ATHERECTOMY FOR LOWER EXTREMITY REVASCULARIZATION CODING GUIDE

Effective January 1, 2025

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INTRODUCTION

This content is intended to provide reference material related to general guidelines for reimbursement when used consistently with the product's labeling. This content includes information regarding coverage, coding and reimbursement. Additional resources can be found at: www.cardiovascular.abbott/us/en/hcp/reimbursement.html

REIMBURSEMENT HOTLINE

Abbott offers a reimbursement hotline, which provides live coding and reimbursement information from dedicated reimbursement specialists. Coding and reimbursement support is available from 8 a.m. to 5 p.m. Central Time, Monday through Friday at (855) 569-6430. This content and all supporting documents are available at: https://www.cardiovascular.abbott/us/en/hcp/reimbursement/vas/peripheral.html
Coding and reimbursement assistance is provided subject to the disclaimers set forth in this guide.

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COVERAGE OVERVIEW FOR ATHERECTOMY

Atherectomy for lower extremity revascularization procedures is utilized to remove plaque from a blood vessel in the peripheral area. Atherectomy can be performed in the following settings:

Facility setting: Hospital Inpatient, Hospital Outpatient, and Ambulatory Surgical Center (ASC)
Non-facility setting: Physician office / Office-Based Lab (OBL)

PRIOR AUTHORIZATION REQUIREMENTS

Traditional Medicare has implicit coverage for atherectomy procedures and does not require prior authorization. Medicare Advantage plans are managed by commercial payers and may require prior authorization for Medicare Advantage patients. Several commercial plans also require prior authorization; please check with your payers for any requirements.

Additional materials are available for physicians when seeking prior authorization for atherectomy and lower extremity endovascular procedures. The materials can be accessed on Abbott website Peripheral Lower Extremity Endovascular Revascularization Prior Authorization Toolkit

CODING AND REIMBURSEMENT FOR ATHERECTOMY

ICD-10 PCS PROCEDURE CODES

The following ICD-10 PCS codes are commonly reported with atherectomy in the lower extremity area in the hospital inpatient setting. This is not an exhaustive list of relevant ICD-10 PCS codes.

DILATION, PERCUTANEOUS APPROACH[1]	EXTIRPATION, PERCUTANEOUS APPROACH[1]
0 Medical and Surgical **4** Lower Arteries **7** Dilation	**0** Medical and Surgical **4** Lower Arteries **C** Extirpation
Body Part Character	
C Common Iliac Artery, Right **D** Common Iliac Artery, Left **E** Internal Iliac Artery, Right **F** Internal Iliac Artery, Left **H** External Iliac Artery, Right **J** External Iliac Artery, Left **K** Femoral Artery, Right **L** Femoral Artery, Left **M** Popliteal Artery, Right **N** Popliteal Artery, Left	**P** Anterior Tibial Artery, Right **Q** Anterior Tibial Artery, Left **R** Posterior Tibial Artery, Right **S** Posterior Tibial Artery, Left **T** Peroneal Artery, Right **U** Peroneal Artery, Left **V** Foot Artery, Right **W** Foot Artery, Left **Y** Lower Artery
Approach Character	**3** Percutaneous
Device Character	**Z** No Device
Qualifier Character	**Z** No Qualifier

CODING AND REIMBURSEMENT FOR ATHERECTOMY

HOSPITAL INPATIENT[2]

FY 2025 Inpatient Prospective Payment System (IPPS) reimbursement is effective for inpatient services on October 1, 2024. This is not an all-inclusive list of possible MS-DRGs. MS-DRG assignment is based on many factors including documented patient conditions, as well as services rendered during an inpatient admission.

MS-DRG	DESCRIPTION	NATIONAL MEDICARE RATE
270	Other Major Cardiovascular Procedures with MCC	$36,632
271	Other Major Cardiovascular Procedures with CC	$24,581
272	Other Major Cardiovascular Procedures without CC or MCC	$17,857

CC = Complications/Comorbidities, MCC = Major Complications/Comorbidities

Effective Dates: October 1, 2024 - September 30, 2025

CODING AND REIMBURSEMENT FOR ATHERECTOMY

HOSPITAL OUTPATIENT[4]

CPT‡ CODE[3]	DESCRIPTION	STATUS INDICATOR	APC	NATIONAL MEDICARE RATE
0238T	Atherectomy (iliac)	J1	5194	$17,957
37225	Atherectomy (femoral/popliteal)	J1	5194	$17,957
37227	Atherectomy and stenting (femoral/popliteal)	J1	5194	$17,957
37229	Atherectomy (tibial/peroneal)	J1	5194	$17,957
37231	Atherectomy and stenting (tibial/peroneal)	J1	5194	$17,957
+37233	Atherectomy (tibial/peroneal), additional vessel	N	-	No separate payment
+37235	Atherectomy and stenting (tibial/peroneal), additional vessel	N	-	No separate payment

(+) Indicates add-on code. List add-on code separately in addition to code for primary procedure.

J1 = Hospital Part B services paid through a comprehensive APC

N = Items or services packaged into APC rates

HCPCS C-CODE FOR OUTPATIENT PROCEDURES

Level II HCPCS codes, including C-codes are used in conjunction with the Medicare prospective payment system for outpatient procedures only. Medicare Hospital Outpatient Prospective Payment System (OPPS) requires providers to report device category C-codes on claims to improve the claims data used to annually update the OPPS payment rates.

C-CODE	DESCRIPTION[7]
C1724	Catheter, transluminal atherectomy, rotational

Effective Dates: January 1, 2025 - December 31, 2025

CODING AND REIMBURSEMENT FOR ATHERECTOMY

AMBULATORY SURGICAL SETTING[5]

CPT‡ CODE[3]	DESCRIPTION	NATIONAL MEDICARE RATE
0238T	Atherectomy (iliac)	$11,532
37225	Atherectomy (femoral/popliteal)	$12,445
37227	Atherectomy and stenting (femoral/popliteal)	$12,540
37229	Atherectomy (tibial/peroneal)	$11,855
37231	Atherectomy and stenting (tibial/peroneal)	$12,261
+37233	Atherectomy (tibial/peroneal), additional vessel	No separate payment
+37235	Atherectomy and stenting (tibial/peroneal), additional vessel	No separate payment

(+) Indicates add-on code. List add-on code separately in addition to code for primary procedure.

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CODING AND REIMBURSEMENT FOR ATHERECTOMY

PHYSICIAN[6]

CPT‡ CODE	DESCRIPTION	WORK RVU	NATIONAL MEDICARE RATE	
			FACILITY	NON FACILITY
0238T	Atherectomy (iliac)	0.00	NA	NA
37225	Atherectomy (femoral/popliteal)	11.75	$563	$7,901
37227	Atherectomy and stenting (femoral/popliteal)	14.25	$675	$10,091
37229	Atherectomy (tibial/peroneal)	13.80	$653	$8,070
37231	Atherectomy and stenting (tibial/peroneal)	14.75	$699	$10,596
+37233	Atherectomy (tibial/peroneal), additional vessel	6.50	$304	$979
+37235	Atherectomy and stenting (tibial/peroneal), additional vessel	7.80	$352	$3,639

(+) Indicates add-on code. List add-on code separately in addition to code for primary procedure.

NA: there is currently no Medicare reimbursement rate for physicians.

It is incumbent upon the physician to determine which, if any modifiers should be used first.

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Additional Resources:

Visit the website below for Abbott Reimbursement and Coding page, where you will find reimbursement resources such as coding guides, prior authorization toolkit, and on-demand webinars.
Vascular Resources for Medical Reimbursement | Abbott (cardiovascular.abbott)

For additional information or questions, please contact the Abbott Vascular Reimbursement Hotline at **855-569-6430** or abbotteconomics@abbott.com.

References

1. ICD-10-PCS 2025: https://www.cms.gov/files/document/fy-2025-icd-10-cm-coding-guidelines.pdf
2. FY 2025 Hospital Inpatient Prospective Payment - Final Rule. CMS-1808-F: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page
3. CPT‡ Coding Guidelines. AMA. CPT‡ 2024 Professional Edition. American Medical Association. 2024 https://www.ama-assn.org/
4. Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment Period (NFRM) CY2025. CMS 1809-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc
5. Ambulatory Surgical Center Payment-Notice of Final Rulemaking with Comment Period (NFRM) CY2025. CMS-1809-FC: https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1809-fc
6. Physician Prospective Payment-Final rule with Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY2025. CMS-1807-F: https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f
7. CMS 2020 Alpha-Numeric Index HPCPS file. https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS-Items/2020-Alpha-Numeric- HCPCS-File

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