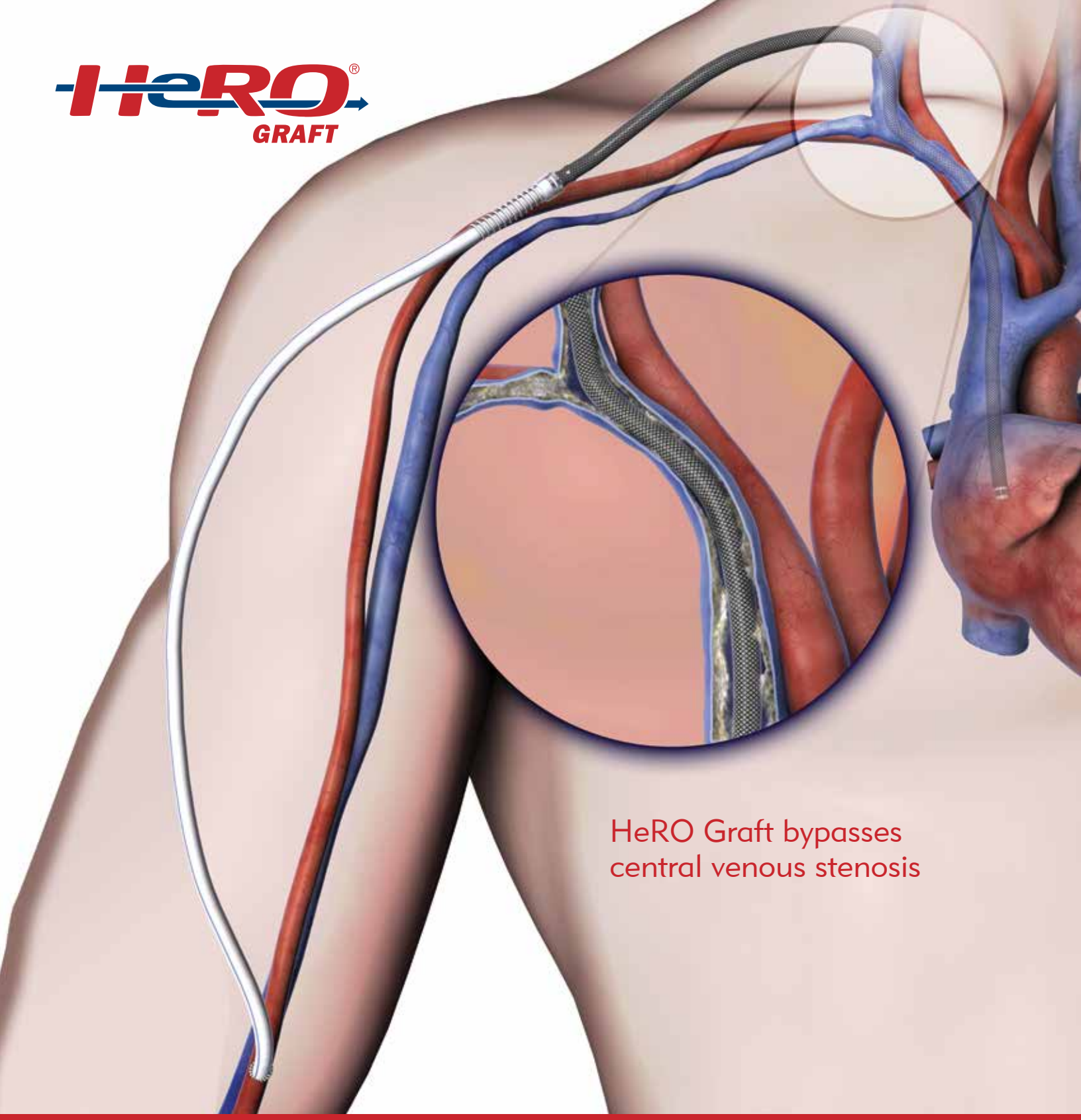
HeRO® GRAFT



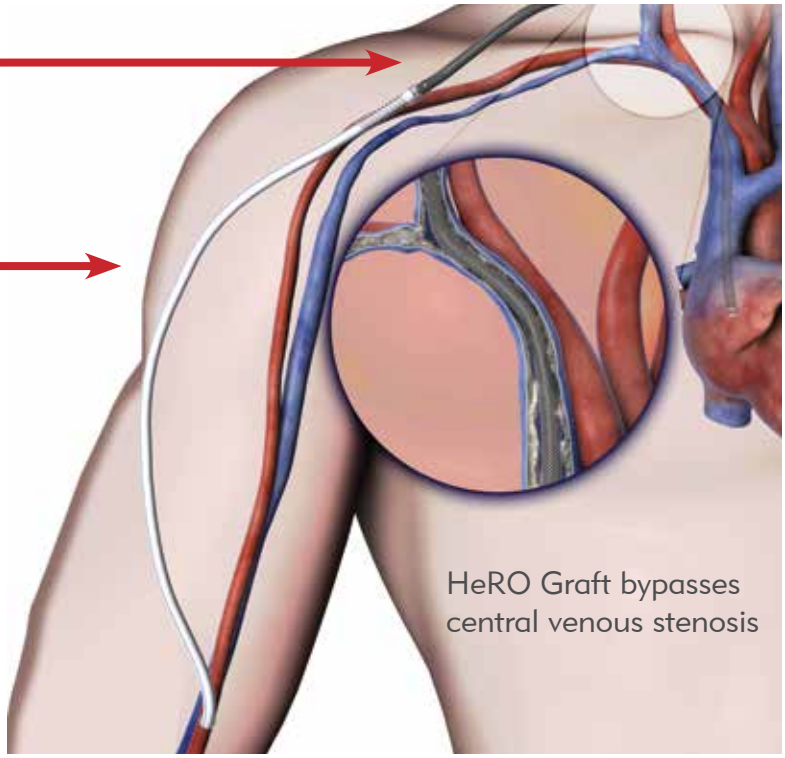
HeRO Graft bypasses central venous stenosis

Potential 2017 Reimbursements
Implant Procedure

MERIT MEDICAL®

VENOUS OUTFLOW COMPONENT
(HERO 1001);
CPT Code 36558* w/C 1750

ARTERIAL GRAFT COMPONENT
(HERO 1002);
CPT Code 36830*



HeRO Graft bypasses central venous stenosis

HeRO (Hemodialysis Reliable Outflow) Graft is the **ONLY** fully subcutaneous AV access solution clinically proven to maintain long-term access for hemodialysis patients with central venous stenosis.

Cost Benefits

- 23% average savings per year with the HeRO Graft compared with catheters[1]
- Reduces device-related infections compared to catheters,[4,5] that can result in hospital admissions projected at $23k to $56k per stay[2,3]
- Lowers interventions and associated costs by more than 50% compared to catheters[4,5]

ACCESSORY COMPONENT KIT (HERO 1003, not pictured) contains disposable tools used to facilitate placement of the Venous Outflow Component.

Product Code	Component	Diameter (ID)	Length
HeRO 1001	Venous Outflow Component	5mm	40cm (customizable)
HeRO 1002	Arterial Graft Component	6mm (ePTFE); 6mm - 5mm (connector)	53cm (connector: 3cm)
HeRO 1003	Accessory Component Kit	N/A	N/A

HeRO Graft Potential Outpatient Codes (If Temporary Bridging Catheter)

CPT® Code	Abbreviated Description	Product	Procedure – To – Device Edit
36830	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis	HERO 1002	None Required
36558	Insertion of tunneled centrally inserted central venous catheter	HERO 1001	C 1750 Required [Catheter, Hemodialysis, Long-Term]
36558	Insertion of tunneled centrally inserted central venous catheter	Bridging Catheter	C 1752 Required [Catheter, Hemodialysis, Short-Term]

*CPT® 36830 and 36558 should be reported together to represent complete HeRO Graft implantation.

Potential Outpatient Reimbursement Codes
APC and Physician Average Payments

Common Diagnosis Codes	
ICD-10-CM Diagnosis Code	**ICD-10-CM Diagnostic Description**
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
N03.0	Chronic nephritic syndrome with minor glomerular abnormality
N03.1	Chronic nephritic syndrome with focal and segmental glomerular lesions
N03.2	Chronic nephritic syndrome with diffuse membranous glomerulonephritis
N03.3	Chronic nephritic syndrome with diffuse mesangial proliferative glomerulonephritis
N03.4	Chronic nephritic syndrome with diffuse endocapillary proliferative glomerulonephritis
N03.5	Chronic nephritic syndrome with diffuse mesangiocapillary glomerulonephritis
N03.6	Chronic nephritic syndrome with dense deposit disease
N03.7	Chronic nephritic syndrome with diffuse crescentic glomerulonephritis
N03.8	Chronic nephritic syndrome with other morphologic changes
N03.9	Chronic nephritic syndrome with unspecified morphologic changes

Potential Oupatient Procedure Codes			Avg Payments	
CPT® Code	**APC**	**CPT® / Code Description**	**APC Payment**	**Physician Payment**
36830*	**5183**	**Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)**	**$3,923**	**$702**
36558*	**5182**	**Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older**	**$2,340**	**$274**
36581	5182	Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access	$2,340	$191
36589	5301	Removal of tunneled central venous catheter, without subcutaneous port or pump	$672	$142
36902**	5192	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty.	$4,823	$225
36905**	5193	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s), with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty.	$9,748	$445
36005	NA	Injection procedure for extremity venography (including introduction of needle or intracatheter)	NA	$50
36901	5181	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report.	$684	$151
36597	5181	Repositioning of previously placed central venous catheter under fluoroscopic guidance	$684	$64
75827	5181	Venography, caval, superior, with serialography, radiological supervision and interpretation	$684	$57 (-26)
76937	NA	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting	Packaged	$15 (-26)
77001	NA	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, and necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position)	Packaged	$19 (-26)
76080	NA	Radiologic examination, abscess, fistula or sinus tract study, radiological supervision and interpretation	Packaged	$27 (-26)
93930	5523	Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study	$219	$41 (-41)
93931	5522	Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study	$117	$25 (-26)

Outpatient APC payments based on Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Final Rule for Calendar Year 2017 (Federal Register, November 14, 2016). Physician payments based on Medicare and Medicaid Programs: Revisions to Payment Policies under the Physician Fee Schedule (Federal Register, November 18, 2016).

Modifier	Description
-26	Professional component only. *Technical fee not included.*
-51	Multiple procedure.
-52	Reduced services.
-59	Distinct procedure.

*CPT® 36830 and 36558 should be reported together to represent complete HeRO Graft implantation. Payment for 36830 is expected to be less than the full payment due to the recommended use of the -52 reduced services modifier. Payers will base payment on supporting documentation describing the actual amount of work performed. When 36558 is used in conjunction with 36830 to describe the HeRO Graft implantation, it is also subject to the multiple procedure reduction. See Potential Implant Scenario as an example.

** Code has a J1 status indicator and its use will result in the assignment of procedure to a comprehensive APC (C-APC) by Medicare. Even though it is possible that separate APC payments may be determined to be appropriate where more than one procedure is performed during the same outpatient visit, many APCs are subject to reduced payment when multiple procedures are performed on the same day. Some comprehensive APCs in 2017 package payments for items and service rather than separate multiple payments for each individual service. Comprehensive APCs will reimburse a single all-inclusive payment for the primary service with no additional reimbursement for additional adjunctive services and supplies used during the delivery of the primary procedure and applies to percutaneous interventions.

Potential Outpatient Implant Scenario

- Existing tunneled cuffed catheter removed
- HeRO Graft implanted
- Temporary bridging catheter placed in new venous site

Modifier	Description
-26	Professional component only. *Technical fee not included.*
-51	Multiple procedure.
-52	Reduced services.
-59	Distinct procedure.

CPT® Code	APC	Abbreviated Description	APC Modified Payment	Physician Modified Payment
36589	5301	Removal of tunneled central venous catheter	$672	$71 (-51)
36830*	**5183**	**Creation of arteriovenous fistula by other than direct arteriovenous anastomosis**	**$1,961**	**<$351 (-51,-52)**
36558*	**5182**	**Insertion of tunneled centrally inserted central venous catheter**	**$1,170**	**$137 (-51)**
36558	5182	Insertion of tunneled centrally inserted central venous catheter	**$1,170**	$137 (-51,-59)
76937	NA	Ultrasound guidance for vascular access	Packaged	$15 (-26)
77001	NA	Fluoroscopic guidance for central venous access device placement	Packaged	$19 (-26)

Potential Inpatient Reimbursement Codes

ICD-10-CM Diagnosis Code	ICD-10-CM Diagnosis Description
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
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N03.7	Chronic nephritic syndrome with diffuse crescentic glomerulonephritis
N03.8	Chronic nephritic syndrome with other morphologic changes
N03.9	Chronic nephritic syndrome with unspecified morphologic changes

ICD-10-PCS Code	Description
03130ZD	Bypass Right Subclavian Artery to Upper Arm Vein, Open Approach
03140ZD	Bypass Left Subclavian Artery to Upper Arm Vein, Open Approach
03150ZD	Bypass Right Axillary Artery to Upper Arm Vein, Open Approach
03160ZD	Bypass Left Axillary Artery to Upper Arm Vein, Open Approach
03170ZD	Bypass Right Brachial Artery to Upper Arm Vein, Open Approach
03180ZD	Bypass Left Brachial Artery to Upper Arm Vein, Open Approach
03190ZF	Bypass Right Ulnar Artery to Lower Arm Vein, Open Approach
031A0ZF	Bypass Left Ulnar Artery to Lower Arm Vein, Open Approach
031B0ZF	Bypass Right Radial Artery to Lower Arm Vein, Open Approach
031C0ZF	Bypass Left Radial Artery to Lower Arm Vein, Open Approach
02H633Z	Insertion of infusion device into right atrium, percutaneous approach

MS-DRG	MS-DRG Description	MS-DRG Payment
252	Other Vascular Procedures with MCC	$18,032
253	Other Vascular Procedures with CC	$14,393
254	Other Vascular Procedures without MCC or CC	$9,670
673	Other Kidney and Urinary Tract Procedures with MCC	$18,196
674	Other Kidney and Urinary Tract Procedures with CC	$12,274
675	Other Kidney and Urinary Tract Procedures without MCC or CC	$8,425

The tables throughout this document list the national average Medicare payments for certain vascular access related procedures and interventions. To accurately report a vascular access related procedure or intervention, multiple code combinations may be needed. Unless otherwise noted, amounts shown represent Medicare national average payment for the full amount without any multiple procedure reduction applied. Providers should select the most appropriate HCPCS/CPT* code(s) with the highest level of detail to describe the service(s) rendered to the patient as well as the most appropriate ICD-9CM diagnosis code(s) to describe the patient's condition. Any questions should be directed to the pertinent local payer. Inpatient MS-DRG payments based on The Centers for Medicare and Medicaid Services Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2017 Rates (Federal Register, August 16, 2016). DISCLAIMER: The information in this brochure is provided with the intent to assist in obtaining appropriate reimbursement for medical devices and services. It is NOT intended as legal advice. Seek legal counsel or a reimbursement specialist for further questions or clarifications. The provider makes all decisions concerning completion of reimbursement claim forms, including code selection and billing amounts. This document is for information purposes only and represents no statement, promise, or guarantee by Merit concerning levels of reimbursement, payment or charges. This coding information may include codes for procedures for which Merit currently offers no cleared or approved products. The coding options listed within this guide are commonly used codes and are NOT intended to be an all-inclusive list. See page 3 for further details about uses and limitations of this document.

*CPT® 36830 and 36558 should be reported together to represent complete HeRO Graft implantation.

References: 1) Dageforde et al., JSR 2012. 2) Ramanathan et al., Infect Control Hosp Epidemiol 2007. 3) O'Grady et al., Pediatrics 2002. 4) Katzman et al., J Vasc Surg 2009. 5) Gage et al., EJVES 2012.

Before using refer to Instructions for Use for indications, contraindications as well as warnings and precautions.

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Understand. Innovate. Deliver.™

Merit Medical Systems, Inc.
1600 West Merit Parkway
South Jordan, Utah 84095
1.801.208.4300
1.800.35.MERIT

Merit.com

Merit Medical Europe, Middle East, & Africa (EMEA)
Amerikalaan 42, 6199 AE Maastricht-Airport
The Netherlands
+31 43 358 82 22

Merit Medical Ireland Ltd.
Parkmore Business Park West
Galway, Ireland
+353 (0) 91 703 733

Austria
0800 295 374

Belgium
0800 72 906 (Dutch)
0800 73 172 (Français)

Denmark
80 88 00 24

Finland
0800 770 586

France
0800 91 60 30

Germany
0800 182 0871

Ireland (Republic)
1800 553 163

Italy
800 897 005

Luxembourg
8002 25 22

Netherlands
0800 022 81 84

Norway
800 11629

Portugal
308 801 034

Russia
+7 495 221 89 02

Spain
+34 911238406

Sweden
020 792 445

Switzerland
(Deutsch)
+41 22 518 02 30
(Français)
+41 22 518 02 52
(Italiano)
+41 22 518 00 35

UK
0800 973 115

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