CY 2024 & FY 2025 National Coding Guide

This coding guide is intended to assist with coding and billing related to select disease sites for procedures performed in an inpatient, outpatient, ambulatory surgical center, and office settings by physicians. This document is only to serve as a guide and not intended to dictate or determine practice patterns. Actual coding will be dependent upon physician orders, documentation and patient needs.

For additional resources, please visit https://gore.rccsclients.com/.

TABLE OF CONTENTS

MEDICARE PAYMENT SYSTEMS

There are multiple payment systems within the Medicare program; this coding guide will focus on the Inpatient Prospective Payment System (IPPS), Hospital Outpatient Prospective Payment System (HOPPS) and Medicare Physician Fee Schedule (MPFS).

Inpatient Prospective Payment System (IPPS)

Hospitals are paid for services on a predetermined, fixed amount based on Diagnosis-Related Groups (DRGs). The hospital will receive a single payment from Medicare based on the diagnosis of the patient and per the procedure code through the ICD-10 PCS procedure coding system. The three – seven-digit alphanumeric codes represented by ICD-10 PCS are different than those billed for outpatient services billed in outpatient hospitals, ambulatory surgical centers and physicians. The first digit of the ICD-10 PCS code represents the section of medical practice the procedure belongs to (surgery) then followed by the body system, root operation, body part, approach and device used. The seventh character is used as a qualifier digit.

The codes reported for the services typically correlate to a Medicare Severity-Diagnosis Related Group (MS-DRG). It is the DRGs which are tied to the reimbursement based on the complications and comorbidities of the patient. The level of reimbursement will vary based upon the presence or absence of Major Complications and Comorbidities (MCC) or Complications and Comorbidities (CC). Inpatient reimbursement rates are updated on the fiscal year calendar.

Hospital Outpatient Prospective Payment System (HOPPS)

The Hospital Outpatient Prospective Payment System (HOPPS) is the route through which hospital outpatient departments are reimbursed for services provided to Medicare beneficiaries. Services reimbursed under HOPPS are assigned an Ambulatory Payment Classification (APC) with multiple CPT® or Healthcare Common Procedure Coding System (HCPCS) codes receiving the same APC designation. Services considered similar from both a clinical and resource aspect may be placed in a single APC. The rates assigned to the APCs are also a predetermined fixed amount, but unlike IPPS, the reimbursement is not tied to the diagnosis of the patient.

Ambulatory surgical centers (ASCs) follow the payment rules of HOPPS and services are designated as either surgical or ancillary and reimbursement is typically less than hospital based.

Medicare Physician Fee Schedule (MPFS)

Medicare Physician Fee Schedule (MPFS) payment rates are based on three key factors: relative value units (RVUs), geographic practice cost indexes (GPCIs) and the conversion factor (CF), although use of the CF is transitioning to be based on Quality Payment Program (QPP) reporting and incentives. Relative Value Units (RVUs) are assigned to all Current Procedural Terminology (CPT®) codes; RVUs are based on resource costs associated with physician work, practice expense and professional liability insurance. The assigned RVUs are adjusted by GPCIs, which reflect the variances in practice costs for locations throughout the country. The Conversion Factor (CF) is a scaling factor used to convert the geographically adjusted RVUs into dollar amounts. Starting in CY 2020, the CF will remain at the CY 2019 rate and reimbursements will be based on performance measures under the Merit-based Incentive Payment System (MIPS) and QPP.

MEDICARE NATIONAL RATE INFO

The following pages collectively outline the coding guidelines and Medicare national reimbursement rates under IPPS, HOPPS, ASC and Physician in a facility setting for the following selected disease sites:

- Abdominal Aortic Aneurysms (AAA)/EVAR
- Thoracic Aortic Aneurysms (TAA)/TEVAR
- Thoracoabdominal Aortic Aneurysms (TAAAs)/Pararenal Abdominal Aortic Aneurysms (PAAAs)
- Transcatheter Closure of Atrial Septal Defects/Patent Foramen Ovale (ASD/PFO)
- Biliary Tree Strictures
- End Stage Renal Disease (ESRD)/Dialysis
- Endovascular Stent and Stent-Graft Placement with Adjunctive Therapy for Arterial Disease
- Hernia Repair
- Surgical Bypass Grafting with Other Than Vein for Peripheral Arterial Disease (PAD)
- Portal Hypertension/Transjugular Intrahepatic Portosystemic Shunt (TIPS)
- Bariatric/Staple Line Reinforcement
- Tissue Reinforcement

The coding and reimbursement information on the following pages is not meant to dictate practice patterns. The information serves as a guide to the potential codes and reimbursement if the orders, medical necessity and documentation are appropriate and supported within the medical record. The rates do not reflect the Medicare 2% sequestration reduction.

Endovascular Repair of Abdominal Aortic Aneurysm (EVAR)

Coverage, Coding and Reimbursement Overview — Physician

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Physician rates effective March 9, 2024 through December 31, 2024.

PROCEDURE		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional/ Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
34701	Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	36.11	090	$1,202
34702	for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	53.93	090	$1,795
34703	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	40.11	090	$1,335
34704	for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	66.86	090	$2,226
34705	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	44.60	090	$1,485
34706	for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	66.47	090	$2,213
34707	Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)	33.92	090	$1,129
34708	for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	53.17	090	$1,770

AAA (EVAR) Physician in Facility cont.

PROCEDURE		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional/ Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
+34717	Endovascular repair of iliac artery at the time of aorto- iliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption), unilateral (List separately in addition to code for primary procedure)	12.91	ZZZ	$430
+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 (List separately in addition to code for primary procedure)	9.39	ZZZ	$313
34718	Endovascular repair of iliac artery, not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer), unilateral	36.18	090	$1,204
34710	Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated	23.30	090	$776
+34711	each additional vessel treated (List separately in addition to code for primary procedure)	8.58	ZZZ	$286
34712	Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation	19.20	090	$639
+34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	3.59	ZZZ	$119
+34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	6.01	ZZZ	$200
+34714	Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)	7.87	ZZZ	$262
+34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	9.82	ZZZ	$327

AAA (EVAR) Physician in Facility cont.

PROCEDURE		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional/ Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
+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 (List separately in addition to code for primary procedure)	11.46	ZZZ	$381
+34834	Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)	3.77	ZZZ	$125
+34715	Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	8.71	ZZZ	$290
+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 (List separately in addition to code for primary procedure)	10.87	ZZZ	$362
+34808	Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)	5.91	ZZZ	$197
+34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)	6.85	ZZZ	$228
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	51.60	090	$1,718
34831	aorto-bi-iliac prosthesis	56.43	090	$1,878
34832	aorto-bifemoral prosthesis	55.47	090	$1,846
ANCILLARY PROCEDURES				
+37252	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)	2.59	ZZZ	$86
+37253	each additional noncoronary vessel (List separately in addition to code for primary procedure)	2.06	ZZZ	$69

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

C. Status Indicators: 000-global postoperative period is day of surgical procedure; 090-global postoperative period is 90 days from the date of surgery; XXX-global concept does not apply to the code; YYY-contractor-priced codes, for which MACs determine the global period; ZZZ-related to another service and is always included in the global period of the other service.

Endovascular Repair of Abdominal Aortic Aneurysm (EVAR)

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE	REIMBURSEMENT
Procedures which treat iliac aneurysms with the IBE, which also include treatment of a AAA, are typically captured under the DRGs for "Aortic and Heart Assist Procedures", MS-DRGs 268-269.		
Procedures which treat isolated iliac aneurysms by IBE with the GORE® EXCLUDER® AAA Endoprosthesis are typically captured under the DRGs for "Other Major Cardiovascular Procedures", MS-DRGs 270-272.		
For IBE cases that also involve treatment of an aortic aneurysm, report the appropriate associated codes separately.		

ENDOVASCULAR REPAIR – AAA (Aortic Trunk Endoprosthesis)		MS-DRG[B]	Relative Weight[C]	Rate[D]
Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach	04V03DZ	268 269	6.6672 4.1604	$47,451 $29,610

ENDOVASCULAR REPAIR - ILIAC ANEURYSM (ISOLATED – Tube Endoprosthesis)		MS-DRG[B]	Relative Weight[C]	Rate[D]
Restriction of Right Common Iliac Artery with Intraluminal Device, Percutaneous Approach	04VC3DZ	270 271 272	5.1328 3.4444 2.5020	$36,530 $24,514 $17,807
Restriction of Left Common Iliac Artery with Intraluminal Device, Percutaneous Approach	04VD3DZ			
Restriction of Right Internal Iliac Artery with Intraluminal Device, Percutaneous Approach	04VE3DZ			
Restriction of Left Internal Iliac Artery with Intraluminal Device, Percutaneous Approach	04VF3DZ			
Restriction of Right External Iliac Artery with Intraluminal Device, Percutaneous Approach	04VH3DZ			
Restriction of Left External Iliac Artery with Intraluminal Device, Percutaneous Approach	04VJ3DZ			

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.
B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.
C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.
D. Rates per CMS 1808-F.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions:
DRG 268 Aortic and heart assist procedures except pulsation balloon with MCC
DRG 269 Aortic and heart assist procedures except pulsation balloon without MCC
DRG 270 Other major cardiovascular procedures with MCC
DRG 271 Other major cardiovascular procedures with CC
DRG 272 Other major cardiovascular procedures without CC/MCC

Endovascular Repair of Thoracic Aortic Aneurysm (TEVAR)

Coverage, Coding and Reimbursement Overview — Physician in Facility

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Physician rates effective March 9, 2024 through December 31, 2024.

PROCEDURE		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional/ Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
Open Arterial Exposure for Delivery or Aortic Endoprosthesis (also code catheter placement)				
+34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	6.01	ZZZ	$200
+34714	Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)	7.87	ZZZ	$262
+34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	9.82	ZZZ	$327
+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 (List separately in addition to code for primary procedure)	11.46	ZZZ	$381
+34834	Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)	3.77	ZZZ	$125
+34715	Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	8.71	ZZZ	$290
+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 (List separately in addition to code for primary procedure)	10.87	ZZZ	$362
Percutaneous Catheter Placements				
36200	Introduction of catheter, aorta	4.07	000	$135
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	6.21	000	$207
36216	initial second order thoracic or brachiocephalic branch, within a vascular family	7.97	000	$265
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	6.88	XXX	$229
Delivery and Deployment of Endoprosthesis				
33880	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	52.26	090	$1,740

TAA (TEVAR) Physician in Facility cont.

PROCEDURE		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional /Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
Delivery and Deployment of Endoprosthesis cont.				
75956	Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation [Radiological S&I for 33880]	9.78	XXX	$326
33881	not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin	44.89	090	$1,494
75957	not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation [Radiological S&I for 33881]	8.40	XXX	$280
33883	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension	32.58	090	$1,085
+33884	each additional proximal extension (List separately in addition to code for primary procedure)	11.52	ZZZ	$383
75958	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation [Radiological S&I for 33883, +33884]	5.51	XXX	$183
33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta	28.13	090	$936
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation [Radiological S&I for 33886]	4.89	XXX	$163
Other Procedures that may be reported if performed				
+34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	3.59	ZZZ	$119
33889	Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral	23.22	000	$773
33891	Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision	28.08	000	$935
35226	Repair blood vessel, direct; lower extremity	24.35	090	$811
35286	Repair blood vessel with graft other than vein; lower extremity	27.20	090	$905

TAA (TEVAR) Physician in Facility cont.

PROCEDURE		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional /Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
Other Procedures that may be reported if performed				
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	12.84	000	$427
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)	13.84	000	$461

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

C. Status Indicators: 000-global postoperative period is day of surgical procedure; 090-global postoperative period is 90 days from the date of surgery; XXX-global concept does not apply to the code; YYY-contractor-priced codes, for which MACs determine the global period; ZZZ-related to another service and is always included in the global period of the other service.

Endovascular Repair of Thoracic Aortic Aneurysm (TEVAR)

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE	REIMBURSEMENT		
TEVAR		**MS-DRG[B]**	**Relative Weight[C]**	**Rate[D]**
Restriction of Thoracic Aorta, Descending with Intraluminal Device, Percutaneous Approach	02VW3DZ	216 217 218 219 220 221	9.6504 6.4574 5.9491 7.7370 5.2963 4.5923	$68,682 $45,957 $42,340 $55,064 $37,694 $32,683
TEVAR with Thoracic Branch Endoprosthesis (TBE)				
Procedures which treat descending thoracic aortic aneurysms with the TBE are reported with the following codes, and are typically captured under the DRGs for "Cardiac Valve and Other Major Cardiothoracic Procedures" with and without cardiac catheterization, MS-DRGs 216-220.				
Restriction of Thoracic Aorta, Descending with Intraluminal Device, Percutaneous Approach	02VW3DZ	216 217 218 219 220 221	9.6504 6.4574 5.9491 7.7370 5.2963 4.5923	$68,682 $45,957 $42,340 $55,064 $37,694 $32,683
Restriction of Thoracic Aorta, Ascending/Arch with Branched or Fenestrated Intraluminal Device, One or Two Arteries, Percutaneous Approach	02VX3EZ			

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.

D. Rates per CMS 1808-F.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions

DRG 216 Cardiac valve and other major cardiothoracic procedures w/ cardiac catheterization with MCC

DRG 217 Cardiac valve and other major cardiothoracic procedures w/ cardiac catheterization with CC

DRG 218 Cardiac valve and other major cardiothoracic procedures w/ cardiac catheterization without CC/MCC

DRG 219 Cardiac valve and other major cardiothoracic procedures w/o cardiac catheterization with MCC

DRG 220 Cardiac valve and other major cardiothoracic procedures w/o cardiac catheterization with CC

DRG 221 Cardiac valve and other major cardiothoracic procedures w/o cardiac catheterization without CC/MCC

Endovascular Repair of Thoracoabdominal Aneurysm (TAAA) or Pararenal Aortic Aneurysm (PAAA) with Thoracoabdominal Branch Endoprosthesis (TAMBE)

Coverage, Coding and Reimbursement Overview — Physician in Facility

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Physician rates effective March 9, 2024 through December 31, 2024.

PROCEDURE		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional/ Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
37799	Unlisted procedure, vascular surgery	N/A	YYY	Carrier Priced

A. Provided is the recommended unlisted CPT® code since there is no listed CPT® code for this procedure. Review CPT® coding guidelines and modifier usage for unlisted CPT® codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. Unlisted CPT® codes do not have associated RVUs. When billing for this procedure, it is recommended to provide the payer with comparable listed CPT® codes for physician work RVUs.

C. Status Indicator: YYY – Carrier will determine if global period applies and will establish postoperative period at the time of pricing, if appropriate.

By using this content, provider/client acknowledges all information provided is the opinion of Revenue Cycle Coding Strategies and it is not being relied upon for billing decisions. Revenue Cycle Coding Strategies provides this information solely as education/guidance for the provider/client. It is the sole responsibility of the provider/client to make an independent determination about the appropriate billing for all individual claims.

Endovascular Repair of Thoracoabdominal Aneurysm (TAAA) or Pararenal Aortic Aneurysm (PAAA) with Thoracoabdominal Branch Endoprosthesis (TAMBE)

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE	REIMBURSEMENT		
ENDOVASCULAR REPAIR - TAMBE		**MS-DRG[B]**	**Relative Weight[C]**	**Rate[D]**
Restriction of Descending Thoracic Aorta and Abdominal Aorta with Branched Intraluminal Device, Manufactured Integrated System, Four or More Arteries, Percutaneous Approach, New Technology Group 10	X2VE3SA	216	9.6504	$68,682
		217	6.4574	$45,957
		218	5.9491	$42,340
		219	7.7370	$55,064
		220	5.2963	$37,694
		221	4.5923	$32,683

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.

D. Rates per CMS 1808-F.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions

DRG 216 Cardiac valve and other major cardiothoracic procedures w/ cardiac catheterization with MCC

DRG 217 Cardiac valve and other major cardiothoracic procedures w/ cardiac catheterization with CC

DRG 218 Cardiac valve and other major cardiothoracic procedures w/ cardiac catheterization without CC/MCC

DRG 219 Cardiac valve and other major cardiothoracic procedures w/o cardiac catheterization with MCC

DRG 220 Cardiac valve and other major cardiothoracic procedures w/o cardiac catheterization with CC

DRG 221 Cardiac valve and other major cardiothoracic procedures w/o cardiac catheterization without CC/MCC

Transcatheter Closure of Atrial Septal Defects/Patent Foramen Ovale (ASD/PFO)

Coverage, Coding and Reimbursement Overview — Hospital Outpatient, Physician in Facility and Global Office

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital Outpatient rates effective January 1, 2024 through December 31, 2024. Physician rates effective March 9, 2024 through December 31, 2024.

PROCEDURE		REIMBURSEMENT		
HCPCS/CPT® Code[A]	Description	HOPPS 2024 Rate[B]	MPFS Physician in Facility 2024 Rate[C]	MPFS Total in Office 2024 Rate[C]
Device Code*				
C1817	Septal defect implant system, intracardiac	----	----	----
Procedure				
93580	Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant	$16,707	$949	----
Ancillary Services				
93303	Transthoracic echocardiography for congenital cardiac anomalies; complete	$526	$60	$219
93304	follow-up or limited study	$526	$35	$155
C8921	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete	$763	----	----
C8922	follow-up or limited study	$763	----	----
93306	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography (for non-complex CHD)	$526	$67	$196
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography (for non-complex CHD)	$233	$42	$136
93308	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study (for non-complex CHD)	$233	$24	$99
C8923	Transthoracic echocardiography (TTE) with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color doppler echocardiography	$763	----	----
C8924	Transthoracic echocardiography (TTE) with contrast, or without contrast followed by with contrast, real-time with image documentation (2D), includes M-mode recording when performed, follow-up or limited study	$366	----	----
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	$526	$123	Carrier Priced
93316	placement of transesophageal probe only	$526	----	$25
93317	image acquisition, interpretation and report only	----	$86	Carrier Priced

ASD/PFO Physician in Facility cont.

PROCEDURE		REIMBURSEMENT		
HCPCS/CPT® Code[A]	Description	HOPPS 2024 Rate[B]	MPFS Physician in Facility 2024 Rate[C]	MPFS Total in Office 2024 Rate[C]
C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report	$763	----	----
+93319	3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging)	----	$23	$55
+93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)	----	$68	Carrier Priced

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. Rates are from CY 2024 Hospital Outpatient Prospective Payment System Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

C. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

***Per CMS-1786-F, device-intensive procedures require the reporting of a device HCPCS code. Device code reporting requirements apply.**

Transcatheter Closure of Atrial Septal Defects/Patent Foramen Ovale (ASD/PFO)

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
Supplement Atrial Septum with Synthetic Substitute, Percutaneous Approach	02U53JZ	273	3.9100	$27,828
Supplement Atrial Septum with Synthetic Substitute, Percutaneous Endoscopic Approach	02U54JZ	274	3.1208	$22,211

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.

D. Rates per CMS 1808-F.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions:

DRG 273 Percutaneous and Other Intracardiac Procedures with MCC

DRG 274 Percutaneous and Other Intracardiac Procedures without MCC

Biliary Endoprosthesis

Coverage, Coding and Reimbursement Overview — Hospital Outpatient, ASC, Physician in Facility and Global Office

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital Outpatient & ASC rates effective January 1, 2024 through December 31, 2024. Physician rates effective March 9, 2024 through December 31, 2024.

PROCEDURE		REIMBURSEMENT			
HCPCS/CPT® Code[A]	Stent Placement (Internal Drain) in Biliary Tract; Surgical and Guidance Services	HOPPS 2024 Rate[B]	ASC 2024 Rate[C]	MPFS Physician in Facility 2024 Rate[D]	MPFS Total in Office 2024 Rate[D]
Device Code*					
C1874	Stent, coated/covered, with delivery system	----	----	----	----
Endoscopic Approach (Transoral) with ERCP					
43274	Endoscopic retrograde cholangiopancreatography (ERCP); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent	$5,430	$3,319	$453	----
43275	with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)	$1,813	$832	$368	----
43276	with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged	$5,430	$3,323	$472	----
removal without ERCP					
43247	Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s) (If fluoroscopic guidance is performed, use 76000)	$864	$470	$174	$382
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time	$233	$31	$15	$43
Percutaneous Approach					
47538	Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access	$5,498	$3,826	$226	$3,660
47539	new access, without placement of separate biliary drainage catheter	$5,498	$2,705	$411	$4,116
47540	new access, with placement of separate biliary drainage catheter (eg, external or internal-external)	$5,498	$3,807	$423	$4,107
Open Surgical Approach					
47801	Placement of choledochal stent	----	Non-Covered	$1,116	----

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. Rates are from CY 2024 Hospital Outpatient Prospective Payment System Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

C. Rates are from the CY 2024 Ambulatory Surgical Center Payment Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

D. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

***Per CMS-1786-F, device-intensive procedures require the reporting of a device HCPCS code. Device code reporting requirements apply.**

Biliary Endoprosthesis

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE/ CODE RANGE	REIMBURSEMENT
		MS-DRG[B]
Dilation of Right Hepatic Duct/Left Hepatic Duct/Common Hepatic Duct/Cystic Duct/Common Bile Duct/Ampulla of Vater/Pancreatic Duct/Pancreatic Duct Accessory with Intraluminal Device, Percutaneous Approach	0F753DZ-0F7F3DZ	These non-OR status procedures can be included in but not limited to DRGs in MDC 07: "Diseases and Disorders of the Hepatobiliary System and Pancreas" (405-446)
Dilation of Right Hepatic Duct/Left Hepatic Duct/Common Hepatic Duct/Cystic Duct/Common Bile Duct/Ampulla of Vater/Pancreatic Duct/ Pancreatic Duct Accessory with Intraluminal Device, Percutaneous Endoscopic Approach	0F754DZ-0F7F4DZ	
Dilation of Right Hepatic Duct/Left Hepatic Duct/Common Hepatic Duct/Cystic Duct/Common Bile Duct/Ampulla of Vater/Pancreatic Duct/Pancreatic Duct Accessory with Intraluminal Device, Via Natural or Artificial Opening Endoscopic Approach	0F758DZ-0F7F8DZ	
Extirpation of Right Hepatic Duct/Left Hepatic Duct/Common Hepatic Duct/Cystic Duct/Common Bile Duct/Ampulla of Vater/Pancreatic Duct/Pancreatic Duct Accessory, Via Natural or Artificial Opening Endoscopic Approach	0FC58ZZ-0FCF8ZZ	
Removal of Intraluminal Device from Hepatobiliary/Pancreatic Duct, Via Natural or Artificial Opening Endoscopic Approach	0FPB8DZ, 0FPD8DZ	

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

Dialysis Vascular Access

Coverage, Coding and Reimbursement Overview — Hospital Outpatient, ASC, Physician in Facility and Global Office

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital Outpatient & ASC rates effective January 1, 2024 through December 1, 2024. Physician rates effective March 9, 2024 through December 31, 2024.

PROCEDURE		REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 Rate[B]	ASC 2024 Rate[C]	MPFS Physician in Facility 2024 Rate[D]	MPFS Total in Office 2024 Rate[D]
Device Code*					
C1768	Graft, vascular	----	----	----	----
C1874	Stent, coated/covered, with delivery system	----	----	----	----
CREATION					
Procedure					
36818	Arteriovenous anastomosis, open; by upper arm cephalic vein transposition	$5,236	$2,903	$674	-----
36819	by upper arm basilic vein transposition	$5,236	$2,903	$714	-----
36820	by forearm vein transposition	$5,236	$2,903	$710	-----
36821	direct, any site (eg, Cimino type) (separate procedure)	$3,037	$1,548	$645	-----
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft	$5,236	$2,903	$776	-----
36830	nonautogenous graft (eg, biological collagen, thermoplastic graft)	$5,236	$2,903	$652	-----
Imaging					
36005	Injection procedure for extremity venography (including introduction of needle or intracatheter)	----	Packaged	$46	$249
75820	Venography, extremity, unilateral, radiological supervision and interpretation	$1,526	Packaged	$48	$108
75822	Venography, extremity, bilateral, radiological supervision and interpretation	$1,526	$78	$68	$133
93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study	$105	Non-Covered	$21	$119
93985	Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study	$233	$127	$37	$247
93986	complete unilateral study	$105	$57	$23	$145
MAINTENANCE					
36831	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	$5,236	$2,903	$604	-----

Dialysis Vascular Access Hospital Outpatient, ASC, Physician in Facility and Global Office cont.

PROCEDURE		REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 Rate[B]	ASC 2024 Rate[C]	MPFS Physician in Facility 2024 Rate[D]	MPFS Total in Office 2024 Rate[D]
MAINTENANCE					
Procedure					
36832	Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	$5,236	$2,903	$740	-----
36833	with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	$5,236	$2,903	$789	-----
36838	Distal revascularization and interval ligation (DRIL), upper extremity hemodialysis access (steal syndrome)	$5,236	Non-Covered	$1,112	-----
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;	$1,526	$554	$163	$692
36902	with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$5,446	$2,526	$233	$1,183
36903	with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	$10,482	$6,926	$306	$4,145
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);	$5,446	$3,221	$357	$1,770
36905	with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$10,482	$6,103	$428	$2,225
36906	with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	$16,707	$11,281	$495	$5,275

Dialysis Vascular Access Hospital Outpatient, ASC, Physician in Facility and Global Office cont.

PROCEDURE		REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 Rate[B]	ASC 2024 Rate[c]	MPFS Physician in Facility 2024 Rate[D]	MPFS Total in Office 2024 Rate[D]
MAINTENANCE					
Procedure					
+36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	----	Packaged	$142	$577
+36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	----	Packaged	$201	$1,382
+36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	----	Packaged	$195	$1,849
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	$5,446	$3,450	$431	$2,850
Other					
90940	Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method	----	Non-Covered	Non-Covered	Non-Covered
93990	Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)	$105	Non-Covered	$23	$147

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. Rates are from CY 2024 Hospital Outpatient Prospective Payment System Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

C. Rates are from the CY 2024 Ambulatory Surgical Center Payment Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

D. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

***Per CMS-1786-F, device-intensive procedures require the reporting of a device HCPCS code. Device code reporting requirements apply.**

Dialysis Vascular Access

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE/ CODE RANGE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
Bypass Right/Left Subclavian Artery to Upper Arm Vein with Synthetic Substitute, Open Approach	03130JD, 03140JD	252 253 254	3.4302 2.5529 1.7493	$24,413 $18,169 $12,450
Bypass Right/Left Axillary Artery to Upper Arm Vein with Synthetic Substitute, Open Approach	03150JD, 03160JD			
Bypass Right/Left Brachial Artery to Upper Arm Vein with Synthetic Substitute, Open Approach	03170JD, 03180JD	264 673 674 675	3.4949 4.1900 2.3083 1.5652	$24,873 $29,820 $16,428 $11,140
Bypass Right Ulnar/Radial Artery to Lower Arm Vein with Synthetic Substitute, Open Approach	03190JF, 031B0JF			
Bypass Left Ulnar/Radial Artery to Lower Arm Vein with Synthetic Substitute, Open Approach	031A0JF, 031C0JF			

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.

D. Rates per CMS 1808-F.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions:

DRG 252 Other vascular procedures with MCC
DRG 253 Other vascular procedures with CC
DRG 254 Other vascular procedures without CC/MCC
DRG 264 Other circulatory system O.R. procedures
DRG 673 Other kidney and urinary tract procedures with MCC
DRG 674 Other kidney and urinary tract procedures with CC
DRG 675 Other Kidney and urinary tract procedures without CC/MCC

Endovascular Stent and Stent-Graft Placement with Adjunctive Therapy for Arterial Disease

Coverage, Coding and Reimbursement Overview — Hospital Outpatient, ASC, Physician in Facility and Global Office

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital Outpatient & ASC rates effective January 1, 2024 through December 31, 2024. Physician rates effective March 9, 2024 through December 31, 2024.

CODING	PROCEDURE[A]	REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 Rate[B]	ASC 2024 Rate[C]	MPFS Physician in Facility 2024 Rate[D]	MPFS Total in Office 2024 Rate[D]
Device Code*					
C1874	Stent, coated/covered, with delivery system	----	----	----	----
Procedure with Imaging Supervision and Interpretation					
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$5,446	$3,273	$387	$2,452
37221	with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$10,481	$6,767	$477	$3,010
+37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	----	Packaged	$179	$605
+37223	with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	----	Packaged	$205	$1,241
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	$5,446	$3,450	$431	$2,850
37225	with atherectomy, includes angioplasty within the same vessel, when performed	$16,707	$11,687	$580	$8,545
37226	with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$10,481	$7,024	$502	$7,915
37227	with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$16,707	$11,864	$693	$10,912
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$10,481	$6,330	$524	$4,039
37229	with atherectomy, includes angioplasty within the same vessel, when performed	$16,707	$11,088	$671	$8,695
37230	with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$16,707	$10,728	$671	$8,709
37231	with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$16,707	$11,972	$711	$11,498

Endovascular Stent Hospital Outpatient, ASC, Physician in Facility and Global Office cont.

CODING	PROCEDURE[A]	REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 Rate[B]	ASC 2024 Rate[C]	MPFS Physician in Facility 2024 Rate[D]	MPFS Total in Office 2024 Rate[D]
Procedure with Imaging Supervision and Interpretation					
+37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	----	Packaged	$193	$804
+37233	with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	----	Packaged	$312	$1,032
+37234	with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	----	Packaged	$272	$3,551
+37235	with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	----	Packaged	$356	$3,857
Other Procedures with Imaging Supervision and Interpretation					
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	$10,481	$6,611	$427	$2,686
+37237	each additional artery (List separately in addition to code for primary procedure)	----	Packaged	$205	$1,263
C9765	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	$16,707	$11,744	----	----
C9767	Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	$16,707	$12,341	----	----
C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed	$16,707	$11,402	----	----
C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed	$16,707	$12,216	----	----

Endovascular Stent Hospital Outpatient, ASC, Physician in Facility and Global Office cont.

CODING	PROCEDURE[A]	REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 Rate[B]	ASC 2024 Rate[C]	MPFS Physician in Facility 2024 Rate[D]	MPFS Total in Office 2024 Rate[D]
MAINTENANCE					
Diagnostic Angiography					
75625	Aortography, abdominal, by serialography, radiological supervision and interpretation	$3,037	Packaged	$66	$126
75630	Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation	$3,037	Packaged	$92	$156
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	$3,037	Packaged	$81	$150
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	$3,037	Packaged	$91	$162
+75774	Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)	----	Packaged	$45	$96
Other					
93925	Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study	$233	Non-Covered	$37	$240
93926	unilateral or limited study	$105	Non-Covered	$23	$144
+37252	Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (List separately in addition to code for primary procedure)	----	Packaged	$86	$927
+37253	each additional noncoronary vessel (List separately in addition to code for primary procedure)	----	Packaged	$69	$170

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. Rates are from CY 2024 Hospital Outpatient Prospective Payment System Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

C. Rates are from the CY 2024 Ambulatory Surgical Center Payment Final Rule, CMS-1786-F Centers for Medicare and Medicaid Services.

D. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

***Per CMS-1786-F, device-intensive procedures require the reporting of a device HCPCS code. Device code reporting requirements apply.**

Endovascular Stent and Stent-Graft Placement with Adjunctive Therapy for Peripheral Arterial Disease

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE/ CODE RANGE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
Dilation of Right/Left Common Iliac Artery, Right/Left Internal Iliac Artery, Right/Left External Iliac Artery, Right/Left Femoral Artery, Right/Left Popliteal Artery, Right/Left Anterior Tibial Artery, Right/Left Posterior Tibial Artery, Right/Left Peroneal Artery, with Intraluminal Device, Percutaneous Approach	047C3DZ-047U3DZ	252 253 254	3.4302 2.5529 1.7493	$24,413 $18,169 $12,450

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.

D. Rates per CMS 1808-F.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions:

DRG 252 Other vascular procedures with MCC

DRG 253 Other vascular procedures with CC

DRG 254 Other vascular procedures without CC/MCC

Hernia Repair

Coverage, Coding and Reimbursement Overview — Hospital Outpatient (Facility), ASC & Physician in Facility

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital Outpatient & ASC rates effective January 1, 2024 through December 31, 2024. Physician rates effective March 9, 2024 through December 31, 2024.

CODING		REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 SI[B]	HOPPS 2024 Rate[C]	ASC 2024 Rate[D]	MPFS Physician in Facility 2024 Rate[E]
Device Code*					
C1781	Mesh, Implantable	N	----	----	----
Procedure (Non-Inguinal)					
DIAPHRAGMATIC REPAIR					
39503	Repair, neonatal diaphragmatic hernia, with or without chest tube insertion and with or without creation of ventral hernia	C	----	Non-Covered	$5,692
39540	Repair, diaphragmatic hernia (other than neonatal), traumatic; acute	C	----	Non-Covered	$864
39541	chronic	C	----	Non-Covered	$928
ANTERIOR ABDOMINAL HERNIA REPAIR, INITIAL					
49591	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including placement of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible	J1	$3,296	$1,622	$341
49592	less than 3 cm, incarcerated or strangulated	J1	$5,498	$2,705	$474
49593	3 cm to 10 cm, reducible	J1	$3,296	$1,622	$571
49594	3 cm to 10 cm, incarcerated	J1	$5,498	$2,705	$743
49595	greater than 10 cm, reducible	J1	$3,296	$1,622	$768
49596	greater than 10 cm, incarcerated or strangulated	C	----	Non-Covered	$1,019
ANTERIOR ABDOMINAL HERNIA REPAIR, RECURRENT					
49613	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible	J1	$3,296	$1,622	$420
49614	less than 3 cm, incarcerated or strangulated	J1	$5,498	$2,705	$569
49615	3 cm to 10 cm, reducible	J1	$3,296	$1,622	$636
49616	3 cm to 10 cm, incarcerated	C	----	Non-Covered	$855
49617	greater than 10 cm, reducible	C	----	Non-Covered	$881
49618	greater than 10 cm, reducible	C	----	Non-Covered	$1,234

Hernia Repair Hospital Outpatient, ASC & Physician in Facility cont.

CODING	PROCEDURE[A]	REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 SI[B]	HOPPS 2024 Rate[C]	ASC 2024 Rate[D]	MPFS Physician in Facility 2024 Rate[E]
Procedure (Non-Inguinal)					
FEMORAL HERNIA REPAIR					
49550	Repair initial femoral hernia, any age; reducible	J1	$3,296	$1,622	$582
49553	incarcerated or strangulated	J1	$3,296	$1,622	$636
49555	Repair recurrent femoral hernia; reducible	J1	$3,296	$1,622	$608
49557	incarcerated or strangulated	J1	$3,296	$1,622	$726
LAPAROSCOPIC HERNIA REPAIR					
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	J1	$9,808	Non-Covered	$1,529
43282	with implantation of mesh	J1	$9,808	Non-Covered	$1,722
+43283	Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	C	----	Non-Covered	$155
49659	Unlisted laparoscopy procedure, hernioplasty, herniorrhaphy, herniotomy	J1	$5,498	Non-Covered	Carrier Priced
LUMBAR HERNIA REPAIR					
49540	Repair lumbar hernia	J1	$5,498	$2,705	$674
OMPHALOCELE HERNIA REPAIR					
49600	Repair of small omphalocele, with primary closure	J1	$3,296	$1,622	$738
49605	Repair of large omphalocele or gastroschisis; with or without prosthesis	C	----	Non-Covered	$4,882
49606	with removal of prosthesis, final reduction and closure, in operating room	C	----	Non-Covered	$1,135
49610	Repair of omphalocele (Gross type operation); first stage	C	----	Non-Covered	$698
49611	second stage	C	----	Non-Covered	$615

Hernia Repair Hospital Outpatient, ASC & Physician in Facility cont.

CODING	PROCEDURE[A]	REIMBURSEMENT			
HCPCS/CPT® Code[A]	Description	HOPPS 2024 SI[B]	HOPPS 2024 Rate[C]	ASC 2024 Rate[D]	MPFS Physician in Facility 2024 Rate[E]
Procedure (Non-Inguinal)					
PARAESOPHAGEAL HERNIA REPAIR					
43332	Repair, paraesophageal hiatal hernia (including fundoplication), via laparotomy, except neonatal; without implantation of mesh or other prosthesis	C	----	Non-Covered	$1,144
43333	with implantation of mesh or other prosthesis	C	----	Non-Covered	$1,253
43334	Repair, paraesophageal hiatal hernia (including fundoplication), via thoracotomy, except neonatal; without implantation of mesh or other prosthesis	C	----	Non-Covered	$1,222
43335	with implantation of mesh or other prosthesis	C	----	Non-Covered	$1,313
43336	Repair, paraesophageal hiatal hernia, (including fundoplication), via thoracoabdominal incision, except neonatal; without implantation of mesh or other prosthesis	C	----	Non-Covered	$1,426
43337	with implantation of mesh or other prosthesis	C	----	Non-Covered	$1,519
+43338	Esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code for primary procedure)	C	----	Non-Covered	$112
PARASTOMAL HERNIA REPAIR					
49621	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including placement of mesh or other prosthesis, when performed; reducible	C	----	Non-Covered	$739
49622	incarcerated or strangulated	C	----	Non-Covered	$911
REMOVAL OF NON-INFECTED MESH					
+49623	Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic)	N	----	Non-Covered	$196
REMOVAL OF INFECTED MESH					
+11008	Removal of prosthetic material or mesh, abdominal wall for infection (eg, for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)	C	----	Non-Covered	$269

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. Status Indicators: C-Inpatient Only procedure; J1-Hospital Part B Services Paid Through a Comprehensive APC; N-Items and Services Packaged into APC Rates; Q1-STV-Packaged Codes; Q2-T-Packaged Codes; S-Procedure or Service, Not Discounted When Multiple; T-Procedure or Service, Multiple Procedure Reduction Applies

C. Rates are from CY 2024 Hospital Outpatient Prospective Payment System Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

D. Rates are from the CY 2024 Ambulatory Surgical Center Payment Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

E. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

***Per CMS-1786-F, device-intensive procedures require the reporting of a device HCPCS code. Device code reporting requirements apply.**

Hernia Repair

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE/ CODE RANGE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
ANTERIOR ABDOMINAL WALL REPAIR				
Supplement Abdominal Wall with Synthetic Substitute, Open/Percutaneous Endoscopic Approach	0WUF0JZ, 0WUF4JZ	353 354 355	2.9328 1.7011 1.3331	$20,873 $12,107 $9,488
ANTERIOR ABDOMINAL WALL REPAIR, STOMA				
Repair Abdominal Wall, Stoma, External Approach	0WQFXZ2	347 348 349	2.3666 1.2588 0.8809	$16,843 $8,959 $6,269
DIAPHRAGMATIC REPAIR				
Supplement Diaphragm with Synthetic Substitute, Open/Percutaneous Endoscopic Approach	0BUT0JZ, 0BUT4JZ	326 327 328	5.0787 2.4281 1.5934	$36,145 $17,281 $11,340
FEMORAL REPAIR				
Supplement Right Femoral Region with Synthetic Substitute, Open/ Percutaneous Endoscopic Approach	0YU70JZ, 0YU74JZ	350 351 352	2.4198 1.5047 1.1025	$17,222 $10,709 $7,847
Supplement Left Femoral Region with Synthetic Substitute, Open/ Percutaneous Endoscopic Approach	0YU80JZ, 0YU84JZ			
Supplement Bilateral Femoral Region with Synthetic Substitute, Open/Percutaneous Endoscopic Approach	0YUE0JZ, 0YUE4JZ			

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.
B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.
C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.
D. Rates per CMS 1808-F.
***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions:

DRG 326 Stomach, esophageal, and duodenal procedures with MCC
DRG 327 Stomach, esophageal, and duodenal procedures with CC
DRG 328 Stomach, esophageal, and duodenal procedures without CC/MCC
DRG 347 Anal and stomal procedures with MCC
DRG 348 Anal and stomal procedures with CC
DRG 349 Anal and stomal procedures without CC/MCC
DRG 350 Inguinal and femoral hernia procedures with MCC
DRG 351 Inguinal and femoral hernia procedures with CC
DRG 352 Inguinal and femoral hernia procedures without CC/MCC
DRG 353 Hernia procedures except inguinal and femoral with MCC
DRG 354 Hernia procedures except inguinal and femoral with CC
DRG 355 Hernia procedures except inguinal and femoral without CC/MCC

Surgical Bypass Grafting with Other Than Vein for Peripheral Arterial Disease

Coverage, Coding and Reimbursement Overview — Physician in Facility

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Physician rates effective March 9, 2024 through December 31, 2024.

PROCEDURE[A]		REIMBURSEMENT		
CPT® Code[A]	Description	2023 Total Professional/ Facility RVUs[B]	2023 Global Surgery Indicator[C]	2023 Rate[B]
35601	Bypass graft, with other than vein; common carotid-ipsilateral internal carotid	41.00	090	$1,365
35606	carotid-subclavian	34.45	090	$1,147
35612	subclavian-subclavian	30.68	090	$1,021
35616	subclavian-axillary	32.28	090	$1,075
35621	axillary-femoral	32.10	090	$1,069
35623	axillary-popliteal or -tibial	38.51	090	$1,282
35626	aortosubclavian, aortoinnominate, or aortocarotid	46.54	090	$1,549
35631	aortoceliac, aortomesenteric, aortorenal	54.22	090	$1,805
35632	ilio-celiac	52.88	090	$1,760
35633	ilio-mesenteric	58.00	090	$1,931
35634	iliorenal	51.75	090	$1,723
35636	splenorenal (splenic to renal arterial anastomosis)	46.70	090	$,1555
35637	aortoiliac	48.55	090	$1,616
35638	aortobi-iliac	50.75	090	$1,689
35642	carotid-vertebral	29.02	090	$966
35645	subclavian-vertebral	27.80	090	$925
35646	aortobifemoral	49.88	090	$1,660
35647	aortofemoral	45.37	090	$1,510

Surgery Bypass Graft w/ Other Than Vein of Peripheral Artery Disease Physician in Facility cont.

PROCEDURE[A]		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional/ Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
35650	axillary-axillary	29.94	090	$997
35654	axillary-femoral-femoral	39.91	090	$1,328
35656	femoral-popliteal	31.40	090	$1,045
35661	femoral-femoral	31.71	090	$1,056
35663	ilioiliac	35.73	090	$1,189
35665	iliofemoral	34.38	090	$1,144
35666	femoral-anterior tibial, posterior tibial, or peroneal artery	37.71	090	$1,255
35671	popliteal-tibial or -peroneal artery	33.20	090	$1,105

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

C. Status Indicators: 000-global postoperative period is day of surgical procedure; 090-global postoperative period is 90 days from the date of surgery; XXX-global concept does not apply to the code; YYY-contractor-priced codes, for which MACs determine the global period; ZZZ-related to another service and is always included in the global period of the other service.

Surgical Bypass Grafting with Other Than Vein for Peripheral Arterial Disease

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE/ CODE RANGE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
GREAT HEART AND VESSELS				
Bypass Descending Thoracic Aorta to Innominate/Subclavian/Carotid with Synthetic Substitute, Open Approach	021W0JA, 021W0JB, 021W0JD	037 038 039	3.3207 1.6111 1.1382	$23,633 $11,466 $8,101
Bypass Ascending/Arch Thoracic Aorta to Innominate/Subclavian/Carotid with Synthetic Substitute, Open Approach	021X0JA, 021X0JB, 021X0JD	270 271 272	5.1328 3.4444 2.5020	$36,530 $24,514 $17,807
UPPER ARTERIES				
Bypass Innominate Artery to Right/Left/Bilateral Upper/Lower Arm/Leg Artery with Synthetic Substitute, Open Approach	03120J0-03120JC			
Bypass Right Subclavian Artery to Right/Left/Bilateral Upper/Lower Arm/Leg Artery with Synthetic Substitute, Open Approach	03130J0-03130JC			
Bypass Left Subclavian Artery to Right/Left/Bilateral Upper/Lower Arm/Leg with Synthetic Substitute, Open Approach	03140J0-03140JC			
Bypass Right Subclavian Artery to Right/Left Extracranial Artery with Synthetic Substitute, Open Approach	03130JJ, 03130JK	252	3.4302	$24,413
Bypass Left Subclavian Artery to Right/Left Extracranial Artery with Synthetic Substitute, Open Approach	03140JJ, 03140JK	253 254	2.5529 1.7493	$18,169 $12,450
Bypass Right Axillary Artery to Right/Left/Bilateral Upper/Lower Arm/Leg/Abdominal Artery with Synthetic Substitute, Open Approach	03150J0-03150JC, 03150JT			
Bypass Left Axillary Artery to Right/Left/Bilateral Upper/Lower Arm/Leg/Abdominal Artery with Synthetic Substitute, Open Approach	03160J0-03160JC, 03160JT			
Bypass Right Brachial Artery to Right Upper/Lower Arm Artery with Synthetic Substitute, Open Approach	03170J0, 03170J3			

Surgery Bypass Graft w/ Other Than Vein of Peripheral Artery Disease Hospital (Facility) Inpatient cont.

DESCRIPTION[A]	ICD-10-PCS CODE/ CODE RANGE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
UPPER ARTERIES				
Bypass Left Brachial Artery to Left Upper/Lower Arm Artery with Synthetic Substitute, Open Approach	03180J1, 03180J4	252 253 254	3.4302 2.5529 1.7493	$24,413 $18,169 $12,450
Bypass Right Ulnar Artery to Right Lower Arm Artery with Synthetic Substitute, Open Approach	03190J3			
Bypass Left Ulnar Artery to Left Lower Arm Artery with Synthetic Substitute, Open Approach	031A0J4			
Bypass Right Radial Artery to Right Lower Arm Artery with Synthetic Substitute, Open Approach	031B0J3			
Bypass Left Radial Artery to Left Lower Arm Artery with Synthetic Substitute, Open Approach	031C0J4			
Bypass Right Common Carotid Artery to Right, Left Extracranial/Upper Artery with Synthetic Substitute, Open Approach	031H0JJ-031H0JY	037 038 039 252 253 254	3.3207 1.6111 1.1382 3.4302 2.5529 1.7493	$23,633 $11,466 $8,101 $24,413 $18,169 $12,450
Bypass Left Common Carotid Artery to Right, Left Extracranial/Upper Artery with Synthetic Substitute, Open Approach	031J0JJ-031J0JY			
Bypass Right Internal Carotid Artery to Right/Left Extracranial Artery with Synthetic Substitute, Open Approach	031K0JJ, 031K0JK			
Bypass Left Internal Carotid Artery to Right/Left Extracranial Artery with Synthetic Substitute, Open Approach	031L0JJ, 031L0JK			
Bypass Right External Carotid Artery to Right/Left Extracranial Artery with Synthetic Substitute, Open Approach	031M0JJ, 031M0JK			
Bypass Left External Carotid Artery to Right/Left Extracranial Artery with Synthetic Substitute, Open Approach	031N0JJ, 031N0JK			

Surgery Bypass Graft w/ Other Than Vein of Peripheral Artery Disease Hospital (Facility) Inpatient cont.

DESCRIPTION[A]	ICD-10-PCS CODE/ CODE RANGE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
LOWER ARTERIES				
Bypass Abdominal Aorta to Right/Left/Bilateral Renal Artery with Synthetic Substitute, Open Approach	04100J3-04100J5	268 269	6.6672 4.1604	$47,451 $29,610
Bypass Abdominal Aorta to Abdominal Aorta/Celiac/Mesenteric/Right, Left, Bilateral Common Iliac/Right, Left, Bilateral Internal Iliac/Right, Left, Bilateral External Iliac/Right, Left, Bilateral Femoral/Lower Extremity Artery/Lower Artery with Synthetic Substitute, Open Approach	04100J0-04100J2, 04100J6-04100JR			
Bypass Splenic Artery to Right/Left/Bilateral Renal Artery with Synthetic Substitute, Open Approach	04140J3-04140J5			
Bypass Right Common Iliac Artery to Abdominal Aorta/Celiac/Mesenteric/Right, Left, Bilateral Renal/Right, Left, Bilateral Common Iliac/Right, Left, Bilateral Internal Iliac/Right, Left, Bilateral External Iliac/Right, Left, Bilateral Femoral/Lower Extremity Artery/Lower Artery with Synthetic Substitute, Open Approach	041C0J0-041C0JR			
Bypass Left Common Iliac Artery to Abdominal Aorta/Celiac/Mesenteric/Right, Left, Bilateral Renal/Right, Left, Bilateral Common Iliac/Right, Left, Bilateral Internal Iliac/Right, Left, Bilateral External Iliac/Right, Left, Bilateral Femoral/Lower Extremity Artery/Lower Artery with Synthetic Substitute, Open Approach	041D0J0-041D0JR			
Bypass Right Internal Iliac Artery to Right, Left, Bilateral Internal Iliac/Right, Left, Bilateral External Iliac/Right, Left, Bilateral Femoral/Foot Artery/Lower Extremity Artery with Synthetic Substitute, Open Approach	041E0J9-041E0JQ	270 271 272	5.1328 3.4444 2.5020	$36,530 $24,514 $17,807
Bypass Left Internal Iliac Artery to Right, Left, Bilateral Internal Iliac/Right, Left, Bilateral External Iliac/Right, Left, Bilateral Femoral/Foot Artery/Lower Extremity Artery with Synthetic Substitute, Open Approach	041F0J9-041F0JQ			
Bypass Right External Iliac Artery to Right, Left, Bilateral Internal Iliac/Right, Left, Bilateral External Iliac/Right, Left, Bilateral Femoral/Foot Artery/Lower Extremity Artery with Synthetic Substitute, Open Approach	041H0J9-041H0JQ			
Bypass Left External Iliac Artery to Right, Left, Bilateral Internal Iliac/Right, Left, Bilateral External Iliac/Right, Left, Bilateral Femoral/Foot Artery/Lower Extremity Artery with Synthetic Substitute, Open Approach	041J0J9-041J0JQ			
Bypass Left External Iliac Artery to Right, Left, Bilateral Internal Iliac/Right, Left, Bilateral External Iliac/Right, Left, Bilateral Femoral/Foot Artery/Lower Extremity Artery with Synthetic Substitute, Open Approach	041J0J9-041J0JQ			

Surgery Bypass Graft w/ Other Than Vein of Peripheral Artery Disease Hospital (Facility) Inpatient cont.

DESCRIPTION[A]	ICD-10-PCS CODE/ CODE RANGE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
LOWER ARTERIES				
Bypass Right Femoral Artery to Right, Left, Bilateral Femoral/Popliteal/Peroneal/Posterior Tibial/Foot/Lower Extremity Artery with Synthetic Substitute, Open Approach	041K0JH-041K0JQ			
Bypass Left Femoral Artery to Right, Left, Bilateral Femoral/Popliteal/Peroneal/Posterior Tibial/Foot/Lower Extremity Artery with Synthetic Substitute, Open Approach	041L0JH-041L0JQ			
Bypass Right Popliteal Artery to Popliteal/Peroneal/Foot/Lower Extremity Artery with Synthetic Substitute, Open Approach	041M0JL-041M0JQ			
Bypass Left Popliteal Artery to Popliteal/Peroneal/Foot/Lower Extremity Artery with Synthetic Substitute, Open Approach	041N0JL-041N0JQ			
Bypass Right Anterior Tibial Artery to Lower Extremity Artery with Synthetic Substitute, Open Approach	041P0JQ	252	3.4302	$24,413
Bypass Left Anterior Tibial Artery to Lower Extremity Artery with Synthetic Substitute, Open Approach	041Q0JQ	253	2.5529	$18,169
Bypass Right Posterior Tibial Artery to Lower Extremity Artery with Synthetic Substitute, Open Approach	041R0JQ	254	1.7493	$12,450
Bypass Left Posterior Tibial Artery to Lower Extremity Artery with Synthetic Substitute, Open Approach	041S0JQ			
Bypass Right Peroneal Artery to Foot/Lower Extremity Artery with Synthetic Substitute, Open Approach	041T0JP, 041T0JQ			
Bypass Left Peroneal Artery to Foot/Lower Extremity Artery with Synthetic Substitute, Open Approach	041U0JP, 041U0JQ			
Bypass Right Foot Artery to Foot/Lower Extremity Artery with Synthetic Substitute, Open Approach	041V0JP, 041V0JQ			
Bypass Left Foot Artery to Foot/Lower Extremity Artery with Synthetic Substitute, Open Approach	041W0JP, 041W0JQ			

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.

D. Rates per CMS 1808-F.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions

DRG 037 Extracranial procedures with MCC
DRG 038 Extracranial procedures with CC
DRG 039 Extracranial procedures without CC/MCC
DRG 252 Other vascular procedures with MCC
DRG 253 Other vascular procedures with CC
DRG 254 Other vascular procedures without CC/MCC
DRG 268 Aortic and heart assist procedures except pulsation balloon with MCC
DRG 269 Aortic and heart assist procedures except pulsation balloon without MCC
DRG 270 Other major cardiovascular procedures with MCC
DRG 271 Other major cardiovascular procedures with CC
DRG 272 Other major cardiovascular procedures without CC/MCC

Transvenous Intrahepatic Portosystemic Shunt (TIPS)

Coverage, Coding and Reimbursement Overview — Hospital Outpatient (Facility), Ambulatory Surgical Center & Physician in Facility

2024 Edition – All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do not Include the 2% Sequestration Reduction

Hospital Outpatient & ASC rates effective January 1, 2024 through December 31, 2024. Physician rates effective March 9, 2024 through December 31, 2024.

CODING	PROCEDURE	REIMBURSEMENT			
HCPCS/CPT® Code[A]		HOPPS 2024 Rate[B]	ASC 2024 Rate[C]	MPFS Physician in Facility 2024 Rate[D]	MPFS Total in Office 2024 Rate[D]
Device Code*					
C1874	Stent, coated/covered, with delivery system	----	----	----	----
Procedure					
37182	Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)	----	Non-Covered	$787	-----
37183	Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)	$5,446	Non-Covered	$361	$5,666
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)	$10,482	$6,105	$414	$4,516
36012	Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)	----	Packaged	$169	$818

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. Rates are from CY 2024 Hospital Outpatient Prospective Payment System Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

C. Rates are from the CY 2024 Ambulatory Surgical Center Payment Final Rule, CMS-1786-F, Centers for Medicare and Medicaid Services.

D. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

***Per CMS-1786-F, device-intensive procedures require the reporting of a device HCPCS code. Device code reporting requirements apply.**

Transvenous Intrahepatic Portosystemic Shunt (TIPS)

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
Bypass Portal Vein to Hepatic Vein/Lower Vein with Synthetic Substitute, Percutaneous Approach	06183J4, 06183JY	405 406 407	5.4284 2.8082 2.1356	$38,634 $19,986 $15,199
Bypass Portal Vein to Hepatic Vein/Lower Vein with Synthetic Substitute, Percutaneous Endoscopic Approach	06184J4, 06184JY			

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F, Table 5.

D. Rates per CMS 1808-F.

***Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.**

MS-DRG Descriptions

DRG 405 Pancreas, liver and shunt procedures with MCC

DRG 406 Pancreas, liver and shunt procedures with CC

DRG 407 Pancreas, liver and shunt procedures without CC/MCC

Bariatric/Staple Line Reinforcement

Coverage, Coding and Reimbursement Overview — Physician in Facility

2024 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Physician in Facility rates effective March 9, 2024 through December 31, 2024.

PROCEDURE		REIMBURSEMENT		
CPT® Code[A]	Description	2024 Total Professional/ Facility RVUs[B]	2024 Global Surgery Indicator[C]	2024 Rate[B]
LAPAROSCOPIC APPROACH				
43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	52.09	090	$1,734
43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	55.34	090	$1,842
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	33.03	090	$1,099
OPEN APPROACH				
43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	----	----	----
43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	38.59	090	$1,285
43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	58.74	090	$1,955
43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy	49.59	090	$1,651
43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	54.24	090	$1,806
OPEN REVISION				
43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	58.07	090	$1,933
43860	Revision of gastrojejunal anastomosis (gastrojejunostomy) with reconstruction, with or without partial gastrectomy or intestine resection; without vagotomy	49.01	090	$1,631

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. 2024 national rates calculated with 2024 conversion factor effective March 9, 2024 of $33.2875 from the Consolidated Appropriations Act, 2024.

C. Status Indicators: 000-global postoperative period is day of surgical procedure; 090-global postoperative period is 90 days from the date of surgery; XXX-global concept does not apply to the code; YYY-contractor-priced codes, for which MACs determine the global period; ZZZ-related to another service and is always included in the global period of the other service.

Bariatric/Staple Line Reinforcement

Coverage, Coding and Reimbursement Overview — Hospital (Facility) Inpatient

2025 Edition — All Reimbursement Amounts are Listed at National Unadjusted Medicare Rates and Do Not Include the 2% Sequestration Reduction

Hospital (Facility) Inpatient rates effective October 1, 2024 through September 30, 2025.

DESCRIPTION[A]	ICD-10-PCS CODE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
ROUX-EN-Y GASTROENTEROSTOMY				
Bypass Stomach to Jejunum with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute/ No Device, Open Approach	0D1607A, 0D160JA, 0D160KA, 0D160ZA	619 620 621	2.7264 1.5969 1.4617	$19,404 $11,365 $10,403
Bypass Stomach to Jejunum with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute/ No Device, Percutaneous Endoscopic Approach	0D1647A, 0D164JA, 0D164KA, 0D164ZA			
SLEEVE GASTRECTOMY				
Excision of Stomach, Open/Percutaneous Endoscopic Approach, Vertical	0DB60Z3, 0DB64Z3	619 620 621	2.7264 1.5969 1.4617	$19,404 $11,365 $10,403
V-BAND GASTROPLASTY W/WO BAND				
Restriction of Stomach with Extraluminal/Intraluminal/No Device, Open Approach	0DV60CZ, 0DV60DZ, 0DV60ZZ	619 620 621	2.7264 1.5969 1.4617	$19,404 $11,365 $10,403
Restriction of Stomach with Extraluminal/Intraluminal/No Device, Percutaneous Endoscopic Approach	0DV64CZ, 0DV64DZ, 0DV64ZZ			
PARTIAL GASTRECTOMY W/ BILIOPANCREATIC DIVERSION WITH DUODENAL SWITCH (BPD/DS) - 3 step procedure:				
Excision of Stomach, Open/Percutaneous Endoscopic Approach, Vertical	0DB60Z3, 0DB64Z3	619 620 621	2.7264 1.5969 1.4617	$19,404 $11,365 $10,403
Bypass Duodenum to Ileum, Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute/ No Device, Open Approach	0D1907B, 0D190JB, 0D190KB, 0D190ZB			
Bypass Duodenum to Ileum, Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute/ No Device, Percutaneous Endoscopic Approach	0D1947B, 0D194JB, 0D194KB, 0D194ZB			
Bypass Ileum to Ileum, with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute/ No Device, Open Approach	0D1B07B, 0D1B0JB, 0D1B0KB, 0D1B0ZB			
Bypass Ileum to Ileum, with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute/ No Device, Percutaneous Endoscopic Approach	0D1B47B, 0D1B4JB, 0D1B4KB, 0D1B4ZB			

Bariatric/Staple Line Reinforcement Hospital (Facility) Inpatient cont.

DESCRIPTION[A]	ICD-10-PCS CODE	REIMBURSEMENT		
		MS-DRG[B]	Relative Weight[C]	Rate[D]
REVISION/REPAIR ***REPAIR IS ONLY REPORTED WHEN THE METHOD TO ACCOMPLISH THE REPAIR IS NOT ONE OF THE OTHER OPERATIONS**				
Bypass - See Roux-en-Y gastroenterostomy, BPD/DS				
Excision - See Sleeve gastrectomy				
Restriction - See V-band gastroplasty				
*Repair Stomach, Open/Percutaneous Endoscopic Approach	0DQ60ZZ, 0DQ64ZZ	619 620 621	2.7264 1.5969 1.4617	$19,404 $11,365 $10,403
Supplement Stomach with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute, Open Approach	0DU607Z, 0DU60JZ, 0DU60KZ			
Supplement Stomach with Autologous Tissue/ Synthetic/ Nonautologous Substitute, Percutaneous Endoscopic Approach	0DU647Z, 0DU64JZ, 0DU64KZ			
*Repair Duodenum, Open/Percutaneous Endoscopic Approach	0DQ90ZZ, 0DQ94ZZ	326 327 328	5.0790 2.4974 1.5973	$35,561 $17,486 $11,184
*Repair Jejunum, Open/Percutaneous Endoscopic Approach	0DQA0ZZ, 0DQA4ZZ	329 330 331	4.5168 2.3721 1.6720	$31,625 $16,608 $11,707
*Repair Ileum, Open/Percutaneous Endoscopic Approach	0DQB0ZZ, 0DQB4ZZ			
Supplement Duodenum with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute, Open Approach	0DU907Z, 0DU90JZ, 0DU90KZ			
Supplement Duodenum with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	0DU947Z, 0DU94JZ, 0DU94KZ			
Supplement Jejunum with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute, Open Approach	0DUA07Z, 0DUA0JZ, 0DUA0KZ			
Supplement Jejunum with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	0DUA47Z, 0DUA4JZ, 0DUA4KZ			
Supplement Ileum with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute, Open Approach	0DUB07Z, 0DUB0JZ, 0DUB0KZ			
Supplement Ileum with Autologous Tissue/ Synthetic/ Nonautologous Tissue Substitute, Percutaneous Endoscopic Approach	0DUB47Z, 0DUB4JZ, 0DUB4KZ			

Bariatric/Staple Line Reinforcement Hospital (Facility) Inpatient cont.

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.

B. MS-DRG assignment is determined by the patient ICD-10 diagnoses and procedure code(s). Listed are examples of possible MS-DRGs. Injury and trauma not listed.

C. Hospital reimbursement varies significantly based on a number of variables. Relative weight is provided as a constant used in the calculation of individual hospital reimbursement. Relative weights per CMS 1808-F Table 5.

D. Rates per CMS 1808-F.

*Devices typically utilized for inpatient procedures are generally not reported with C codes. Inpatient-only procedures (Status C) are listed in Addendum E, "HCPCS Codes That Will Be Paid Only as Inpatient Procedures" of the Hospital Outpatient Prospective Payment System Final Rule (OPPS) for the current year.

MS-DRG Descriptions:
DRG 619 O.R. procedures for obesity with MCC
DRG 620 O.R. procedures for obesity with CC
DRG 621 O.R. procedures for obesity without CC/MCC
DRG 326 Stomach, esophageal, and duodenal procedures with MCC
DRG 327 Stomach, esophageal, and duodenal procedures with CC
DRG 328 Stomach, esophageal, and duodenal procedures without CC/MCC
DRG 329 Major small and large bowel procedures with MCC
DRG 330 Major small and large bowel procedures with CC
DRG 331 Major small and large bowel procedures without CC/MCC

Tissue Reinforcement Coding Information for the Facility Purchasing Committee

Bioabsorbable Tissue Reinforcement Hospital Outpatient (Facility) & Physician in Facility

2024 Edition

PURPOSE OF THIS INFORMATION

The addition of new products to the facility formulary often involves review by a cross-functional committee. Review may include evaluation for necessary additions or adjustments to, for example, the facility's inventory and charge systems, to appropriately account for the new products. For this administrative purpose, new products are sometimes correlated with the surgical services in which they are commonly used, either alone or in conjunction with other products or materials.

Bioabsorbable tissue reinforcement is intended for use in the reinforcement of soft tissue. Examples of applications where bioabsorbable tissue reinforcement may be used include hernia repair as suture-line reinforcement, muscle flap reinforcement, and general tissue reconstructions. It is contraindicated for reconstruction of cardiovascular defects.

Bioabsorbable tissue reinforcement may be used in a wide spectrum of surgical services, making it impractical to list all service/procedure codes that could be involved. Instead, examples of particular services with which this material could reasonably be used are provided below. Provision of these codes does not imply the clinical appropriateness for use in any particular clinical situation. Clinical appropriateness can only be determined by a physician on a case-by-case basis. Guidance intended for assistance with coding of individual claims for service requires a much greater level of specificity which is beyond the scope of this review. Please refer to appropriate coding resources and specialty coding guides intended for that purpose.

EXAMPLES: SURGICAL INTERVENTIONS POTENTIALLY UTILIZING BIOABSORBABLE TISSUE REINFORCEMENT

CPT® SECTION[A]	EXAMPLES, CPT® CODE RANGE WITHIN SECTION[A]		EXAMPLES, CPT® DESCRIPTIONS AND CODES[A]	
Integumentary	Flaps (Skin and/or Deep Tissues)	15570-15738	Muscle/myocutaneous/fasciocutaneous flap; trunk	15734
	Repair and/or Reconstruction, Breast	19316-19499	Breast reconstruction with free flap	19364
Musculoskeletal	Excision, Neck/Thorax	21550-21632	Radical resection of tumor	21557
	Excision, Back/Flank	21930-21936	Radical resection of tumor	21935
	Excision, Abdomen	22900-22905	Excision of tumor, subfascial	22900
	Excision, Shoulder	23065-23220	Radical resection of tumor	23077
Mediastinal and Diaphragm	Repair, Diaphragm	39501-39561	Resection with complex repair	39561
Digestive	Repair, Esophagus	43300-43425	Repair of paraesophageal hiatal hernia	43333, 43335, 43337
	Excision, Abdomen/ Peritoneum/Omentum	49180-49255	Excision of intra-abdominal tumors	49203-49205
	Repair, Hernia	49491-49999	Repair, incisional or ventral hernia	49591, 49592, 49593, 49594, 49595, 49596

OTHER INFORMATION

HCPCS LEVEL III,III		
Device C Code (Medicare)	Not applicable for status C - Inpatient only procedures. This implant is typically used in inpatient only procedures and therefore does not have an associated C code.	
SUGGESTED COST CENTER	**REVENUE CODE**	**COMMENT**
Implantable Devices Charged to Patients	278 - Other Implants	Refer to CMS 2552-10[B]

A. Listed are common procedures. Review CPT® coding guidelines, modifiers, and NCCI edits for these codes. Current Terminology (CPT®) is a registered trademark of the American Medical Association (AMA). Copyright 2023 AMA. All rights reserved.

B. Medicare Provider Reimbursement Manual P2, Ch 40, Form CMS 2552-10.

Tissue Reinforcement Coding Information for the Facility Purchasing Committee

Bioabsorbable Tissue Reinforcement Hospital (Facility) Inpatient

2025 Edition

PURPOSE OF THIS INFORMATION

The addition of new products to the facility formulary often involves review by a cross-functional committee. Review may include evaluation for necessary additions or adjustments to, for example, the facility's inventory and charge systems, to appropriately account for the new products. For this administrative purpose, new products are sometimes correlated with the surgical services in which they are commonly used, either alone or in conjunction with other products or materials.

Bioabsorbable tissue reinforcement is intended for use in the reinforcement of soft tissue. Examples of applications where bioabsorbable tissue reinforcement may be used include hernia repair as suture-line reinforcement, muscle flap reinforcement, and general tissue reconstructions. It is contraindicated for reconstruction of cardiovascular defects.

Bioabsorbable tissue reinforcement may be used in a wide spectrum of surgical services, making it impractical to list all service/procedure codes that could be involved. Instead, examples of particular services with which this material could reasonably be used are provided below. Provision of these codes does not imply the clinical appropriateness for use in any particular clinical situation. Clinical appropriateness can only be determined by a physician on a case-by-case basis. Guidance intended for assistance with coding of individual claims for service requires a much greater level of specificity which is beyond the scope of this review. Please refer to appropriate coding resources and specialty coding guides intended for that purpose.

EXAMPLES: SURGICAL INTERVENTIONS POTENTIALLY UTILIZING BIOABSORBABLE TISSUE REINFORCEMENT

ICD-10-PCS BODY SYSTEM	EXAMPLES, ICD-10-PCS ROOT OPERATIONS	EXAMPLES, ICD-10-PCS DESCRIPTIONS AND CODES[A]	
Respiratory	Supplement	Supplement Diaphragm with Synthetic Substitute, Open Approach	0BUT0JZ
Muscles	Transfer	Transfer Right/Left Abdomen Muscle, TRAM Flap, Open Approach	0KXK0Z6, 0KXL0Z6
Skin/Breast	Replacement	Replacement of Right/Left/Bilateral Breast using TRAM Flap, Open Approach	0HRT076, 0HRU076, 0HRV076
Anatomical Regions	Supplement	Supplement Abdominal Wall with Synthetic Substitute, Open Approach	0WUF0JZ

OTHER INFORMATION

HCPCS LEVEL III		
Device C Code (Medicare)	Not applicable for status C - Inpatient only procedures. This implant is typically used in inpatient only procedures and therefore does not have an associated C code.	
SUGGESTED COST CENTER	**REVENUE CODE**	**COMMENT**
Implantable Devices Charged to Patients	278 - Other Implants	Refer to CMS 2552-10[B]

A. ICD-10-PCS descriptions are from the Medical and Surgical section unless otherwise specified. Abbreviated ICD-10-PCS descriptions. See ICD-10-PCS codebook for complete descriptions.
B. Medicare Provider Reimbursement Manual P2, Ch 40, Form CMS 2552-10.