ABBOTT CODING GUIDE

AMBULATORY SURGICAL CENTER (ASC) AND OFFICE BASED LAB (OBL) REIMBURSEMENT GUIDE

Effective Dates: January 1, 2022 to December 31, 2022

TABLE OF CONTENTS

PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
ILIAC ARTERY REVASCULARIZATION			
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$393	$2,630
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	$484	$3,245
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)	$182	$636
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$209	$1,341
FEMORAL/POPLITEAL ARTERY REVASCULARIZATION			
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	$436	$3,077
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$589	$9,274
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$510	$8,652
37227	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$705	$11,883
TIBIAL/PERONEAL ARTERY REVASCULARIZATION			
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$531	$4,375
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$682	$9,387
37230	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$683	$9,447
37231	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$722	$12,326
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)	$195	$853
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$318	$1,069

It is incumbent upon the physician to determine which, if any modifiers should be used first.

ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
ILIAC ARTERY REVASCULARIZATION		
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$2,923
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	$6,374
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)	No separate payment
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment
FEMORAL/POPLITEAL ARTERY REVASCULARIZATION		
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	$3,142
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$6,902
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$6,674
37227	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$11,536
TIBIAL/PERONEAL ARTERY REVASCULARIZATION		
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$5,941
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$10,776
37230	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$10,625
37231	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$10,814
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)	No separate payment
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment

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PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
TIBIAL/PERONEAL ARTERY REVASCULARIZATION (CONT'D)			
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$278	$3,806
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$376	$4,073
TRANSLUMINAL BALLOON ANGIOPLASTY			
37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	$340	$1,910
37247	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)	$167	$567
37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	$291	$1,423
37249	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	$142	$457
ARTERIAL MECHANICAL THROMBECTOMY			
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	$422	$1,791
37185	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)	$159	$489
37186	Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)	$239	$1,242
VENOUS MECHANICAL THROMBECTOMY			
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$384	$1,794

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ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
TIBIAL/PERONEAL ARTERY REVASCULARIZATION (CONT'D)		
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment
TRANSLUMINAL BALLOON ANGIOPLASTY		
37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	$2,877
37247	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (List separately in addition to code for primary procedure)	No separate payment
37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	$2,208
37249	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	No separate payment
ARTERIAL MECHANICAL THROMBECTOMY		
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	$6,789
37185	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)	No separate payment
37186	Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)	No separate payment
VENOUS MECHANICAL THROMBECTOMY		
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$6,688

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PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
VENOUS MECHANICAL THROMBECTOMY (CONT'D)			
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$272	$1,533
THROMBOLYSIS			
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	$378	N/A
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	$330	N/A
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	$227	N/A
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	$119	N/A
EMBOLIZATION/CATHETER ACCESS			
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)	$420	$4,907
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)	$463	$7,502
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	$543	$9,050
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	$643	$6,908
36140	Introduction of needle or intracatheter, upper or lower extremity artery	$88	$534
36160	Introduction of needle or intracatheter, aortic, translumbar	$122	$579
36200	Introduction of catheter, aorta	$137	$619
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	$230	$1,292
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	$248	$866
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	$292	$1,481

NA: There is no established Medicare payment in this setting.
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ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
VENOUS MECHANICAL THROMBECTOMY (CONT'D)		
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$1,932
THROMBOLYSIS		
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	$3,167
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	$1,899
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	No separate payment
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	No separate payment
EMBOLIZATION/CATHETER ACCESS		
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)	$5,685
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)	$6,497
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	$4,369
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	No separate payment
36140	Introduction of needle or intracatheter, upper or lower extremity artery	No separate payment
36160	Introduction of needle or intracatheter, aortic, translumbar	No separate payment
36200	Introduction of catheter, aorta	No separate payment
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	No separate payment
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	No separate payment
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	No separte payment

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PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
EMBOLIZATION/CATHETER ACCESS (CONT'D)			
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	$47	$119
DIAGNOSTIC ANGIOGRAPHY LOWER EXTREMITY			
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	$82*	$152
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	$92*	$164
DIALYSIS CIRCUIT			
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 contract, 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	$165	$731
36902	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$235	$1,257
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	$309	$4,525
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 thrombolytic injection(s);	$359	$1,877
36905	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$434	$2,380
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 segment	$499	$5,722
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)	$143	$613
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)	$203	$1,486
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)	$197	$2,029
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)	$121	No separate payment

CPT‡ Code 34713 is applicable only for aortic and iliac artery repair procedures using an endograft. The code may be listed twice for bilateral procedures. This will result in a total payment of 150% of the base payment rate (National Average Payment = $177).

* Modifier 26 signifies the professional component of the hospital based services
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ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
EMBOLIZATION/CATHETER ACCESS (CONT'D)		
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	No separate payment
DIAGNOSTIC ANGIOGRAPHY		
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	NA
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	NA
DIALYSIS CIRCUIT		
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 contract, 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	$558
36902	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$2,208
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	$6,590
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 thrombolytic injection(s);	$2,955
36905	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$5,672
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 segment	$10,903
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)	No separate payment
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)	No separate payment
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)	No separate payment
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)	No separate payment

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PHYSICIAN REIMBURSEMENT FOR CORONARY PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
PCI PROCEDURES			
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$522	NA
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	No separate payment	No separate payment
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$581	NA
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	No separate payment	No separate payment
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	$651	NA
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	$580	NA
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	$652	NA
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	See 92928 for payment	NA
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	No separate payment	No separate payment
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	See 92933 for payment	NA
C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	No separate payment	No separate payment
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	See 92937 for payment	NA
C9605	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)	No separate payment	No separate payment
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	See 92943 for payment	NA
C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	No separate payment	No separate payment
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	$236*	$941

*Modifier 26 signifies the professional component of the hospital based services
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PHYSICIAN REIMBURSEMENT FOR CORONARY PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
PCI PROCEDURES (CONT'D)			
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	$273*	$1,047
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	$305*	$1,170
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	$344*	$1,276
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	$290*	$1,079
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	$329*	$1,160
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	$368*	$1,290
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	$407*	$1,422

*Modifier 26 signifies the professional component of the hospital based services
It is incumbent upon the physician to determine which, if any modifiers should be used first.

ASC REIMBURSEMENT FOR CORONARY PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
PCI PROCEDURES		
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$3,128
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	No separate payment
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$6,113
92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	No separate payment
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$6,405
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	No separate payment
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	No separate payment
C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	No separate payment
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	No separate payment
C9605	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)	No separate payment
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	No separate payment
C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	No separate payment
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	$1,439
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	$1,439
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	$1,439

No Separate Payment expresses that Medicare has no payment associated with those codes in the ASC setting as they do not designate ASCs as an appropriate site of service for those procedures. Some private payers may reimburse these procedures in an ASC according to their policies and contracts with your program. Please verify with your professional coding and billing staff for this information.

It is incumbent upon the physician to determine which, if any modifiers should be used first.

ASC REIMBURSEMENT FOR CORONARY PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
PCI PROCEDURES (CONT'D)		
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	$1,439
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	$1,439
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	$1,439
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	$1,439
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	$1,439

No Separate Payment expresses that Medicare has no payment associated with those codes in the ASC setting as they do not designate ASCs as an appropriate site of service for those procedures. Some private payers may reimburse these procedures in an ASC according to their policies and contracts with your program. Please verify with your professional coding and billing staff for this information.

It is incumbent upon the physician to determine which, if any modifiers should be used first.

PHYSICIAN REIMBURSEMENT FOR PACEMAKERS

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
SYSTEM IMPLANT OR REPLACEMENT			
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	$454	NA
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	$476	NA
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	$516	NA
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)			
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	$338	NA
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	$354	NA
SYSTEM UPGRADE: SINGLE CHAMBER TO DUAL CHAMBER PACEMAKER			
33214	Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)	$477	NA
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)			
33233	Removal of permanent pacemaker pulse generator only	$233	NA
GENERATOR IMPLANT			
33212	Insertion of pacemaker pulse generator only; with existing single lead	$321	NA
33213	Insertion of pacemaker pulse generator only; with existing dual leads	$335	NA
RELOCATION OF SKIN POCKET			
33222	Relocation of skin pocket for pacemaker	$341	NA
LEAD PROCEDURES			
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$371	NA
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$367	NA
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$308	NA
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$388	NA
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$376	NA
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	$483	NA
33235	Removal of transvenous pacemaker electrode(s); dual lead system	$635	NA

NA: There is no established Medicare payment in this setting.
It is incumbent upon the physician to determine which, if any, modifiers should be used first.

ASC REIMBURSEMENT FOR PACEMAKERS

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
SYSTEM IMPLANT OR REPLACEMENT		
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	$7,796
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	$7,906
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	$8,065
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)		
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	$6,575
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	$7,864
SYSTEM UPGRADE: SINGLE CHAMBER TO DUAL CHAMBER PACEMAKER		
33214	Upgrade of implanted pacemaker system, conversion of single-chamber system to dual-chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)	$7,935
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)		
33233	Removal of permanent pacemaker pulse generator only	$5,881
GENERATOR IMPLANT		
33212	Insertion of pacemaker pulse generator only; with existing single lead	$6,876
33213	Insertion of pacemaker pulse generator only; with existing dual leads	$8,048
RELOCATION OF SKIN POCKET		
33222	Relocation of skin pocket for pacemaker	$887
LEAD PROCEDURES		
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$5,675
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$7,308
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$1,399
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$1,783
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$2,382
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	$2,385
33235	Removal of transvenous pacemaker electrode(s); dual lead system	$2,339

It is incumbent upon the physician to determine which, if any, modifiers should be used first.

PHYSICIAN REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
PACEMAKER/CRT-P DEVICE MONITORING - IN PERSON			
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber	$31*	$69
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	$37*	$82
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	$41*	$86
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	$20*	$58
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	$15*	$48
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	$14*	$47
PACEMAKER/CRT-P DEVICE MONITORING - REMOTE			
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	$30	$30
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	NA	$23
ICD/CRT-D DEVICE MONITORING - IN PERSON			
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	$41*	$82
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	$55*	$100
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	$60*	$108

93296: The physician practice may only bill the technical service if the physician personally performs the technical service or employs the staff member who performs the technical service. If a device industry representative is involved in performing the technical service under the physician's direction, then the physician may only bill the professional service, i.e., physician analysis, review(s) and reports(s).
*The National Facility rates shown with an * reflect payment when modifier 26 is used (i.e. payment only for the professional component).
NA: There is no established Medicare payment in this setting.
It is incumbent upon the physician to determine which, if any, modifiers should be used first.

PHYSICIAN REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
ICD/CRT-D DEVICE MONITORING - IN PERSON continued			
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	$36*	$74
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	$22*	$55
ICD/CRT-D DEVICE MONITORING - REMOTE			
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	$37	$37
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	NA	$23
IMPLANTABLE CARDIOVASCULAR PHYSIOLOGIC MONITORING - IN PERSON			
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	$21*	$55
IMPLANTABLE CARDIOVASCULAR PHYSIOLOGIC MONITORING - REMOTE			
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	$26	$26
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Carrier priced	Carrier priced
ICM DEVICE MONITORING - IN PERSON			
93285	Programming device evaluation, (in person) with iterative adjustment of the implantable device to test function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	$25*	$62
93291	Interrogation device evaluation, (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; including heart rhythm derived data analysis, subcutaneous cardiac rhythm monitor system, including heart rhythm derived data	$18*	$51

93296/G2066: The physician practice may only bill the technical service if the physician personally performs the technical service or employs the staff member who performs the technical service. If a device industry representative is involved in performing the technical service under the physician's direction, then the physician may only bill the professional service, i.e., physician analysis, review(s) and reports(s).
*The National Facility rates shown with an * reflect payment when modifiers 26 is used (i.e. payment only for the professional component).
Carrier priced: Medicare has not established a payment amount for this code. Check with your local Medicare Administrative Contractor (MAC) to verify the payment amount.
NA: There is no established Medicare payment in this setting.
It is incumbent upon the physician to determine which, if any, modifiers, should be used first.

PHYSICIAN REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of heart rhythm derived data, analysis review(s) and report(s) by a physician or other qualified health care professional	$26	$26
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Carrier priced	Carrier priced

93296/G2066: The physician practice may only bill the technical service if the physician personally performs the technical service or employs the staff member who performs the technical service. If a device industry representative is involved in performing the technical service under the physician's direction, then the physician may only bill the professional service, i.e., physician analysis, review(s) and reports(s).
*The National Facility rates shown with an * reflect payment when modifiers 26 is used (i.e. payment only for the professional component).
Carrier priced: Medicare has not established a payment amount for this code. Check with your local Medicare Administrative Contractor (MAC) to verify the payment amount.
It is incumbent upon the physician to determine which, if any, modifiers, should be used first.

ASC REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
PACEMAKER/CRT-P DEVICE MONITORING - IN PERSON		
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber	NA
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	NA
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	NA
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	NA
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	NA
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	NA
PACEMAKER/CRT-P DEVICE MONITORING - REMOTE		
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	NA
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	NA
ICD/CRT-D DEVICE MONITORING - IN PERSON		
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	NA
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	NA
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	NA
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	NA
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	NA

"NA" expresses that Medicare has no payment associated with those codes in the ASC setting as they do not designate ASCs as an appropriate site of service for those procedures. Some private payers may reimburse these procedures in an ASC according to their policies and contracts with your program. Please verify with your professional coding and billing staff for this information.

ASC REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
ICD/CRT-D DEVICE MONITORING - REMOTE		
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	NA
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	NA
IMPLANTABLE CARDIOVASCULAR PHYSIOLOGIC MONITORING - IN PERSON		
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	NA
IMPLANTABLE CARDIOVASCULAR PHYSIOLOGIC MONITORING - REMOTE		
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	NA
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	NA
ICM DEVICE MONITORING - IN PERSON		
93285	Programming device evaluation, (in person) with iterative adjustment of the implantable device to test function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	NA
93291	Interrogation device evaluation, (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; including heart rhythm derived data analysis, subcutaneous cardiac rhythm monitor system, including heart rhythm derived data	NA
ICM DEVICE MONITORING - REMOTE		
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of heart rhythm derived data, analysis review(s) and report(s) by a physician or other qualified health care professional	NA
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	NA

"NA" expresses that Medicare has no payment associated with those codes in the ASC setting as they do not designate ASCs as an appropriate site of service for those procedures. Some private payers may reimburse these procedures in an ASC according to their policies and contracts with your program. Please verify with your professional coding and billing staff for this information.

Table of Contents

PHYSICIAN REIMBURSEMENT FOR IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE	
		2022 FACILITY	2022 NON-FACILITY
IMPLANT			
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	$87	$4,607
REMOVAL			
33286	Removal, subcutaneous cardiac rhythm monitor	$86	$134

It is incumbent upon the physician to determine which, if any, modifiers should be used first.

ASC REIMBURSEMENT FOR IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
IMPLANT		
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	$7,201
REMOVAL		
33286	Removal, subcutaneous cardiac rhythm monitor	$322

It is incumbent upon the physician to determine which, if any, modifiers should be used first.

Table of Contents

PHYSICIAN REIMBURSEMENT FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
SYSTEM IMPLANT OR REPLACEMENT			
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	$912	NA
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)			
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	$372	NA
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	$387	NA
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)			
33241	Removal of implantable defibrillator pulse generator only	$215	NA
GENERATOR IMPLANT			
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	$365	NA
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	$383	NA
RELOCATION OF SKIN POCKET			
33223	Relocation of skin pocket for implantable defibrillator	$408	NA
LEAD PROCEDURES			
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$371	NA
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$367	NA
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$308	NA
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$388	NA
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$376	NA
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction	$863	NA

NA: There is no established Medicare payment in this setting.
It is incumbent upon the physician to determine which, if any, modifiers should be used first.

ASC REIMBURSEMENT FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
SYSTEM IMPLANT OR REPLACEMENT		
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	$27,319
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)		
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	$20,226
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	$20,423
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)		
33241	Removal of implantable defibrillator pulse generator only	$1,783
GENERATOR IMPLANT		
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	$20,820
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	$21,243
RELOCATION OF SKIN POCKET		
33223	Relocation of skin pocket for implantable defibrillator	$887
LEAD PROCEDURES		
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$5,675
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$7,308
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$1,399
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$1,783
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$2,382

It is incumbent upon the physician to determine which, if any, modifiers should be used first.

Table of Contents

PHYSICIAN REIMBURSEMENT FOR CARDIAC RESYNCHRONIZATION THERAPY (CRT)

CRT procedures are often reported with add-on code 33225. Add-on code 33225 can be performed when medically appropriate with the primary service/procedure codes listed below. Add-on codes may not be reported as a stand-alone and must be billed when performed in conjunction with the primary service or procedure. Add-on codes qualify for separate payment for physicians and are not subject to the Physician Multiple Payment Reduction Rule.

CPT‡ CODE	ADD-ON CODE CPT‡ CODE DESCRIPTOR (LIST SEPARATELY IN ADDITION TO CODE FOR THE PRIMARY PROCEDURE)	MEDICARE RATE 2021 FACILITY	MEDICARE RATE 2021 NON-FACILITY	REPORT WITH PRIMARY PROCEDURE CODE
LEFT VENTRICULAR LEAD PLACEMENT FOR CRT PROCEDURES				
+33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (e.g., for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	$463	NA	33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33221, 33223, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263, or 33264

PHYSICIAN ADDITIONAL CODES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2021 FACILITY	MEDICARE RATE 2021 NON-FACILITY
OTHER CRT PROCEDURES			
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)	$510	NA
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	$489	NA
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	$374	NA
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	$360	NA
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	$403	NA
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	$397	NA

NA: There is no established Medicare payment in this setting.
+ Indicates an add-on-code. List add-on-code(s) separately in addition to the primary procedure performed.
It is incumbent upon the physician to determine which, if any, modifiers should be used first.

ASC REIMBURSEMENT FOR CARDIAC RESYNCHRONIZATION THERAPY (CRT)

Table of Contents

CRT procedures are often reported with add-on code 33225. Add-on code 33225 can be performed when medically appropriate with the primary service/procedure codes listed below. Add-on codes may not be reported as a stand-alone and must be billed when performed in conjunction with the primary service or procedure. Medicare does not make separate payment for add-on code 33225 in the ASC setting.

CPT‡ CODE	ADD-ON CODE CPT‡ CODE DESCRIPTOR (LIST SEPARATELY IN ADDITION TO CODE FOR THE PRIMARY PROCEDURE)	REPORT WITH PRIMARY PROCEDURE CODE	MEDICARE RATE ASC
LEFT VENTRICULAR LEAD PLACEMENT FOR CRT PROCEDURES			
+33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (e.g., for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	33206	$7,796
		33207	$7,906
		33208	$8,065
		33212	$6,876
		33213	$8,048
		33214	$7,935
		33216	$5,675
		33217	$7,308
		33221	$12,338
		33223	$887
		33228	$7,864
		33229	$12,287
		33230	$21,243
		33231	$27,334
		33233	$5,881
		33234	$2,385
		33235	$2,339
		33240	$20,820
		33249	$27,319
		33263	$20,423
		33264	$27,212

ASC ADDITIONAL CODES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
OTHER CRT PROCEDURES		
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)	$7,817
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	$1,399
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	$12,287
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	$12,338
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	$27,212
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	$27,334

+ Indicates an add-on-code. List add-on-code(s) separately in addition to the primary procedure performed.
It is incumbent upon the physician to determine which, if any, modifiers should be used first.

PHYSICIAN REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$409	$2,378
PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$409	$2,378
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	$837	NA
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling (Do not report 63685) in conjunction with 63688 for the same pulse generator or receiver)	$360	NA
REVISION AND REMOVAL PROCEDURES			
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	$326	$692
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	$848	NA
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	$446	$910
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	$882	NA
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	$371	NA
ELECTRONIC ANALYSIS AND DEVICE PROGRAMMING			
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	$18	$19
95971*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	$39	$48
95972*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	$40	$55

* A physician or an auxiliary person employed by and under the direct supervision of that physician may provide, with or without the support of the manufacturer's representative, analysis and programming of a patient's medical product or device "incident to" the physician's other services performed in the office setting. A patient or his payer should not be billed for analysis and programming services performed at the direction of the physician by a manufacturer's representative. Contact your MAC or other payer for any questions regarding coverage, coding and payment.

NA: There is no Medicare valuations for these codes and these procedures are not typically performed in an in-office setting.

It is incumbent upon the physician to determine which, if any, modifiers should be used first.

ASC REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
TRIAL PROCEDURE		
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$4,571
PERMANENT PROCEDURES		
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$4,571
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	$17,146
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling (Do not report 63685) in conjunction with 63688 for the same pulse generator or receiver)	$24,424
REVISION AND REMOVAL PROCEDURES		
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	$826
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	$1,876
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	$4,597
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	$9,283
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	$2,591
ELECTRONIC ANALYSIS AND DEVICE PROGRAMMING		
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	NA
95971*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	NA
95972*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	NA

"NA" expresses that Medicare has no payment associated with those codes in the ASC setting as they do not designate ASCs as an appropriate site of service for those procedures. Some private payers may reimburse these procedures in an ASC according to their policies and contracts with your program. Please verify with your professional coding and billing staff for this information.
It is incumbent upon the physician to determine which, if any, modifiers should be used first.

PHYSICIAN REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
CERVICAL SPINE/THORACIC SPINE			
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	$189	$446
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	$66	$264
LUMBAR SPINE/SACRAL SPINE			
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	$189	$450
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	$58	$249
GENICULAR NERVE			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	$144	$397
SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	$192	$481
OTHER PERIPHERAL NERVES			
*64640	Destruction by neurolytic agent; other peripheral nerve or branch	$117	$250
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	$27	$117
UNLISTED PROCEDURE			
64999	Unlisted procedure, nervous system	NA	Carrier priced

*CPT‡ code 64640 may not be billed more than 5 times on a single date of service.
Carrier Priced: Reimbursement amount is determined by the geographic location
NA: There are no Medicare Evaluations for these codes as these procedures are not typically performed in an in-office setting.
It is incumbent upon the physician to determine which, if any modifiers should be used first.

ASC REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
CERVICAL SPINE/THORACIC SPINE		
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	$826
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	NA
LUMBAR SPINE/SACRAL SPINE		
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	$826
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	NA
GENICULAR NERVE		
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	$826
SACROILIAC JOINT		
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	$826
OTHER PERIPHERAL NERVES		
*64640	Destruction by neurolytic agent; other peripheral nerve or branch	$176
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	NA
UNLISTED PROCEDURE		
64999	Unlisted procedure, nervous system	NA

*CPT‡ code 64640 may not be billed more than 5 times on a single date of service.
"NA" expresses that Medicare has no payment associated with those codes in the ASC setting as they do not designate ASCs as an appropriate site of service for those procedures. Some private payers may reimburse these procedures in an ASC according to their policies and contracts with your program. Please verify with your professional coding and billing staff for this information.
It is incumbent upon the physician to determine which, if any modifiers should be used first.

PHYSICIAN REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
DIAGNOSTIC SERVICES			
70450-26	Computed tomography, head or brain; without contrast material	$40	$40
70551-26	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material	$70	$70
76376-26	3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality with image post processing under concurrent supervision; not requiring image post processing on an independent workstation	$9	$9
76377-26	3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality with image post processing under concurrent supervision; requiring image post processing on an independent workstation	$38	$38
LEAD PROCEDURES			
61863	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus, globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; first array	$1,505	NA
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	$280	NA
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; first array	$2,274	NA
61868	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), with use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	$494	NA
61880	Revision or removal of intracranial neurostimulator electrodes	$588	NA
INTRAOPERATIVE STIMULATION WITH MICROELECTRODE RECORDING			
95961-26	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; initial hour of attendance by a physician or other qualified health care professional	$159	$159
95962-26	Functional cortical and subcortical mapping by stimulation and/or recording of electrodes on brain surface, or of depth electrodes, to provoke seizures or identify vital brain structures; each additional hour of attendance by a physician or other qualified health care professional (List separately in addition to code for primary procedure)	$170	$170

NA: There are no Medicare Evaluations for these codes as these procedures are not typically performed in an in-office setting.
Modifier 26 signifies the professional component of the hospital-based services
It is incumbent upon the physician to determine which, if any modifiers should be used first.

PHYSICIAN REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS) CONT'D

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2022 FACILITY	MEDICARE RATE 2022 NON-FACILITY
IMPLANTABLE PULSE GENERATOR (IPG) PROCEDURES			
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	$527	NA
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	$877	NA
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	$400	NA
IMPLANTABLE PULSE GENERATOR (IPG) ANALYSIS AND PROGRAMMING*			
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	$18	$19
95983*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/ transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	$49	$50
95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/ transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	$43	$44

NA: There are no Medicare Evaluations for these codes as these procedures are not typically performed in an in-office setting.
*Modifier 26 signifies the professional component of the hospital-based services
It is incumbent upon the physician to determine which, if any modifiers should be used first.

ASC REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
IMPLANTABLE PULSE GENERATOR (IPG) PROCEDURES		
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	$18,592
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	$24,541
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	$10,260
IMPLANTABLE PULSE GENERATOR (IPG) ANALYSIS AND PROGRAMMING*		
61880	Revision or removal of intracranial neurostimulator electrodes	1,876

It is incumbent upon the physician to determine which, if any modifiers should be used first.

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Table of Contents

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1. Physician Prospective Payment-Final rule with Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY2022. CMS-1751-F: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-f

2. Ambulatory Surgical Center Payment-Notice of Final Rulemaking with Comment Period(NFRM) CY2022. CMS-1753-FC: https://www.cms.gov/medicaremedicare-fee-service-paymentascpaymentasc-regulations-and-notices/cms-1753-fc

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