# Atherectomy for Lower Extremity Revascularization Reimbursement Guide

## ATHERECTOMY COVERAGE OVERVIEW

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 lower extremity endovascular procedures and does not require prior authorization. Medicare Advantage plans are managed by commercial payers and may require prior authorization. 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 Reimbursement & Coding

## ATHERECTOMY CODING AND REIMBURSEMENT

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

## HOSPITAL INPATIENT

Effective October 1, 2023 – September 30, 2024. MS-DRG assignment is based on many factors including documented patient conditions as well as services rendered during an admission. This is not an all-inclusive list of possible MS-DRGs.

| MS-DRG | Description | 2024 Medicare National Rate [2] |
|---|---|---|
| 270 | Other major cardiovascular procedures with MCC | $35,406 |
| 271 | Other major cardiovascular procedures with CC | $24,199 |
| 272 | Other major cardiovascular procedures without CC/MCC | $17,080 |

MCC: major complications or comorbidities. CC: complications or comorbidities.

## HOSPITAL OUTPATIENT

Effective January 1, 2024 – December 31, 2024.

| CPT‡ code [3] | APC | Description | 2024 Medicare National Rate [4] |
|---|---|---|---|
| 0238T | 5194 | Atherectomy (iliac) | $16,725 |
| 37225 | 5194 | Atherectomy (femoral/popliteal) | $16,725 |
| 37227 | 5194 | Atherectomy and stenting (femoral/popliteal) | $16,725 |
| 37229 | 5194 | Atherectomy (tibial/peroneal) | $16,725 |
| 37231 | 5194 | Atherectomy and stenting (tibial/peroneal) | $16,725 |
| +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.

## AMBULATORY SURGICAL CENTER (ASC)

Effective January 1, 2024 – December 31, 2024.

| CPT‡ code [3] | APC | Description | 2024 Medicare National Rate [5] |
|---|---|---|---|
| 0238T | 5194 | Atherectomy (iliac) | $9,910 |
| 37225 | 5194 | Atherectomy (femoral/popliteal) | $11,695 |
| 37227 | 5194 | Atherectomy and stenting (femoral/popliteal) | $11,873 |
| 37229 | 5194 | Atherectomy (tibial/peroneal) | $11,096 |
| 37231 | 5194 | Atherectomy and stenting (tibial/peroneal) | $11,981 |
| +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.

## PHYSICIAN

Effective January 1, 2024 – December 31, 2024.

| CPT‡ code [3] | Description | 2024 Medicare National Rate [6] | |
|---|---|---|---|
| | | Facility | Non-facility |
| 0238T | Atherectomy (iliac) | N/A | N/A |
| 37225 | Atherectomy (femoral/popliteal) | $570 | $8,404 |
| 37227 | Atherectomy and stenting (femoral/popliteal) | $682 | $10,732 |
| 37229 | Atherectomy (tibial/peroneal) | $660 | $8,551 |
| 37231 | Atherectomy and stenting (tibial/peroneal) | $699 | $11,308 |
| +37233 | Atherectomy (tibial/peroneal), additional vessel | $306 | $1,015 |
| +37235 | Atherectomy and stenting (tibial/peroneal), additional vessel | $350 | $3,794 |

(+) Indicates add-on code. List add-on code separately in addition to code for primary procedure.
N/A: there is currently no Medicare reimbursement rate for physicians.

## HCPCS C-CODE FOR OUTPATIENT PROCEDURES

Level II HCPCS codes, including C-codes, are used with Medicare outpatient procedures only. Medicare requires C-codes on claims to help improve data and update yearly payment rates.

| C- code | Description [7] |
|---|---|
| C1724 | Catheter, transluminal atherectomy, rotational |

## ADDITIONAL REIMBURSEMENT RESOURCES

Scanning the QR code will take you to the Abbott Reimbursement & Coding page:

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

**References**:


1. CMS ICD-10-PCS 2024: https://www.cms.gov/medicare/icd-10/2024-icd-10-cm
2. Hospital Inpatient Prospective Payment - Final Rule FY2024 Payment Rates. CMS-1785-F: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page
3. CPT® Coding Guidelines. AMA. CPT‡ 2023 Professional Edition. American Medical Association. 2023
4. Hospital Outpatient Prospective Payment- Notice of Final Rulemaking with Comment Period (NFRM) CY2024. CMS 1786-FC. https://www.cms.gov/ medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc
5. Ambulatory Surgical Center Payment-Notice of Final Rulemaking with Comment Period (NFRM) CY2024. CMS-1786cms-FC: https://www.cms.gov/ medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-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 CY2024. CMS-1784-F: https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-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


**Disclaimer**

This material and the information contained herein is for general information purposes only and is not intended, and does not constitute, legal, reimbursement, business, clinical, or other advice. Furthermore, it is not intended to and does not constitute a representation or guarantee of reimbursement, payment, or charge, or that reimbursement or other payment will be received. It is not intended to increase or maximize payment by any payer. Abbott makes no express or implied warranty or guarantee that the list of codes and narratives in this document is complete or error-free. Similarly, nothing in this document should be viewed as instructions for selecting any particular code, and Abbott does not advocate or warrant the appropriateness of the use of any particular code. The ultimate responsibility for coding and obtaining payment/reimbursement remains with the customer. This includes the responsibility for accuracy and veracity of all coding and claims submitted to third-party payers. In addition, the customer should note that laws, regulations, and coverage policies are complex and are updated frequently and is subject to change without notice. The customer should check with its local carriers or intermediaries often and should consult with legal counsel or a financial, coding, or reimbursement specialist for any questions related to coding, billing, reimbursement, or any related issues. This material reproduces information for reference purposes only. It is not provided or authorized for marketing use.

Information contained herein for DISTRIBUTION in the U.S. ONLY.


**Abbott**

3200 Lakeside Dr., Santa Clara, CA 95054 USA Tel: 1.800.227.9902

One St. Jude Medical Dr., St. Paul, MN 55117, USA, Tel: 1 651 756 2000

www.cardiovascular.abbott





MAT-2310973 v2.0 | Item approved for U.S. use only

HE&R approved for non-promotional use only.