Physician Coding And Reimbursement

Billing requirements for physician claims

- Append modifiers 62 and “Q0” (zero) to the CPT® code e.g. 33361-33365
- Diagnosis code Z00.6 - Encounter for examination for normal comparison and control in clinical research program
- Place of Service 21 – Inpatient hospital
- Enter the 8 digit registry number preceded by ‘CT’ in field 19 of the CMS 1500 paper claim form

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Description</th>
<th>2018 Work RVUs</th>
<th>2018 Total Facility RVUs</th>
<th>2018 Medicare National Average</th>
<th>Modifier -62 Payment for EACH Provider. Payment is 62.5% of Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>33361</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach</td>
<td>25.13</td>
<td>39.46</td>
<td>$1,421</td>
<td>$888</td>
</tr>
<tr>
<td>33362</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open femoral artery approach</td>
<td>27.52</td>
<td>43.08</td>
<td>$1,551</td>
<td>$969</td>
</tr>
<tr>
<td>33363</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open axillary artery approach</td>
<td>28.50</td>
<td>44.68</td>
<td>$1,608</td>
<td>$1,005</td>
</tr>
<tr>
<td>33364</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; open iliac artery approach</td>
<td>30.00</td>
<td>47.06</td>
<td>$1,694</td>
<td>$1,059</td>
</tr>
<tr>
<td>33365</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)</td>
<td>33.12</td>
<td>51.76</td>
<td>$1,863</td>
<td>$1,165</td>
</tr>
</tbody>
</table>

Add-on Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Description</th>
<th>2018 Work RVUs</th>
<th>2018 Total Facility RVUs</th>
<th>2018 Medicare National Average</th>
<th>Modifier -62 Payment for EACH Provider. Payment is 62.5% of Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>33367</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg femoral vessels) (List separately in addition to code for primary procedure)</td>
<td>11.88</td>
<td>18.26</td>
<td>$657</td>
<td>Do not use 62-modifier</td>
</tr>
<tr>
<td>33368</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)</td>
<td>14.39</td>
<td>21.70</td>
<td>$781</td>
<td>Do not use 62-modifier</td>
</tr>
<tr>
<td>33369</td>
<td>Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)</td>
<td>19.00</td>
<td>28.65</td>
<td>$1,031</td>
<td>Do not use 62-modifier</td>
</tr>
</tbody>
</table>

Add-on codes 33367-33369 for cardiopulmonary bypass during the TAVR/TAVI procedure, when performed, are billed by the cardiac surgeon only as applicable. These codes do not require appending modifier 62.

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2 CY2018 payment calculated with the Conversion Factor (CF) $35.9996. CMS CY 2018 Medicare Physician Fee Schedule Final Rule. Available at: https://tinyurl.com/ydh2kvh3. CMS may make adjustments to any or all of the data inputs from time to time without notice.

*CMS has indicated for selected procedures the -62 modifier is required for payment.
### Physician Billing Detail

**Differences in Physician Billing Requirements**

All TAVR Claims: FDA-Approved Indications and IDE Clinicals Trials

<table>
<thead>
<tr>
<th>ITEM AND CODE INSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis Code</strong></td>
</tr>
<tr>
<td>Z00.6 - Encounter for examination for normal comparison and control in clinical research program</td>
</tr>
<tr>
<td><strong>Place of Service</strong></td>
</tr>
<tr>
<td>21 – Inpatient hospital</td>
</tr>
<tr>
<td><strong>CPT Procedure Codes</strong></td>
</tr>
<tr>
<td>33361-33365 for TAVR procedure</td>
</tr>
<tr>
<td><strong>Modifiers</strong></td>
</tr>
<tr>
<td>62 – Two surgeons/ co-surgeons</td>
</tr>
<tr>
<td>Q0 (zero) – Participation in a qualifying registry or qualified clinical study</td>
</tr>
</tbody>
</table>

### Differences in Submitting Claims for FDA-Approved Indications vs. IDE Clinical Trials

<table>
<thead>
<tr>
<th>ITEM AND CODE INSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form Type</strong></td>
</tr>
<tr>
<td><strong>Item</strong></td>
</tr>
<tr>
<td>Paper Form CMS-1500</td>
</tr>
<tr>
<td>Item 19 (Addl Claim Information)</td>
</tr>
<tr>
<td>CT 01737528 (CT + Registry #)</td>
</tr>
<tr>
<td>CT 99999999 (CT + NCT #)</td>
</tr>
<tr>
<td>Item 23 (PAN – used for IDE #)</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
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<tr>
<td>Electronic Form 837p</td>
</tr>
<tr>
<td>Loop 2300 REF02 (REF01=P4) (Addl Claim Information)</td>
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<tr>
<td>01737528 (Registry #)</td>
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<tr>
<td>99999999 (NCT #)</td>
</tr>
<tr>
<td>Segment 2300, REF02(REF01=LX) (PAN – used for IDE #)</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>G999999 (IDE #)</td>
</tr>
</tbody>
</table>

**FL:** Form Locator  
**NCT:** National Clinical Trial Number  
**IDE:** Investigational Device Exemption


### Reimbursement Disclaimer

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no