2023 Mechanical Thrombectomy Coding & Reimbursement Information

		Physician Fee [1] (National Medicare Avg)		APC [2] (National Medicare Avg)		ASC [3] (National Medicare Avg)
CPT Code	CPT Code Descriptor	Non-Facility	Facility	APC Code	APC Payment	ASC Payment
	Dialysis Circuit Imaging and Intervention					
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural thrombolytic injection(s)	$1,846.85	$363.61	5192	$5,061.89	$3,070.60
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	$2,325.68	$437.15	5193	$10,258.49	$5,907.18
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural thrombolytic injection(s);with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	$5,542.59	$503.90	5194	$16,402.31	$11,245.21
	Venous Mechanical Thrombectomy					
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	$1,738.75	$387.33	5192	$5,061.89	$7,321.44
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	$501.54	$277.20	5183	$2,923.63	$2,488.30

ICD-10-PCS [4]	Description
05C_3ZZ	Extirpation of Matter from Upper Veins, Percutaneous Approach
05C_3ZZ	Extirpation of Matter from Lower Veins, Percutaneous Approach

MS-DRG [5]	Description
252	Other vascular procedures with MCC
253	Other vascular procedures with CC
254	Other vascular procedures without CC/MCC
270	Other Major Cardiovascular Procedures with MCC
271	Other Major Cardiovascular Procedures with CC
272	Other Major Cardiovascular Procedures without MCC/CC

C-Code [6]	Description
C1757	Catheter, thrombectomy/embolectomy

Reimbursement for a product or procedure may vary depending upon the setting in which the product is used. The reimbursements listed in this guide are based on 2020 Medicare National Average Payment or Rates (unadjusted) therefore actual reimbursement rates will vary for each provider or institution. Reference CMS resources below to locate details specific to your area.

[1] 2020 Medicare Physician Services Fee Schedule (Physician) (www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx)

[2] 2020 Medicare Outpatient Hospital Fee Schedule (APC) (www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1717-cn)

[3] 2020 Medicare Ambulatory Surgery Center Fee Schedule (ASC) (www.cms.gov/apps/ama/license.asp?file=/files/zip/july-2020-asc-approved-hcpcs-code-and-payment-rates.zip)

[4] Procedural codes (PCS) from the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD) used on hospitalized inpatients. ICD-10-CM comes from the same revision but is specific to clinical modifiers for diagnosing (CM) (www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-PCS)

[5] The Medicare Severity Diagnosis Related Groups is a classification system for an inpatient stay based on principal diagnosis, additional diagnoses, and procedures (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software)

[6] Unique temporary pricing codes established by the Centers for Medicare and Medicaid Services (CMS) and only valid for Medicare on claims for hospital outpatient department services and procedures (https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf)
