2022 commonly billed codes
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The Harmony™ transcatheter pulmonary valve (TPV) system is indicated for use in the management of pediatric and adult patients with severe pulmonary regurgitation (i.e., severe pulmonary regurgitation as determined by echocardiography and/or pulmonary regurgitant fraction ≥ 30% as determined by cardiac magnetic resonance imaging) who have a native or surgically repaired right ventricular outflow tract and are clinically indicated for surgical pulmonary valve replacement.

Medtronic provides this information for your convenience only. It does not constitute legal advice or a recommendation regarding clinical practice. Information provided is gathered from third-party sources and is subject to change without notice due to frequently changing laws, rules, and regulations.

The provider has the responsibility to determine medical necessity and to submit appropriate codes and charges for care provided. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other payers as to the correct form of billing or the amount that will be paid to providers of service. Please contact your Medicare contractor, other payers, reimbursement specialists, and/or legal counsel for interpretation of coding, coverage, and payment policies.

This document provides assistance for FDA-approved only indications. Where reimbursement is sought for FDA-approved only use of a product that may be inconsistent with, or not expressly specified in, the FDA-approved only labeling (e.g., instructions for use, operator’s manual, or package insert), consult with your billing advisors or payers on handling such billing issues. Some payers may have policies that make it inappropriate to submit claims for such items or related service.

For native or surgically repaired RVOTs
ICD-10 PCS procedure codes

Select ICD-10 PCS codes

Note: The ICD-10 PCS codes shown are those that reflect the typical procedure, using known Medtronic devices where appropriate. Theoretical possibilities are not shown, e.g., approaches that are not common and device types that are not currently on the market.

Transcatheter pulmonary valve procedure codes

<table>
<thead>
<tr>
<th>ICD-10 PCS procedure code</th>
<th>ICD-10 PCS procedure code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02RH38M</td>
<td>Replacement of pulmonary valve with zooplastic tissue, native site</td>
</tr>
</tbody>
</table>

Transcatheter pulmonary valve DRGs

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
<th>FY22 Medicare national average</th>
</tr>
</thead>
<tbody>
<tr>
<td>266</td>
<td>Endovascular cardiac valve replacement and supplement procedures with MCC</td>
<td>$46,476</td>
</tr>
<tr>
<td>267</td>
<td>Endovascular cardiac valve replacement and supplement procedures without MCC</td>
<td>$36,915</td>
</tr>
</tbody>
</table>

MCC = major complication or comorbidity

1 2022 ICD-10 PCS American Medical Association.
CPT procedure codes

Physicians use CPT codes for services and hospitals use CPT for outpatient services. Relative value units (RVUs) present a mechanism for calculating payment. For carrier-priced codes, the carrier establishes RVUs and payment amounts on an individual case basis following review of documentation, such as an operative report.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>2022 total facility RVUs</th>
<th>2022 Medicare ntl pymt</th>
</tr>
</thead>
<tbody>
<tr>
<td>33477</td>
<td>Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed</td>
<td>39.78</td>
<td>$1,377</td>
</tr>
</tbody>
</table>

Included in the procedure:

- Code 33477 includes the work, when performed, of percutaneous access, placing the access sheath, advancing the repair device delivery system into position, repositioning the device as needed, and deploying the device(s). Angiography, radiological supervision, and interpretation performed to guide TPVI (e.g., guiding device placement and documenting completion of the intervention) are included in the code.
- Code 33477 includes all cardiac catheterization(s), intraprocedural contrast injection(s), fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the pulmonary valve procedure. Do not report 33477 in conjunction with 76000, 76001, 93451, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93530, 93531, 93532, 93533, 93535, 93563, 93566, 93567, 93568 for angiography intrinsic to the procedure.
- Code 33477 includes percutaneous balloon angioplasty of the conduit/treatment zone, valvuloplasty of the pulmonary valve conduit, and stent deployment within the pulmonary conduit or an existing bioprosthetic pulmonary valve, when performed. Do not report 33477 in conjunction with 37236, 37237, 92997, 92998 for pulmonary artery angioplasty/valvuloplasty or stenting within the prosthetic valve delivery site.

Separately reportable:

- Codes 92997, 92998 may be reported separately when pulmonary artery angioplasty is performed at a site separate from the prosthetic valve delivery site.
- Codes 37236, 37237 may be reported separately when pulmonary artery stenting is performed at a site separate from the prosthetic valve delivery site.

Other procedures:

- Diagnostic right heart catheterization and diagnostic coronary angiography codes (93451, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93530, 93531, 93532, 93533, 93563, 93566, 93567, 93568) should not be used with 33477 to report:
  1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TPVI,
  2. Pulmonary conduit angiography for guidance of TPVI, or
  3. Right heart catheterization for hemodynamic measurements before, during, and after TPVI for guidance of TPVI.

* CMS CY 2022 Medicare Physician Fee Schedule Final Rule. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched. Accessed January, 2022

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• Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93530, 93531, 93532, 93533), diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564), and diagnostic pulmonary angiography code (93568) may be reported with 33477, representing separate and distinct services from TPVI, if:
  1. No prior study is available and a full diagnostic study is performed, or
  2. A prior study is available, but as documented in the medical record:
     a. There is inadequate visualization of the anatomy and/or pathology, or
     b. The patient’s condition with respect to the clinical indication has changed since the prior study, or
     c. There is a clinical change during the procedure that requires new evaluation.
• Other cardiac catheterization services may be reported separately when performed for diagnostic purposes not intrinsic to TPVI.
• For same session/same day diagnostic cardiac catheterization services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 to indicate separate and distinct procedural services from TPVI.
• Diagnostic coronary angiography performed at a separate session from an interventional procedure may be separately reportable, when performed.
• Percutaneous coronary interventional procedures may be reported separately, when performed.
• Percutaneous pulmonary artery branch interventions may be reported separately, when performed.
• When transcatheter ventricular support is required in conjunction with TPVI, the appropriate code may be reported with the appropriate percutaneous ventricular assist device (VAD) procedure codes (33990, 33991, 33992, 33993), extracorporeal membrane oxygenation (ECMO) or extracorporeal life support services (ECLS) procedure codes (33946-33989), or balloon pump insertion codes (33967, 33970, 33973).
• When cardiopulmonary bypass is performed in conjunction with TPVI, code 33477 may be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

**Medicare ambulatory payment classifications (APCs)**

Medicare pays for hospital outpatient procedures separately via APCs. Hospital outpatient services are identified using the CPT Level I HCPCS codes. These CPT codes are grouped to one of approximately 800 different APCs.

The category I CPT code (33477) for endovascular replacement of pulmonic valve has no APC assignment because this code is on Medicare’s “inpatient-only” list. This means that Medicare will only reimburse for the procedure in the inpatient setting for Medicare beneficiaries. Site-of-service determination is the responsibility of the clinician relative to the patient’s clinical condition.

**Private payers**

Private payers use various payment mechanisms such as APCs, percent of charge, carve-out, fee schedule, etc. Private payers may or may not follow Medicare. Working with private payers during the pre-certification/pre-authorization process may provide insight on how the specific payer intends to adjudicate the claim for reimbursement.
### Transcatheter pulmonary valve potential diagnosis codes

<table>
<thead>
<tr>
<th>Potential equivalent ICD-10 CM diagnosis code</th>
<th>ICD-10 CM procedure code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q20.1</td>
<td>Double outlet right ventricle</td>
</tr>
<tr>
<td>Q20.3</td>
<td>Discordant ventriculoarterial connection</td>
</tr>
<tr>
<td>Q20.5</td>
<td>Discordant atrioventricular connection</td>
</tr>
<tr>
<td>Q21.3</td>
<td>Tetralogy of Fallot</td>
</tr>
<tr>
<td>Q22.0</td>
<td>Pulmonary valve atresia</td>
</tr>
<tr>
<td>Q22.1</td>
<td>Congenital pulmonary valve stenosis</td>
</tr>
<tr>
<td>Q22.2</td>
<td>Congenital pulmonary valve insufficiency</td>
</tr>
<tr>
<td>Q25.5</td>
<td>Atresia of pulmonary artery</td>
</tr>
<tr>
<td>Q25.72</td>
<td>Congenital pulmonary arteriovenous malformation</td>
</tr>
<tr>
<td>Q25.79</td>
<td>Other congenital malformations of pulmonary artery</td>
</tr>
</tbody>
</table>
The Medtronic CardioVascular Dataline is available to respond to your coding questions at 866-616-8400.