

ABBOTT CODING GUIDE

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

Effective Dates: January 1, 2023 to December 31, 2023

TABLE OF CONTENTS

VASCULAR

Peripheral Vascular Procedures	3-10
Coronary Procedures	11-14

CARDIAC RHYTHM MANAGEMENT

Pacemakers	15-16
Cardiac Device Monitoring	17-21
Implantable/Insertable Cardiac Monitors (ICM)	22-23
Implantable Cardioverter Defibrillators (ICD)	24-25
Cardiac Resynchronization Therapy (CRT).....	26-27

NEUROMODULATION

Spinal Cord Stimulation (SCS)	28-29
Radiofrequency Ablation (RFA)	30-31
Deep Brain Stimulation (DBS)	32-34

SUMMARY

Disclaimer	35
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PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

[Table of Contents](#)

CPT+ CODE	CPT+ CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 NON-FACILITY
ILIAC ARTERY REVASCULARIZATION			
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	\$385	\$2,498
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	\$474	\$3,073
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)	\$178	\$611
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)	\$203	\$1,270
FEMORAL/POPLITEAL ARTERY REVASCULARIZATION			
37224	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty	\$427	\$2,914
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	\$574	\$8,739
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	\$499	\$8,134
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	\$689	\$11,193
TIBIAL/PERONEAL ARTERY REVASCULARIZATION			
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	\$520	\$4,138
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	\$667	\$8,880
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	\$666	\$8,893
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	\$705	\$11,746
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)	\$191	\$816
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)	\$309	\$1,036

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

ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

[Table of Contents](#)

CPT+ CODE	CPT+ CODE DESCRIPTION	MEDICARE RATE ASC
ILIAC ARTERY REVASCULARIZATION		
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	\$3,074
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	\$6,599
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	\$3,230
37225	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	\$7,056
37226	Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	\$6,969
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	\$11,792
TIBIAL/PERONEAL ARTERY REVASCULARIZATION		
37228	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with transluminal angioplasty	\$6,085
37229	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	\$11,119
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	\$11,352
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	\$11,322
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

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.

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PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

[Table of Contents](#)

CPT+ CODE	CPT+ CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 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)	\$270	\$3,621
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)	\$356	\$3,949
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	\$335	\$1,809
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)	\$166	\$561
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	\$285	\$1,351
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)	\$140	\$438
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	\$415	\$1,703
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)	\$157	\$469
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)	\$234	\$1,181
VENOUS MECHANICAL THROMBECTOMY			
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	\$378	\$1,696

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ASC REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

[Table of Contents](#)

CPT+ CODE	CPT+ CODE DESCRIPTION	MEDICARE RATE ASC
TIBIAL/PERONEAL ARTERY REVASCULARIZATION (CONT'D)		
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment
37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	No separate payment
TRANSLUMINAL BALLOON ANGIOPLASTY		
37246	Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery	\$3,037
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	\$2,327
37249	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (List separately in addition to code for primary procedure)	No separate payment
ARTERIAL MECHANICAL THROMBECTOMY		
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	\$6,563
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	\$7,321

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PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

[Table of Contents](#)

CPT+ CODE	CPT+ CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 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	\$270	\$1,465
THROMBOLYSIS			
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	\$372	NA
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	\$325	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	\$222	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	\$118	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)	\$414	\$4,655
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)	\$459	\$7,107
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	\$539	\$8,632
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	\$637	\$6,587
36140	Introduction of needle or intracatheter, upper or lower extremity artery	\$86	\$507
36160	Introduction of needle or intracatheter, aortic, translumbar	\$119	\$559
36200	Introduction of catheter, aorta	\$134	\$589
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$227	\$1,236
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$242	\$828
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	\$288	\$1,414

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

[Table of Contents](#)

CPT+ CODE	CPT+ CODE DESCRIPTION	MEDICARE RATE ASC
VENOUS MECHANICAL THROMBECTOMY (CONT'D)		
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	\$2,488
THROMBOLYSIS		
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	\$3,395
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	\$1,444
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)	\$5,889
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	\$6,720
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	\$4,579
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

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PHYSICIAN REIMBURSEMENT FOR PERIPHERAL VASCULAR PROCEDURES

[Table of Contents](#)

CPT+ CODE	CPT+ CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 NON-FACILITY
EMBOLIZATION/CATHETER ACCESS (CONT'D)			
36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	\$47	\$116
DIAGNOSTIC ANGIOGRAPHY LOWER EXTREMITY			
75710	Angiography, extremity, unilateral, radiological supervision and interpretation	\$80*	\$149
75716	Angiography, extremity, bilateral, radiological supervision and interpretation	\$90*	\$161
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	\$162	\$702
36902	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	\$231	\$1,201
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	\$303	\$4,264
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);	\$355	\$1,801
36905	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	\$426	\$2,269
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	\$492	\$5,407
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)	\$141	\$587
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)	\$199	\$1,411
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)	\$194	\$1,907
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)	\$119	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 = \$178.50).

NA: There is no established Medicare payment in this 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 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	\$574
36902	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	\$2,327
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	\$6,835
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);	\$3,071
36905	... with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	\$5,907
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	\$11,245
36907	Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (List separately in addition to code for primary procedure)	No separate payment
36908	Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (List separately in addition to code for primary procedure)	No separate payment
36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	No separate payment
34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	No separate payment

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PHYSICIAN REIMBURSEMENT FOR CORONARY PROCEDURES

[Table of Contents](#)

CPT [†] CODE	CPT [†] CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 NON-FACILITY
PCI PROCEDURES			
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	\$509	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	\$567	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;	\$229*	\$896
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	\$267*	\$998
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	\$299*	\$1,115
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	\$335*	\$1,215
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	\$283*	\$1,030
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	\$321*	\$1,108
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	\$359*	\$1,231
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	\$397*	\$1,357

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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	\$3,274
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	\$6,339
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	\$6,489
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;	\$1,489
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	\$1,489
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	\$1,489
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	\$1,489
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	\$1,489
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	\$1,489
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	\$1,489
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	\$1,489

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

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

PHYSICIAN REIMBURSEMENT FOR CORONARY PROCEDURES

CPT [†] CODE	CPT [†] CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 NON-FACILITY
ANGIOGRAPHY WITH OCT IMAGING AND PHYSIOLOGY ASSESSMENT*			
C7516	Coronary angiography with IVUS or OCT	NA	NA
C7518	Coronary angiography in graft with IVUS or OCT	NA	NA
C7519	Coronary angiography in graft with “flow reserve”	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 CORONARY PROCEDURES

CPT ⁺ CODE	CPT ⁺ CODE DESCRIPTION	MEDICARE RATE ASC
ANGIOGRAPHY WITH OCT IMAGING AND PHYSIOLOGY ASSESSMENT		
C7516	Coronary angiography with IVUS or OCT	\$2,327
C7518	Coronary angiography in graft with IVUS or OCT	\$2,327
C7519	Coronary angiography in graft with “flow reserve”	\$2,327
C7521	Right heart catheterization with IVUS or OCT	\$2,327
C7522	Right heart catheterization with “flow reserve”	\$2,327
C7523	Left heart catheterization with IVUS or OCT	\$2,327
C7524	Left heart catheterization with “flow reserve”	\$2,327
C7525	Coronary angiography in graft with left heart catheterization with IVUS or OCT	\$2,327
C7526	Coronary angiography in graft with left heart catheterization with “flow reserve”	\$2,327
C7527	Coronary angiography with right and left heart catheterization with IVUS or OCT	\$2,327
C7528	Coronary angiography with right and left heart catheterization with “flow reserve”	\$2,327
C7529	Coronary angiography in graft with right and left heart catheterization with “flow reserve”	\$2,327

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	
		2023 FACILITY	2023 NON-FACILITY
SYSTEM IMPLANT OR REPLACEMENT			
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	\$445	NA
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	\$467	NA
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	\$506	NA
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)			
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	\$332	NA
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	\$346	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)	\$469	NA
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)			
33233	Removal of permanent pacemaker pulse generator only	\$229	NA
GENERATOR IMPLANT			
33212	Insertion of pacemaker pulse generator only; with existing single lead	\$314	NA
33213	Insertion of pacemaker pulse generator only; with existing dual leads	\$329	NA
RELOCATION OF SKIN POCKET			
33222	Relocation of skin pocket for pacemaker	\$337	NA
LEAD PROCEDURES			
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	\$365	NA
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	\$361	NA
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	\$303	NA
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	\$383	NA
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	\$368	NA
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	\$474	NA
33235	Removal of transvenous pacemaker electrode(s); dual lead system	\$623	NA

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

ASC REIMBURSEMENT FOR PACEMAKERS

[Table of Contents](#)

CPT* CODE	CPT* CODE DESCRIPTION	MEDICARE RATE ASC
SYSTEM IMPLANT OR REPLACEMENT		
33206	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial	\$7,557
33207	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular	\$7,529
33208	Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular	\$7,722
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)		
33227	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system	\$6,410
33228	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system	\$7,547
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)	\$7,466
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)		
33233	Removal of permanent pacemaker pulse generator only	\$5,999
GENERATOR IMPLANT		
33212	Insertion of pacemaker pulse generator only; with existing single lead	\$6,563
33213	Insertion of pacemaker pulse generator only; with existing dual leads	\$7,714
RELOCATION OF SKIN POCKET		
33222	Relocation of skin pocket for pacemaker	\$899
LEAD PROCEDURES		
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	\$5,956
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	\$6,467
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	\$1,444
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	\$1,745
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	\$2,299
33234	Removal of transvenous pacemaker electrode(s); single lead system, atrial or ventricular	\$2,371
33235	Removal of transvenous pacemaker electrode(s); dual lead system	\$2,276

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	
		2023 FACILITY	2023 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*	\$67
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	\$36*	\$79
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	\$41*	\$84
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*	\$56
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*	\$46
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*	\$45
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	\$29	\$29
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	\$22
ICD/CRT-D DEVICE MONITORING - IN PERSON			
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	\$41*	\$80
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	\$55*	\$98
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	\$59*	\$105

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	
		2023 FACILITY	2023 NON-FACILITY
ICD/CRT-D DEVICE MONITORING - IN PERSON <i>continued</i>			
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	\$36*	\$72
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*	\$53
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	\$36	\$36
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	\$22
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*	\$53
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	\$25	\$25
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Carrier priced	Carrier priced
ICM DEVICE MONITORING - IN PERSON			
93285	Programming device evaluation, (in person) with iterative adjustment of the implantable device to test function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	\$25*	\$60
93291	Interrogation device evaluation, (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; including heart rhythm derived data analysis, subcutaneous cardiac rhythm monitor system, including heart rhythm derived data	\$18*	\$49

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	
		2023 FACILITY	2023 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	\$25	\$25
G2066	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Carrier priced	Carrier priced

93296/G2066: The physician practice may only bill the technical service if the physician personally performs the technical service or employs the staff member who performs the technical service. If a device industry representative is involved in performing the technical service under the physician's direction, then the physician may only bill the professional service, i.e., physician analysis, review(s) and reports(s).

*The National Facility rates shown with an * reflect payment when modifiers 26 is used (i.e. payment only for the professional component).

Carrier priced: Medicare has not established a payment amount for this code. Check with your local Medicare Administrative Contractor (MAC) to verify the payment amount.

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

ASC REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

[Table of Contents](#)

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

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

ASC REIMBURSEMENT FOR CARDIAC DEVICE MONITORING

[Table of Contents](#)

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

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

PHYSICIAN REIMBURSEMENT FOR IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

CPT+ CODE	CPT+ CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 NON-FACILITY
IMPLANT			
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	\$86	\$4,313
REMOVAL			
33286	Removal, subcutaneous cardiac rhythm monitor	\$84	\$130

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

ASC REIMBURSEMENT FOR IMPLANTABLE/INSERTABLE CARDIAC MONITORS (ICM)

[Table of Contents](#)

CPT [®] CODE	CPT [®] CODE DESCRIPTION	MEDICARE RATE ASC
IMPLANT		
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	\$7,048
REMOVAL		
33286	Removal, subcutaneous cardiac rhythm monitor	\$338

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

PHYSICIAN REIMBURSEMENT FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

CPT [†] CODE	CPT [†] CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 NON-FACILITY
SYSTEM IMPLANT OR REPLACEMENT			
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	\$893	NA
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)			
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	\$365	NA
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	\$379	NA
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)			
33241	Removal of implantable defibrillator pulse generator only	\$211	NA
GENERATOR IMPLANT			
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	\$358	NA
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	\$375	NA
RELOCATION OF SKIN POCKET			
33223	Relocation of skin pocket for implantable defibrillator	\$401	NA
LEAD PROCEDURES			
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	\$365	NA
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	\$361	NA
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	\$303	NA
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	\$383	NA
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	\$368	NA
33244	Removal of single or dual chamber implantable defibrillator electrode(s); by transvenous extraction	\$846	NA

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

ASC REIMBURSEMENT FOR IMPLANTABLE CARDIOVERTER DEFIBRILLATORS (ICD)

[Table of Contents](#)

CPT ⁺ CODE	CPT ⁺ CODE DESCRIPTION	MEDICARE RATE ASC
SYSTEM IMPLANT OR REPLACEMENT		
33249	Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber	\$25,547
GENERATOR REMOVAL/REVISION (BATTERY REPLACEMENT)		
33262	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system	\$19,382
33263	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system	\$19,333
GENERATOR REMOVAL (BATTERY REMOVAL WITHOUT REPLACEMENT)		
33241	Removal of implantable defibrillator pulse generator only	\$1,745
GENERATOR IMPLANT		
33240	Insertion of implantable defibrillator pulse generator only; with existing single lead	\$20,228
33230	Insertion of implantable defibrillator pulse generator only; with existing dual leads	\$19,718
RELOCATION OF SKIN POCKET		
33223	Relocation of skin pocket for implantable defibrillator	\$899
LEAD PROCEDURES		
33216	Insertion of a single transvenous electrode, permanent pacemaker or implantable defibrillator	\$5,956
33217	Insertion of 2 transvenous electrodes, permanent pacemaker or implantable defibrillator	\$6,467
33215	Repositioning of previously implanted transvenous pacemaker or implantable defibrillator (right atrial or right ventricular) electrode	\$1,444
33218	Repair of single transvenous electrode, permanent pacemaker or implantable defibrillator	\$1,745
33220	Repair of 2 transvenous electrodes for permanent pacemaker or implantable defibrillator	\$2,299

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

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
		2023 FACILITY	2023 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)	\$452	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	
		2023 FACILITY	2023 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)	\$500	NA
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	\$475	NA
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	\$366	NA
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	\$352	NA
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	\$395	NA
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	\$391	NA

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

ASC REIMBURSEMENT FOR CARDIAC RESYNCHRONIZATION THERAPY (CRT)

[Table of Contents](#)

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

CPT+ CODE	ADD-ON CODE CPT+ CODE DESCRIPTOR (LIST SEPARATELY IN ADDITION TO CODE FOR THE PRIMARY PROCEDURE)	REPORT WITH PRIMARY PROCEDURE CODE	MEDICARE RATE ASC
LEFT VENTRICULAR LEAD PLACEMENT FOR CRT PROCEDURES			
		33206	\$7,557
		33207	\$7,529
		33208	\$7,722
		33212	\$6,563
		33213	\$7,714
		33214	\$7,466
		33216	\$5,956
		33217	\$6,467
		33221	\$11,581
		33223	\$899
+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)	33228	\$7,547
		33229	\$11,850
		33230	\$19,718
		33231	\$25,823
		33233	\$5,999
		33234	\$2,371
		33235	\$2,276
		33240	\$20,228
		33249	\$25,547
		33263	\$19,333
		33264	\$25,557

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)	\$7,725
33226	Repositioning of previously implanted cardiac venous system (left ventricular) electrode (including removal, insertion and/or replacement of existing generator)	\$1,856
33229	Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system	\$11,850
33221	Insertion of pacemaker pulse generator only; with existing multiple leads	\$11,581
33264	Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system	\$25,557
33231	Insertion of implantable defibrillator pulse generator only; with existing multiple leads	\$25,823

+ 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	
		2023 FACILITY	2023 NON-FACILITY
TRIAL PROCEDURE			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	\$406	\$2,284
PERMANENT PROCEDURES			
63650	Percutaneous implantation of neurostimulator electrode array, epidural	\$406	\$2,284
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	\$837	NA
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling (Do not report 63685) in conjunction with 63688 for the same pulse generator or receiver)	\$358	NA
REVISION AND REMOVAL PROCEDURES			
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	\$324	\$679
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	\$847	NA
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	\$443	\$894
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	\$884	NA
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	\$371	NA
ELECTRONIC ANALYSIS AND DEVICE PROGRAMMING			
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	\$18	\$19
95971*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	\$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	\$40	\$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.

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	\$4,913
PERMANENT PROCEDURES		
63650	Percutaneous implantation of neurostimulator electrode array, epidural	\$4,913
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural	\$17,950
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling (Do not report 63685) in conjunction with 63688 for the same pulse generator or receiver)	\$24,716
REVISION AND REMOVAL PROCEDURES		
63661	Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy when performed	\$854
63662	Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed	\$1,816
63663	Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed	\$5,090
63664	Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) via laminotomy or laminectomy, including fluoroscopy, when performed	\$9,791
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver	\$1,816
ELECTRONIC ANALYSIS AND DEVICE PROGRAMMING		
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	NA
95971*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	NA
95972*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	NA

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

PHYSICIAN REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

[Table of Contents](#)

CPT [†] CODE	CPT [†] CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 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	\$187	\$433
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	\$65	\$255
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	\$187	\$437
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	\$58	\$240
GENICULAR NERVE			
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	\$142	\$385
SACROILIAC JOINT			
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)	\$190	\$467
OTHER PERIPHERAL NERVES			
*64640	Destruction by neurolytic agent; other peripheral nerve or branch	\$116	\$244
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	\$20	\$116
UNLISTED PROCEDURE			
64999	Unlisted procedure, nervous system	NA	Carrier priced

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

ASC REIMBURSEMENT FOR RADIOFREQUENCY ABLATION (RFA)

[Table of Contents](#)

CPT [†] CODE	CPT [†] CODE DESCRIPTION	MEDICARE RATE ASC
CERVICAL SPINE/THORACIC SPINE		
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	\$854
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	\$854
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	\$854
SACROILIAC JOINT		
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	\$854
OTHER PERIPHERAL NERVES		
*64640	Destruction by neurolytic agent; other peripheral nerve or branch	\$172
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)	NA
UNLISTED PROCEDURE		
64999	Unlisted procedure, nervous system	NA

*CPT[†] code 64640 may not be billed more than 5 times on a single date of service.

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

PHYSICIAN REIMBURSEMENT FOR DEEP BRAIN STIMULATION (DBS)

[Table of Contents](#)

CPT [†] CODE	CPT [†] CODE DESCRIPTION	MEDICARE RATE	
		2023 FACILITY	2023 NON-FACILITY
DIAGNOSTIC SERVICES			
70450-26	Computed tomography, head or brain; without contrast material	\$40	\$40
70551-26	Magnetic resonance (e.g., proton) imaging, brain (including brain stem); without contrast material	\$69	\$69
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	\$1,505	NA
61864	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implantation of neurostimulator electrode array in subcortical site (e.g., thalamus globus pallidus, subthalamic nucleus, periventricular, periaqueductal gray), without use of intraoperative microelectrode recording; each additional array (List separately in addition to primary procedure)	\$279	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	\$2,275	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)	\$493	NA
61880	Revision or removal of intracranial neurostimulator electrodes	\$589	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	\$155	\$155
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	
		2023 FACILITY	2023 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	\$529	NA
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	\$880	NA
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	\$399	NA
IMPLANTABLE PULSE GENERATOR (IPG) ANALYSIS AND PROGRAMMING*			
95970*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	\$18	\$19
95983*	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	\$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 DEEP BRAIN STIMULATION (DBS)

[Table of Contents](#)

CPT [†] CODE	CPT [†] CODE DESCRIPTION	MEDICARE RATE ASC
IMPLANTABLE PULSE GENERATOR (IPG) PROCEDURES		
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array	\$19,686
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to two or more electrode arrays	\$24,824
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	\$10,489
IMPLANTABLE PULSE GENERATOR (IPG) ANALYSIS AND PROGRAMMING*		
61880	Revision or removal of intracranial neurostimulator electrodes	\$1,816

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

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[Table of Contents](#)

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1. Physician Prospective Payment-Final rule with Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY2023. CMS-1770-F: <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeeschedpfs-federal-regulation-notices/cms-1770-f>
2. Ambulatory Surgical Center Payment-Notice of Final Rulemaking with Comment Period(NFRM) CY2023. CMS-1772-FC: <https://www.cms.gov/medicare/medicare-fee-service-payment/ascpaymentasc-regulations-and-notices/cms-1772-fc>

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