



# CODMAN® 3000

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CONTINUOUS QUALITY

## CODING SHEETS

## HEPATIC ARTERIAL INFUSION SYSTEMS

Effective January 2011

All Medicare payment rates are current as of the time of printing.

### CODMAN® 3000 NEUROMODULATION AND ONCOLOGY REIMBURSEMENT HOTLINE



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# HEPATIC ARTERIAL INFUSION SYSTEMS

## PHYSICIAN SERVICES – 2011 MEDICARE REIMBURSEMENT

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Note: When performing multiple procedures, review current correct coding guidelines carefully. Services that are considered a component of another procedure cannot always be coded and billed separately. Medicare’s Correct Coding Initiative is reviewed and updated several times a year. Commercial payer policies vary and should be consulted and reviewed thoroughly.

### DIAGNOSTIC WORKUP

Code	Code Description	Medicare Phys Fee Schedule <sup>1</sup>		Global Days <sup>2</sup>
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
<b>CT Scan</b>				
74150-26*	Computed tomography, abdomen; without contrast material	\$248.03 (Global)	\$59.46 (-26, Professional)*	N/A
74160-26*	Computed tomography, abdomen; with contrast material(s)	\$335.35 (Global)	\$63.54 (-26, Professional)*	N/A
74170-26*	Computed tomography, abdomen; w/o contrast material, followed by contrast material(s) & further sections	\$443.05 (Global)	\$69.99 (-26, Professional)*	N/A
<b>PET Scan – Note: If billing for global services, payment will be carrier determined</b>				
78811-26*	Positron emission tomography (PET); limited area (eg, chest, head/neck)	\$79.84 (-26, Professional)*	\$79.84 (-26, Professional)*	N/A
78812-26*	Positron emission tomography (PET); skull base to mid-thigh	\$97.51 (-26, Professional)*	\$97.51 (-26, Professional)*	N/A
<b>Fluoroscopy – code according to fluoroscopic procedure performed (see CPT Manual for appropriate coding)</b>				

\*Modifier -26 (aka –PC) should be used when billing for the professional component of a service.

### Tc99- MAA HAA STUDY (Diagnostic Workup)

Code	Code Description	Medicare Phys Fee Schedule		Global Days
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
78206-26*	Liver imaging (SPECT); with vascular flow	\$347.92 (Global)	\$46.89 (-26, Professional)*	N/A

\*Modifier -26 (aka –PC) should be used when billing for the professional component of a service.

### LAPAROSCOPIC CHOLECYSTECTOMY (does not include Exploratory Laparotomy code 49000)

Code	Code Description	Medicare Phys Fee Schedule		Global Days
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
47562	Laparoscopy, surgical; cholecystectomy	<i>Not typically performed in this setting</i>	\$731.51	090
47563	Laparoscopy, surgical; cholecystectomy w/ cholangiography		\$741.37	090
47564	Laparoscopy, surgical; cholecystectomy w/ expl. of common duct		\$850.09	090

**PHYSICIAN SERVICES (continued)**

**OPEN CHOLECYSTECTOMY (does include Exploratory Laparotomy code 49000)**

Code	Code Description	Medicare Phys Fee Schedule		Global Days
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
47600	Cholecystectomy;	<i>Not typically performed in this setting</i>	\$1,057.35	090
47605	Cholecystectomy; w/ cholangiography		\$963.57	090
47610	Cholecystectomy w/ exploration of common duct;		\$1,233.00	090
47612	Cholecystectomy w/ exploration of common duct; w/ choledochenterostomy		\$1,246.25	090
47620	Cholecystectomy w/ exploration of common duct; w/ transduodenal sphincterotomy or sphincteroplasty, w/ or w/o cholangiography		\$1,354.30	090

**IMPLANTATION**

Code	Code Description	Medicare Phys Fee Schedule		Global Days
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
<b>Pump Implantation</b>				
36260	Insertion of implantable intra-arterial infusion pump (e.g., for chemotherapy of liver)	<i>Not typically performed in this setting</i>	\$630.26	090
<b>Post-Implant Imaging</b>				
78201-26*	Liver imaging; static only	\$185.85 (Global)	\$21.74 (-26, Professional)*	N/A
78202-26*	Liver imaging; with vascular flow	\$202.50 (Global)	\$23.78 (-26, Professional)*	N/A
78205-26*	Liver imaging (SPECT);	\$227.64 (Global)	\$35.00 (-26, Professional)*	N/A
78206-26*	Liver imaging (SPECT); with vascular flow	\$347.92 (Global)	\$46.89 (-26, Professional)*	N/A

\*Modifier -26 (aka -PC) should be used when billing for the professional component of a service.

**CHEMOTHERAPY ADMINISTRATION, REFILL AND MAINTENANCE**

Code	Code Description	Medicare Phys Fee Schedule		Global Days
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
96522 <sup>3</sup>	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	\$111.10	See Note <sup>3</sup>	000
96420 <sup>3</sup>	Chemotherapy administration, intra-arterial, push technique [use for bolus injection into pump]	\$109.06	See Note <sup>3</sup>	000
96422 <sup>3</sup>	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	\$175.32	See Note <sup>3</sup>	000
96423 <sup>3</sup>	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)	\$79.84	See Note <sup>3</sup>	000
96425 <sup>3</sup>	Chemotherapy administration, intra-arterial; infusion technique...requiring use of portable or implantable pump	\$179.74	See Note <sup>3</sup>	000

**PHYSICIAN SERVICES (continued)**

Code	Code Description	Medicare Phys Fee Schedule		Global Days
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
<b>CHEMOTHERAPY ADMINISTRATION, REFILL AND MAINTENANCE (cont)</b>				
A4220 <sup>4</sup>	Refill kit for implantable infusion pump	N/A	N/A	N/A
J1644 -KD <sup>5</sup>	Injection, heparin sodium, per 1,000 units	N/A	N/A	
J3490 <sup>6</sup> -KD <sup>5</sup>	Unclassified Drug [use for Glycerin Injection]	Based on Invoice	N/A	
J9200 -KD <sup>5</sup>	Floxuridine, 500 mg	N/A	N/A	

**PUMP REVISION/REMOVAL**

Code	Code Description	Medicare Phys Fee Schedule		Global Days
		Non-Facility (Phys Office)	Facility (Non-Phys Office)	
36261	Revision of implanted intra-arterial infusion pump	<i>Not typically performed in this setting</i>	\$392.43	090
36262	Removal of implanted intra-arterial infusion pump		\$295.93	090

## HEPATIC ARTERIAL INFUSION SYSTEMS

### OUTPATIENT FACILITIES

#### CY 2011 OUTPATIENT HOSPITAL AND CY 2011 ASC MEDICARE REIMBURSEMENT

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DIAGNOSTIC WORKUP		OUTPATIENT HOSPITAL <sup>7</sup>				AMBULATORY SURGERY CENTER <sup>7</sup>	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
<b>CT Scan</b>							
74150	Computed tomography, abdomen; without contrast material	0332	Computerized Tomography without Contrast	\$193.85	Q3	Z2	\$109.04
74160	Computed tomography, abdomen; with contrast material(s)	0283	Computerized Tomography with Contrast	\$299.81	Q3	Z2	\$168.65
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	0333	Computerized Tomography without Contrast followed by Contrast	\$334.24	Q3	Z2	\$188.01
<b>PET Scan</b>							
78811	Positron emission tomography (PET); limited area (eg, chest, head/neck)	0308	Non-Myocardial Positron Emission Tomography (PET) Imaging	\$1,041.99	S	Z2	\$586.13
78812	Positron emission tomography (PET); skull base to mid-thigh	0308	Non-Myocardial Positron Emission Tomography (PET) Imaging	\$1,041.99	S	Z2	\$586.13
<b>Fluoroscopy - Code according to fluoroscopic procedure performed</b>							

**\*Status/Payment Indicator Key:** A2= ASC payment based on OPFS rate; G2= Non office-based procedure added to ASC list in 2008; H8= Device-intensive procedure; K & K2= Drug/biological paid separately; N & N1= Packaged item/service, not separately paid; Q3 = May be paid through a composite APC; S= Significant procedure, not discounted when multiple; T= Procedure discounted when multiple; X= Ancillary service; Y= Not implantable Durable Equipment - not paid under OPFS; Z2= Radiology service paid separately when integral to surgical procedure on ASC list.

January 2011

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**OUTPATIENT FACILITY (continued)**

Tc99- MAA HAA STUDY (diagnostic)		OUTPATIENT HOSPITAL <sup>7</sup>				AMBULATORY SURGERY CENTER <sup>7</sup>	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
78206	Liver imaging (SPECT); with vascular flow	0394	Hepatobiliary Imaging	\$265.13	S	Z2	\$149.14
A9500	Technetium TC-99m sodium gluceptate, up to 25 millicurie	N/A	N/A	N/A	N	N/A	Not Separately Paid

**CHOLECYSTECTOMY**

CPT codes 47600-47620 (open surgical cholecystectomy) will not be paid by Medicare if performed in the outpatient setting.

**LAPAROSCOPIC CHOLECYSTECTOMY<sup>8,9</sup>**

(does not include exploratory laparotomy code 49000)

		OUTPATIENT HOSPITAL <sup>7</sup>				AMBULATORY SURGERY CENTER <sup>7</sup>	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
47562	Laparoscopy, surgical; cholecystectomy	0131	Level II Laparoscopy	\$3,295.39	T	G2	\$1,853.68
47563	Laparoscopy, surgical; cholecystectomy with cholangiography	0131	Level II Laparoscopy	\$3,295.39	T	G2	\$1,853.68
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct	0131	Level II Laparoscopy	\$3,295.39	T	G2	\$1,853.68

**PUMP IMPLANTATION**

		OUTPATIENT HOSPITAL <sup>7</sup>				AMBULATORY SURGERY CENTER <sup>7</sup>	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
<b>Pump Implantation</b>							
36260	Insertion of implantable intra-arterial infusion pump (chemotherapy of liver)	0623	Level III Vascular Access Procedures	\$2,119.74	T	A2	\$1,192.37
E0782-KF <sup>10</sup> (C1891 if OP <sup>PS</sup> ) <sup>11</sup>	Infusion pump, implantable, non-programmable (includes all components)	N/A	N/A	N/A	N	N1	Not Separately Paid

**\*Status/Payment Indicator Key:** A2= ASC payment based on OP<sup>PS</sup> rate; G2= Non office-based procedure added to ASC list in 2008; H8= Device-intensive procedure; K & K2= Drug/biological paid separately; N & N1= Packaged item/service, not separately paid; Q3 = May be paid through a composite APC; S= Significant procedure, not discounted when multiple; T= Procedure discounted when multiple; X= Ancillary service; Y= Not implantable Durable Equipment – not paid under OP<sup>PS</sup>; Z2= Radiology service paid separately when integral to surgical procedure on ASC list.

January 2011

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OUTPATIENT FACILITY (continued)

PUMP IMPLANTATION (cont)		OUTPATIENT HOSPITAL <sup>7</sup>				AMBULATORY SURGERY CENTER <sup>7</sup>	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
<b>Post-Implant Imaging</b>							
78201	Liver imaging; static only	0394	Hepatobiliary Imaging	\$265.13	S	Z2	\$149.14
78202	Liver imaging; with vascular flow	0394	Hepatobiliary Imaging	\$265.13	S	Z2	\$149.14
78205	Liver imaging (SPECT);	0394	Hepatobiliary Imaging	\$265.13	S	Z2	\$149.14
78206	Liver imaging (SPECT); with vascular flow	0394	Hepatobiliary Imaging	\$265.13	S	Z2	\$149.14
A9500	Technetium TC-99m sodium gluceptate, up to 25 millicurie	N/A	N/A	N/A	N	N1	Not separately paid

CHEMOTHERAPY ADMINISTRATION, REFILL AND MAINTENANCE		OUTPATIENT HOSPITAL <sup>7</sup>				AMBULATORY SURGERY CENTER <sup>7</sup>	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
<b>PUMP REFILL AND MAINTENANCE</b>							
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)	0439	Level IV Drug Administration	\$128.44	S	N/A	Not Payable in the ASC
A4220	Refill kit for implantable infusion pump	N/A	N/A	N/A	N	N1	Not separately Paid
J1644-KD <sup>5</sup>	Injection, heparin sodium, per 1,000 units						
J3490-KD <sup>5</sup>	Unclassified Drug [use for Glycerin Injection]						
J9200-KD <sup>5</sup>	Floxuridine, 500 mg	0827	Floxuridine Inj, 500mg	\$41.33	K	K2	\$37.23

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**OUTPATIENT FACILITY (continued)**

CHEMOTHERAPY ADMINISTRATION, REFILL AND MAINTENANCE (CONT)		OUTPATIENT HOSPITAL <sup>7</sup>				AMBULATORY SURGERY CENTER <sup>7</sup>	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Payment Indicator	ASC Payment Rate
<b>CHEMOTHERAPY ADMINISTRATION</b>							
96425	Chemotherapy administration ... initiation of prolonged infusion (more than 8 hrs), requiring use of portable or implantable pump	0440	Level V Drug Administration	\$205.86	S	N/A	Not Payable in the ASC
96420	Chemotherapy administration... intra-arterial; push technique [use for bolus injection into pump]	0438	Level III Drug Administration	\$75.58	S		
96422	Chemotherapy administration... infusion technique, up to one hour	0440	Level V Drug Administration	\$205.86	S		
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)	0438	Level III Drug Administration	\$75.58	S		

OUTPATIENT REVISION AND/OR EXPLANATION OF PUMP		OUTPATIENT HOSPITAL <sup>7</sup>				AMBULATORY SURGERY CENTER <sup>7</sup>	
Code	Code Description	APC Group	APC Descriptor	APC Payment	*Status Indicator	*Paym ent Indicat or	ASC Payment Rate
36261	Revision of implanted intra- arterial infusion pump	0105	Repair/Revision/Remo val of Pacemakers, AICDs, or Vascular Devices	\$1,565.84	T	A2	\$880.80
36262	Removal of implanted intra- arterial infusion pump	0105	Repair/Revision/Remo val of Pacemakers, AICDs, or Vascular Devices	\$1,565.84	T	A2	\$880.80

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## HEPATIC ARTERIAL INFUSION SYSTEMS

### INPATIENT HOSPITAL – FY 2011 MEDICARE REIMBURSEMENT

#### COMMON MS-DRGS FOR IMPLANTABLE INFUSION PUMP FOR THE INFUSION OF CHEMOTHERAPY (TREATMENT OF LIVER CANCER)

MS-DRG	MS-DRG Description MCC= Major Complication/Comorbidity CC= Complication/Comorbidity	2011 Medicare Natl Avg MS-DRG Payment <sup>12</sup>
<b>Hepatic Arterial Infusion Pump Implant</b>		
356	Other digestive system O.R. procedures with MCC	\$20,808
357	Other digestive system O.R. procedures with CC	\$11,085
358	Other digestive system O.R. procedures without CC/MCC	\$6,719
423	Other hepatobiliary or pancreas O.R. procedures with MCC	\$23,020
424	Other hepatobiliary or pancreas O.R. procedures with CC	\$12,567
425	Other hepatobiliary or pancreas O.R. procedures without CC/MCC	\$8,404
<b>Hepatic Arterial Infusion Pump Implant with Cholecystectomy</b>		
<b>Hepatic Arterial Infusion Pump Implant with Cholecystectomy &amp; Exploratory Laparotomy</b>		
414	Cholecystectomy except by laparoscope w/o common duct exploration with MCC	\$18,939
415	Cholecystectomy except by laparoscope w/o common duct exploration with CC	\$10,791
416	Cholecystectomy except by laparoscope w/o common duct exploration. w/o CC/MCC	\$6,755
<b>Hepatic Arterial Infusion Pump Implant with Exploratory Laparotomy without Cholecystectomy</b>		
420	Hepatobiliary diagnostic procedures with MCC	\$18,820
421	Hepatobiliary diagnostic procedures with CC	\$9,765
422	Hepatobiliary diagnostic procedures without CC/MCC	\$6,580

#### ICD-9-CM PROCEDURE CODES THAT SUPPORT IMPLANTATION OF HEPATIC ARTERIAL INFUSION OF CHEMOTHERAPY FOR LIVER CANCER

ICD-9-CM Procedure Code <sup>13</sup>	Description
<b>Hepatic Arterial Infusion Pump Implant</b>	
38.91	Arterial catheterization
86.06	Insertion of totally implantable infusion pump
<b>Cholecystectomy</b>	
51.21	Other partial cholecystectomy
51.22	Cholecystectomy
51.23	Laparoscopic cholecystectomy
51.24	Laparoscopic partial cholecystectomy
<b>Exploratory Laparotomy</b>	
54.11	Exploratory Laparotomy

## REFERENCES

- <sup>1</sup> Physician national reimbursement levels are based on the Medicare Physician Fee Schedule as published in the Medicare Program: Revisions to Payment Policies, etc.; Final Rule. *Federal Register*, November 29, 2010; and the Medicare and Medicaid Extenders Act of 2010.
- <sup>2</sup> Physician Global Period is based on the Medicare Physician Fee Schedule as published in the Medicare Program: Revisions to Payment Policies, etc.; Final Rule. *Federal Register*, November 29, 2010; and the Medicare and Medicaid Extenders Act of 2010.
- <sup>3</sup> Medicare considers these procedures “incident to” codes. This means that these services are typically performed by, “personnel employed by the physician and working under his or her direct supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department.”
- <sup>4</sup> Many Medicare policies state that a refill kit for the refill of an implanted infusion pump (HCPCS code A4220) is not separately payable to any provider in any place of service. Payment for A4220 is bundled into 96530. Patients may not be billed for this service, even with a properly completed advance beneficiary notice (ABN). Third party payers should be contacted for their rules.
- <sup>5</sup> Effective January 1, 2004, the “KD” modifier should be added to codes for drugs that are not paid on a cost or prospective payment basis and are infused through Durable Medical Equipment (DME) as posted in the 2004 Quarterly Update from the National HCPCS Panel, 1/23/2004, CMS Transmittal 54 dated December 24, 2003, and Medlearn Matters Number MM3105 dated January 30, 2004.
- <sup>6</sup> FDA approved use of Glycerin Injection as an infusate for use with patients who are receiving continuous Hepatic Arterial FudR Chemotherapy with the Model 3000 Series of Implantable Infusion Pumps to keep the catheter patent or to extend the refill interval for patients who require therapy or withdrawal. For more information, see <http://www.fda.gov/cdrh/pma/pmaoct02.html>.
- <sup>7</sup> Outpatient Hospital and Ambulatory Surgery Center national reimbursement levels are based on the Medicare Outpatient Prospective Payment System and Ambulatory Surgery Center Payment System as published in the 11/24/2010 *Federal Register* (Medicare Program: Hospital Outpatient Prospective Payment System and CY2011 Payment Rates; Ambulatory Surgical Payment System and CY2011 Payment Rates;...Final Rule).
- <sup>8</sup> CPT codes 47600-47620 (open surgical cholecystectomy) will not be paid by Medicare if performed in the outpatient setting.
- <sup>9</sup> Medicare does not cover laparoscopic cholecystectomy procedures in the ASC setting. We recommend contacting third-party payers for their individual coverage guidelines.
- <sup>10</sup> The –KF Modifier indicates an item designated by FDA as Class III Device and must be used, if appropriate, on all Medicare claims with dates of service on or after January 1, 2004. For additional information see CMS One-Time Notification R350TN, dated December 24, 2003 with an implementation date of April 1, 2004.
- <sup>11</sup> Based upon the OPPTS Final Rule for CY 2005 (*Federal Register*, November 15, 2004), hospitals must use “C” codes for Medicare outpatient procedure claims.
- <sup>12</sup> Inpatient national reimbursement levels are based on the Medicare Inpatient Prospective Payment System as published in the 08/16/10 and 10/1/10 *Federal Register* (Medicare Program: Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2010 Rates; Final Rule...). National payment estimates are determined using the book *DRG Expert, 2011 Edition*, published by Ingenix, Inc. The following information is directly cited from *DRG Expert, 2011 Edition, Appendix E*, “The national average payment for each DRG is calculated by multiplying the current relative weight of the DRG by the national average hospital Medicare base rate. The national average hospital Medicare base rate is the sum of the full update labor-related and nonlabor-related amounts published in the *Federal Register*, FY2011 Final Rule, Table 1A. National Adjusted Operating Standardized Amounts; Labor/Nonlabor (if wage index is greater than 1) or Table 1B. National Operating Standardized Amounts; Labor/Nonlabor (if wage index less than or equal to 1). This information is provided as a benchmark reference only. There is no official publication of the average hospital base rate, therefore the national average payments provided in this table are approximate”.
- <sup>13</sup> 2011 ICD-9-CM Expert for Hospitals Volumes 1, 2, and 3; published by Ingenix, Inc.