ABBOTT CODING GUIDE

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

Medicare Physician Fee Schedule

Effective Dates: January 1, 2020 to December 31, 2020

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REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
ILIAC ARTERY REVASCULARIZATION			
37220	Iliac revascularization	$421	$2,963
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	$519	$4,012
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)	$196	$767
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)	$223	$1,965
FEMORAL/POPLITEAL ARTERY REVASCULARIZATION			
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	$467	$3,524
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$633	$11,582
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$546	$10,286
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	$761	$14,891
TIBIAL/PERONEAL ARTERY REVASCULARIZATION			
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$570	$5,072
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$738	$11,626
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	$734	$10,457
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	$795	$14,476
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty.	$210	$1,049
37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed.	$342	$1,288

+ Indicates add-on code
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REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
ILIAC ARTERY REVASCULARIZATION		
37220	Iliac revascularization	$2,142
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	$6,179
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	$3,120
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$6,675
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$6,444
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	$10,941
TIBIAL/PERONEAL ARTERY REVASCULARIZATION		
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$5,670
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$10,286
37230	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	$10,101
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	$10,649
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty.	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.	No separate payment

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
TIBIAL/PERONEAL ARTERY REVASCULARIZATION (CONTINUED)			
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.	$300	$3,985
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.	$422	$4,199
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	$365	$2,106
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)	$179	$749
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	$312	$1,549
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)	$153	$566
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)	$458	$5,059
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)	$500	$7,824
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	$588	$9,873
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	$697	$7,246
36140	Introduction of needle or intracatheter; extremity artery	$94	$493
DIAGNOSTIC ANGIOGRAPHY LOWER EXTREMITY			
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	$88	$88
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	$98	$98

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REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
TIBIAL/PERONEAL ARTERY REVASCULARIZATION (CONTINUED)		
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.	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.	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	$2,142
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	$2,142
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
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)	$4,183
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)	$6,096
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	$4,183
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	NA
36140	Introduction of needle or intracatheter; extremity artery	No separate payment
DIAGNOSTIC ANGIOGRAPHY		
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	NA
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	NA

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
EMBOLIZATION/CATHETER ACCESS (CONT'D)			
36160	Introduction of needle or intracatheter, aortic, translumbar	$130	$562
36200	Introduction of catheter, aorta	$147	$608
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	$177	$712
36902	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$250	$1,335
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	$332	$5,281
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);	$388	$1,976
36905	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$465	$2,481
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	$537	$6,556
36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty	$153	$710
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	$217	$2,152
36909	Dialysis circuit permanent vascular embolization or occlusion, endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention	$210	$2,051
34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12F or larger), including ultrasound guidance, when performed, unilateral	$131	NA

This code 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 = $203).

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REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
EMBOLIZATION/CATHETER ACCESS (CONT'D)		
36160	Introduction of needle or intracatheter, aortic, translumbar	No separate payment
36200	Introduction of catheter, aorta	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	$573
36902	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$2,142
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	$6,319
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);	$2,875
36905	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$4,183
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	$10,181
36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty	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	No separate payment
36909	Dialysis circuit permanent vascular embolization or occlusion, endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention	No separate payment
34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12F or larger), including ultrasound guidance, when performed, unilateral	No separate payment

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REIMBURSEMENT FOR CORONARY PROCEDURES

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
PCI PROCEDURES			
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$556	NA
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	NA	NA
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$619	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)	NA	NA
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	NA	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)	NA	NA
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	$250	$250

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REIMBURSEMENT FOR CORONARY PROCEDURES

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
PCI PROCEDURES		
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$3021
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	$6,057
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	
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
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	$1,374

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REIMBURSEMENT FOR PACEMAKERS

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
SYSTEM IMPLANT OR REPLACEMENT			
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	$476	NA
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	$502	NA
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	$546	NA
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)			
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	$354	NA
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	$371	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)	$501	NA
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)			
33233	Removal of permanent pacemaker pulse generator only	$241	NA
GENERATOR IMPLANT			
33212	Insertion of pacemaker pulse generator only; with existing single lead	$336	NA
33213	Insertion of pacemaker pulse generator only; with existing dual leads	$351	NA
RELOCATION OF SKIN POCKET			
33222	Relocation of skin pocket for pacemaker	$355	NA
LEAD PROCEDURES			
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$389	NA
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$384	NA
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$325	NA
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$404	NA
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$394	NA
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	$509	NA
33235	Removal of transvenous pacemaker electrode(s); dual lead system	$668	NA

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REIMBURSEMENT FOR PACEMAKERS

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
SYSTEM IMPLANT OR REPLACEMENT		
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	$7,385
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	$7,633
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	$7,817
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)		
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	$6,061
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	$7,634
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)	$7,566
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)		
33233	Removal of permanent pacemaker pulse generator only	$5,353
GENERATOR IMPLANT		
33212	Insertion of pacemaker pulse generator only; with existing single lead	$6,201
33213	Insertion of pacemaker pulse generator only; with existing dual leads	$7,710
RELOCATION OF SKIN POCKET		
33222	Relocation of skin pocket for pacemaker	$820
LEAD PROCEDURES		
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$5,469
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$6,673
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$1,341
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$1,508
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$2,127
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	$1,508
33235	Removal of transvenous pacemaker electrode(s); dual lead system	$1,951

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REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 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	$33*	$62
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	$40*	$73
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	$44*	$78
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	$22*	$50
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	$16*	$41
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	$16*	$53
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	$32	$32
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	$26
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	$44*	$75
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	$60*	$94
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	$65*	$101
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	$39*	$68

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

REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
ICD/CRT-D DEVICE MONITORING - IN PERSON continued			
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	$24*	$49
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	$39	$39
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	$26
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	$22*	$48
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	$28	$28
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	$27*	$55
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	$19*	$44
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	$28	$28
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

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

REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
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.

REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
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.

REIMBURSEMENT FOR IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
IMPLANT			
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	$93	$5,159
REMOVAL			
33286	Removal, subcutaneous cardiac rhythm monitor	$91	$138

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

REIMBURSEMENT FOR IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
IMPLANT		
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	$6,655
REMOVAL		
33286	Removal, subcutaneous cardiac rhythm monitor	$308

REIMBURSEMENT FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
SYSTEM IMPLANT OR REPLACEMENT			
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	$961	NA
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)			
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	$391	NA
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	$406	NA
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)			
33241	Removal of implantable defibrillator pulse generator only	$224	NA
GENERATOR IMPLANT			
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	$382	NA
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	$400	NA
RELOCATION OF SKIN POCKET			
33223	Relocation of skin pocket for implantable defibrillator	$429	NA
LEAD PROCEDURES			
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$389	NA
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$384	NA
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$325	NA
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$404	NA
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$394	NA
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction	$906	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.

REIMBURSEMENT FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
SYSTEM IMPLANT OR REPLACEMENT		
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	$26,699
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)		
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	$19,502
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	$19,778
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)		
33241	Removal of implantable defibrillator pulse generator only	$1,508
GENERATOR IMPLANT		
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	$19,741
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	$19,949
RELOCATION OF SKIN POCKET		
33223	Relocation of skin pocket for implantable defibrillator	$820
LEAD PROCEDURES		
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$5,469
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$6,673
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$1,341
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$1,508
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$2,127

REIMBURSEMENT FOR CARDIAC RESYNCHRONIZATION THERAPY (CRT)

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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 PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 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)	$493	NA	33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33221, 33223, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263, or 33264

ADDITIONAL CODES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 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)	$541	NA
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	$520	NA
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	$392	NA
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	$379	NA
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	$425	NA
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	$421	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.
+ Indicates an add-on-code

REIMBURSEMENT FOR CARDIAC RESYNCHRONIZATION THERAPY (CRT)

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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	ASC RATE
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	$7,385
		33207	$7,633
		33208	$7,817
		33212	$6,201
		33213	$7,710
		33214	$7,566
		33216	$5,469
		33217	$6,673
		33221	$11,727
		33223	$820
		33228	$7,634
		33229	$11,807
		33230	$19,949
		33231	$26,640
		33233	$5,353
		33234	$1,508
		33235	$1,951
		33240	$19,741
		33249	$26,699
		33263	$19,778
		33264	$26,738

ADDITIONAL CODES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
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)	$7,837
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	$1,341
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	$11,807
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	$11,727
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	$26,738
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	$26,640

+ Indicates an add-on-code.

REIMBURSEMENT FOR ELECTROPHYSIOLOGY

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
COMPREHENSIVE ELECTROPHYSIOLOGY STUDIES			
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia	$409	$409
93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	$655	$655
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	$251	$251
+93621	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium	$123	$123
+93622	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording	$180	$180
INDIVIDUAL STUDIES*			
93600	Bundle of His recording	$125	$125
93602	Intra-atrial recording	$122	$122
93603	Right ventricular recording	$122	$122
93610	Intra-atrial pacing	$171	$171
93612	Intraventricular pacing	$169	$169
MAPPING & ADD-ON PROCEDURES (List separately in addition to code for primary procedure.)			
+93609	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia	$291	$291
+93613	Intracardiac electrophysiologic 3-dimensional mapping	$312	NA
+93623	Programmed stimulation and pacing after intravenous drug infusion	$166	$166
CATHETER ABLATION			
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	$620	NA
93653	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	$877	NA

* 93655 has a medically unlikely edit (MUE) of 2 units. Ablation codes 93653, 93654, and 93656 do not require a modifier - 52. The -26 modifier may be applicable for a number of these codes.

*Component (e.g., individual study) codes cannot be billed in conjunction with comprehensive EP codes.

+ Indicates add-on code

NA: There are no Medicare Evaluations for these codes as these procedures are not typically performed in an in-office setting. The 26 modifier may be applicable for a number of these codes. It is incumbent upon the physician to determine which, if any, modifiers should be used first.

REIMBURSEMENT FOR ELECTROPHYSIOLOGY

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
CATHETER ABLATION continued			
93654	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed	$1,174	NA
+93655*	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia	$447	NA
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation	$1,177	NA
+93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation by pulmonary vein isolation	$447	NA
INTRACARDIAC ECHO / TRANSEPTAL ACCESS (ADD-ON SERVICES) List separately in addition to code for primary procedure.			
+93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation	$147	$147
+93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture	$220	$220
OTHER PROCEDURES: ESOPHAGEAL RECORDING AND INDUCTION OF ARRHYTHMIA			
93615	Esophageal recording of atrial electrogram with or without ventricular electrogram(s)	$39	$39
93616	Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing	$62	$62
93618	Induction of arrhythmia by electrical pacing	$231	$231

* 93655 has a medically unlikely edit (MUE) of 2 units. Ablation codes 93653, 93654, and 93656 do not require a modifier -52.
The -26 modifier may be applicable for a number of these codes.
+ Indicates add-on code
NA: There are no Medicare Evaluations for these codes as these procedures are not typically performed in an in-office setting. The 26 modifier may be applicable for a number of these codes.
It is incumbent upon the physician to determine which, if any, modifiers should be used first.

REIMBURSEMENT FOR ELECTROPHYSIOLOGY

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
COMPREHENSIVE ELECTROPHYSIOLOGY STUDIES		
93619	Comprehensive electrophysiologic evaluation with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording, including insertion and repositioning of multiple electrode catheters, without induction or attempted induction of arrhythmia	NA
93620	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, His bundle recording	NA
93624	Electrophysiologic follow-up study with pacing and recording to test effectiveness of therapy, including induction or attempted induction of arrhythmia	NA
+93621	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium	NA
+93622	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording	NA
INDIVIDUAL STUDIES*		
93600	Bundle of His recording	NA
93602	Intra-atrial recording	NA
93603	Right ventricular recording	NA
93610	Intra-atrial pacing	NA
93612	Intraventricular pacing	NA
MAPPING & ADD-ON PROCEDURES (List separately in addition to code for primary procedure.)		
+93609	Intraventricular and/or intra-atrial mapping of tachycardia site(s) with catheter manipulation to record from multiple sites to identify origin of tachycardia	NA
+93613	Intracardiac electrophysiologic 3-dimensional mapping	NA
+93623	Programmed stimulation and pacing after intravenous drug infusion	NA
CATHETER ABLATION		
93650	Intracardiac catheter ablation of atrioventricular node function, atrioventricular conduction for creation of complete heart block, with or without temporary pacemaker placement	NA
93653	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry	NA
93654	Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia with right atrial pacing and recording, right ventricular pacing and recording (when necessary), and His bundle recording (when necessary) with intracardiac catheter ablation of arrhythmogenic focus; with treatment of ventricular tachycardia or focus of ventricular ectopy including intracardiac electrophysiologic 3D mapping, when performed, and left ventricular pacing and recording, when performed	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.

REIMBURSEMENT FOR ELECTROPHYSIOLOGY

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
CATHETER ABLATION continued		
+93655*	Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnositic maneuvers, to treat a spontaneous or induced arrhythmia	NA
93656	Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with induction or attempted induction of an arrhythmia including left or right atrial pacing/recording when necessary, right ventricular pacing/recording when necessary, and His bundle recording when necessary with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation	NA
+93657	Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation by pulmonary vein isolation	NA
INTRACARDIAC ECHO / TRANSEPTAL ACCESS (ADD-ON SERVICES) List separately in addition to code for primary procedure.		
+93662	Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation	NA
+93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture	NA
OTHER PROCEDURES: ESOPHAGEAL RECORDING AND INDUCTION OF ARRHYTHMIA		
93615	Esophageal recording of atrial electrogram with or without ventricular electrogram(s)	NA
93616	Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing	NA
93618	Induction of arrhythmia by electrical pacing	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.

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REIMBURSEMENT FOR LEFT VENTRICULAR ASSIST DEVICE (LVAD) & ACUTE MCS

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
LEFT VENTRICULAR ASSIST DEVICE (LVAD) PROCEDURES			
LVAD IMPLANT*			
33979	Insertion of ventricular assist device, implantable, intracorporeal, single ventricle	$2,039	NA
LVAD REMOVAL			
33980	Removal of ventricular assist device, implantable, intracorporeal, single ventricle	$1,861	NA
LVAD REPLACEMENT			
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	$2,047	NA
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	$2,420	NA
LVAD INTERROGATION**			
93750	Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, septum status, recovery), with programming, if performed, and report	$50	$59

* Please note that LVAD implant, removal, and replacement procedures are restricted by Medicare to the inpatient hospital site of service.

The LVAD implant procedure has a zero-day global period. This means that the payment only includes the implant procedure and does not account for post implant services needed to support patient care. Surgeons and cardiologists may be eligible for reimbursement for medically appropriate post implant care given they meet the requirements of the codes. These services include but are not limited to daily rounding, VAD interrogation and evaluation and management services provided in the inpatient and outpatient hospital. Please consult your professional coding staff for documentation guidelines. The code for LVAD interrogation is not reported with any of the surgical implantation codes (33975, 33976, 33979, 33981-33983), but is typically reported in conjunction with an evaluation and management visit code (e.g., 99211- 99215) and is reimbursed in addition to the visit code. There are no Correct Coding Initiative (CCI) edits for the interrogation code. Per CMS, Physicians may be eligible for reimbursement for VAD interrogation post date of implant with a Medically unlikely edit of no more than 4 units provided on the same date of service (Must be medically appropriate). Nurse Practitioners should check both with their compliance department as well as their state-specific scope of services before independently billing for a VAD interrogation.

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

ACUTE MCS SYSTEM IMPLANT			
33975	Insertion of ventricular assist device; extracorporeal, single ventricle	$1,367	NA
33976	Insertion of ventricular assist device; extracorporeal, biventricular	$1,662	NA
ACUTE MCS SYSTEM REMOVAL			
33977	Removal of ventricular assist device; extracorporeal, single ventricle	$1,177	NA
33978	Removal of ventricular assist device; extracorporeal, biventricular	$1,392	NA
ACUTE MCS SYSTEM REPLACEMENT			
33981	Replacement of extracorporeal ventricular assist device; single or biventricular, pump(s) single or each pump	$871	NA
ACUTE MCS SYSTEM REVISION			
33993	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion	$182	NA

The CPT‡ codes above describe possible surgeon services in the hospital inpatient setting where the Acute MCS system procedure (e.g., CentriMag™ or PediMag™ Pumps) occurs. These services are restricted to the inpatient hospital site of service.

It is incumbent upon the physician to determine which, if any modifiers should be used first.
A list of CPT‡ code modifiers can be found at cardiovascular.abbott/us/en/hcp/reimbursement.htm

Rx Only
Brief Summary: Prior to using these devices, please review the Instructions For Use for a complete listing of indications, contraindications, warnings, precautions, potential adverse events and directions for use.

REIMBURSEMENT FOR LEFT VENTRICULAR ASSIST DEVICE (LVAD) & ACUTE MCS

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
LEFT VENTRICULAR ASSIST DEVICE (LVAD) PROCEDURES		
LVAD IMPLANT*		
33979	Insertion of ventricular assist device, implantable, intracorporeal, single ventricle	NA
LVAD REMOVAL		
33980	Removal of ventricular assist device, implantable, intracorporeal, single ventricle	NA
LVAD REPLACEMENT		
33982	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass	NA
33983	Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass	NA
LVAD INTERROGATION**		
93750	Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, septum status, recovery), with programming, if performed, and report	NA
ACUTE MCS SYSTEM IMPLANT		
33975	Insertion of ventricular assist device; extracorporeal, single ventricle	NA
33976	Insertion of ventricular assist device; extracorporeal, biventricular	NA
ACUTE MCS SYSTEM REMOVAL		
33977	Removal of ventricular assist device; extracorporeal, single ventricle	NA
33978	Removal of ventricular assist device; extracorporeal, biventricular	NA
ACUTE MCS SYSTEM REPLACEMENT		
33981	Replacement of extracorporeal ventricular assist device; single or biventricular, pump(s) single or each pump	NA
ACUTE MCS SYSTEM REVISION		
33993	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion	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.

Rx Only

Brief Summary: Prior to using these devices, please review the Instructions For Use for a complete listing of indications, contraindications, warnings, precautions, potential adverse events and directions for use.

REIMBURSEMENT FOR CARDIOMEMS™ HF SYSTEM

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
IMPLANT			
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography	$345	NA
REMOTE MONITORING			
93264	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, review(s) and reports(s) by a physician or other qualified health care professional	$37	$52

ADDITIONAL AMERICAN MEDICAL ASSOCIATION (AMA) CPT‡ CODE INSTRUCTIONS/GUIDANCE AROUND REPORTING 93264

- Report 93264 only once per 30 days
- Do not report 93264 if monitoring period is less than 30 days
- Do not report if download(s), interpretation(s), trend analysis, and report(s) do not occur at least weekly during the 30-day time period
- Do not report 93264 if review does not occur at least weekly during 30-day time period

* Effective January 1, 2019, providers should utilize CPT‡ codes 33289 and 93264 for reporting Pulmonary Artery (PA) pressure sensor implant and remote monitoring procedures.

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

Rx Only

Brief Summary: Prior to using these devices, please review the Instructions For Use for a complete listing of indications, contraindications, warnings, precautions, potential adverse events and directions for use.

REIMBURSEMENT FOR CARDIOMEMS™ HF SYSTEM

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
IMPLANT		
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography	NA
REMOTE MONITORING		
93264	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from all internal and external sensors, review(s) and reports(s) by a physician or other qualified health care professional	NA

ADDITIONAL AMERICAN MEDICAL ASSOCIATION (AMA) CPT‡ CODE INSTRUCTIONS/GUIDANCE AROUND REPORTING 93264
- Report 93264 only once per 30 days
- Do not report 93264 if monitoring period is less than 30 days
- Do not report if download(s), interpretation(s), trend analysis, and report(s) do not occur at least weekly during the 30-day time period
- Do not report 93264 if review does not occur at least weekly during 30-day time period

"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.

Rx Only

Brief Summary: Prior to using these devices, please review the Instructions For Use for a complete listing of indications, contraindications, warnings, precautions, potential adverse events and directions for use.

REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$431	$1,955
PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$431	$1,955
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	$867	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)	$374	NA
REVISION AND REMOVAL PROCEDURES			
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	$337	$661
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	$877	NA
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	$469	$880
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	$913	NA
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	$386	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	$20	$20
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	$42	$52
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	$43	$59

* 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.

Check with your carrier to determine reimbursement rates

REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
TRIAL PROCEDURE		
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$4,515
PERMANENT PROCEDURES		
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$4,515
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	$15,942
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)	$23,466
REVISION AND REMOVAL PROCEDURES		
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	$797
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	$1,846
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	$4,413
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	$14,522
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	$1,846
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.

REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 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	$233	$431
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	$71	$193
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	$230	$426
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	$62	$176
GENICULAR NERVE			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	$153	$418
SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	$202	$510
OTHER PERIPHERAL NERVES			
*64640	Destruction by neurolytic agent; other peripheral nerve or branch	$122	$254
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	NA	$110
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.

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

REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
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	$797
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	$797
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	$319
SACROILIAC JOINT		
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	$797
OTHER PERIPHERAL NERVES		
*64640	Destruction by neurolytic agent; other peripheral nerve or branch	$177
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.

REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 NON-FACILITY
DIAGNOSTIC SERVICES			
70450-26	Computed tomography, head or brain; without contrast material	$44	$44
70551-26	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material	$76	$76
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	$10	$10
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	$41	$41
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	$1,565	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)	$296	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	$2,379	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)	$522	NA
61880	Revision or removal of intracranial neurostimulator electrodes	$600	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	$167	$167
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)	$178	$178

NA: There are no Medicare Evaluations for these codes as these procedures are not typically performed in an in-office setting.

REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS) CONT'D

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	MEDICARE PHYSICIAN RATE 2020 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	$539	NA
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	$891	NA
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	$411	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	$20	$20
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	$52	$53
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)	$46	$47

NA: There are no Medicare Evaluations for these codes as these procedures are not typically performed in an in-office setting.

REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
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	$17,306
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	$23,560
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	$4,478
IMPLANTABLE PULSE GENERATOR (IPG) ANALYSIS AND PROGRAMMING*		
61880	Revision or removal of intracranial neurostimulator electrodes	1,846

REIMBURSEMENT FOR CONGENITAL DEFECTS

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	2020 NON-FACILITY
ATRIAL SEPTAL DEFECT/PATENT FORAMEN OVALE			
93580	Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant	$1,021	NA
PATIENT DUCTUS ARTERIOSUS			
93582	Percutaneous transcatheter closure of patent ductus arteriosus	$696	NA
VENTRICULAR SEPTAL DEFECT			
93581	Percutaneous transcatheter closure of congenital ventricular septal defect with implant	$1,391	NA

REIMBURSEMENT FOR SURGICAL HEART VALVES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	2020 NON-FACILITY
SURGICAL HEART VALVES AND ANNULOPLASTY RINGS			
33405	Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	$2,373	NA
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass	$2,857	NA
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	$2,490	NA
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	$2,554	NA
33430	Replacement, mitral valve, with cardiopulmonary bypass	$2,929	NA
33464	Valvuloplasty, tricuspid valve, with ring insertion	$2,552	NA

REIMBURSEMENT FOR AMPLATZER™ PFO OCCLUDER

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE PHYSICIAN RATE 2020 FACILITY	2020 NON-FACILITY
SURGICAL HEART VALVES AND ANNULOPLASTY RINGS			
93580	Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant	$1,021	NA

NA: There are no Medicare Evaluations for these codes as these procedures are not typically performed in an in-office setting. The 26 modifier may be applicable for a number of these codes.

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

REIMBURSEMENT FOR CONGENITAL DEFECTS & VASCULAR PLUGS

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CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
ATRIAL SEPTAL DEFECT/PATENT FORAMEN OVALE		
93580	Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant	NA
PATIENT DUCTUS ARTERIOSUS		
93582	Percutaneous transcatheter closure of patent ductus arteriosus	NA
VENTRICULAR SEPTAL DEFECT		
93581	Percutaneous transcatheter closure of congenital ventricular septal defect with implant	NA

REIMBURSEMENT FOR SURGICAL HEART VALVES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
SURGICAL HEART VALVES AND ANNULOPLASTY RINGS		
33405	Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve	NA
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass	NA
33426	Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring	NA
33427	Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring	NA
33430	Replacement, mitral valve, with cardiopulmonary bypass	NA
33464	Valvuloplasty, tricuspid valve, with ring insertion	NA

REIMBURSEMENT FOR AMPLATZER™ PFO OCCLUDER

CPT‡ CODE	CPT‡ CODE DESCRIPTION	ASC RATE
SURGICAL HEART VALVES AND ANNULOPLASTY RINGS		
93580	Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant	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.

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1. Physician Prospective Payment-Final rule with Comment Period and Final CY2020 Payment Rates. CMS-1715-F: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

2. Ambulatory Surgical Center Payment-Final Rule CY2020 Payment Rates. CMS-1717-FC: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1717-FC.html

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