Medtronic

Stent retriever/ aspiration system

2024 Coding and payment guide

What's inside:

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Physician coding and payment

Effective January 1, 2024 – December 31, 2024

CPT procedure code and description[a]	Multiple procedure discounting	Medicare work RVUs (facility setting)[b]	Medicare national average for physician services provided in facility setting[c]
61645 Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	No	15.00	$824

Thrombectomy code 61645 encompasses intracranial thrombectomy by any method, including mechanical retrieval device and aspiration catheter.[1]

CPT defines code 61645 as a comprehensive procedure which includes: catheterization, diagnostic angiography in the vessel territory treated, imaging guidance, radiological supervision and interpretation, thrombolytic injection during the procedure, completion angiography, and all neurologic and hemodynamic monitoring of the patient. These components are not coded separately. However, diagnostic angiography in vessel territories that were not treated can be coded separately. Code 61645 may be reported once for each intracranial vascular territory treated. There are three territories: 1) right carotid, 2) left carotid, and 3) vertebro-basilar.[1]

Hospital inpatient coding and payment

Effective October 1, 2023 – September 30, 2024

ICD-10-PCS procedure codes[d]

Stent retriever thrombectomy uses qualifier 7-Stent Retriever while direct clot aspiration thrombectomy uses default qualifier Z. When thrombectomy is performed using stent retriever and aspiration together, only the stent retriever code is assigned. No additional code is needed.[2]

Procedure code[3]	Procedure code description
Thrombectomy via stent retriever device with local adjunctive aspiration syringe	
03CG3Z7	Extirpation of matter from intracranial artery using stent retriever, percutaneous approach
Thrombectomy via aspiration system	
03CG3ZZ	Extirpation of matter from intracranial artery, percutaneous approach
Thrombectomy via stent retriever and adjunctive aspiration system	
03CG3Z7	Extirpation of matter from intracranial artery using stent retriever, percutaneous approach
Cerebral arteriograhpy	
B31R1ZZ	Fluoroscopy of intracranial arteries using low osmolar contrast
B31RYZZ	Fluoroscopy of intracranial arteries using other contrast
Administration of thrombolytic (IV-tPA)	
3E03317	Introduction of other thrombolytic into peripheral vein, percutaneous approach

MS-DRG assignments

MS-DRG[e]	MS-DRG title[e]	Relative weight[e]	Geometric mean length of stay[e]	Subject to PACT[e,4]	Medicare national average[f]
Ischemic stroke with removal of thrombus via stent retriever OR aspiration system OR both					
023	Craniotomy with major device implant/acute complex central nervous system principal diagnosis W MCC[5,10]	5.6688	7.5	Yes	$39,691
024	Craniotomy with major device implant/acute complex central nervous system principal diagnosis WO MCC[5,10]	3.7888	4.0	Yes	$26,528
Ischemic stroke with administration of thrombolytic only					
061	Ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent W MCC	2.8028	5.0	No	$19,624
062	Ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent W CC	1.8717	3.2	No	$13,105
063	Ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent WO CC/MCC	1.4868	2.2	No	$10,410
Ischemic stroke with medical management only					
064	Intracranial hemorrhage or cerebral infarction W MCC	2.0030	4.6	Yes	$14,024
065	Intracranial hemorrhage or cerebral Infarction W CC or TPA in 24 Hours	1.0164	2.9	Yes	$7,116
066	Intracranial hemorrhage or cerebral Infarction WO CC/ MCC	0.6875	1.9	Yes	$4,814

Diagnosis and procedure coding scenarios for hospitals and physicians

Scenario 1: A patient arrives at a primary or comprehensive stroke center and is admitted for care as an in-patient with a diagnosis of acute ischemic stroke. No interventions are performed, and the patient is treated with medical management only.

Hospital inpatient procedure coding

Because no interventions are performed, no inpatient ICD-10-PCS procedure codes are assigned.

Hospital inpatient payment - MS-DRG payment

MS-DRG	MS-DRG title	Relative weight	Geometric mean length of stay	Subject to PACT	Medicare national average
064	Intracranial hemorrhage or cerebral infarction W MCC	2.0030	4.6	Yes	$14,024
065	Intracranial hemorrhage or cerebral infarction W CC or TPA in 24 Hours	1.0164	2.9	Yes	$7,116
066	Intracranial hemorrhage or cerebral infarction WO CC/ MCC	0.6875	1.9	Yes	$4,814

Physician procedure coding and RBRVS payment

Because no procedures are performed, physician coding and payment are determined by the evaluation and management services provided to the patient during the inpatient admission.

Scenario 2: A patient arrives at a primary stroke center. Following a CT scan, IV t-PA is administered for acute ischemic stroke, and the patient is admitted for medical care as an inpatient. No further interventions are performed.

Hospital inpatient procedure coding – ICD-10-PCS procedure codes

Code	Code description
Administration of thrombolytic (IV-tPA)	
3E03317	Introduction of other thrombolytic into peripheral vein, percutaneous approach

Hospital inpatient payment - MS-DRG payment

MS-DRG	MS-DRG title	Relative weight	Geometric mean length of stay	Subject to PACT	Medicare national average
061	Ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent W MCC	2.8028	5.0	No	$19,624
062	Ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent W CC	1.8717	3.2	No	$13,105
063	Ischemic stroke, precerebral occlusion or transient ischemia with thrombolytic agent WO CC/MCC	1.4868	2.2	No	$10,410

Scenario 2 (continued)

Physician procedure coding and RBRVS payment

Code	Code description	Medicare work RVUs (facility setting)	Medicare national average (facility setting)
Administration of thrombolytic (IV t-PA)			
37195	Thrombolysis, cerebral, by intravenous infusion	Contractor priced	

Note: This service is usually performed by the hospital nurse, under physician supervision, and is generally paid only to the hospital. The Medicare Administrative Contractor establishes RVUs and any payment to the physician on a case-by-case basis after review of documentation.

Evaluation and management
Physician coding and payment are determined by the evaluation and management services provided to the patient during the inpatient admission

Scenario 3: In this "drip-and-ship" scenario, a patient arrives at a primary stroke center. After CT scan, IV t-PA is administered in the emergency department for acute ischemic stroke and the patient is transferred to a comprehensive stroke center for inpatient admission. *The codes and payments shown below are for the transferring primary stroke center only.*

Hospital outpatient procedure and drug coding and APC payment

CPT/ HCPCS II codes	Code description	APC	APC title	Status indicator	Relative weight	Medicare national average
Administration of thrombolytic (IV t-PA)						
37195	Thrombolysis, cerebral, by intravenous infusion	5694	Level 4 drug administration	S	3.6966	$323
Thrombolytic (IV t-PA) drug						
J2997	Injection, alteplase recombinant, 1 mg	7048	Alteplase recombinant	K	N/A	$89 per unit
Hospital emergency department visit						
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	5041	Critical care	S	9.6858	$846
+99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes	N/A	N/A	N	N/A	N/A

Note: Status Indicator shows how the code is handled for the purpose of hospital outpatient payment. S = always paid at 100% of rate; T = paid at 50% of rate when billed with another higher-weighted T procedure; N = packaged service, no separate payment; K= specified covered outpatient drug, paid separately. The rate shown is for 1st Q 2024 and can be revised each quarter.

Physician procedure coding and RBRVS payment

Code	Code description	Medicare work RVUs (facility setting)	Medicare national average (facility setting)
Administration of thrombolytic (IV t-PA)			
37195	Thrombolysis, cerebral, by intravenous infusion	Contractor priced	

Note: This service is usually performed by the hospital nurse, under physician supervision, and is generally paid only to the hospital. The Medicare Administrative Contractor establishes RVUs and any payment to the physician on a case-by-case basis after review of documentation.

Scenario 3 (continued)

Physician procedure coding and RBRVS payment

Code	Code description	Medicare work RVUs (facility setting)	Medicare national average (facility setting)
Evaluation and management in the emergency department			
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	4.50	$207
+99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes	2.25	$104

Scenario 4: In this "drip-and-ship" scenario, a patient was previously diagnosed with acute ischemic stroke due to thrombus of the left internal carotid artery and treated with IV t-PA in the emergency department of another hospital, then transferred to a comprehensive stroke center. The patient is admitted to the comprehensive stroke center as an inpatient and does not undergo any further interventions or procedures. *The codes and payments shown below are for the receiving comprehensive stroke center only.*

Hospital inpatient payment - MS-DRG payment

MS-DRG	MS-DRG title	Relative weight	Geometric mean length of stay	Subject to PACT	Medicare national average
065	Intracranial hemorrhage or cerebral infarction W CC or TPA in 24 Hours	1.0164	2.9	Yes	$7,116

Physician procedure coding and RBRVS payment

Because no procedures are performed at the comprehensive stroke center, physician coding and payment are determined by the evaluation and management services provided to the patient during the inpatient admission.

Scenario 5: In this "drip-and-ship" scenario, a patient was previously treated with IV t-PA in the emergency department of a primary stroke center and was then transferred to a comprehensive stroke center and admitted as an inpatient Following diagnostic angiography, a stent retriever device is deployed in the right supraclinoid internal carotid artery and thrombectomy is performed. *The codes and payments shown below are for the receiving comprehensive stroke center only.*

Hospital inpatient procedure coding - ICD-10-PCS procedure codes

Code	Code description
Thrombectomy via stent retriever	
03CG3Z7	Extirpation of matter from intracranial artery, using stent retriever, percutaneous approach
Diagnostic cerebral angiography	
B31RYZZ	Fluoroscopy of intracranial arteries using other contrast

Hospital inpatient payment - MS-DRG payment

MS-DRG	MS-DRG title	Relative weight	Geometric mean length of stay	Subject to PACT	Medicare national average
023	Craniotomy with major device implant/acute complex central nervous system principal diagnosis W MCC	5.6688	7.5	Yes	$39,691
024	Craniotomy with major device implant/acute complex central nervous system principal diagnosis WO MCC	3.7888	4.0	Yes	$26,528

Scenario 5 (continued)

Physician procedure coding and RBRVS payment

CPT code	Code description	Multiple procedure discounting	Medicare work RVUs (facility setting)	Medicare national average (facility setting)
Mechanical thrombectomy via stent retriever				
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	No	15.00	$824
Diagnostic cerebral angiography (coded only for non-treated territories)				
36223	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch when performed	Yes	5.75	$319
36224	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch when performed	Yes	6.25	$358
36225	Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch when performed	Yes	5.75	$316
36226	Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch when performed	Yes	6.25	$356
+36228	Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery)	No	4.25	$242

Note: Diagnostic angiography is integral and not coded separately when performed in the treated territory. However, diagnostic angiography may be coded separately when performed in non-treated territories. The arteriography codes identify the location of the catheter for injection as well as the areas that are imaged following the injection. Only one code can be used from 36223-36224 for carotid imaging. Likewise, only one code can be used from 36225-36226 for vertebral imaging. Add-on code +36228 for additional cerebral vessel catheterization and injection must be used together with one of the carotid or vertebral codes. Depending on the specific nature of the diagnostic angiography, the payment shown for each code may be subject to 150% increase for bilateral angiography or 50% reduction for multiple procedure discounting. When submitted with thrombectomy code 61645, the diagnostic angiography codes require a modifier, eg, -59, to indicate the distinct procedural service in a non-treated territory.

Evaluation and management

Physician coding and payment are determined by the evaluation and management services provided to the patient during the inpatient admission.

Scenario 6: A patient is treated with IV t-PA in the emergency department of the comprehensive stroke center and admitted as an inpatient. Diagnostic angiography is performed with catheterization of the left and right vertebral arteries. Clot is identified in the right middle cerebral artery and the catheter is advanced to the site for further angiography. A stent retriever device is then deployed in the right middle carotid artery and thrombectomy is performed.

Hospital inpatient procedure coding - ICD-10-PCS procedure codes

Code	Code description
Thrombectomy via stent retriever	
03CG3Z7	Extirpation of matter from intracranial artery, using stent retriever, percutaneous approach
Administration of thrombolytic (IV t-PA)	
3E03317	Introduction of other thrombolytic into peripheral vein, percutaneous approach
Diagnostic cerebral angiography	
B31RYZZ	Fluoroscopy of intracranial arteries using other contrast

Hospital inpatient payment - MS-DRG payment

MS-DRG	MS-DRG title	Relative weight	Geometric mean length of stay	Subject to PACT	Medicare national average
023	Craniotomy with major device implant/acute complex central nervous system principal diagnosis W MCC	5.6688	7.5	Yes	$39,691
024	Craniotomy with major device implant/acute complex central nervous system principal diagnosis WO MCC	3.7888	4.0	Yes	$26,528

Physician procedure coding and RBRVS payment

CPT code	Code description	Multiple procedure discounting	Medicare work RVUs (facility setting)	Medicare national average (facility setting)
Mechanical thrombectomy via stent retriever				
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	No	15.00	$824
Diagnostic cerebral angiography (coded only for non-treated territories)				
36226-50-59	Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch when performed	Yes	6.25	$356
Diagnostic cerebral angiography (coded only for non-treated territories)				
36224-59	Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch when performed	Yes	6.25	$358

Scenario 7: A patient arrives in the emergency department of a comprehensive stroke center. Following CT angiography which shows occlusion in the distal basilar artery, the patient is treated with IV t-PA and admitted as an inpatient. Diagnostic angiography of the vertebro-basilar circulation is performed, and clot is seen the distal basilar artery. A distal access catheter, a part of an aspiration system, is advanced to the occluded basilar segment and direct aspiration thrombectomy is performed.

Hospital inpatient procedure coding - ICD-10-PCS procedure codes

Code	Code description
Thrombectomy via aspiration system	
03CG3ZZ	Extirpation of matter from intracranial artery, percutaneous approach
Administration of thrombolytic (IV t-PA)	
3E03317	Introduction of other thrombolytic into peripheral vein, percutaneous approach
Diagnostic cerebral angiography	
B31RYZZ	Fluoroscopy of intracranial arteries using other contrast

Hospital inpatient payment - MS-DRG payment

MS-DRG	MS-DRG title	Relative weight	Geometric mean length of stay	Subject to PACT	Medicare national average
023	Craniotomy with major device implant/acute complex central nervous system principal diagnosis W MCC	5.6688	7.5	Yes	$39,691
024	Craniotomy with major device implant/acute complex central nervous system principal diagnosis WO MCC	3.7888	4.0	Yes	$26,528

Physician procedure coding and RBRVS payment

CPT code	Code description	Multiple procedure discounting	Medicare work RVUs (facility setting)	Medicare national average (facility setting)
Mechanical thrombectomy via aspiration system				
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	No	15.00	$824

Note: Diagnostic angiography is integral and not coded separately when performed in the treated territory, as is the case in this scenario.

Administration of thrombolytic (IV t-PA)		
37195	Thrombolysis, cerebral, by intravenous infusion	Contractor Priced

Note: This service is usually performed by the hospital nurse, under physician supervision, and is generally paid only to the hospital. The Medicare Administrative Contractor establishes RVUs and any payment to the physician on a case-by-case basis after review of documentation

Evaluation and management

Physician coding and payment are determined by the evaluation and management services provided to the patient during the inpatient admission.

Scenario 8: A patient arrives in the emergency department of a comprehensive stroke center. Following CT angiography which shows occlusion in the distal basilar artery, the patient is treated with IV t-PA and admitted as an inpatient. Diagnostic angiography is performed of the vertebro-basilar circulation and clot is seen the distal basilar artery. A distal access catheter, a part of an aspiration system, is advanced to the occluded basilar segment and direct aspiration thrombectomy is applied. Although blood flow has been restored, the physician identifies an opportunity to further improve blood flow and decides to deliver and deploy a stent retriever to the occlusion site. While retrieving the stent retriever, an adjunctive aspiration system is also used.

Hospital inpatient procedure coding - ICD-10-PCS procedure codes

Code	Code description
Thrombectomy via aspiration system	
03CG3ZZ	Extirpation of matter from intracranial artery, percutaneous approach
Administration of thrombolytic (IV t-PA)	
3E03317	Introduction of other thrombolytic into peripheral vein, percutaneous approach
Diagnostic cerebral angiography	
B31RYZZ	Fluoroscopy of intracranial arteries using other contrast

Hospital inpatient payment - MS-DRG payment

MS-DRG	MS-DRG title	Relative weight	Geometric mean length of stay	Subject to PACT	Medicare national average
023	Craniotomy with major device implant/acute complex central nervous system principal diagnosis W MCC	5.6688	7.5	Yes	$39,691
024	Craniotomy with major device implant/acute complex central nervous system principal diagnosis WO MCC	3.7888	4.0	Yes	$26,528

Physician procedure coding and RBRVS payment

CPT code	Code description	Multiple procedure discounting	Medicare work RVUs (facility setting)	Medicare national average (facility setting)
Mechanical thrombectomy via aspiration system				
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	No	15.00	$824

Note: Diagnostic angiography is integral and not coded separately when performed in the treated territory, as is the case in this scenario.

Administration of thrombolytic (IV t-PA)		
37195	Thrombolysis, cerebral, by intravenous infusion	Contractor Priced

Note: This service is usually performed by the hospital nurse, under physician supervision, and is generally paid only to the hospital. The Medicare Administrative Contractor establishes RVUs and any payment to the physician on a case-by-case basis after review of documentation

Evaluation and management

Physician coding and payment are determined by the evaluation and management services provided to the patient during the inpatient admission.

Scenario 9: A patient arrives in the emergency department of a comprehensive stroke center. Following CT angiography which shows occlusion in the distal basilar artery, the patient is treated with IV t-PA and admitted as an inpatient. Diagnostic angiography is performed of the vertebro-basilar circulation and clot is seen the distal basilar artery. The stent retriever is advanced through a distal access catheter (a part of an aspiration system) to the occluded basilar segment. While adjunctive aspiration is being applied via the aspiration system, the stent retriever restores blood flow in the basilar artery upon clot retrieval.

Hospital inpatient procedure coding - ICD-10-PCS procedure codes

Code	Code description
Thrombectomy with stent retriever and aspiration system	
03CG3Z7	Extirpation of matter from intracranial artery, using stent retriever, percutaneous approach
Administration of thrombolytic (IV t-PA)	
3E03317	Introduction of other thrombolytic into peripheral vein, percutaneous approach
Diagnostic cerebral angiography	
B31RYZZ	Fluoroscopy of intracranial arteries using other contrast

Hospital inpatient payment - MS-DRG payment

MS-DRG	MS-DRG title	Relative weight	Geometric mean length of stay	Subject to PACT	Medicare national average
023	Craniotomy with major device implant/acute complex central nervous system principal diagnosis W MCC	5.6688	7.5	Yes	$39,691
024	Craniotomy with major device implant/acute complex central nervous system principal diagnosis WO MCC	3.7888	4.0	Yes	$26,528

Physician procedure coding and RBRVS payment

CPT code	Code description	Multiple procedure discounting	Medicare work RVUs (facility setting)	Medicare national average (facility setting)
Thrombectomy via stent retriever with adjunctive aspiration system				
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	No	15.00	$824

Note: Diagnostic angiography is integral and not coded separately when performed in the treated territory, as is the case in this scenario.

Administration of thrombolytic (IV t-PA)		
37195	Thrombolysis, cerebral, by intravenous infusion	Contractor Priced

Note: This service is usually performed by the hospital nurse, under physician supervision, and is generally paid only to the hospital. The Medicare Administrative Contractor establishes RVUs and any payment to the physician on a case-by-case basis after review of documentation

Evaluation and management

Physician coding and payment are determined by the evaluation and management services provided to the patient during the inpatient admission.

Annual references

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b. Centers for Medicare & Medicaid Services. CY 2024 MPFS Final Rule. Although the total RVU consists of three components, only the physician work RVU is shown.

c. Medicare national average payment is determined by multiplying the total RVU for a CPT code by the conversion factor, which is $32.7375 for CY 2024. CY 2024 MPFS Final Rule.

d. Centers for Medicare & Medicaid Services. 2024 ICD-10 Procedure Coding System (ICD-10-PCS).

e. Center for Medicare & Medicaid Services. FY 2024 IPPS Final Rule.

f. Payment is based on the average standardized operating amount ($6,497.99) plus the capital standard amount ($508.83). The payment rate shown is the standardized amount for facilities with a wage index greater than one. The average standard amounts shown also assume facilities receive the full quality update. FY 2024 IPPS Final Rule.

Coding footnotes

1. See CPT manual instructions (Surgery section, Nervous System, Endovascular Therapy). See also CPT Assistant, September 2019, p.6, for completion angiography.
2. See Coding Clinic 4th Q 2018, p.47.
3. Per ICD-10-PCS indexing, C-Extirpation is used for thrombectomy.
4. Post-Acute Care Transfer (PACT) status refers to selected DRGs in which payment to the hospital may be reduced when the patient is discharged by being transferred out. The DRGs impacted are those marked "Yes," and the patient must be transferred out before the geometric mean length of stay to certain post-acute care providers, including rehabilitation hospitals, long term care hospitals, skilled nursing facilities, hospice, or to home under the care of a home health agency. When these conditions are met, the DRG payment is converted to a per diem and payment is made at double the per diem rate for the first day plus the per diem rate for each remaining day up to the full DRG payment.
5. All ischemic stroke codes are classified as "acute complex central nervous system" diagnoses in DRG logic.