# ABBOTT CODING GUIDE

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

Medicare Physician Fee Schedule

Effective Dates: January 1, 2019 to December 31, 2019

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## REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 NON-FACILITY |
|---|---|---|---|
| **ILIAC ARTERY REVASCULARIZATION** | | | |
| 37220 | Iliac revascularization | $421 | $3,019 |
| 37221 | Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed | $520 | $4,284 |
| 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) | $195 | $816 |
| 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 | $2,256 |
| **FEMORAL/POPLITEAL ARTERY REVASCULARIZATION** | | | |
| 37224 | Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty | $466 | $3,628 |
| 37225 | Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed | $635 | $12,444 |
| 37226 | Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed | $547 | $10,793 |
| 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 | $763 | $16,033 |
| **TIBIAL/PERONEAL ARTERY REVASCULARIZATION** | | | |
| 37228 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty | $570 | $5,260 |
| 37229 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed | $741 | $12,451 |
| 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 | $735 | $10,600 |
| 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 | $799 | $15,230 |
| 37232 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty. | $211 | $1,122 |
| 37233 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed. | $343 | $1,367 |

+ 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 PERIPHERAL VASCULAR PROCEDURES

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **ILIAC ARTERY REVASCULARIZATION** | | |
| 37220 | Iliac revascularization | $2,002 |
| 37221 | Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed | $5,834 |
| 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 | $2,887 |
| 37225 | Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed | $6,410 |
| 37226 | Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed | $6,223 |
| 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 | $10,354 |
| **TIBIAL/PERONEAL ARTERY REVASCULARIZATION** | | |
| 37228 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty | $5,484 |
| 37229 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed | $9,787 |
| 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 | $9,604 |
| 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 | $9,851 |
| 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 |

+ Indicates add-on code
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It is incumbent upon the physician to determine which, if any modifiers should be used first.

## REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 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 | $3,955 |
| 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. | $421 | $4,291 |
| **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 | $2,136 |
| 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 | $814 |
| 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 | $1,527 |
| 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) | $152 | $604 |
| **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) | $463 | $4,950 |
| 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 | $7,622 |
| 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 | $589 | $9,861 |
| 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 | $696 | $7,052 |
| 36140 | Introduction of needle or intracatheter; extremity artery | $94 | $459 |

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## REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

| CPT‡ CODE | CPT‡ 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 | $2,002 |
| 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 | $2,002 |
| 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) | $4,056 |
| 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) | $5,787 |
| 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 | $4,056 |
| 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 |

+ 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.

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## REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | 2019 NON-FACILITY |
|---|---|---|---|
| **EMBOLIZATION/CATHETER ACCESS (CONT'D)** | | | |
| 36160 | Introduction of needle or intracatheter, aortic, translumbar | $129 | $527 |
| 36200 | Introduction of catheter, aorta | $146 | $585 |
| **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 | $176 | $661 |
| 36902 | ... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty | $251 | $1,301 |
| 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 | $333 | $5,485 |
| 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 | $1,914 |
| 36905 | ... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty | $465 | $2,407 |
| 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 | $6,723 |
| 36907 | Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty | $154 | $736 |
| 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 | $2,451 |
| 36909 | Dialysis circuit permanent vascular embolization or occlusion, endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention | $210 | $1,981 |

**New Coding Updates:** A new CPT procedure code was creatd for vessel access and closure in endograft procedures.

| CPT‡ CODE | CPT‡ DESCRIPTION | 2019 FACILITY | 2019 NON-FACILITY |
|---|---|---|---|
| 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 | $134 | 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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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.

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## REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

| CPT‡ CODE | CPT‡ 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 | $523 |
| 36902 | ... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty | $2,002 |
| 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 | $6,002 |
| 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); | $2,663 |
| 36905 | ... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty | $4,056 |
| 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 | $9,724 |
| 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 |

**New Coding Updates:** A new CPT procedure code was creatd for vessel access and closure in endograft procedures.

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| 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 |

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).

+ 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.

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## REIMBURSEMENT FOR PACEMAKERS

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 NON-FACILITY |
|---|---|---|---|
| **PACEMAKER SYSTEM IMPLANT** | | | |
| 33206 | Insertion of new or replacement of permanent pacemaker with transvenous electrode(s);atrial | $474 | NA |
| 33207 | Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular | $503 | NA |
| 33208 | Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular | $546 | NA |
| **PACEMAKER 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 |
| 33221 | Insertion of pacemaker pulse generator only; with existing multiple leads | $376 | NA |
| **INSERTION OF LEAD(S)** | | | |
| 33216 | Insertion of single lead | $388 | NA |
| 33217 | Insertion of two leads | $382 | NA |
| 33224 | Insertion of pacing LV lead, with attachment to previously placed pacemaker or ICD generator including revision of pocket, removal, insertion and/or replacement of existing generator | $541 | NA |
| +33225 | Insertion of pacing LV lead at time of insertion of ICD or pacemaker generator (including up-grade to dual-chamber system) | $493 | NA |
| **REPOSITIONING/REPAIR/REVISION** | | | |
| 33215 | Repositioning of previously implanted transvenous pacemaker or ICD (right atrial or right ventricular) electrode | $325 | NA |
| 33226 | Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator) | $521 | NA |
| 33218 | Repair of single transvenous electrode, permanent pacemaker or ICD | $405 | NA |
| 33222 | Relocation of skin pocket for pacemaker | $354 | NA |
| **REMOVAL AND/OR REPLACEMENT** | | | |
| 33214 | Upgrade of implanted pacemaker system, conversion of single-chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator | $501 | NA |
| 33227 | Removal of permanent pacemaker pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator | $354 | NA |
| 33228 | Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system | $370 | NA |
| 33229 | Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system | $392 | NA |
| 33233 | Removal of permanent pacemaker pulse generator only | $241 | NA |
| 33234 | Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular | $508 | NA |
| 33235 | Removal of transvenous pacemaker electrode(s); dual lead system | $667 | NA |

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## REIMBURSEMENT FOR PACEMAKERS

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **PACEMAKER SYSTEM IMPLANT** | | |
| 33206 | Insertion of new or replacement of permanent pacemaker with transvenous electrode(s);atrial | $7,940 |
| 33207 | Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular | $7,920 |
| 33208 | Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular | $8,065 |
| **PACEMAKER GENERATOR IMPLANT** | | |
| 33212 | Insertion of pacemaker pulse generator only; with existing single lead | $5,877 |
| 33213 | Insertion of pacemaker pulse generator only; with existing dual lead | $8,088 |
| 33221 | Insertion of pacemaker pulse generator only; with existing multiple leads | $12,777 |
| **INSERTION OF LEAD(S)** | | |
| 33216 | Insertion of single lead | $5,326 |
| 33217 | Insertion of two leads | $5,898 |
| 33224 | Insertion of pacing LV lead, with attachment to previously placed pacemaker or ICD generator including revision of pocket, removal, insertion and/or replacement of existing generator | $7,919 |
| +33225 | Insertion of pacing LV lead at time of insertion of ICD or pacemaker generator (including upgrade to dual-chamber system) | NA |
| **REPOSITIONING/REPAIR/REVISION** | | |
| 33215 | Repositioning of previously implanted transvenous pacemaker or ICD (right atrial or right ventricular) electrode | $1,305 |
| 33226 | Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator) | $1,690 |
| 33218 | Repair of single transvenous electrode, permanent pacemaker or ICD | $1,612 |
| 33222 | Relocation of skin pocket for pacemaker | $798 |
| **REMOVAL AND/OR REPLACEMENT** | | |
| 33214 | Upgrade of implanted pacemaker system, conversion of single-chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator | $7,883 |
| 33227 | Removal of permanent pacemaker pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator | $5,831 |
| 33228 | Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system | $7,875 |
| 33229 | Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system | $12,783 |
| 33233 | Removal of permanent pacemaker pulse generator only | $3,701 |
| 33234 | Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular | $1,612 |
| 33235 | Removal of transvenous pacemaker electrode(s); dual lead system | $1,612 |

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## REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 NON-FACILITY |
|---|---|---|---|
| **PACEMAKER DEVICE MONITORING** | | | |
| 93279 | Programming device evaluation, single lead system | NA | $56 |
| 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 | $66 |
| 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 | $71 |
| 93288 | Interrogation device evaluation (in person), single, dual or multiple lead system | NA | $45 |
| 93286 | Peri-procedural programming, single, dual or multiple lead system | NA | $36 |
| 93293 | Trans-telephonic rhythm strip pacemaker evaluation | NA | $53 |
| 93296 | Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker or ICD systems, remote data acquisition(s), transmissions, technician review and support, results distribution | NA | $26 |
| **IMPLANTABLE CARDIOVASCULAR PHYSIOLOGIC MONITORING SYSTEMS** | | | |
| 93290 | Interrogation device evaluation (in person) with analysis, review and by a physician or other qualified health care professional, includes connection, recording per patient encounter: implantable cardiovascular monitor system, including analysis of one or more recorded physiologic cardiovascular data elements from internal and external sensors | NA | $43 |
| 93297 | 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, analysis, reviews(s) and reports(s) | $27 | $27 |
| 93299 | 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 |

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## REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **PACEMAKER DEVICE MONITORING** | | |
| 93279 | Programming device evaluation, single lead system | 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), single, dual or multiple lead system | NA |
| 93286 | Peri-procedural programming, single, dual or multiple lead system | NA |
| 93293 | Trans-telephonic rhythm strip pacemaker evaluation | NA |
| 93296 | Interrogation device evaluation(s) (remote), up to 90 days; single, dual or multiple lead pacemaker or ICD systems, remote data acquisition(s), transmissions, technician review and support, results distribution | NA |
| **IMPLANTABLE CARDIOVASCULAR PHYSIOLOGIC MONITORING SYSTEMS** | | |
| 93290 | Interrogation device evaluation (in person) with analysis, review and by a physician or other qualified health ca e professional, includes connection, recording per patient encounter: implantable cardiovascular monitor system, includinganalysis of one or more recorded physiologic cardiovascular data elements from internal and external sensors | NA |
| 93297 | 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, analysis, reviews(s) and reports(s) | NA |
| 93299 | Interrogation device evaluation(s) (remote) up to 30 days; implantable cardiovascular physiologic monitor system or remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results | NA |

+ 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 CARDIAC DEVICE MONITORING

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 NON-FACILITY |
|---|---|---|---|
| **ICD DEVICE MONITORING** | | | |
| 93282 | Programming device evaluation, (in person) single lead ICD system | NA | $68 |
| 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 | $86 |
| 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 | $93 |
| 93289 | Interrogation device evaluation (in person), single, dual or multiple ICD system | NA | $61 |
| 93287 | Peri-procedural programming evaluation (in-person), single, dual or multiple ICD system | NA | $44 |
| 93295 | Interrogation device evaluation (remote), single, dual or multiple lead ICD system | $45 | $45 |
| 93296 | Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results | NA | $26 |
| **INSERTABLE/IMPLANTABLE CARDIAC MONITOR (ICM) DEVICE MONITORING** | | | |
| 93285 | 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 | $49 |
| 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 | $39 |
| 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 | $27 | $27 |
| 93299 | 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 |

+ 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 CARDIAC DEVICE MONITORING

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **ICD DEVICE MONITORING** | | |
| 93282 | Programming device evaluation, (in person) single lead ICD 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), single, dual or multiple ICD system | NA |
| 93287 | Peri-procedural programming evaluation (in-person), single, dual or multiple ICD system | NA |
| 93295 | Interrogation device evaluation (remote), single, dual or multiple lead ICD system | NA |
| 93296 | nterrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results | NA |
| **INSERTABLE/IMPLANTABLE CARDIAC MONITOR (ICM) DEVICE MONITORING** | | |
| 93285 | 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 |
| 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 |
| 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 |
| 93299 | 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 |

+ 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 IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 NON-FACILITY |
|---|---|---|---|
| **INSERTABLE CARDIAC MONITORS** | | | |
| 33285 | Insertion of a subcutaneous cardiac rhythm monitor | $93 | $5,264 |
| 33286 | Removal of a subcutaneous cardiac rhythm monitor | $92 | $137 |
| **INSERTABLE CARDIAC MONITORING** | | | |
| 93285 | Programming device evaluation, (in person) with iterative adjustment of the im-plantable device to test function of the device and select optimal permanent pro-grammed values with analysis, review and report by a physician or other qualified health care professional; implantable loop recorder system | NA | $49 |
| 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; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis | NA | $39 |
| 93298 | Interrogation device evaluation(s), (remote) up to 30 days; implantable loop re-corder system, including analysis of recorded heart rhythm data, analysis review(s) and report(s) by a physician or other qualified health ca e professional | $27 | $27 |
| 93299 | Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovas-cular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmission and technician review, technical support and distribution of results | NA | NA |

+ 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 IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **INSERTABLE CARDIAC MONITORS** | | |
| 33285 | Insertion of a subcutaneous cardiac rhythm monitor | $6,375 |
| 33286 | Removal of a subcutaneous cardiac rhythm monitor | $298 |
| **INSERTABLE CARDIAC MONITORING** | | |
| 93285 | Programming device evaluation, (in person) with iterative adjustment of the im-plantable device to test function of the device and select optimal permanent pro-grammed values with analysis, review and report by a physician or other qualified health care professional; implantable loop recorder system | NA |
| 93291 | Interrogation device evaluation, (in person) with analysis, review and report by a physician or other qualified health ca e professional, includes connection, record-ing and disconnection per patient encounter; implantable loop recorder system, in-cluding heart rhythm derived data analysis | NA |
| 93298 | Interrogation device evaluation(s), (remote) up to 30 days; implantable loop re-corder system, including analysis of recorded heart rhythm data, analysis review(s) and report(s) by a physician or other qualified health ca e professional | NA |
| 93299 | Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovas-cular monitor system or implantable loop recorder system, remote data acquisi-tion(s), receipt of transmission and technician review, technical support and distri-bution of results | NA |

+ 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 IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 NON-FACILITY |
|---|---|---|---|
| **ICD SYSTEM IMPLANT** | | | |
| 33249 | Insertion or replacement of permanent ICD system with leads(s); single or dual | $961 | NA |
| **ICD GENERATOR** | | | |
| 33240 | Insertion ICD generator only with existing single lead | $382 | NA |
| 33230 | Insertion ICD generator only with existing dual lead | $400 | NA |
| 33231 | Insertion ICD generator only with existing multiple lead | $420 | NA |
| **LEAD(S)** | | | |
| 33216 | Insertion ICD single lead | $386 | NA |
| 33217 | Insertion two leads | $382 | NA |
| 33224 | Insertion of pacing LV lead, with attachment to previously place pacemaker or ICD generator (including revision pocket, removal, insertion and/or replacement or existing generator) | $541 | NA |
| +33225 | Insertion of pacing LV lead at time of insertion of pacemaker or ICD gnerator (including upgrade to dual chamber system and pocket revision) | $493 | NA |
| **REPOSITIONING/REPAIR/REVISION** | | | |
| 33215 | Repositioning of previously implanted ransvenous pacemaker or ICD (right atrial or right ventricular) electrode | $325 | NA |
| 33226 | Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator) | $521 | NA |
| 33218 | Repair of single transvenous electrode, permanent pacemaker or ICD | $405 | NA |
| 33220 | Repair of 2 transvenous electrodes for permanent pacemaker or ICD | $408 | NA |
| 33223 | Relocation of skin pocket ICD | $428 | NA |
| **REMOVAL WITH REPLACEMENT** | | | |
| 33262 | Removal of ICD pulse generator with replacement of ICD generator, single lead system | $390 | NA |
| 33263 | Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system | $406 | NA |
| 33264 | Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system | $424 | NA |
| **REMOVAL ONLY** | | | |
| 33241 | Removal of ICD generator only | $225 | NA |
| 33244 | Removal of single or dual chamber ICD electrode(s); by transvenous extraction | $904 | NA |

+ 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 IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **ICD SYSTEM IMPLANT** | | |
| 33249 | Insertion or replacement of permanent ICD system with leads(s); single or dual | $27,056 |
| **ICD GENERATOR** | | |
| 33240 | Insertion ICD generator only with existing single lead | $19,901 |
| 33230 | Insertion ICD generator only with existing dual lead | $19,715 |
| 33231 | Insertion ICD generator only with existing multiple lead | $19,843 |
| **LEAD(S)** | | |
| 33216 | Insertion ICD single lead | $5,326 |
| 33217 | Insertion two leads | $5,898 |
| 33224 | Insertion of pacing LV lead, with attachment to previously place pacemaker or ICD generator (including revision pocket, removal, insertion and/or replacement or existing generator) | $7,919 |
| +33225 | Insertion of pacing LV lead at time of insertion of pacemaker or ICD gnerator (including upgrade to dual chamber system and pocket revision) | NA |
| **REPOSITIONING/REPAIR/REVISION** | | |
| 33215 | Repositioning of previously implanted ransvenous pacemaker or ICD (right atrial or right ventricular) electrode | $1,305 |
| 33226 | Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator) | $1,690 |
| 33218 | Repair of single transvenous electrode, permanent pacemaker or ICD | $1,612 |
| 33220 | Repair of 2 transvenous electrodes for permanent pacemaker or ICD | $1,612 |
| 33223 | Relocation of skin pocket ICD | $798 |
| **REMOVAL WITH REPLACEMENT** | | |
| 33262 | Removal of ICD pulse generator with replacement of ICD generator, single lead system | $19,280 |
| 33263 | Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system | $19,564 |
| 33264 | Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system | $27,119 |
| **REMOVAL ONLY** | | |
| 33241 | Removal of ICD generator only | $1,612 |
| 33244 | Removal of single or dual chamber ICD electrode(s); by transvenous extraction | NA |

+ 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

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | 2019 NON-FACILITY |
|---|---|---|---|
| **COMPREHENSIVE ELECTROPHYSIOLOGY STUDIES** | | | |
| +93619 | Comprehensive electrophysiologic evaluation without induction | $410 | $410 |
| +93620 | Comprehensive electrophysiologic evaluation without induction | $659 | $659 |
| +93624 | Electrophysiologic follow-up study | $254 | $254 |
| +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 | $122 | $122 |
| +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 | $181 | $181 |
| +93623 | Stimulation pacing heart, after drug infusion | $166 | $166 |
| **LIMITED STUDIES** | | | |
| +93600 | Bundle of His recording | $124 | $124 |
| +93602 | Intr-atrial recording | $122 | $122 |
| +93603 | Right ventricular recording | $122 | $122 |
| +93610 | Intr-atrial pacing | $172 | $172 |
| +93612 | Intaventricular pacing | $170 | $170 |
| **CATHETER ABLATION** | | | |
| 93650 | Intracardiac ablation of AV node, with or without temporary pacemaker placement | $620 | NA |
| 93653 | Comprehensive electrophysiologic evaluation and ablation, SVT | $878 | NA |
| 93654 | Comprehensive electrophysiologic evaluation and ablation, VT | $1,175 | NA |
| 93655 | Ablate arrhythmia | $447 | NA |
| 93656 | Comprehensive electrophysiologic evaluation and ablation, PVI | $1,178 | NA |
| 93657 | Ablate left/right atrium arrhythmia | $446 | NA |
| **ADD-ON SERVICE ES (ECHOCARDIOGRAPHY/TRANSSEPTAL PUNCTURE/MAPPING)** | | | |
| +93662 | Intracardiac echocardiography (ICE) | $147 | $147 |
| 93462 | Left heart catheterization by transseptal puncture | $220 | $220 |
| +93609 | Intraventricular and/or intra-atrial mapping of tachycardia | $292 | $292 |
| 93613 | Intracardiac electrophysiologic 3-D mapping | $311 | NA |
| **ESOPHAGEAL RECORDING AND INDUCTION OF ARRHYTHMIA** | | | |
| +93615 | Esophageal recording of atrial electrogram | $39 | $39 |
| +93616 | Esophageal recording of atrial electrogram; with pacing | $62 | $62 |
| +93618 | Induction of arrhythmia by electrical pacing | $232 | $232 |

+ 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

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **COMPREHENSIVE ELECTROPHYSIOLOGY STUDIES** | | |
| +93619 | Comprehensive electrophysiologic evaluation without induction | NA |
| +93620 | Comprehensive electrophysiologic evaluation without induction | NA |
| +93624 | Electrophysiologic follow-up study | 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 |
| +93623 | Stimulation pacing heart, after drug infusion | NA |
| **LIMITED STUDIES** | | |
| +93600 | Bundle of His recording | NA |
| +93602 | Intr-atrial recording | NA |
| +93603 | Right ventricular recording | NA |
| +93610 | Intr-atrial pacing | NA |
| +93612 | Intaventricular pacing | NA |
| **CATHETER ABLATION** | | |
| 93650 | Intracardiac ablation of AV node, with or without temporary pacemaker placement | NA |
| 93653 | Comprehensive electrophysiologic evaluation and ablation, SVT | NA |
| 93654 | Comprehensive electrophysiologic evaluation and ablation, VT | NA |
| 93655 | Ablate arrhythmia | NA |
| 93656 | Comprehensive electrophysiologic evaluation and ablation, PVI | NA |
| 93657 | Ablate left/right atrium arrhythmia | NA |
| **ADD-ON SERVICE ES (ECHOCARDIOGRAPHY/TRANSSEPTAL PUNCTURE/MAPPING)** | | |
| +93662 | Intracardiac echocardiography (ICE) | NA |
| 93462 | Left heart catheterization by transseptal puncture | NA |
| +93609 | Intraventricular and/or intra-atrial mapping of tachycardia | NA |
| 93613 | Intracardiac electrophysiologic 3-D mapping | NA |
| **ESOPHAGEAL RECORDING AND INDUCTION OF ARRHYTHMIA** | | |
| +93615 | Esophageal recording of atrial electogram | NA |
| +93616 | Esophageal recording of atrial electrogram; with pacing | NA |
| +93618 | Induction of arrhythmia by electrical pacing | NA |

+ 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 LEFT VENTRICULAR ASSIST DEVICE (LVAD)

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 NON-FACILITY |
|---|---|---|---|
| **LEFT VENTRICULAR ASSIST DEVICE (LVAD) PROCEDURES** | | | |
| **LVAD IMPLANT*** | | | |
| 33979 | Insertion of ventricular assist device, implantable, intracorporeal, single ventricle | $2,042 | NA |
| **LVAD REMOVAL** | | | |
| 33980 | Removal of ventricular assist device, implantable, intracorporeal, single ventricle | $1,868 | NA |
| **LVAD REPLACEMENT** | | | |
| 33982 | Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, without cardiopulmonary bypass | $2,055 | NA |
| 33983 | Replacement of ventricular assist device pump(s); implantable intracorporeal, single ventricle, with cardiopulmonary bypass | $2,419 | 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 | $48 | $57 |

* Surgeons are able to bill for post implant visits and VAD interrogation starting the day after the VAD implantation, when documented appropriately, as there is a zero-day global period. Please consult your professional coding staff for documentation guidelines.

**This codes 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. Documentation in the patient's chart must support both the level chosen for the visit as well as the VAD interrogation code. There are no Correct Coding Initiative (CCI) edits for the interrogation code. It can be billed once, per day, per patient, per specialty, if medical necessity is adequately documented. 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.

+Indicates add-on code. For more information on the unlisted code, please go to: https://www.sjm.com/en/professionals/resources-and-reimbursement/reimbursement-support/hf-management
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 LEFT VENTRICULAR ASSIST DEVICE (LVAD)

| CPT‡ CODE | CPT‡ 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 |

* Surgeons are able to bill for post implant visits and VAD interrogation starting the day after the VAD implantation, when documented appropriately, as there is a zero-day global period. Please consult your professional coding staff for documentation guidelines.

**This codes 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. Documentation in the patient's chart must support both the level chosen for the visit as well as the VAD interrogation code. There are no Correct Coding Initiative (CCI) edits for the interrogation code. It can be billed once, per day, per patient, per specialty, if medical necessity is adequately documented. 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.

+Indicates add-on code. For more information on the unlisted code, please go to: https://www.sjm.com/en/professionals/resources-and-reimbursement/reimbursement-support/hf-management
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 CARDIOMEMS™ HF SYSTEM

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 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 | $343 | 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 |

+Indicates add-on code. For more information on the unlisted code, please go to: https://www.sjm.com/en/professionals/resources-and-reimbursement/reimbursement-support/hf-management
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 CARDIOMEMS™ HF SYSTEM

| CPT‡ CODE | CPT‡ 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 |

+Indicates add-on code. For more information on the unlisted code, please go to: https://www.sjm.com/en/professionals/resources-and-reimbursement/reimbursement-support/hf-management
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 SPINAL CORD STIMULATION (SCS)

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 NON-FACILITY |
|---|---|---|---|
| **TRIAL PROCEDURE** | | | |
| 63650 | Percutaneous implantation of neurostimulator electrode array, epidural | $426 | $1,657 |
| **PERMANENT PROCEDURES** | | | |
| 63650 | Percutaneous implantation of neurostimulator electrode array, epidural | $426 | $1,657 |
| 63655 | Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural | $869 | 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) | $375 | NA |
| **REVISION AND REMOVAL PRCEDURES** | | | |
| 63661 | Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed | $336 | $602 |
| 63662 | Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed | $879 | NA |
| 63663 | Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed | $467 | $845 |
| 63664 | Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy,when performed | $911 | NA |
| 63688 | Revision or removal of implanted spinal neurostimulator pulse generator or receiver | $387 | NA |
| **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 | $19 | $19 |
| 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 | $42 | $52 |
| 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 | $43 | $58 |

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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 SPINAL CORD STIMULATION (SCS)

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **TRIAL PROCEDURE** | | |
| 63650 | Percutaneous implantation of neurostimulator electrode array, epidural | $4,449 |
| **PERMANENT PROCEDURES** | | |
| 63650 | Percutaneous implantation of neurostimulator electrode array, epidural | $4,449 |
| 63655 | Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural | $15,741 |
| 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) | $22,580 |
| **REVISION AND REMOVAL PRCEDURES** | | |
| 63661 | Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed | $781 |
| 63662 | Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed | $1,483 |
| 63663 | Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed | $4,091 |
| 63664 | Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy,when performed | $14,142 |
| 63688 | Revision or removal of implanted spinal neurostimulator pulse generator or receiver | $1,483 |
| **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 |

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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 RADIOFREQUENCY ABLATION (RFA)

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 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 | $232 | $429 |
| 64634 | Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint | $70 | $192 |
| **LUMBAR SPINE/SACRAL SPINE** | | | |
| 64635 | Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imagingguidance (fluoroscopy or CT); lumbar or sacral, single facet joint | $228 | $424 |
| 64636 | Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint | $62 | $175 |
| **OTHER PERIPHERAL NERVES** | | | |
| 64640 | Destruction by neurolytic agent; other peripheral nerve or branch | $97 | $139 |
| 77002 | Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) | NA | $103 |

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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 RADIOFREQUENCY ABLATION (RFA)

| CPT‡ CODE | CPT‡ 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 | $781 |
| 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 imagingguidance (fluoroscopy or CT); lumbar or sacral, single facet joint | $781 |
| 64636 | Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint | NA |
| **OTHER PERIPHERAL NERVES** | | |
| 64640 | Destruction by neurolytic agent; other peripheral nerve or branch | $91 |
| 77002 | Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) | NA |

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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 DEEP BRAIN STIMULATION (DBS)

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 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 | $1,585 | 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) | $301 | 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 | $2,410 | 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) | $531 | NA |
| 61880 | Revision or removal of intracranial neurostimulator electrodes | $601 | 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 |

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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 DEEP BRAIN STIMULATION (DBS)

| CPT‡ CODE | CPT‡ DESCRIPTION | ASC RATE |
|---|---|---|
| **DIAGNOSTIC SERVICES** | | |
| 70450-26 | Computed tomography, head or brain; without contrast material | NA |
| 70551-26 | Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material | NA |
| 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 | NA |
| 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 | NA |
| **LEAD PRCEDURES** | | |
| 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 | 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) | 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 | 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) | NA |
| 61880 | Revision or removal of intracranial neurostimulator electrodes | $1,483 |
| **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 | NA |
| 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) | NA |

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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 DEEP BRAIN STIMULATION (DBS) CONT'D

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 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 | $540 | NA |
| 61886 | Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays | $893 | NA |
| 61888 | Revision or removal of cranial neurostimulator pulse generator or receiver | $417 | 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 | $19 | $19 |
| 95983 | Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/ transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional | $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) | $45 | $46 |

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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 DEEP BRAIN STIMULATION (DBS) CONT'D

| CPT‡ CODE | CPT‡ 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 | $16,949 |
| 61886 | Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays | $22,650 |
| 61888 | Revision or removal of cranial neurostimulator pulse generator or receiver | $4,536 |
| **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 | NA |
| 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 | NA |
| 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) | NA |

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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

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 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 | $1,025 | NA |
| **PATIENT DUCTUS ARTERISUS** | | | |
| 93582 | Percutaneous transcatheter closure of patent ductus arteriosus | $700 | NA |
| **VENTRICULAR SEPTAL DEFECT** | | | |
| 93581 | Percutaneous transcatheter closure of congenital ventricular septal defect with implant | $1,397 | 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

| CPT‡ CODE | CPT‡ 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 ARTERISUS** | | |
| 93582 | Percutaneous transcatheter closure of patent ductus arteriosus | NA |
| **VENTRICULAR SEPTAL DEFECT** | | |
| 93581 | Percutaneous transcatheter closure of congenital ventricular septal defect with implant | 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 SURGICAL HEART VALVES

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 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 | $2,367 | NA |
| 33411 | Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus | $3,508 | NA |
| 33412 | Replacement, aortic valve, with transventricular aortic annulus enlargement (Konno procedure) | $3,282 | NA |
| 33413 | Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (ross procedure) | $3,343 | NA |
| 33420 | Valvotomy, mitral valve; closed heart | $1,524 | NA |
| 33422 | Valvotomy, mitral valve; open heart, with cardiopulmonary bypass | $1,730 | NA |
| 33425 | Valvuloplasty, mitral valve, with cardiopulmonary bypass | $2,849 | NA |
| 33426 | Valvuloplasty, mitral valve, with cardiopulmonary bypass; with prosthetic ring | $2,486 | NA |
| 33427 | Valvuloplasty, mitral valve, with cardiopulmonary bypass; radical reconstruction, with or without ring | $2,552 | NA |
| 33430 | Replacement, mitral valve, with cardiopulmonary bypass | $2,921 | NA |
| 33460 | Valvectomy, tricuspid valve, with cardiopulmonary bypass | $2,504 | NA |
| 33464 | Valvuloplasty, tricuspid valve, with ring insertion | $2,548 | NA |
| 33465 | Replacement, tricuspid valve, with cardiopulmonary bypass | $2,880 | NA |
| 33468 | Tricuspid valve repositioning and plication for ebstein anomaly | $2,519 | NA |
| 33999 | Unlisted procedure, cardiac surgery | Carrier determined | Carrier determined |

## REIMBURSEMENT FOR AMPLATZER™ PFO OCCLUDER

| CPT‡ CODE | CPT‡ DESCRIPTION | MEDICARE PHYSICIAN RATE 2019 FACILITY | MEDICARE PHYSICIAN RATE 2019 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 | $1,025 | 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 SURGICAL HEART VALVES

| CPT‡ CODE | CPT‡ 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 |
| 33411 | Replacement, aortic valve; with aortic annulus enlargement, noncoronary sinus | NA |
| 33412 | Replacement, aortic valve, with transventricular aortic annulus enlargement (Konno procedure) | NA |
| 33413 | Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (ross procedure) | NA |
| 33420 | Valvotomy, mitral valve; closed heart | NA |
| 33422 | Valvotomy, mitral valve; open heart, with cardiopulmonary bypass | 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 |
| 33460 | Valvectomy, tricuspid valve, with cardiopulmonary bypass | NA |
| 33464 | Valvuloplasty, tricuspid valve, with ring insertion | NA |
| 33465 | Replacement, tricuspid valve, with cardiopulmonary bypass | NA |
| 33468 | Tricuspid valve repositioning and plication for ebstein anomaly | NA |
| 33999 | Unlisted procedure, cardiac surgery | NA |

## REIMBURSEMENT FOR AMPLATZER™ PFO OCCLUDER

| CPT‡ CODE | CPT‡ 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: 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.

## DISCLAIMER

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1. CY 2019 PFS Final Rule CY2019 Payment Rates. CMS-1693-F: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html
2. Ambulatory Surgical Center Payment-Final Rule CY2019 Payment Rates. CMS-1678-FC: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices-Items/CMS-1695-FC.html

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