

# Coronary Intravascular Ultrasound (IVUS)

2016 Coding and Medicare Payment Guide

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# 1 Hospital Inpatient

Hospitals are reimbursed by Medicare for inpatient procedures and services under the Inpatient Prospective Payment System (IPPS), which utilizes the Medicare Severity Diagnosis Related Group (MS-DRG) system.

## 1.1 Hospital Inpatient Diagnosis Codes

Not an all-inclusive list. Refer to ICD-10-CM 2016: The Complete Official Codebook for additional codes. Depending on procedure performed, multiple codes may be reported.

ICD-10-CM <sup>1</sup>	DESCRIPTOR
<b>I21.0-I21.4</b>	ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
<b>I22.0-I22.9</b>	Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction
<b>I23.8-I23.8</b>	Certain current complications following ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction (within the 28 day period)
<b>I24.0-I24.9</b>	Other acute ischemic heart disease
<b>I25.1-I25.9</b>	Chronic ischemic heart disease

## 1.2 Hospital Inpatient Procedure Codes

Not an all-inclusive list. Refer to ICD-10-PCS 2016: The Complete Official Codebook. Multiple codes may be reported.

ICD-10-PCS <sup>2</sup>	DESCRIPTOR
<b>B240ZZ3</b>	Ultrasonography of single coronary artery, intravascular
<b>B241ZZ3</b>	Ultrasonography of multiple coronary arteries, intravascular

## 1.3 Hospital Inpatient Diagnosis Related Groups

For cardiac primary interventional procedures; assignment varies based on patient condition.

DRG	DESCRIPTOR <sup>3, 4</sup>	PAYMENT
<b>231</b>	Coronary bypass with PTCA with MCC	\$46,090.04
<b>232</b>	Coronary bypass with PTCA without MCC	\$34,117.00
<b>246</b>	Percutaneous cardiovascular procedure with drug-eluting stent with MCC or 4+ vessels/stents	\$19,186.86
<b>247</b>	Perc cardiovasc proc with drug-eluting stent without MCC	\$12,581.23
<b>248</b>	Perc cardiovasc proc with non-drug-eluting stent with MCC or 4+ ves/stents	\$18,125.19
<b>249</b>	Perc cardiovasc proc with non-drug-eluting stent without MCC	\$11,301.67
<b>250</b>	Perc cardiovasc proc without coronary artery stent with MCC	\$15,928.04
<b>251</b>	Perc cardiovasc proc without coronary artery stent without MCC	\$9,957.16
<b>286</b>	Circulatory disorders except AMI, with card cath with MCC	\$12,857.57
<b>287</b>	Circulatory disorders except AMI, with card cath without MCC	\$6,827.06

## 2 Hospital Outpatient

Hospitals are reimbursed by Medicare for outpatient procedures and services under the Outpatient Prospective Payment System (OPPS), which utilizes the Ambulatory Payment Classification (APC) system.

### 2.1 Hospital Outpatient Procedure Codes - IVUS

CPT	DESCRIPTOR	APC / STATUS INDICATOR <sup>6</sup>	PAYMENT
<b>CORONARY IVUS</b>			
<b>+92978</b>	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (list separately in addition to code for primary procedure)	Status: N	0
<b>+92979</b>	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (list separately in addition to code for primary procedure)	Status: N	0

### 2.2 HCPCS Supply Code

In the outpatient setting, when devices are used in combination with device-related procedures, hospitals report C codes. While the supply codes are not paid separately from the procedure, the assignment of charges and reporting these supply codes identify device-related costs. This information is important for future rate-setting by Medicare. Private payers' policies vary if they accept the use of these C codes.

HCPCS	DESCRIPTOR	APC / STATUS INDICATOR <sup>6</sup>	PAYMENT
<b>CORONARY IVUS CATHETER</b>			
<b>C1753</b>	Catheter, intravascular ultrasound	Status: N	0

# 3 Physician

Physicians services are paid by Medicare based on the Physician Fee Schedule.

## 3.1 Physician Procedure Codes - Inpatient, Outpatient and Office

CPT	DESCRIPTOR	IN HOSPITAL FACILITY <sup>7</sup>		IN OFFICE NON-FACILITY <sup>8</sup>	
		PAYMENT	RVU <sup>9</sup>	PAYMENT	GLOBAL RVU <sup>10</sup>
<b>CORONARY IVUS</b>					
<b>+92978-26<sup>11</sup></b>	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (list separately in addition to code for primary procedure)	\$99.54	2.78	\$99.54	2.78
<b>+92979-26<sup>11</sup></b>	Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (list separately in addition to code for primary procedure)	\$79.49	2.22	\$79.49	2.22

# Highlights

For complete guidance, refer to CPT, Medicare and private payer edits and rules.

## INTRAVASCULAR ULTRASOUND

- » CPT codes 92978 and 92979 are add-on codes. An add-on code is always performed in conjunction with another primary service.  
*CPT Assistant December 2014, Volume 24, Issue 12, pages 6-10)*
- » Intravascular ultrasound services include all transducer manipulations and repositioning within the specific vessel being examined, both before and after therapeutic intervention (eg, stent placement).  
*CPT Changes: An Insider's View 2000 -Medicine Cardiovascular*
- » 92978 may be reported with the following codes: 92975, 92920, 92924,92928, 92933, 92937, 92941, 92943, 93454-93461, 93563, 93564  
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- » Use 92979 in conjunction with 92978.  
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## THIRD-PARTY SOURCES

- » Medicare Physician Fee Schedule 2016 Final Rule (CMS-1631-FC) Federal Register Vol 80 No. 220, November 16, 2015 Update January 5, 2016
- » Medicare Inpatient Prospective Payment System 2016 Final Rule (CMS-1632-F) Federal Register Vol 80 No. 158, August 17, 2015
- » Medicare Outpatient Prospective Payment System 2016 Final Rule (CMS-1633-FC) Federal register Vol 80 No.219, November 13, 2015 Update December 14, 2015
- » 2016 CPT Professional Edition
- » 2016 CPT Changes, An Insider's View
- » CPT Assistant
- » 2016 ICD-10-CM and ICD-10-PCS

<sup>1</sup> Refer to ICD-10-CM 2016: The Complete Official Codebook for a complete list of codes and specific character codes

<sup>2</sup> Refer to ICD-10-PCS 2016: The Complete Official Codebook for a complete list of codes and specific character codes

<sup>3</sup> CC: Complications and Comorbidities

<sup>4</sup> MCC: Major Complications and Comorbidities

<sup>5</sup> Payment rates assume full update amount for hospitals which have submitted quality data and that hospitals have a wage index greater than 1. Actual payment rates will vary by locality. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.

<sup>6</sup> Status Indicator N; No separate APC payment. Packaged into payment for other services.

<sup>7</sup> Procedures performed by the physician in the hospital setting are reimbursed at the facility rate. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.

<sup>8</sup> Procedures performed in the physician office are reimbursed at the Medicare non-facility rate. Payment rates are Medicare national, unadjusted rates. Actual payment rates will vary by locality.

<sup>9</sup> RVU-Relative Value Units assigned under the Physician Fee Schedule. For each CPT code, RVUs are assigned to account for the relative resource costs used to provide the service.

<sup>10</sup> No RVUs have been established for the technical or global service in the office setting. Medicare local carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation such as an operative report.

<sup>11</sup> Modifier 26 - Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

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