MicroVention®
TERUMO

U.S. PRODUCT LINE REIMBURSEMENT GUIDE

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Leading the Way with New Technologies and Products

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Introduction

MicroVention, Inc. is pleased to provide you with this ***Reimbursement Guide.*** This guide has been written to provide our customers with third-party reimbursement information designed to minimize reimbursement problems and questions and to help facilitate appropriate claims submission. This guide is designed to help anticipate reimbursement issues proactively and efficiently so that you can spend more time caring for patients and less time addressing reimbursement. Nothing in this Guide is intended to interfere with your independent clinical decision making related to patient treatment decisions. Further, nothing herein directly or indirectly condones false, inaccurate or partial billing practices by you or your entity.

This Guide is intended for health care professionals, if you are a patient, it is important to discuss health information with your doctor.

Medicare policies play an influential role with respect to the policies established by other third-party payers. Therefore, throughout this guide, Medicare coding, coverage and payment guidelines are referenced unless otherwise indicated.

Specifically, this guide is intended to:

- ✓ Offer coding information pertaining to both Medicare and non-Medicare payers and related to our products use as indicated on the label;
- ✓ Provide guidelines applicable during the preauthorization process and related to our products use as indicated on the label; and
- ✓ Assist with the submission of properly documented claims.

Many innovative techniques and technologies may outpace third party coding and reimbursement policies.

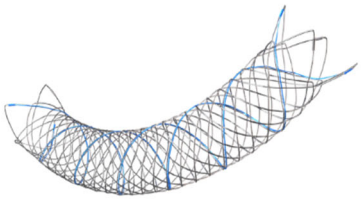
This reimbursement guide is an example of our commitment to providers and their patients to facilitate accurate billing and coding information related to reimbursement of our products and/or related to treatment of diseases that our products are indicated for. We have made an effort to provide information that is current at the time of its issue, but the information may not be as current or comprehensive when you view it. This guide provides current reimbursement information about third party payers in the US market, how to preauthorize and appeal claims and resources for additional information. Payors policies will vary and should be verified for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

Product Information

MicroVention, Inc. offers a wide variety of products in the U.S. market, including Platinum Coils, Hydrogel Coils, stents and several types of Access Products, including SOFIA™ Flow Plus Catheters.

Below is a summary of the products addressed in this reimbursement guide. Please also refer to www.microvention.com for additional details.

STENTS
LVIS®, LVIS ®Jr. Intraluminal Support Devices
FRED® Flow Re-Direction Endoluminal Device



COILS
Cosmos® Coils
VFC® Versatile Range Fill Coils
HyperSoft®3D Coils
HyperSoft® Helical Coils
HydroFrame® Coils
HydroFill® Coils
HydroSoft® Helical Coils
Complex Coils
HyperSoft® 3D Coils
Helical Coils

ACCESS PRODUCTS
Chaperon® Guiding Catheter System
Chaperon® Guiding Catheter Single
SOFIA® Distal Access Catheter- SOFIA® Flow Plus Aspiration Catheter
Traxcess® Guidewires and Docking Wire
Glidewire® Gold Neuro Guidewires
Headliner® Guidewires
Headway® Microcatheters
Headway® Duo Microcatheters
VIA® Microcatheters
WEDGE™ Microcatheter
Scepter C® Occlusion Balloon Catheter
Scepter XC® Occlusion Balloon Catheter

Coding Reference Sheet

The information contained in this document is provided for informational purposes only and represents no statement, promise, or guarantee by MicroVention, Inc. concerning levels of reimbursement, payment, or charge, or that reimbursement will be made. It is not intended to increase or maximize reimbursement by any payer. Providers assume full responsibility for reimbursement decisions or actions. The coding options listed in this guide are not intended to be all-inclusive nor a recommendation for coding. As always, payer policies should be reviewed for coverage & coding guidelines.

This coding sheet is limited to the reporting and billing of the procedures for selective catheterization and device placement. All preoperative, postoperative, and follow-up services should be billed according to the service performed in conjunction with standard billing and coding guidelines.

Note: When performing multiple procedures, review current correct coding guidelines carefully. Services that are considered a component of another procedure cannot always be coded and billed separately. Medicare's Correct Coding Initiative is reviewed and updated several times a year. Commercial payer policies vary and should be consulted and reviewed thoroughly on a regular basis.

ICD-10-CM Coding

Common ICD-10-CM Diagnosis Codes for MicroVention Products*

Indication	ICD-10-CM Diagnosis code	Code Description
Cerebral aneurysm	I60.00-I60.9	Nontraumatic subarachnoid hemorrhage from carotid siphon and bifurcation
	I61.0-I61.9	Nontraumatic intracerebral hemorrhage
	I62.9	Nontraumatic intracranial hemorrhage, unspecified
	I67.0	Dissection of cerebral arteries, nonruptured
Dural arteriovenous fistulae (DAVF)	I77.0	Arteriovenous fistula, acquired
	Q28.2-Q28.3	Other congenital malformations of circulatory system
Carotid cavernous fistulae (CCF)	I72.0	Aneurysm of carotid artery
	I67.1	Cerebral aneurysm, nonruptured
	Q28.2-Q28.3	Other congenital malformations of circulatory system
	S15.8XXA	Injury of other specified blood vessels at neck level, initial encounter
Parent vessel occlusion (PAO)	I65.8	Occlusion and stenosis of other precerebral arteries
	I63.09-I63.59	Cerebral infarction due to thrombosis of precerebral arteries
	I65.9	Occlusion and stenosis of unspecified precerebral artery
	I63.00-I63.29	Cerebral infarction due to thrombosis of precerebral arteries
	I66.01-I66.9	Occlusion and stenosis of middle cerebral artery
	I63.50-I63.9	Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries
	G45.1-G46.2	Transient cerebral ischemic attacks and related syndromes
	I67.841-I67.848	Cerebral vasospasm and vasoconstriction
Arteriovenous malformations (AVM)	Q28.2-Q28.3	Other congenital malformations of circulatory system
	C47.0-C49.0	Malignant neoplasm of peripheral nerves and autonomic nervous system

Indication	ICD-10-CM Diagnosis code	Code Description
Vascular neoplasms/Tumors	C71.0	Malignant neoplasm of cerebrum, except lobes and ventricles
	L08.89	Other specified local infections of the skin and subcutaneous tissue
	T07	Unspecified multiple injuries
	C70.0-C70.9	Malignant neoplasm of meninges
	C79.31	Secondary malignant neoplasm of brain
	C79.32	Secondary malignant neoplasm of cerebral meninges
	C79.40	Secondary malignant neoplasm of unspecified part of nervous system
	C79.49	Secondary malignant neoplasm of other parts of nervous system
	C79.89-C79.9	Secondary malignant neoplasm of other specified sites
	D21.0	Benign neoplasm of connective and other soft tissue of head, face and neck
	D32.0-D32.9	Benign neoplasm of meninges
	D33.0-D33.2	Benign neoplasm of brain and other parts of central nervous system
	D33.7	Benign neoplasm of other specified parts of central nervous system
	D18.00-D18.09	Hemangioma
	D42.0-D42.9	Neoplasm of uncertain behavior of meninges
	D43.0-D43.4	Neoplasm of uncertain behavior of brain and central nervous system
	D48.1-D48.2	Neoplasm of uncertain behavior of other and unspecified sites
	D49.6	Neoplasm of unspecified behavior of brain
	D49.7	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
	G45.0	Vertebro-basilar artery syndrome
	G46.0-G46.8	Vascular syndromes of brain in cerebrovascular diseases
	G97.32	Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating other procedure
	I67.81-I67.89	Other specified cerebrovascular diseases
	I67.89	Other cerebrovascular disease
	I67.9	Cerebrovascular disease, unspecified
	168.8	Other cerebrovascular disorders in diseases classified elsewhere
	I77.71	Dissection of carotid artery
	I97.810-I97.821	Other intraoperative and postprocedural complications and disorders of the circulatory system, not elsewhere classified
	S06.360A	Traumatic hemorrhage of cerebrum, unspecified, without loss of consciousness, initial encounter
	S09.0XXA	Injury of blood vessels of head, not elsewhere classified, initial encounter
	S15.001A-S15.099A	Unspecified injury of carotid artery
	S15.8XXA	Injury of other specified blood vessels at neck level, initial encounter
	S15.101A-S15.199A	Injury of vertebral artery
	S15.9XXA	Injury of unspecified blood vessel at neck level, initial encounter
Stroke	I66.01-I66.9	Occlusion and stenosis of middle cerebral artery
	I63.30-I63.339	Cerebral infarction due to thrombosis of cerebral arteries
	I63.40-I63.49	Cerebral infarction due to embolism of cerebral arteries

Indication	ICD-10-CM Diagnosis code	Code Description
	I63.50-I63.9	Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries
	G45.0-G45.9	Transient cerebral ischemic attacks and related syndromes

*Not inclusive or representative of all diagnosis codes. Code according to documentation in the patient's medical record.

Common ICD-10-CM Procedure Codes*

ICD-10-CM Procedure Code	Code Description
03[L,V][G,H,J,K,L,M,N,P,Q,R,S,T,U,V][0,3][D,Z]Z	Occlusion or restriction, upper arteries
05L[L,M,N,P,Q,R,S,T,V][0,3][D,Z]Z	Occlusion, upper veins
03CG[3,4]Z[6,Z]	Extirpation of matter from intracranial artery

*Not inclusive or representative of all procedure codes. Code according to documentation in the patient's medical record.

Common CPT Codes for Physician Professional Services

CPT Code	Code Description	2019 Medicare National Average Physician Payment Facility Setting†
Selective Catheterization – Code according to procedure performed		
36215*	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	$222.00
36216*	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	$285.79
36217*	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	$342.73
+36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	$54.42
Cervicocerebral Angiography		
36222	Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed	$296.24
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	$330.84
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	$377.69
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	$330.12
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	$372.28
+36227	Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)	$122.89

CPT Code	Code Description	2019 Medicare National Average Physician Payment Facility Setting†
+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) (List separately in addition to code for primary procedure)	$253.35
Endovascular Therapy / Device Deployment		
61623	Endovascular temporary balloon arterial occlusion, head or neck (extracranial/intracranial) including selective catheterization of vessel to be occluded, positioning and inflation of occlusion balloon, concomitant neurological monitoring, and radiologic supervision and interpretation of all angiography required for balloon occlusion and to exclude vascular injury post occlusion	$598.61
61624	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)	$1214.88
61626	Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)	$921.52
61630	Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous	$1464.63
61635	Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed	$1,535.63
61640	Balloon dilatation of intracranial vasospasm, percutaneous; initial vessel	$504.91
+61641	Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in same vascular territory (List separately in addition to code for primary procedure)	$177.31
+61642	Balloon dilatation of intracranial vasospasm, percutaneous; each additional vessel in different vascular territory (List separately in addition to code for primary procedure)	$354.62
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)	$876.83
61680	Surgery of intracranial arteriovenous malformation; supratentorial, simple	$2382.18
61682	Surgery of intracranial arteriovenous malformation; supratentorial, complex	$4450.83
61684	Surgery of intracranial arteriovenous malformation; infratentorial, simple	$2996.65
61686	Surgery of intracranial arteriovenous malformation; infratentorial, complex	$4916.81
61690	Surgery of intracranial arteriovenous malformation; dural, simple	$2294.61
61692	Surgery of intracranial arteriovenous malformation; dural, complex	$3921.41
61697	Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation	$4521.83

CPT Code	Code Description	2019 Medicare National Average Physician Payment Facility Setting†
61698	Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation	$5045.83
61700	Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation	$3630.94
61702	Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation	$4263.07
61705	Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery	$2652.48
75894 -26	Transcatheter therapy, embolization, any method, radiological supervision and interpretation	$74.24
75898 -26	Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis	$92.62
OR		
64999	Unlisted procedure, nervous system	Carrier priced

*Per NCCI edits, 36215-36217 cannot be used in conjunction with 61623 or 61630
†Medicare 2019 Physician Fee Schedule: (www.cms.gov)

CPT Code	Code Description	2019 Medicare National Average Physician Payment Facility Setting†
Fluoroscopy		
76000 -26*	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	$15.86

*Per NCCI edits, Fluoroscopy codes cannot be used in conjunction with 61630 Balloon angioplasty, intracranial (eg, atherosclerotic stenosis), percutaneous
†Medicare 2019 Physician Fee Schedule: (www.cms.gov)

Common Modifiers for Physician Coding

Modifier	Description[1]
-22	Increased procedural services
It may be required to report modifier 22 when the work required to provide a service is substantially greater than typically required. These circumstances may: • Indicate that substantially greater services than what is typically provided must be performed • Eliminate ambiguity of the previous definition by adding a parenthetical note that defines criteria for increased work, such as time, or increased intensity	
-26	Professional component
Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.	
-51	Multiple procedure
When multiple procedures are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code. Subsequent procedures, following the primary procedure, are subject to a 50% payment reduction.	
-52	Reduced services
A service or procedure that is partially reduced or eliminated at the physician's discretion should be identified by its usual procedure code and the addition of modifier 52, indicating that the service is reduced. A statement along with an operative report should accompany the claim when it is submitted to Medicare and many other third-party payers.	
-53	Discontinued procedure
In some instances, a physician may elect to terminate a surgical or diagnostic procedure. Use modifier 53 when the procedure is discontinued after anesthesia is administered. Modifier 53 is not valid in the following situations: • With E/M services • For elective cancellation of a procedure before anesthesia induction and/or surgical preparation • When a laparoscopic or endoscopic procedure is converted to an open procedure or is changed or converted to a more extensive procedure.	
-58	Staged or Related Procedure of Service by the Same Physician or Other Qualified HealthCare Professional During the Postoperative Period
Modifier 58 is used to indicate the performance of a procedure or service during the postoperative period that was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. These circumstances are reported by adding the modifier 58 to the staged or related procedure.	
-59	Distinct procedural service
Modifier 59 is used to identify procedure/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. This may represent any of the following: • Different session • Different procedure/surgery • Different site/organ system • Separate incision/excision • Separate lesion • Separate injury	

[1] AMA Coding with Modifiers, A Guide to Correct CPT and HCPCS Level II Modifier Usage, 5h edition

Common Hospital Revenue Coding Options

Revenue Code	Code Description
0270	Medical / surgical supply – general
0272	Medical / surgical supply - sterile supply
0278	Medical / surgical supply – other implants
0279	Medical / surgical supply - other supplies/devices
0360	Operating Room Services – general classification

Common C-Codes for MicroVention Access Products*

C-Code	Code Description	Possible MicroVention Product(s)
C1769	Guide wire	E.g., Traxcess, Glidewire Gold Neuro Guidewire
C1887	Catheter, guiding (may include infusion/perfusion capability)	E.g., Headway, Headway DUO, VIA, WEDGE Microcatheter, Chaperon, SOFIA Distal Access Catheter, SOFIA Flow Plus Aspiration Catheter
C2628	Catheter, occlusion	E.g., Scepter C and XC Occlusion Balloon Catheters
C1876	Stent, non-coated/non-covered, with delivery system	E.g., LVIS and LVIS Jr., FRED 27 and 21.
C1757	Catheter, thrombectomy, embolectomy	E.g. Sofia Flow Plus Aspiration Catheter

*C-Codes are used for outpatient services and products; however, some hospitals use c-codes for tracking purposes.

For WEB Intrasaccular device please refer to the WEB Reimbursement Guide

Common MS-DRGs*

MS-DRG	MS-DRG Description*	FY2019 National Average Medicare Payment†
020	Intracranial Vascular Procedures with Principal Diagnosis of Hemorrhage with MCC	$58,020
021	Intracranial Vascular Procedures with Principal Diagnosis of Hemorrhage with CC	$43,997
022	Intracranial Vascular Procedures with Principal Diagnosis of Hemorrhage without CC/MCC	$28,703
023	Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principle Diagnosis w/MCC or Chemotherapy Implant or Epilepsy with Neurostimulator	$30,387
024	Craniotomy with Major Device Implant or Acute Complex Central Nervous System Principle Diagnosis without MCC	$21,813
025	Craniotomy and Endovascular Intracranial Procedures with MCC	$23,806
026	Craniotomy and Endovascular Intracranial Procedures with CC	$16,783
027	Craniotomy and Endovascular Intracranial Procedures without CC/MCC	$13,388

* (M)CC = (major) complications and/or comorbidities

† DRG Expert 20193, Optum 360, LLC Hospital payment rates vary tremendously based on a Medicare hospital profile. The rates shown herein are national average rates. We recommend checking with your hospital's finance department for your hospital specific MS-DRG payment rate.

Preauthorization for Non-Medicare Private Payers

Many of MicroVention, Inc. products are used in emergent circumstances. If preauthorization is not possible before the patient's payer can be contacted, the payer should be notified as soon as possible. For emergency or other extenuating circumstances, most payers require notification within 48 hours of the procedure. The following steps should assist in the preauthorization process.

NOTE: Medicare does not preauthorize services

Preauthorization is a process that allows physicians and other health care providers to determine prior to treating a patient if the proposed procedure or service is eligible for coverage. A preauthorization is never a guarantee of payment. Final determination will be subject to valid eligibility and applicable benefits at the time of rendered services.

The most effective way to ensure payment for the MicroVention, Inc. products is to preauthorize benefits prior to ordering, using, or dispensing the products. Preauthorization clarifies benefits and payment rates in advance, allowing you and your patient to make informed decisions about their care.

Process

- ✓ A call should be placed to the patient's payer to verify insurance benefits and to determine if preauthorization is required to use any of the MicroVention Inc. products.

- ✓ If a written inquiry is required, the following information should be included when drafting the preauthorization letter:

    - ◊ Patient's brief medical history;
    - ◊ Medical necessity;
    - ◊ Relationship of the diagnosis to the use of any MicroVention Inc. product(s);
    - ◊ Complicating co-morbidities
    - ◊ Duration of the diagnosis (acute, acute but refractory to treatment, chronic); and
    - ◊ Overall expected course of treatment

- ✓ The letter should be mailed and/or faxed to the payer's attention and followed up within a few days to determine the status of the request and verify receipt of request.

- ✓ If the decision is negative, call the payer and determine why. Non-coverage decisions are usually based on lack of medical necessity which will be the basis for the appeal.

- ✓ Inquire about the appeal process. All payers have an appeal process; you should determine what the process is, where the appeal letter should be sent, and to whom the letter should be sent.

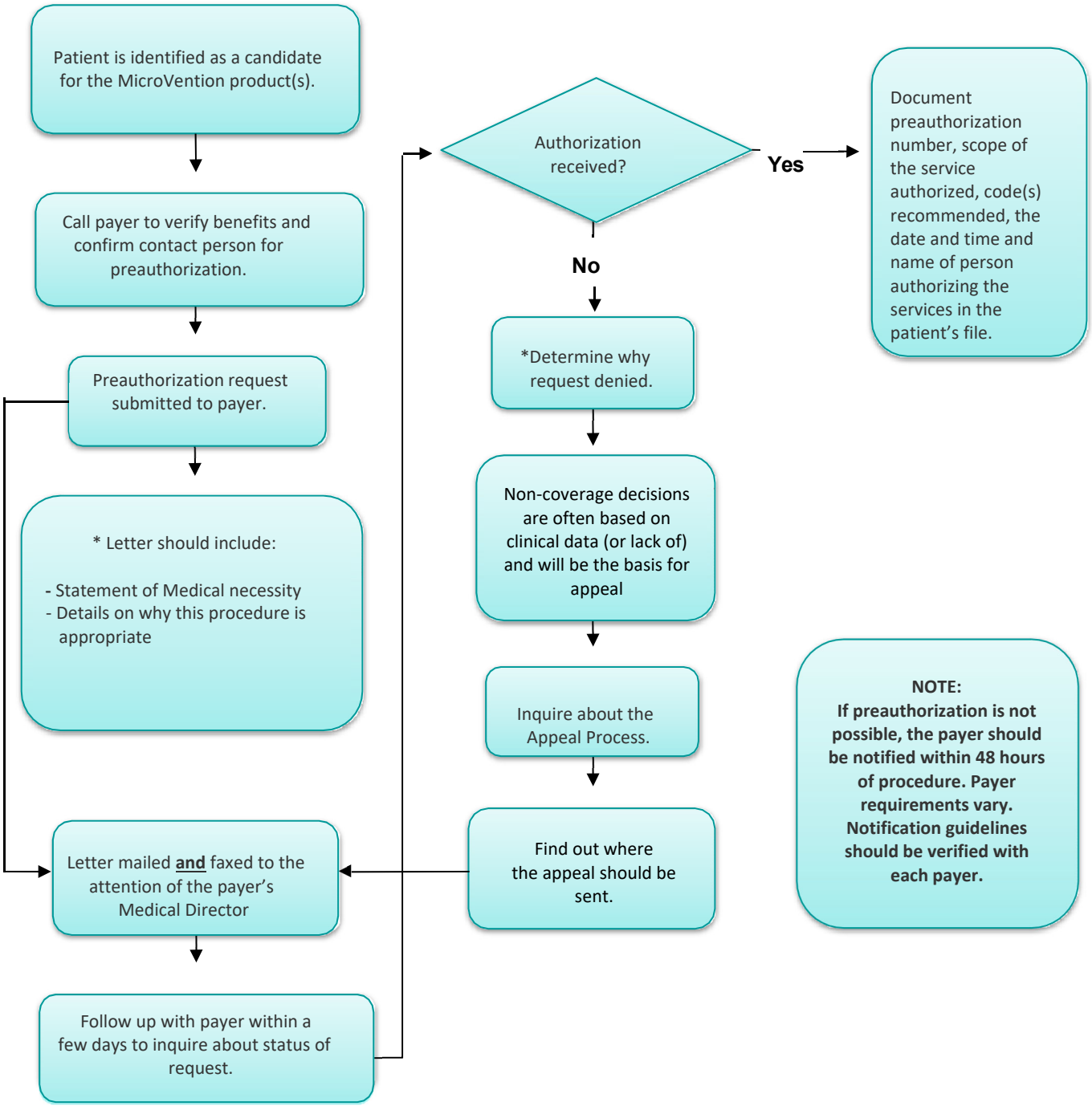
Preauthorization Program Checklist

The below is offered for your convenience and reference as a suggested checklist to support your efforts related to the timely pre-authorization process at your institution. The following information may be requested by the payer when initiating a preauthorization from an insurer. Some of the below information may be protected patient information and require your compliance with HIPAA.

- Name of treating center with contact information
- Name of treating provider
  - ✓ Treating provider's Tax ID #
  - ✓ Contact person's phone and email address
- Patient information
  - ✓ Patient name
  - ✓ Address, Zip Code
  - ✓ Social Security Number
  - ✓ Date of birth
  - ✓ Phone Number
  - ✓ Policy and Group Number
  - ✓ Insured's Social Security Number
  - ✓ Patient's relationship to insured
- Treatment information
  - ✓ Patient ICD-10 diagnosis code and written description of diagnosis
  - ✓ Patient CPT code and written description of procedure
  - ✓ Anticipated treatment date
- Letter of Medical Necessity
- Please be prepared to have all relevant medical records that show medical necessity if payer requests them

Preauthorization Flowchart for Private Payers

Note: Medicare does not preauthorize services



Frequently Asked Questions

Q. What is coil embolization?

A: Coil embolization is a transcatheter procedure that is used for the closure of abnormal blood flow into a blood vessel. A metallic coil is inserted into an artery via catheter, typically in the femoral artery and is then advanced to the abnormal blood vessel. Once positioned correctly, the coil is released into position within the vessel. It remains secure by the expansion of the coil against the vessel wall and eventually a blood clot will form around the coil, obstructing blood flow beyond the coil. A scar will form over the coil and create a permanent seal.

Q. Do the coil products have device C-codes?

A. No, C-Codes are not used for hospital inpatient services; however, they may be used for tracking or other administration purposes. Although the coils often include additional components, they cannot be separately billed because they are deemed to be part of the overall coil system.

Q. Are the MicroVention, Inc. products eligible for separate and distinct reimbursement separate from the DRG payment?

A. No, the DRGs are all inclusive payments meaning all supplies and products used for the procedure, are included in one single payment.

Q. What is preauthorization, and should I preauthorize services involving MicroVention Inc. products?

A. Preauthorization is a process that allows physicians and other health care providers to determine, before the service is performed, if the patient is eligible for coverage of the proposed service and if the service meets medical necessity criteria. A preauthorization is never a guarantee of payment. Final determination will be subject to valid eligibility, medical necessity and applicable benefits at the time of rendered services.

The most effective way to secure insurance benefits for your patients is to preauthorize benefits prior to scheduling any surgical procedure.

Preauthorization clarifies benefits and payment rates under the patient's insurance and in advance of the service, allowing you and your patient to make informed decisions about their care. The only notable exception to this general rule is Medicare. **Traditional Medicare does NOT preauthorize medical procedures. Medicare Advantage Plans do require preauthorization.**

Q. What kind of documentation is needed when billing with an unlisted CPT code?

A: Typically, the documentation requested by the payer and submitted by the provider includes detailed description of what was done, how long the procedure took and what equipment/supplies were used. This is sometimes called a Special Report. The more detailed, the easier it is for someone determining payment and/or auditing the claim to have a good understanding of the services provided. In the case of radiology services, the documentation should also include the interpretation and written report of the findings and the image (either hard-copy or digital) in the patient's medical records.

Q. What should I do if a claim is denied?

A: You should begin by reviewing the EOB for an explanation or reason for the denial. If the EOB does not explain the reason for denial, you should contact the claims department listed on the EOB, and request an explanation. All insurance carriers and payers have an appeals process. Inquire into the process for appeal, including where and to whom the appeal should be sent. Obviously, if the procedure was preauthorized, details should be provided to the payer.

Q. Do payers cover endovascular embolization for extracranial malformations?

A: Generally, payers consider this procedure medically necessary, but we recommend you verify with the individual payer as payer policies vary.

Q. Do payers cover endovascular repair of wide-neck aneurysms?

A: Some payers consider this procedure medically necessary, but we recommend you verify with the individual payer as payer policies vary.

Q. Are there any published articles available related to the safe and effective use of MV products?

A: Please refer to www.microvention.com for a complete Bibliography

Q. What if I have additional questions concerning reimbursement?

A: Contact your designated MicroVention sales representative who will know how to re-direct you to the adequate resource.

Medicare Contractor Contact Information*

Disclaimer: Medicare Administrative Contractors (MACs) and other billing requirements can change at any time without notice; verify with your hospital and billing department before submitting any information. The MAC Geographic Assignment Rule provides an exception for qualified national hospital chains. Please verify with your hospital whether the facility is part of a qualified chain (e.g., HCA) and which Fiscal Intermediary (FI) is responsible for Part A hospital related services. In addition, further consolidation of the MACs is scheduled in the future.

*https://www.cms.gov/medicare-coverage-database/indexes/contacts-alphabetical-index.aspx Accessed 06.20.2018

State	MAC	Medical Directors	Contact Information
Alabama	Palmetto GBA	Dr. Antonietta Sculimbrene Dr. Harry Feliciano Dr. Leland Garrett Dr. Anitra Graves	**Address:** Palmetto GBA Attn: Medical Affairs, AG-275 P.O. Box 100305 Columbia, SC 29202-3505 **Emails:** antonietta.sculimbrene@palmettogba.com harry.feliciano@palmettogba.com leland.garrett@palmettogba.com
Alaska	Noridian Healthcare Solutions, LLC	Dr. Gary Oakes Dr. Janet Lawrence	**Address:** Noridian Healthcare Solutions, LLC 900 42nd Street South Fargo, ND 58103 **Emails:** Gary.oakes@noridian.com Janet.lawrence@noridian.com
Arizona	Noridian Healthcare Solutions, LLC	Dr. Gary Oakes Dr. Janet Lawrence	**Address:** Noridian Healthcare Solutions, LLC 900 42nd Street South Fargo, ND 58103 **Emails:** Gary.oakes@noridian.com Janet.lawrence@noridian.com
Arkansas	Novitas Solutions, Inc.	Dr. Debra Patterson	**Debra Patterson, MD :** Novitas Solutions, Inc. Suite 100 2020 Technology Parkway Mechanicsburg, PA 17050 **Email:** Debra.patterson@novitas-solutions.com

State	MAC	Medical Directors	Contact Information
California	Noridian Healthcare Solutions, LLC	Dr. Arthur Lurvey Dr. Eileen Moynihan	**Address:** Noridian Healthcare Solutions, LLC 900 42nd Street South Fargo, ND 58103 **Emails:** arthur.lurvey@noridian.com eileen.moynihan@noridian.com
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