MERITMEDICAL®

PERIPHERAL INTERVENTION

Uterine Fibroid Embolization (UFE)

Reimbursement & Coding Guide

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2016 UPDATE TO EMBOLIZATION REIMBURSEMENT & CODING

This Uterine Fibroid Embolization (UFE) Guide was designed to help Merit Medical's customers with reporting of UFE services. The UFE procedure is a non-surgical and less invasive alternative for the treatment of symptomatic fibroids. Though reported prevalence varies, uterine fibroids (leiomyomas) are common non-cancerous (benign) tumors of the uterus. The UFE procedure typically involves selective catheterization services from radial or femoral access through which embolic material is injected to occlude the blood flow to the fibroid(s) resulting in infarction and shrinkage of the fibroids. Intra-procedural angiography is used to map the procedure, guide the intervention, and perform post-procedure angiographic assessment.

Physician: The 2016 edition of Current Procedural Terminology (CPT®) reflects changes to the embolization and occlusion coding guidelines and payments. In 2014, the American Medical Association's CPT Editorial Panel approved deletion of codes 37204 and 37210 effective in the 2014 cycle. Four new codes to report vascular embolization and occlusion procedures were developed as a replacement for and stronger delineation of services. The new CPT codes are 37241-37244. The new codes are specific to the clinical reason for the procedure and whether the procedure is arterial or venous. For 2016, Uterine Fibroid Embolization (UFE) services should be reported under CPT 37243 (See Table 2).

Codes 37241-37244 bundle all associated radiological supervision and interpretation, as well as intra-procedural guidance necessary to document completion of the procedure for the target organ, vessel to be embolized. According to guidance for the codes, diagnostic studies and respective catheter placement(s) may be separately reportable using the appropriate diagnostic angiography codes and with an appropriate modifier (eg, modifier 59). Please see the guidelines on reporting of diagnostic angiography preceding CPT code 75625 in the Radiology Guidelines, Vascular Procedures, Aorta and Arteries section.

Facility: The previous year's CPT code for UFE, 37243, was approved for services in the office and in outpatient (hospital or ambulatory surgery center) settings comparing 2015 to 2016 codes and payment.

Table 1: Facility Reporting UFE

2015			2016		
CPT Code	APC	Amount	CPT Code	APC	Amount
37243	0229	$9,627.86	37243	5192	$9,542.35

Table 2: Physician & Coding Guide (payments reflect the 2016 Medicare update to the respective fee schedule[1])

CPT	Brief Descriptor	Physician		Hospital Outpatient	
		Medicare National Avg Facility	Medicare National Avg Office	Medicare APC/SI	Medicare Avg Payment
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles) for tumors, organ ischemia, or infarction	$610.11	$9,943.21	5192/J1	$9,542.35
HCPCS Code	**Device specific codes used with revenue in a hospital outpatient setting**				
C1887[2]	Catheter; guiding (may include injection/perfusion capability)			X	
C1769[2]	Guide wire			X	

1. Physician payment January 21, 2016 Medicare physician fee schedule. APC payment January 1, 2016 fee schedule update.
2. Appropriate billing with revenue codes enables CMS to capture relevant charges to be later included into the comprehensive procedure payment.

When billing 37243 other medical necessary procedures that are modifier 59 eligible include: 36468, 36470, 36471, 36476, 36479, 75894 and 75898. Medical document must differentiate the medical necessity of the code that is modifier 59 eligible. Codes 36475 and 36578 are not modifier 59 eligible. Codes 36469 and 61623 are mutually exclusive with 37243.

The payors also report as a valid code 37244 if the symbolization is arterial or venous and not just for the uterus. This may be relevant to patients hemorrhaging post abortion, or ectopic pregnancy.

Status indicator J1 indicates the services associated with this procedure are paid as a comprehensive APC payment. Procedures identified with a modifier 59 with appropriate medical documentation will be paid based upon their specific status indicator.

Table 3. International Classification of Disease and Procedure Codes - ICD-9 to ICD-10

ICD-9 Procedure	Description	ICD-10 Procedure	Description
68.24	Uterine artery embolization [UAE] with coils	04LE3DT	Occlusion of right uterine artery with intraluminal device, percutaneous approach
68.25	Uterine artery embolization [UAE] without coils	04LE3ZT	Occlusion of right uterine artery, percutaneous approach
68.24	Uterine artery embolization [UAE] with coils	04LF3DU	Occlusion of left uterine artery with intraluminal device, percutaneous approach
68.25	Uterine artery embolization [UAE] without coils	04LF3ZU	Occlusion of left uterine artery, percutaneous approach

ICD-9 Diagnosis	Description	ICD-10 Diagnosis	Description
218.0	Submucous leiomyoma of uterus	D25.0	Submucous leiomyoma of uterus
218.1	Intramural leiomyoma of uterus	D25.1	Intramural leiomyoma of uterus
218.2	Subserous leiomyoma of uterus	D25.2	Subserosal leiomyoma of uterus
218.9	Leiomyoma of uterus, unspecified	D25.9	Leiomyoma of uterus, unspecified
626.2	Excessive or frequent menstruation	N92.0	Excessive and frequent menstruation with regular cycle
626.6	Metrorrhagia	N92.1	Excessive and frequent menstruation with irregular cycle
626.3	Puberty bleeding	N92.2	Excessive menstruation at puberty
626.5	Ovulation bleeding	N92.3	Ovulation bleeding
627.0	Premenopausal menorrhagia	N92.4	Excessive bleeding in the premenopausal period
626.4/626.8	Other disorders of menstruation and other abnormal bleeding from female genital tract	N92.5	Other specified irregular menstruation
626.4/626.9	Unspecified disorders of menstruation and other abnormal bleeding from female genital tract	N92.6	Irregular menstruation, unspecified
633.00	Abdominal pregnancy without intrauterine pregnancy	O00.0	Abdominal pregnancy
633.10	Tubal pregnancy without intrauterine pregnancy	O00.1	Tubal pregnancy
633.20	Ovarian pregnancy without intrauterine pregnancy	O00.2	Ovarian pregnancy
633.80	Other ectopic pregnancy without intrauterine pregnancy	O00.8	Other ectopic pregnancy
633.90	Unspecified ectopic pregnancy without intrauterine pregnancy	O00.9	Ectopic pregnancy, unspecified
634.10	Spontaneous abortion, complicated by delayed or excessive hemorrhage, unspecified or 634.12 complete	O03.6	Delayed or excessive hemorrhage following complete or unspecified abortion
635.12	Legally induced abortion, complicated by delayed or excessive hemorrhage, complete	O04.6	Delayed or excessive hemorrhage following (induced) termination of pregnancy
638.1	Failed attempted abortion complicated by delayed or excessive hemorrhage	O07.1	Delayed or excessive hemorrhage following failed attempted termination of pregnancy
639.1	Delayed or excessive hemorrhage following abortion or ectopic and molar pregnancies	O08.1	Delayed or excessive hemorrhage following ectopic and molar pregnancy

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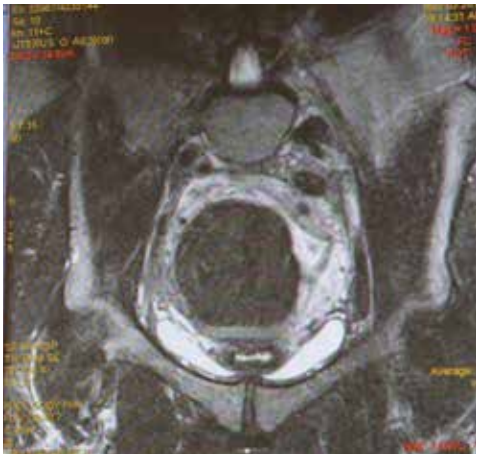


REIMBURSEMENT DEFINITIONS:

Ambulatory Surgical Center (ASC): An ASC, for Medicare purposes, is a distinct entity that operates exclusively for the purpose of furnishing surgical services to patients who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission.

Ambulatory Payment Classification (APC): In most cases, the unit of payment under the Outpatient Prospective Payment System (OPPS) is the APC. CMS assigns individual HCPCS (including CPT) to APCs based on similar clinical characteristics and costs.

Current Procedural Terminology (CPT): CPT® is a registered trademark of the American Medical Association. CPT is the nation's official Health Information Portability and Accountability Act (HIPAA) compliant code set for procedures and services provided by physicians, ASCs, Hospital Outpatient Services, as well as Laboratories, Imaging Centers, Physical Therapy Clinics, Urgent Care Centers, and others.

Healthcare Common Procedure Coding System (HCPCS): The HCPCS Level II Coding System is maintained by CMS, though used by all Insurers. It is a comprehensive, standardized system that classifies similar products that are medical in nature into categories for the purpose of efficient claims processing.

International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS): Code set identifying medical procedures.

International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM): Code set identifying clinical diagnoses.

Status Indicator (SI) identifies how a procedure code is paid in the APC payment system of Medicare. Most commercial payors calculate payment similar to the status indicator provided by Medicare.

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Merit Medical Systems, Inc.
1600 West Merit Parkway
South Jordan, Utah 84095
1.801.208.4300
1.800.35.MERIT

Merit.com

Merit Medical Europe, Middle East, & Africa (EMEA)
Amerikalaan 42, 6199 AE Maastricht-Airport
The Netherlands
+31 43 358 82 22

Merit Medical Ireland Ltd.
Parkmore Business Park West
Galway, Ireland
+353 (0) 91 703 733

Austria
0800 295 374

Belgium
0800 72 906 (Dutch)
0800 73 172 (Français)

Denmark
80 88 00 24

Finland
0800 770 586

France
0800 91 60 30

Germany
0800 182 0871

Ireland (Republic)
1800 553 163

Italy
800 897 005

Luxembourg
8002 25 22

Netherlands
0800 022 81 84

Norway
800 11629

Portugal
308 801 034

Russia
+7 495 221 89 02

Spain
+34 911238406

Sweden
020 792 445

Switzerland
(Deutsch)
+41 225180252
(Français)
+41 225948000
(Italiano)
+41 225180035

UK
0800 973 115

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