Total RVUs = physician work RVUs + facility RVUs + malpractice RVUs.

1. 2019 CPT Professional Edition, USA American Medical Association Page 260.
2. 2019 Final Physician Fee Schedule, CMS Transmittal 1693-F.

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Providers should consult with their payers, reimbursement specialists and or/legal counsel regarding coding, coverage and reimbursement matters.

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