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

Effective Dates: January 1, 2024 to December 31, 2024

TABLE OF CONTENTS

PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
ILIAC ARTERY REVASCULARIZATION			
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	NA	NA
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$381	$2,411
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	$469	$2,960
+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)	$176	$595
+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)	$202	$1,221
FEMORAL/POPLITEAL ARTERY REVASCULARIZATION			
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	$424	$2,803
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$570	$8,404
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$494	$7,785
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	$682	$10,732
TIBIAL/PERONEAL ARTERY REVASCULARIZATION			
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$515	$3,972
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$660	$8,551
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	$660	$8,565
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	$699	$11,308
+37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	$190	$790
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$306	$1,015

(+) = Indicates add-on code. List add-on code separately in addition to code for primary procedure.

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

PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
TIBIAL/PERONEAL ARTERY REVASCULARIZATION (CONT'D)			
+37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$268	$3,492
+37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$350	$3,794
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	$332	$1,746
+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)	$165	$568
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	$283	$1,302
+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)	$139	$426
ARTERIAL MECHANICAL THROMBECTOMY			
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	$411	$1,645
+37185	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)	$155	$457
+37186	Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)	$232	$1,140
VENOUS MECHANICAL THROMBECTOMY			
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$375	$1,626

(+) = Indicates add-on code. List add-on code separately in addition to code for primary procedure.

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

PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
VENOUS MECHANICAL THROMBECTOMY (CONT'D)			
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$268	$1,393
THROMBOLYSIS			
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	$369	NA
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	$322	NA
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	$220	NA
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	$116	NA
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)	$407	$4,441
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)	$453	$6,788
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	$532	$8,226
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	$628	$6,284
36140	Introduction of needle or intracatheter, upper or lower extremity artery	$85	$494
36160	Introduction of needle or intracatheter, aortic, translumbar	$118	$533
36200	Introduction of catheter, aorta	$133	$572
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	$225	$1,195
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	$242	$805
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	$284	$1,367

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

PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
EMBOLIZATION/CATHETER ACCESS (CONT'D)			
+36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	$46	$112
DIAGNOSTIC ANGIOGRAPHY LOWER EXTREMITY			
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	$80*	$147
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	$89*	$160
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 contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report	$160	$681
36902	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$229	$1,163
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	$301	$4,076
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);	$351	$1,740
36905	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$421	$2,189
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	$486	$5,188
+36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	$139	$567
+36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	$197	$1,360
+36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	$192	$1,818
+34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	$118	NA

CPT‡ Code 34713 is applicable only for aortic and iliac artery repair procedures using an endograft. The code may be listed twice for bilateral procedures. This will result in a total payment of 150% of the base payment rate (National Average Payment = $177.00).

NA: There is no established Medicare payment in this setting.

(+) = Indicates add-on code. List add-on code separately in addition to code for primary procedure.

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

PHYSICIAN REIMBURSEMENT FOR CORONARY PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
PCI PROCEDURES			
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$506	NA
+92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	No separate payment	No separate payment
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$563	NA
+92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	No separate payment	No separate payment
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	See 92928 for payment	NA
+C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)	No separate payment	No separate payment
93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;	$228*	$875
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	$266*	$976
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	$297*	$1,089
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	$333*	$1,187
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	$281*	$1,007
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	$319*	$1,083
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	$356*	$1,202
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	$394*	$1,326

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

PHYSICIAN REIMBURSEMENT FOR CORONARY PROCEDURES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
ANGIOGRAPHY WITH OCT IMAGING AND PHYSIOLOGY ASSESSMENT*			
C7516	Coronary angiography with IVUS or OCT	NA	NA
C7521	Right heart catheterization with IVUS or OCT	NA	NA
C7522	Right heart catheterization with “flow reserve”	NA	NA
C7523	Left heart catheterization with IVUS or OCT	NA	NA
C7524	Left heart catheterization with “flow reserve”	NA	NA
C7525	Coronary angiography in graft with left heart catheterization with IVUS or OCT	NA	NA
C7526	Coronary angiography in graft with left heart catheterization with “flow reserve”	NA	NA
C7527	Coronary angiography with right and left heart catheterization with IVUS or OCT	NA	NA
C7528	Coronary angiography with right and left heart catheterization with “flow reserve”	NA	NA
C7529	Coronary angiography in graft with right and left heart catheterization with “flow reserve”	NA	NA

*These codes only apply to the ASC site of service and do not impact physician reimbursement.

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

ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
ILIAC ARTERY REVASCULARIZATION		
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	$9,910
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$3,275
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	$6,772
+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	$3,452
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$11,695
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$7,029
37227	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	$11,873
TIBIAL/PERONEAL ARTERY REVASCULARIZATION		
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$6,333
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$11,096
37230	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$10,735
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	$11,981
+37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	No separate payment
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment

(+) = Indicates add-on code. List add-on code separately in addition to code for primary procedure.

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

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

ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
TIBIAL/PERONEAL ARTERY REVASCULARIZATION (CONT'D)		
+37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment
+37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment
TRANSLUMINAL BALLOON ANGIOPLASTY		
37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	$3,280
+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	$2,526
+37249	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	No separate payment
ARTERIAL MECHANICAL THROMBECTOMY		
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	$10,116
+37185	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)	No separate payment
+37186	Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)	No separate payment
VENOUS MECHANICAL THROMBECTOMY		
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$7,269

(+) = Indicates add-on code. List add-on code separately in addition to code for primary procedure.

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

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

ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
VENOUS MECHANICAL THROMBECTOMY (CONT'D)		
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$2,568
THROMBOLYSIS		
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	$3,658
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	$1,964
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	NA
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	NA
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)	$6,108
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)	$11,286
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	$4,848
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, upper or lower extremity artery	No separate payment
36160	Introduction of needle or intracatheter, aortic, translumbar	No separate payment
36200	Introduction of catheter, aorta	No separate payment
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	No separate payment
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	No separate payment
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	No separate payment

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

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

ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
EMBOLIZATION/CATHETER ACCESS (CONT'D)		
+36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	No separate payment
DIAGNOSTIC ANGIOGRAPHY		
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	NA
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	NA
DIALYSIS CIRCUIT		
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report	$554
36902	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$2,526
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	$6,931
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);	$3,223
36905	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$6,106
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	$11,288
+36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	No separate payment
+36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	No separate payment
+36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	No separate payment
+34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	No separate payment

(+) = Indicates add-on code. List add-on code separately in addition to code for primary procedure.

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

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

ASC REIMBURSEMENT FOR CORONARY PROCEDURES

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
PCI PROCEDURES		
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$3,413
+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	$6,616
+92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	No separate payment
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$6,706
+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;	$1,633
93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	$1,633
93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	$1,633
93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	$1,633
93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	$1,633
93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	$1,633
93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	$1,633
93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	$1,633

(+) = Indicates add-on code. List add-on code separately in addition to code for primary procedure.

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

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

ASC REIMBURSEMENT FOR CORONARY PROCEDURES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
ANGIOGRAPHY WITH OCT IMAGING AND PHYSIOLOGY ASSESSMENT		
C7516	Coronary angiography with IVUS or OCT	$2,526
C7521	Right heart catheterization with IVUS or OCT	$2,526
C7522	Right heart catheterization with “flow reserve”	$2,526
C7523	Left heart catheterization with IVUS or OCT	$2,526
C7524	Left heart catheterization with “flow reserve”	$2,526
C7525	Coronary angiography in graft with left heart catheterization with IVUS or OCT	$2,526
C7526	Coronary angiography in graft with left heart catheterization with “flow reserve”	$2,526
C7527	Coronary angiography with right and left heart catheterization with IVUS or OCT	$2,526
C7528	Coronary angiography with right and left heart catheterization with “flow reserve”	$2,526
C7529	Coronary angiography in graft with right and left heart catheterization with “flow reserve”	$2,526

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

PHYSICIAN REIMBURSEMENT FOR PACEMAKERS

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
SYSTEM IMPLANT OR REPLACEMENT			
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	$439	NA
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	$461	NA
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	$499	NA
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)			
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	$328	NA
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	$343	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)	$463	NA
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)			
33233	Removal of permanent pacemaker pulse generator only	$227	NA
GENERATOR IMPLANT			
33212	Insertion of pacemaker pulse generator only; with existing single lead	$313	NA
33213	Insertion of pacemaker pulse generator only; with existing dual leads	$327	NA
RELOCATION OF SKIN POCKET			
33222	Relocation of skin pocket for pacemaker	$333	NA
LEAD PROCEDURES			
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$359	NA
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$357	NA
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$300	NA
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$377	NA
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$369	NA
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	$467	NA
33235	Removal of transvenous pacemaker electrode(s); dual lead system	$614	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.

PHYSICIAN REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 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	$30*	$66
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	$35*	$77
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	$40*	$82
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	$20*	$55
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	$14*	$44
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	$14*	$43
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	$28	$28
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	$21
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	$39*	$78
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	$53*	$95
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	$58*	$103

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

PHYSICIAN REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
ICD/CRT-D DEVICE MONITORING - IN PERSON continued			
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	$35*	$70
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	$21*	$51
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	$35	$35
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	$21
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	$20*	$52
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	$59
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	$24*	$59
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	$17*	$48

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

PHYSICIAN REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of heart rhythm derived data, analysis review(s) and report(s) by a physician or other qualified health care professional	NA	$100

PHYSICIAN REIMBURSEMENT FOR IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
IMPLANT			
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	$84	$4,071
REMOVAL			
33286	Removal, subcutaneous cardiac rhythm monitor	$82	$127

*The National Facility rates shown with an * reflect payment when modifiers 26 is used (i.e. payment only for the professional component).
Carrier priced: Medicare has not established a payment amount for this code. Check with your local Medicare Administrative Contractor (MAC) to verify the payment amount.

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

Table of Contents

PHYSICIAN REIMBURSEMENT FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
SYSTEM IMPLANT OR REPLACEMENT			
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	$879	NA
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)			
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	$360	NA
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	$374	NA
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)			
33241	Removal of implantable defibrillator pulse generator only	$209	NA
GENERATOR IMPLANT			
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	$356	NA
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	$362	NA
RELOCATION OF SKIN POCKET			
33223	Relocation of skin pocket for implantable defibrillator	$396	NA
LEAD PROCEDURES			
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$359	NA
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$357	NA
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$300	NA
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$377	NA
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$369	NA
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction	$833	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.

Table of Contents

PHYSICIAN REIMBURSEMENT FOR CARDIAC RESYNCHRONIZATION THERAPY (CRT)

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

CPT‡ CODE	ADD-ON CODE CPT‡ CODE DESCRIPTOR (LIST SEPARATELY IN ADDITION TO CODE FOR THE PRIMARY PROCEDURE)	MEDICARE RATE		REPORT WITH PRIMARY PROCEDURE CODE
		2024 FACILITY	2024 NON-FACILITY	
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)	$442	NA	33206, 33207, 33208, 33212, 33213, 33214, 33216, 33217, 33221, 33223, 33228, 33229, 33230, 33231, 33233, 33234, 33235, 33240, 33249, 33263, or 33264

PHYSICIAN ADDITIONAL CODES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE	
		2024 FACILITY	2024 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)	$419	NA
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	$470	NA
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	$360	NA
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	$346	NA
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	$390	NA
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	$388	NA

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

ASC REIMBURSEMENT FOR PACEMAKERS

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
SYSTEM IMPLANT OR REPLACEMENT		
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	$7,223
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	$7,421
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	$7,639
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)		
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	$6,297
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	$7,465
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)	$7,663
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)		
33233	Removal of permanent pacemaker pulse generator only	$5,580
GENERATOR IMPLANT		
33212	Insertion of pacemaker pulse generator only; with existing single lead	$6,316
33213	Insertion of pacemaker pulse generator only; with existing dual leads	$7,588
RELOCATION OF SKIN POCKET		
33222	Relocation of skin pocket for pacemaker	$946
LEAD PROCEDURES		
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$5,643
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$5,430
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$1,548
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$2,037
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$2,662
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	$2,690
33235	Removal of transvenous pacemaker electrode(s); dual lead system	$2,037

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

ASC REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

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

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

ASC REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

Table of Contents

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

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

ASC REIMBURSEMENT FOR IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
IMPLANT		
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	$6,904
REMOVAL		
33286	Removal, subcutaneous cardiac rhythm monitor	$365

ASC REIMBURSEMENT FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
SYSTEM IMPLANT OR REPLACEMENT		
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	$24,843
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)		
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	$19,146
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	$19,129
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)		
33241	Removal of implantable defibrillator pulse generator only	$2,037
GENERATOR IMPLANT		
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	$19,843
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	$19,039
RELOCATION OF SKIN POCKET		
33223	Relocation of skin pocket for implantable defibrillator	$946
LEAD PROCEDURES		
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	$5,643
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	$5,430
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	$1,548
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	$2,037
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	$2,662

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

ASC REIMBURSEMENT FOR CARDIAC RESYNCHRONIZATION THERAPY (CRT)

Table of Contents

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

CPT‡ CODE	ADD-ON CODE CPT‡ CODE DESCRIPTOR (LIST SEPARATELY IN ADDITION TO CODE FOR THE PRIMARY PROCEDURE)	REPORT WITH PRIMARY PROCEDURE CODE	MEDICARE RATE ASC
LEFT VENTRICULAR LEAD PLACEMENT FOR CRT PROCEDURES			
+33225	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of implantable defibrillator or pacemaker pulse generator (e.g., for upgrade to dual chamber system) (List separately in addition to code for primary procedure)	33206	$7,223
		33207	$7,421
		33208	$7,639
		33212	$6,316
		33213	$7,588
		33214	$7,663
		33216	$5,643
		33217	$5,430
		33221	$13,052
		33223	$946
		33228	$7,466
		33229	$12,867
		33230	$19,039
		33231	$25,183
		33233	$5,580
		33234	$2,690
		33235	$2,037
		33240	$19,843
		33249	$24,843
		33263	$19,129
		33264	$25,027

ASC ADDITIONAL CODES

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
OTHER CRT PROCEDURES		
33224	Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or implantable defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of existing generator)	$7,724
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	$1,950
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	$12,867
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	$13,052
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	$25,027
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	$25,183

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

PHYSICIAN REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$407	$2,236
PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$407	$2,236
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	$838	NA
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	$337	NA
REVISION AND REMOVAL PROCEDURES			
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	$326	$675
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	$851	NA
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	$444	$889
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	$886	NA
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	$298	NA
ELECTRONIC ANALYSIS AND DEVICE PROGRAMMING			
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	$18	$18
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	$38	$47
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	$39	$56

* A physician or an auxiliary person employed by and under the direct supervision of that physician may provide, with or without the support of the manufacturer's representative, analysis and programming of a patient's medical product or device "incident to" the physician's other services performed in the office setting. A patient or his payer should not be billed for analysis and programming services performed at the direction of the physician by a manufacturer's representative. Contact your MAC or other payer for any questions regarding coverage, coding and payment.
NA: There is no Medicare valuations for these codes and these procedures are not typically performed in an in-office setting.
It is incumbent upon the physician to determine which, if any, modifiers should be used first.

PHYSICIAN REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 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	$188	$430
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	$65	$251
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	$188	$434
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	$57	$236
GENICULAR NERVE			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	$143	$382
SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	$191	$465
OTHER PERIPHERAL NERVES			
*64640	Destruction by neurolytic agent; other peripheral nerve or branch	$117	$244
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	NA	$114
UNLISTED PROCEDURE			
64999	Unlisted procedure, nervous system	NA	Carrier priced

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

PHYSICIAN REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 NON-FACILITY
DIAGNOSTIC SERVICES			
70450-26	Computed tomography, head or brain; without contrast material	$39	$39
70551-26	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material	$68	$68
76376-26	3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality with image post processing under concurrent supervision; not requiring image post processing on an independent workstation	$9	$9
76377-26	3-D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality with image post processing under concurrent supervision; requiring image post processing on an independent workstation	$37	$37
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	$1,506	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)	$278	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	$2,272	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)	$491	NA
61880	Revision or removal of intracranial neurostimulator electrodes	$591	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	$156	$156
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)	$166	$166

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

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

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE 2024 FACILITY	MEDICARE RATE 2024 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	$530	NA
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	$885	NA
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	$398	NA
IMPLANTABLE PULSE GENERATOR (IPG) ANALYSIS AND PROGRAMMING*			
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	$18	$18
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	$48	$49
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)	$42	$43

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

ASC REIMBURSEMENT FOR SPINAL CORD STIMULATION (SCS)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
TRIAL PROCEDURE		
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$4,952
PERMANENT PROCEDURES		
63650	Percutaneous implantation of neurostimulator electrode array, epidural	$4,952
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	$17,993
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, requiring pocket creation and connection between electrode array and pulse generator or receiver	$25,298
REVISION AND REMOVAL PROCEDURES		
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	$898
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	$1,898
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	$4,864
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	$10,317
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver, with detachable connection to electrode array	$1,898
ELECTRONIC ANALYSIS AND DEVICE PROGRAMMING		
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	NA
95971*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	NA
95972*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	NA

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

ASC REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

Table of Contents

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
CERVICAL SPINE/THORACIC SPINE		
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	$898
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	$898
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	$898
SACROILIAC JOINT		
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	$898
OTHER PERIPHERAL NERVES		
*64640	Destruction by neurolytic agent; other peripheral nerve or branch	$173
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	NA
UNLISTED PROCEDURE		
64999	Unlisted procedure, nervous system	NA

ASC REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS)

CPT‡ CODE	CPT‡ CODE DESCRIPTION	MEDICARE RATE ASC
IMPLANTABLE PULSE GENERATOR (IPG) PROCEDURES		
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	$19,380
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	$25,340
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	$10,782
IMPLANTABLE PULSE GENERATOR (IPG) ANALYSIS AND PROGRAMMING*		
61880	Revision or removal of intracranial neurostimulator electrodes	$1,898

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

DISCLAIMER

Table of Contents

This material and the information contained herein is for general information purposes only and is not intended, and does not constitute, legal, reimbursement, business, clinical, or other advice. Furthermore, it is not intended to and does not constitute a representation or guarantee of reimbursement, payment, or charge, or that reimbursement or other payment will be received. It is not intended to increase or maximize payment by any payer. Abbott makes no express or implied warranty or guarantee that the list of codes and narratives in this document is complete or error-free. Similarly, nothing in this document should be viewed as instructions for selecting any particular code, and Abbott does not advocate or warrant the appropriateness of the use of any particular code. The ultimate responsibility for coding and obtaining payment/reimbursement remains with the customer. This includes the responsibility for accuracy and veracity of all coding and claims submitted to third-party payers. In addition, the customer should note that laws, regulations, and coverage policies are complex and are updated frequently and is subject to change without notice. The customer should check with its local carriers or intermediaries often and should consult with legal counsel or a financial, coding, or reimbursement specialist for any questions related to coding, billing, reimbursement, or any related issues. This material reproduces information for reference purposes only. It is not provided or authorized for marketing use.

The information provided in this document was obtained from third-party sources and is subject to change without notice as a result of changes in reimbursement laws, regulations, rules, policies, and payment amounts. All content is informational only, general in nature, and does not cover all situations or all payers' rules and policies. It is the responsibility of the hospital or physician to determine appropriate coding for a particular patient and/or procedure. Any claim should be coded appropriately and supported with adequate documentation in the medical record. A determination of medical necessity is a prerequisite that Abbott assumes will have been made prior to assigning codes or requesting payments. Any codes provided are examples of codes that specify some procedures, or which are otherwise supported by prevailing coding practices. They are not necessarily correct coding for any specific procedure using Abbott's products.

Hospitals and physicians should consult with appropriate payers, including Medicare Administrative Contractors, for specific information on proper coding, billing, and payment levels for healthcare procedures. Abbott makes no express or implied warranty or guarantee that (i) the list of codes and narratives in this document is complete or error-free, (ii) the use of this information will prevent difference of opinions or disputes with payers, (iii) these codes will be covered [or (iv) the provider will receive the reimbursement amounts set forth herein]. Reimbursement policies can vary considerably from one region to another and may change over time.

The FDA-approved/cleared labeling for all products may not be consistent with all uses described herein. This document is in no way intended to promote the off-label use of medical devices. The content is not intended to instruct hospitals and/or physicians on how to use medical devices or bill for healthcare procedures.

1. Physician Prospective Payment-Final rule with Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY2024. CMS-1784-F: https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f

2. Ambulatory Surgical Center Payment-Notice of Final Rulemaking with Comment Period(NFRM) CY2024. CMS-1786cms-FC: https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc

Information contained herein for DISTRIBUTION in the US ONLY.

CAUTION: This product is intended for use by or under the direction of a physician. Prior to use, reference the Instructions for Use, inside the product carton (when available) or at vascular.eifu.abbott or at manuals.eifu.abbott for more detailed information on Indications, Contraindications, Warnings, Precautions and Adverse Events.

Abbott

One St. Jude Medical Dr., St. Paul, MN 55117, USA, Tel: 1 651 756 2000
3200 Lakeside Dr, Santa Clara, CA 95054 USA, Tel: 1 800 227 9902

www.cardiovascular.abbott
www.neuromdulation.abbott

Abbott