

2008 CODING & PAYMENT QUICK REFERENCE

Background

Boston Scientific Corporation has compiled this Reimbursement Guide for coding, billing and reimbursement personnel at medical facilities. As always, the provider is responsible for determining coverage and submitting appropriate codes, modifiers and charges for the services that were rendered. All rates shown are 2008 Medicare national averages; actual rates will vary.

The set of procedures shown below are not typically performed in a physician office or ASC setting. Payment amounts shown are for physicians performing these procedures in facilities and for outpatient hospital services

MEDICARE HOSPITAL OUTPATIENT & PHYSICIAN PAYMENT

CPT® ¹ Code	Description	In-Facility M.D Payment ² (1/1/2008 – 12/31/2008)	Hospital Outpatient Payment ³ (1/1/2008 – 12/31/2008)
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck	\$895	APC 82: Coronary or Non-Coronary Atherectomy \$5,574
96420	Chemotherapy administration, intra-arterial; push technique	\$9	APC 436: Level IV Drug Administration \$105
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	\$64	Status N, items and services packaged into APC rate. No separate payment.
75898	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion	\$80	Status Q, CPT code assigned to APC 263, however, not paid separately in addition to the embolization procedure as it does not meet OPPS criteria for separate payment
Total reimbursement for a typical procedure		\$1,048	\$5,679

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² Sources: Medicare, Medicaid, and SCHIP Act of 2007, November 27, 2007 Federal Register, and PFS 2008 Addendum B revised December 4, 2007. MD payments calculated using the 2008 conversion factor of \$38.0870 and mandated budget neutrality work adjuster of 0.8806. MD rates are effective through December 31, 2008.

³Source: November 27, 2007 Federal Register.

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MEDICARE HOSPITAL INPATIENT

CD-9-CM Diagnosis Code ⁴	ICD-9-CM Procedure Code ⁴	Possible DRG Assignment ⁵ (10/1/2007 – 9/30/2008)
V58.1 - Chemotherapy, encounter or admission for chemotherapy	99.25 - Injection or infusion of cancer chemotherapeutic substance	MS-DRG 435: Malignancy of hepatobiliary system or pancreas w MCC \$8,483
155.0 - Carcinoma of liver, primary	38.91 - Arterial catheterization	MS-DRG 436: Malignancy of hepatobiliary system or pancreas w CC \$6,991
155.2 - Carcinoma of liver, not specified as primary or secondary	88.47 - Arteriography of other intra-abdominal arteries	MS-DRG 437: Malignancy of hepatobiliary system or pancreas w/o CC/MCC \$6,343
197.7 - Carcinoma of liver, secondary		MS-DRG 846: Chemotherapy w/o acute leukemia as secondary diagnosis w MCC \$8,950
		MS-DRG 847: Chemotherapy w/o acute leukemia as secondary diagnosis w CC \$5,577
		MS-DRG 848: Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/ MCC \$4,938

⁴Source: The Educational Annotation of ICD-9-CM, Reno, NV; Channel Publishing Ltd. Copyright 2007 Craig D. Puckett, Fifth Edition

⁵Source: October 10, 2007 Federal Register (update). National average (wage index greater than one) MS- DRG rates calculated using the national adjusted full update standardized labor, non-labor and capital amounts (\$5416.74). The MS-DRG assignment will depend on the circumstances of the admission and will vary depending on the patient's principal diagnosis.

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