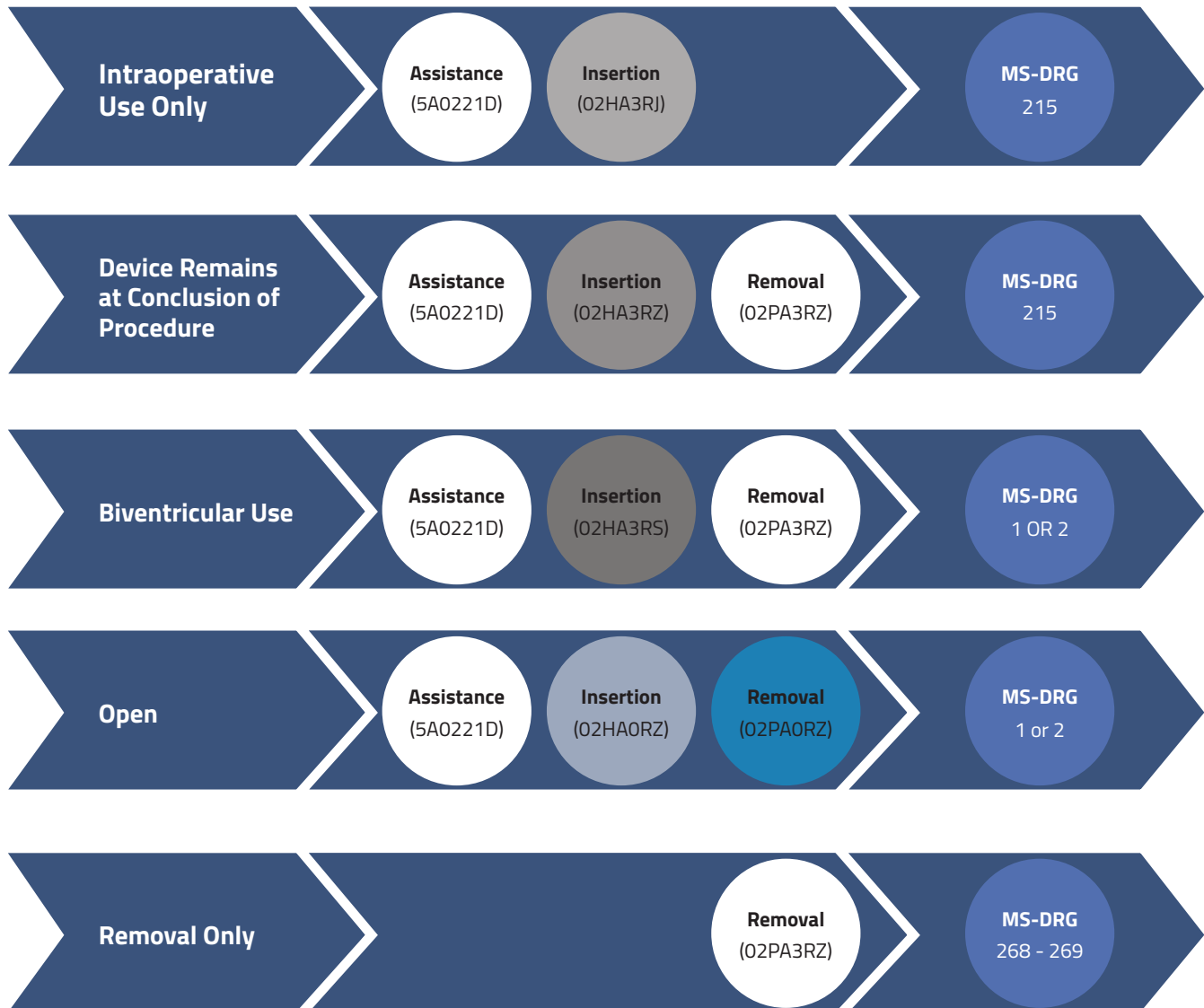


Hospital Coding for Impella Procedures

ICD-10-PCS Coding Guidance

As of October 2017



According to ICD-10 PCS Official Guideline B6.1a, a device is coded only if a device remains after the procedure is completed.

If no device remains, the device value No Device is coded. In limited root operations, the classification provides the qualifier values Temporary and Intraoperative, for specific procedures involving clinically significant devices, where the purpose of the device is to be utilized for a brief duration during the procedure or current inpatient stay.

The ICD-10 PCS device removal code may be used when the hospital that receives the patient only monitors care and removes the Impella device prior to patient discharge. If escalation of care therapy occurs, use the appropriate ICD-10 PCS code that corresponds to the therapy or services that are provided.

Please note applicable guidelines and instructions of ICD-10-PCS codes are subject to change at any time.



2017 Impella® Percutaneous Circulatory Support Physician Coding and Billing

Impella 2.5®, 5.0® and Impella CP® Heart Pump Procedures	
CPT® Code ¹	Description
33990	Insertion of ventricular assist device, percutaneous including radiological supervision and interpretation; arterial only
33992	Removal of percutaneous ventricular assist device at separate and distinct session from insertion
33993	Repositioning of percutaneous ventricular assist device with imaging guidance at separate and distinct session from insertion
Other Procedural Activities	
34812	Open femoral artery exposure for delivery of endovascular prosthesis; by groin incision, unilateral
33999	Unlisted Procedure, Cardiac Surgery (for RP venous insertion and Artery exposure in the upper extremity; see additional information below*)
Critical Care Codes	
CPT® Code ¹	Description
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
Additional Guidance	
Removal and Repositioning	
CPT code 33992 (removal) and CPT code 33993 (repositioning) may be billed and paid for in addition to CPT code 33990 (insertion) if performed during a separate session. Medicare's definition of a separate session is that the services be performed during a different patient encounter. Payers may require the use of a modifier to report multiple procedures by the same physician on the same day.	
Radiology and Imaging	
CPT Codes 33990 and 33993 include radiology or imaging guidance in their description. This indicates to some payers that the imaging and radiology procedures are included in the primary procedure and are not eligible for separate payment.	
Other Procedural Activities	
* When using an unlisted procedure code, it is important to submit a copy of the procedure to explain the services performed. It is strongly recommended that the freeform field of the claim form (Field 19,"Reserved For Local Use,") be used to document a crosswalk to another procedure believed to be fairly equivalent. You should also indicate in Field 19 an expected payment amount for the payer's reference. It is important to check with each payer regarding their specific coding policy for axillary insertion and repair and, if covered, obtain instruction as to how to report the service (i.e., code 33999 or another CPT code).	

1. CPT® 2017 Codebook Professional Edition.

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