



2009 Coding and Reimbursement Guide

Coding and Reimbursement Guide

Vascular Designs Inc. is pleased to provide this Reimbursement Information Guide which has been developed specifically for healthcare providers and professionals responsible for coding and reporting health care services.

The IsoFlow™ Infusion Catheter received 510(k) clearance on May 29, 2009. The indications for use are:

The IsoFlow™ Infusion Catheter is a multi-lumen dual balloon catheter designed to isolate a specific treatment region from blood flow while allowing infusion of fluids into the region and perfusion of blood past the region. The device also has the ability to deliver physician specified fluids out the distal tip with or without inflation of the balloons.

If you have any questions, please feel free to contact us.

The reimbursement information provided by Vascular Designs Inc. (Vascular Designs) is gathered from third-party sources and is presented for illustrative purposes only. It does not guarantee coverage or reimbursement for services performed utilizing the IsoFlow Infusion Catheter. Vascular Designs has made every effort to ensure the completeness and accuracy of the information contained herein; however, no representations or warranties are made regarding the selection of codes for the use of Vascular Design's products or the services in which the products may be used, or for compliance with any billing protocols or procedures, requirements, or prerequisites. As with all coverage claims, individual physicians, healthcare providers and facilities are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient's condition and the services provided to a patient. Healthcare providers are encouraged to contact the individual Medicare contractor, carrier, fiscal intermediary or other third-party payers, as needed.

Physician and Hospital Outpatient Coding and Payment Information

Transcatheter arterial chemoembolization, also commonly referred to as chemoembolization, and related procedures, may be performed in the hospital outpatient or inpatient settings. Currently, these procedures are not on the list of Medicare approved procedures for the Ambulatory Surgery Setting.

These procedures may be appropriately reported with the CPT codes shown below. Payment rates indicated are 2009 Medicare national unadjusted average payment rates:

CPT Code ¹	Descriptor	Physician (in facility) payment ²	Hospital Outpatient Payment ³
Embolization or Occlusion			
37204	Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	\$947	\$5,962
Chemotherapy Administration			
96420	Chemotherapy administration, intra-arterial; push technique	\$9	\$129
Imaging and Radiological Supervision and Interpretation			
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	\$68	Not separately paid
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	\$85	Not separately paid

Please note:

CPT code 37204 for transcatheter embolization or occlusion does not include the selective catheter placement. Physicians should select the CPT code that most accurately describes placement of the catheter. Physicians should also bill the appropriate “J” code depending on the type of infusion used. Physicians should also report any initial diagnostic arteriography procedures performed prior to the transcatheter embolization or occlusion procedure.

¹ Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association (AMA). Copyright 2009 AMA. All rights reserved.

² Federal Register, Vol. 73:224 dated November 19, 2008. Physician payment rates effective January 1 through December 31, 2009. Actual payment rates will vary based on geographical adjustments to payments.

³ Federal Register, Vol. 73:223 dated November 18, 2008. Actual payment rates will vary based on geographical adjustments to payments.

CPT Code 37204 is intended to be reported for each operative field addressed. Therefore, multiple vessels in the same field should be identified with one code for all vessels treated in that operative field. If more than one operative field is addressed, then it would be appropriate to report the code to identify each separate operative field treated. In this case, the use of the -59 modifier would be appropriate to designate the separate sites addressed.

Hospital Inpatient Coding and Payment Information

Transcatheter arterial chemoembolization may also be performed in the hospital inpatient setting. These procedures may be appropriately reported with the ICD-9-CM Procedure Codes shown below:

ICD-9-CM Procedure Code	ICD-9-CM Procedure Code Description
99.25	Injection or infusion of cancer chemotherapeutic substance
38.91	Arterial catheterization
88.47	Arteriography of other intra-abdominal arteries

Listed below are possible MS-DRG assignments along with the associated payment rate for each MS-DRG. Payment rates indicated are 2009 Medicare national unadjusted average payment rates:

Possible MS- DRG Assignment	MS-DRG Description	Hospital Inpatient Payment
435	Malignancy of hepatobiliary system or pancreas w MCC	\$9,553
436	Malignancy of hepatobiliary system or pancreas w/CC	\$6,619
437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	\$5,292
846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	\$11,811
847	Chemotherapy w/o acute leukemia as secondary diagnosis w/CC	\$5,231
848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/ MCC	\$4,425

ICD-9-CM Diagnosis Codes

All claim forms must include ICD-9-CM diagnosis codes to report the patient's condition. These codes reflect the physician's assessment of a particular patient's condition, and it is the physician's responsibility to select the code that most appropriately describes the patient's condition. Most Medicare Contractors and private payers have established Local Coverage Determinations (LCD's), or medical coverage policies, respectively, which list medical indications of coverage along with the ICD-9-CM diagnosis codes that support medical necessity for transcatheter occlusion or embolization procedures. The following are codes that may apply to patients undergoing treatment.

ICD-9 Diagnosis Code	Description
155.0	Malignant neoplasm of liver, primary
155.2	Malignant neoplasm of liver, not specified as primary or secondary
157.4	Malignant neoplasm of pancreas, Islets of Langerhans
193	Malignant neoplasm of the thyroid
194.0-194.9	Malignant neoplasm of other endocrine glands and related structures
197.7	Secondary malignant neoplasm of liver, specified as secondary

The above list is not all-inclusive, and there may be additional codes which are appropriate to report.

Documentation Tips

Medical record documentation is critical to the communication of essential information for making a decision as to whether a procedure was reasonable and necessary for a particular patient. Always review the payer's policy for specific documentation and clinical coverage criteria.