Coding and Billing Guidelines

Contractor Name
Wisconsin Physicians Service (WPS)

Contractor Number
00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302, 05402,
52280

LCD Title
Non-Coronary Vascular Stents/Endovascular Graft Placement

LCD Database ID Number

Contractor's Determination Number
CV-028

CMS National Coverage Policy
Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary/

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services.

Medicare Benefit Policy Manual
Chapter 16 - General Exclusions From Coverage
10 - General Exclusions From Coverage
(Rev. 1, 10-01-03)
180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare (Rev. 1, 10-01-03)

Medicare National Coverage Determinations Manual Chapter 1 - Coverage Determinations
Table of Contents *(Rev.22, 10-01-04)* Transmittal 22 Date: OCTOBER 1, 2004
CHANGE REQUEST 3489

Formerly:
MCM 2300.00, 2303.1
Federal Register (09/95) Vol. 60, No. 181
PM AB-01-74
Payment for the PTA is included in the payment for the stent placement.

General Coding Guidelines

A. Correct Coding Indications and Limitations with Sequential Procedures:

1. Vascular obstructions may be caused by thrombosis, embolism, atherosclerosis, or other conditions. Treatment may, therefore, include thrombectomy, embolectomy, endarterectomy, percutaneous angioplasty, and/or thrombolytic infusion. These

procedures may be performed alone or in combination. Often treatment of vascular obstructions will require the skills of several physicians. Payment for these codes will be subject to the edits of the Correct Coding Initiative.

2. Angioplasty for stent deployment is not separately reportable.

3. Component Coding

Consistent with the coding conventions for interventional radiology services as mandated by Medicare payment policy, the coding of vascular stents will utilize component coding. In component coding, each major aspect of the procedure is separately reported. In other words, catheterizations are separately reportable from transcatheter procedures (e.g., angioplasty, stent placements, thrombolytic infusion, embolization) and from imaging services (for guidance or for diagnostic purposes) and vice versa. Moreover, depending on the approach and body site(s) evaluated and/or treated, there could be multiple arterial accesses and/or catheterizations. The surgical codes are subject to Medicare's multiple surgery discounting rules in which the code with the highest fee schedule amount is paid fully with subsequent surgical codes paid at half the full fee schedule amount. Imaging codes are not subject to the discounting rule.

Accordingly, depending on the range of services provided and Correct Coding Edits, other CPT/HCPCS codes may be reported in conjunction with those specifically for stents (37205-37208; 75960):

Catheterization

36000-36140	Nonselective catheterizations
36145	Introduction of needle or intracatheter; arteriovenous shunt created for dialysis (cannula, fistula, or graft)
36200-36248	Introduction of catheter, arterial system (e.g., aorta, iliac)
36010-36012	Introduction of catheter, venous system (e.g., vena cava)
36013-36015	Introduction of catheter, pulmonary artery

Therapy

35450-35476	Angioplasty, either open or percutaneous
35480-35495	Atherectomy, either open or percutaneous
37201	Transcatheter infusion for thrombolysis

Imaging

G0288	Reconstruction computed tomographic angiography of aorta for surgical planning for vascular surgery
75600-75774	Angiography (e.g., aorta, extremity, pulmonary)
75790	Fistulogram
75820-75833	Venography (e.g., extremity, caval, renal)
75896	Guidance for infusion
75962-75968	Guidance for arterial angioplasty
75978	Guidance for venous angioplasty

B. Endovascular Repair of Abdominal Aortic Aneurysm

1. Use the following codes to bill for endovascular AAA repair

   a. Only one of the following codes should be reported as the primary procedure code. (These codes include placement of the device under fluoroscopic guidance

including vascular access, all catheter manipulations, balloon angioplasty within the prosthesis, and closure of the arteriotomy site.)

34800	Endovascular Repair of infrarenal abdominal aortic aneurysm or dissection, using aorto-aortic tube prosthesis
34802	---, using modular bifurcated prosthesis (one docking limit)
34803	---, using modular bifurcated prosthesis (two docking limbs)
34804	---, using unibody bifurcated prosthesis
34805	---, using aorto uniiliac or aorto unifemoral prosthesis

b. The following codes may be billed in addition to the primary code:

34808	Endovascular placement of iliac artery occlusion device (Add-on code)
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral
34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (Add-on code)
34820	Open line artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (If bilateral use the 50 modifier)
34825	Placement of proximal or distal extension prothesis for endovascular repair of infrarenal abdominal aortic aneurysm or iliac artery aneurysm, false aneurysm or dissection, initial vessel
34826	Each additional vessel (Add-on code)
34833	Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
34834	Open brachial artery exposure to assist in deployment of aortic or iliac endovascular prosthesis, by arm incision, unilateral

c. One of the following codes would be billed when the initial procedure (34800, 34802 or 34804) failed:

34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair, tube prosthesis
34831	---, aorto-iliac prosthesis
34832	---, aorto-bifemoral prosthesis

d. To report the radiological supervision and interpretation use the following codes. They include fluoroscopic guidance

75952	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation (This code includes angiography of the aorta and it's branches prior to deployment of the device,[including all routine components of modular devices] and intra-procedural angiography.)

75953	Placement of proximal or distal extension prosthesis for endovascular repair of abdominal aortic aneurysm or iliac artery aneurysm, pseudoaneurysm or dissection, radiological supervision and interpretation (This code includes additional analogous services for placement of an extension, [not routine components of modular devices].
75954	Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation or trauma, supervision and interpretation.
75960	Transcatheter introduction of intravascular stent(s), (except coronary, carotid and vertebral vessel), percutaneous and or open, supervision and interpretation, each vessel

C. Endovascular Repair of Thoracic Aortic Aneurysm

Codes 33881-33887 represent a family of procedures to report placement of an endovascular graft for repair of the descending thoracic aorta. These codes include all device introduction, manipulation, positioning and deployment. All balloon angioplasty and or/stent deployment in the target treatment zone for the endoprosthesis either before or after endograft deployment, are not separately reportable. Open arterial exposure and associated closure of the arteriotomy sites (eg, 34812, 34820, 34833, 34834), introduction of guidewires and catheters (eg 36200-36218, 36140), and extensive repair or replacement of an artery (eg , 35226, 35286) should be additionally reported. Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending aorta (eg, 33886, 33887) should be separately reported

1. Use the following codes to bill for endovascular TAA repair

a. Only one of the following codes should be reported as the primary procedure code. (These codes include placement of the device under fluoroscopic guidance including vascular access, all catheter manipulations, balloon angioplasty within the prosthesis, and closure of the arteriotomy site.)

33880	Endovascular repair of descending thoracic aorta (e.g. aneurysm, psuedoaneurysm or dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin; initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin.
33881	Endovascular repair of descending thoracic aorta (e.g. aneurysm, psuedoaneurysm or dissection, penetrating ulcer, intramural hematoma or traumatic disruption); not involving coverage of left subclavian artery origin; initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

b. The following codes may be billed in addition to the primary code:

33883	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g. aneurysm, psuedoaneurysm or dissection, pentrating ulcer, intramural hematoma or traumatic disruption); initial extension

33884	--- each additional proximal extension
33886	Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta
33889	Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta; by neck incision, unilateral
33891	Bypass graft, with other than vein, transcervical retropharngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision

c. To report the radiological supervision and interpretation use the following codes. They include fluoroscopic guidance

75956	Endovascular repair of descending thoracic aorta (e.g. aneurysm, psuedoaneurysm dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin; initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation
75957	Endovascular repair of descending thoracic aorta (e.g. aneurysm, psuedoaneurysm dissection, penetrating ulcer, intramural hematoma or traumatic disruption); **not** involving coverage of left subclavian artery origin; initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation
75958	Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta ((e.g. aneurysm, psuedoaneurysm dissection, penetrating ulcer, intramural hematoma or traumatic disruption), radiological supervision and interpretation
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation

D. If more than one physician is involved with the procedure, he or she should bill the code that represents the service they were primarily responsible for.

E. Documentation, which includes the operative report and indicates the brand of the endovascular Aneurysm repair device, must be submitted with the claim.

Investigational Devices

1. Medicare covers only those repair devices that are FDA approved. There are other devices under investigational development. If a device is listed on the Category B device exemption lists, special procedures must be followed to receive payment by Medicare. <u>Stenting devices must be FDA approved for use in the human body, regardless of site. Devices not submitted to the FDA or devices on the FDA Exemption lists are not covered under this policy.</u>

   a. If a stent is on the list of Category B devices or part of a FDA post market approval study and the investigator has gained written approval from the Medical Directors, claims

for these procedures may be submitted for payment. The assigned IDE or post approval number needs to be paced in Box 23 of the 1500 form.

- NSF version 2.0 billers should place this information in the EAO record, positions 296-310.
- NSF version 3.01 billers should place this information in the EAO record field 54.
- ANSI billers should place an LX qualifier in data element, 2-180.B-REF01.

b. *Section 731 (b) of the MMA authorizes Medicare to cover the routine costs of clinical trials involving IDE Category A devices effective for routine costs incurred on or after January 1, 2005. Category A (experimental/investigational) devices are innovative medical devices believed to be in Class III, for which "absolute risk" of the device has not been established (that is, initial questions of safety and effectiveness have not been resolved and the Food and Drug Administration (FDA) is unsure whether the device can be safe and effective). For a trial to qualify for payment of routine costs, it must meet certain criteria established by the Secretary to ensure that the trial conforms to appropriate scientific and ethical standards. In addition, the MMA established additional criteria for trials initiated before January 1, 2010, to ensure that the devices involved in these trials be intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition. As guidance in evaluating the immediately life-threatening requirement, contractors should use the following definition: "a stage of a disease in which there is a reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment."*
CMS defines and provides examples for routine costs in the Medicare NCD Manual section 310.1.
It is the responsibility of the provider participating in the clinical trial to furnish all necessary information concerning the device, the clinical trial, and participating Medicare beneficiaries that the contractor deems necessary for a coverage determination and claims processing. The provider must contact their local Medicare contractor before billing for this service.

Physicians billing for routine costs in a clinical trial where a Category A device is used for a patient with a life-threatening condition, must place the IDE number of the Category A device on Form CMS-1500 paper claim in Item 23. Physicians who bill electronically must place the IDE number on the 2300 Investigational Device Exemption Number REF segment, data element REF02 (REF01=LX) of the 837p.

The Q0 modifier must be placed in Box 24d following the correct CPT code. *The use of this modifier indicates that the provider is certifying FDA approval of a clinical trial for the device.*
- NSF submitters should place this information in the FAO – 10 record.
- ANSI billers should place this information in the SVI segment, composite element 01.

2. If the device has not been submitted to the FDA for approval; if it has a category A classification; or it has category B classification; or it is part of a post market approval study, and has not been approved by the appropriate Carrier Medical Directors in writing, indicate this with use of ICD-9 code 996.70. Place this icd-9 code in position **one** on Box

21 of the 1500 form to receive the appropriate, non-covered denial. No other ICD-9 code should be listed in order to receive a non-covered denial.

- NSF format EAO-32.
- ANSI Format HI segment, composit element 01.

D. Claims Submission:

1. List the appropriate CPT code(s) to indicate the service provided.
2. List the appropriate ICD-9 code to indicate the reason for the service.