2025

Peripheral Embolization Coding & Reimbursement Guide

INTRODUCTION

The information contained in this document is provided to assist health care providers understand reimbursement guidelines and procedures. It is intended to help obtain accurate coding, coverage and payment for medically necessary health care services provided to patients under physician orders. It is not intended to increase or maximize reimbursement.

The information referenced is based upon coding experience and research of current coding practices and published payer policies. They are based upon commonly used codes and procedures. The final decision for coding of any procedure must be made by the provider of care considering the medical necessity of the services, supplies provided and the regulations of insurance carriers including local, state or federal laws that apply.

Although a particular service or supply may be considered medically necessary by the provider, the final coverage decision is based upon a review of the available clinical information and does not mean the service or supply will be covered by any payer. Each payer and benefit plan contains its own specific provisions for coverage and exclusions. Please consult individual payers to determine policy specific guidelines and whether there are any exclusions or other benefit limitations applicable to a particular service or supply.

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Prepared by

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CODING METHODOLOGY

The Physicians' Current Procedural Terminology® (CPT) developed by the American Medical Association (AMA) and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive and identifying codes for medical services and procedures performed by health care providers and reported to third party carriers. The codes in the CPT Manual are copyrighted by the AMA and updated annually by the CPT Editorial Panel.

Third party payers have adopted the CPT coding system for use by providers to communicate services provided to patients. Therefore, it is important to identify the various potential combinations of services to accurately adjudicate claims. For this system to be effective, it is essential that the coding description accurately describes what transpired at the patient encounter.

CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to ensure that payment policies and procedures were standardized for all Medicare Administrative Contractors (MACs) to promote national correct coding methodologies. The coding policies developed are based on coding conventions defined in the AMA's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and reviews of current coding practice.

Procedures should be reported with the CPT/HCPCS codes that most comprehensively describe the services performed. Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code or when a single payment episode is split into two or more episodes so multiple payments can be collected.

The NCCI edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The NCCI represents a more comprehensive approach to unifying coding practices. Quarterly updates are available for hospitals and physicians at Medicare National Correct Coding Initiative (NCCI) Edits.

LOBO® VASCULAR OCCLUSION SYSTEM CODE

There is no product specific HCPCS code to report the use of LOBO. Reimbursement for the device is included in the embolization procedure reported.

INPATIENT PROCEDURE CODING

The International Classification of Diseases, Tenth Revision Procedure Coding System (ICD-10-PCS) is used by facilities to report procedures performed in the inpatient setting. ICD-10-PCS codes are 7-digit alpha-numeric codes with each digit/character conveying a feature of the procedure as outlined in the table below:

There are over 300 ICD-10-PCS codes associated with occlusion procedures using intraluminal devices. Provided below are some examples for reference:

• 02LQ3DZ - Occlusion of right pulmonary artery with intraluminal device, percutaneous approach

• 04LE3DT - Occlusion of right uterine artery with intraluminal device, percutaneous approach

• 03LY3DZ - Occlusion of upper artery with intraluminal device, percutaneous approach

Character	Definition/ Information Provided	Embolization Examples
1	Section	0 – Medical & Surgical
2	Body System	3 – Upper Arteries 4 – Lower Arteries
3	Root Operation	L – Occlusion *Used for tumors, fibroids, endoleak, collateral vessels with AAA, AVMs, and traumatic hemorrhage.* V – Restriction *Used for unruptured aneurysm*
4	Body Part	L – Femoral Artery Q – Pulmonary Artery
5	Approach	3 – Percutaneous
6	Device (if used)	D – Intraluminal
7	Qualifier	Z – No Qualifier

INPATIENT REIMBURSEMENT

Diagnostic Related Groups (DRGs) are assigned using the principal diagnosis and additional diagnoses, the principal procedure and additional procedures, sex and discharge status. The DRGs provided represent the most likely assignment for a patient admitted for an embolization. This is not intended to be a comprehensive list.

Embolization Procedure	MS-DRG	MS-DRG Descriptor	Payment
Pulmonary Ateriovenous Malformation	252	Other Vascular Procedures with MCC	$24,411
	253	Other Vascular Procedures with CC	$18,167
	254	Other Vascular Procedures without CC/MCC	$12,449
Embolization of Collateral Vessel(s) in Conjunction with AAA Endograft	268	Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC	$47,447
	269	Aortic and Heart Assist Procedures Except Pulsation Balloon without MCC	$29,608
Embolization of AAA Endoleak from Branch Vessels	270	Other Major Cardiovascular Procedures with MCC	$36,527
	271	Other Major Cardiovascular Procedures with CC	$24,510
	272	Other Major Cardiovascular Procedures without MCC	$17,806
Ruptured Aneurysm of Renal Artery	673	Other Kidney and Urinary Tract Procedures with MCC	$29,813
	674	Other Kidney and Urinary Tract Procedures with CC	$16,427
	675	Other Kidney and Urinary Tract Procedures without CC/MCC	$11,139
Embolization For Uterine Fibroids	749	Other Female Reproductive System OR Procedures Except Malignancy with CC/MMC	$18,421
	750	Other Female Reproductive System OR Procedures Except Malignancy without CC/MMC	$9,176
Embolization to occlude vessels with hemorrhage due to trauma or vessel injury	907	Other OR Procedures for Injuries with MCC	$28,348
	908	Other OR Procedures for Injuries with CC	$14,354
	909	Other OR Procedures for Injuries without CC/MCC	$9,025
	957	Other OR Procedures for Multiple Significant with MCC	$53,115
	958	Other OR Procedures for Multiple Significant with CC	$29,245
	959	Other OR Procedures for Multiple Significant without CC/MCC	$18,814
Embolization of Uterine Arteriovenous Malformation	981	Extensive OR Procedures Unrelated to Principal Diagnosis with MCC	$33,829
	982	Extensive OR Procedures Unrelated to Principal Diagnosis with CC	$17,422
	983	Extensive OR Procedures Unrelated to Principal Diagnosis without CC/MCC	$11,871
Embolization of Non-Target Vascular Beds (prior to Yttrium-90 radioembolization of liver cancer)	987	Non-Extensive OR Procedures Unrelated to Principal Diagnosis with MCC	$24,925
	988	Non-Extensive OR Procedures Unrelated to Principal Diagnosis with CC	$12,211
	989	Non-Extensive OR Procedures Unrelated to Principal Diagnosis without CC/MCC	$8,223

OPPS & ASC CODING AND REIMBURSEMENT

Through the hospital outpatient prospective payment system (OPPS), the Centers for Medicare and Medicaid Services (CMS) assigns all CPT and HCPCS codes a status indicator (SI) to indicate if and how a service is reimbursed. For Ambulatory Surgical Centers (ASCs), CMS assigns CPT and HCPCS codes a payment indicator (PI) to indicate how payment rates are determined. The definition of the SIs and PIs used in this guide are provided below:

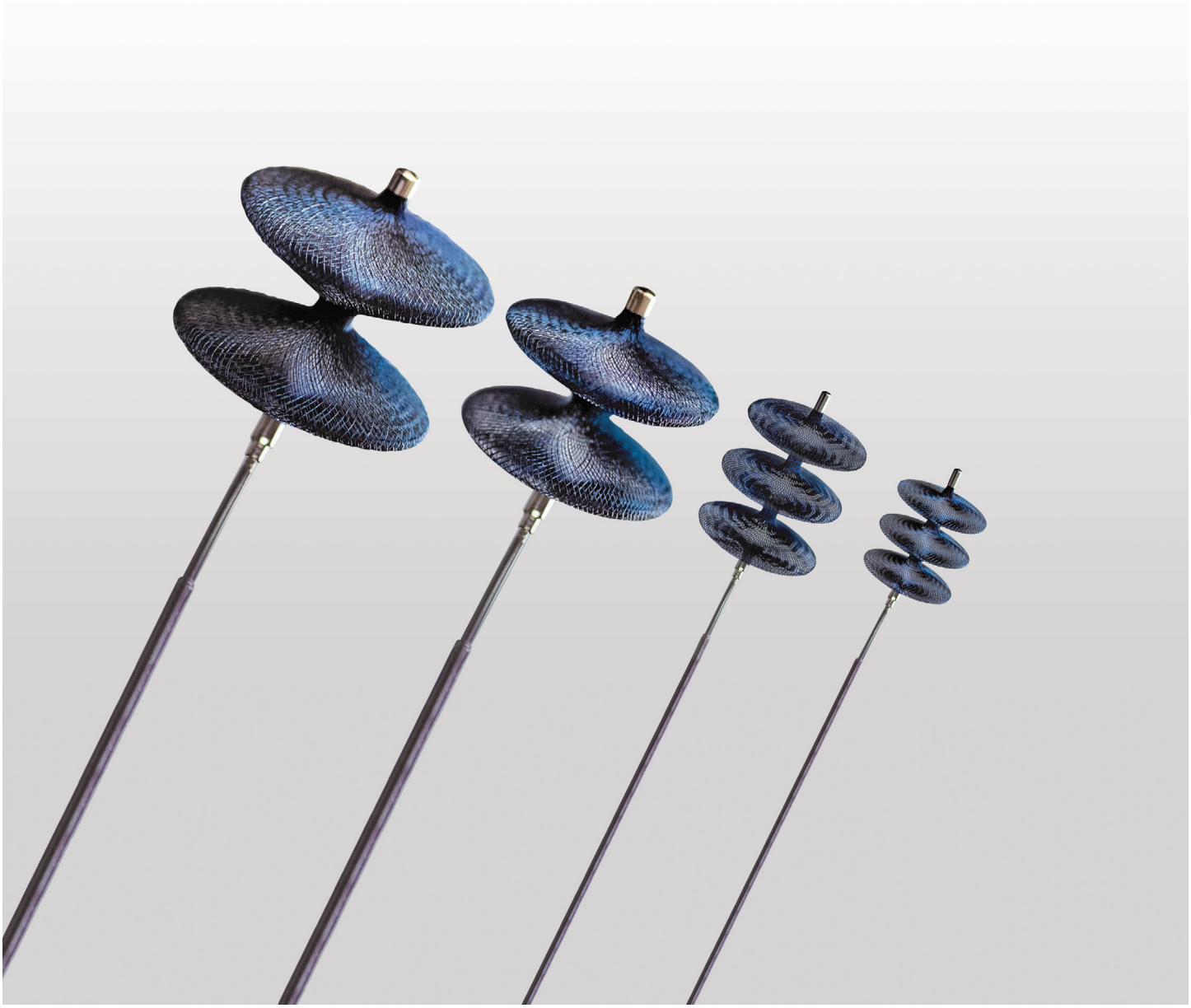
G2 Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.

J1 Comprehensive APC; all services reported on hospital claim will be packaged with payment for J1 procedure except services with a status indicator of F, G, H, L, & U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. Please note that this applies to the OPPS setting only; services in the ASC setting continue to be separately if eligible.

J8 Device-intensive procedure; paid at adjusted rate.

N Payment is packaged into payment for other procedures; no separate payment

N1 Packaged service/item; no separate payment made



CPT	Descriptor	OPPS		ACS	
		SI	Payment	PI	Payment
EMBOLIZATION					
37241	Vascular embolization or occlusion, venous, other than Hemorrhage	J1	$11,431	J8	$6,454
37242	Vascular embolization or occlusion, arterial, other than hemorrhage or tumor	J1	$17,857	J8	$11,861
37243	Vascular embolization or occlusion, for tumors, organ ischemia, or infarction	J1	$11,431	G2	$6,530
37244	Vascular embolization or occlusion, for arterial or venous hemorrhage or lymphatic extravasation	J1	$11,431	J8	$3,422
ARTERIAL CATHETERIZATION					
36215	Selective catheter placement, arterial system; 1st order thoracic or brachiocephalic branch, within a vascular family	N	Packaged	N1	Packaged
36216	Selective catheter placement, arterial system; 2nd order thoracic or brachiocephalic branch, within a vascular family	N	Packaged	N1	Packaged
36217	Selective catheter placement, arterial system; 3rd order thoracic or brachiocephalic branch, within a vascular family	N	Packaged	N1	Packaged
+36218	Selective catheter placement, arterial system; additional 2nd or 3rd order thoracic or brachiocephalic branch	N	Packaged	N1	Packaged
36245	Selective catheter placement, arterial system; 1st order abdominal, pelvic, or lower extremity artery branch	N	Packaged	N1	Packaged
36246	Selective catheter placement, arterial system; 2nd order abdominal, pelvic, or lower extremity artery branch	N	Packaged	N1	Packaged
36247	Selective catheter placement, arterial system; 3rd order abdominal, pelvic, or lower extremity artery branch	N	Packaged	N1	Packaged
+36248	Selective catheter placement, arterial system; additional 2nd or 3rd order abdominal, pelvic, or lower extremity artery branch	N	Packaged	N1	Packaged
VENOUS CATHETERIZATION					
336011	Selective catheter placement, venous system; 1st order branch (eg, renal vein, jugular vein)	N	Packaged	N1	Packaged
36012	Selective catheter placement, venous system; 2nd order or more selective (eg, left adrenal vein, petrosal sinus)	N	Packaged	N1	Packaged
PULMONARY ARTERY CATHETERIZATION					
36015	Selective catheter placement, segmental or subsegmental pulmonary artery	N	Packaged	N1	Packaged
PORTAL VEIN CATHETERIZATION					
36481	Percutaneous portal vein catheterization by any method	N	Packaged	N1	Packaged

PHYSICIAN CODING & REIMBURSEMENT

CPT	Descriptor	MPFS	
		Non-Facility	Facility
EMBOLIZATION			
37241	Vascular embolization or occlusion, venous, other than Hemorrhage	$4,198	$404
37242	Vascular embolization or occlusion, arterial, other than hemorrhage or tumor	$6,466	$449
37243	Vascular embolization or occlusion, for tumors, organ ischemia, or infarction	$7,841	$530
37244	Vascular embolization or occlusion, for arterial or venous hemorrhage or lymphatic extravasation	$5,993	$624
ARTERIAL CATHETERIZATION			
36215	Selective catheter placement, arterial system; 1st order thoracic or brachiocephalic branch, within a vascular family	$964	$203
36216	Selective catheter placement, arterial system; 2nd order thoracic or brachiocephalic branch, within a vascular family	$995	$259
36217	Selective catheter placement, arterial system; 3rd order thoracic or brachiocephalic branch, within a vascular family	$1,738	$322
+36218	Selective catheter placement, arterial system; additional 2nd or 3rd order thoracic or brachiocephalic branch	$198	$50
36245	Selective catheter placement, arterial system; 1st order abdominal, pelvic, or lower extremity artery branch	$1,144	$224
36246	Selective catheter placement, arterial system; 2nd order abdominal, pelvic, or lower extremity artery branch	$770	$239
36247	Selective catheter placement, arterial system; 3rd order abdominal, pelvic, or lower extremity artery branch	$1,310	$282
+36248	Selective catheter placement, arterial system; additional 2nd or 3rd order abdominal, pelvic, or lower extremity artery branch	$110	$46
VENOUS CATHETERIZATION			
336011	Selective catheter placement, venous system; 1st order branch (eg, renal vein, jugular vein)	$740	$148
36012	Selective catheter placement, venous system; 2nd order or more selective (eg, left adrenal vein, petrosal sinus)	$772	$166
PULMONARY ARTERY CATHETERIZATION			
36015	Selective catheter placement, segmental or subsegmental pulmonary artery	$776	$164
PORTAL VEIN CATHETERIZATION			
36481	Percutaneous portal vein catheterization by any method	$1,602	$308

HOSPITAL OUTPATIENT COMPLEXITY ADJUSTMENT

To recognize more costly, complex cases where multiple J1 procedures are performed during the same surgical session, CMS has established a "complexity adjustment" policy. CMS annually reviews its claims data to determine if certain code combinations meet specific thresholds for both cost and frequency. If these thresholds are met, the code combination qualifies for reassignment to the next highest C-APC in the clinical group.

For CY 2025, the following embolization code combinations qualify for a complexity adjustment:

1º CPT	1º CPT Descriptor	1º CPT APC	2º CPT	2º CPT Descriptor	2º CPT APC	Complexity Adj APC	Complexity Adj Pmt
37243	Vasc embolize/ occlude organ	5193	47382	Percut ablate liver rf	5361	5194	$17,957
37243	Vasc embolize/ occlude organ	5193	50593	Perc cryo ablate renal tum	5362	5194	$17,957

NOTES & REFERENCES:

CY 2025 Hospital Outpatient Prospective Payment and Ambulatory Payment Systems – Final Rule (CMS-1809-FC); Addendum B and ASC Addenda.

CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; (CMS-1807-F); Addendum B. All MPFS Fee Schedules calculated using CF of $32.3465 effective January 1, 2025.

DRG values were calculated using a base rate of $6,606.51 and Capital Standard Payment of $510.51. The base payment rate assumes the hospital submitted quality data and is a user of EHR. The weighted rate used the 10% Cap Applied. The hospital's base payment rate will change if the hospital does not meet either or both of these measures. Calculations were based on data provided in FY 2025 IPPS Final Rule CN (Tables 1A, 1D, and 5CN).

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See Instructions for Use for a complete list of warnings, precautions, and contraindications.

Rx Only: Federal (USA) law restricts device to sale by or on the order of a physician.

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