2021 CODING AND REIMBURSEMENT GUIDE

PERCUTANEOUS CORONARY AND PERIPHERAL VASCULAR INTERVENTIONS

CSI® CARDIOVASCULAR SYSTEMS, INC.

INTRODUCTION

Coverage, coding and payment are the three fundamental components of reimbursement. The CSI Coding and Reimbursement Guide provides information for physicians and healthcare facilities for percutaneous cardiovascular intervention procedures.

The codes included in this guide are intended to represent typical percutaneous cardiovascular intervention procedures and are in no way intended to promote the off-label use of devices. The codes are listed according to the site of service they are provided in or the specialty which they fall under (coronary or peripheral).

Payment is based upon the coverage and codes that exist for a particular procedure or service. Payment is not guaranteed and is determined by many factors, for example: geographic indexes, hospital/facility type, and proportion of low-income patients. The payments provided in this guide are based on National Medicare reimbursement averages and should be verified by your organizations coding and compliance teams.

Coverage is determined by payers such as Medicare and private payers based on reasonable and necessary standards. Coverage policies for percutaneous cardiology and peripheral vascular interventions may vary. Check with your local Medicare Contractor or payer to confirm coverage for these procedures.

For additional reimbursement information, please visit www.csi360.com/reimbursement or email csireimbursement@csi360.com.

HCPCS CODES

C-CODES FOR OUTPATIENT PROCEDURES

Healthcare Common Procedure Coding System (HCPCS) Level II codes were developed to help categorize, document, and track the use of products, supplies, and services. C-Codes should be reported for all device-dependent Ambulatory Payment Classifications (APCs) for procedures conducted in the hospital outpatient setting. While C-Codes do not generally result in additional payment, it is important for hospitals to use C-Codes as CMS uses the data collected from the codes and associated charges to help determine future payment rates. The C-Codes listed below may be used for both coronary and peripheral intervention procedures.

Device Category

HCPCS CODE	DESCRIPTION	CSI® PRODUCTS
C1724	Catheter, transluminal atherectomy, rotational	Diamondback 360® Peripheral Orbital Atherectomy System Diamondback 360® Peripheral Orbital Atherectomy System, Exchangeable Series Diamondback 360® Coronary Orbital Atherectomy System Stealth 360® Peripheral Orbital Atherectomy System
C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)	JADE® PTA Balloon Catheter† Sapphire® NC Plus Coronary Balloon Dilatation Catheter† Sapphire® II PRO Balloon Dilatation Catheter† Scoreflex® NC Coronary Scoring Dilatation Catheter†
C1769	Guidewire	Zilient® Peripheral Guidewire (distributed by CSI) ViperWire Advance® Guidewire and ViperWire Advance® with Flex Tip Guidewire (to be used with the Diamondback 360 and Stealth 360 systems)
C1884	Embolization protective system	WIRION® Embolic Protection System
C1887	Catheter, guiding (may include infusion/perfusion capability)	Teleport® Microcatheter† VIPERCATH™ XC Peripheral Exchange Catheter

†This product is distributed by CSI and manufactured by OrbusNeich Medical Company Limited or its affiliates.

PHYSICIAN SERVICES

PHYSICIAN FACILITY REIMBURSEMENT

Current Procedural Terminology (CPT®) Codes are used to document the procedures or medical services health care professionals provide. Physicians always report CPT codes regardless of site of service. Relative Value Units (RVU) assigned to CPT codes determine procedure payment under Medicare. Below is a list of commonly reported CPT codes for percutaneous coronary atherectomy and stent interventions, the total procedure RVUs, and Medicare national average payment rates in a facility setting.

Percutaneous Coronary Atherectomy and Stent Interventions

Effective Dates: January 1, 2021 – December 31, 2021

CPT CODE[1]	DESCRIPTION	TOTAL FACILITY RVUS[2]	MEDICARE NATIONAL AVERAGE PAYMENT[2]
92920	Percutaneous transluminal coronary, angioplasty; single major coronary artery or branch	15.45	$539
+92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery	0	NA*
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	18.42	$643
+92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery	0	NA*
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	17.19	$600
+92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery	0	NA*
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	19.30	$673
+92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery	0	NA*
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	19.31	$674
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	19.33	$674
+92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	0	NA*

CY 2021 conversion factor is $34.8931.

+Add-on code. Each add on code description includes: "(List separately in addition to code for primary procedure.)" Add-on codes represent procedures always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. They are not subject to multiple procedure discount rules.

*Bundled code. Payments for covered services are always bundled into payment for other services, which are not specified.

HOSPITAL OUTPATIENT FACILITY SERVICES

HOSPITAL OUTPATIENT REIMBURSEMENT

Many of the hospital outpatient procedures in this guide are assigned to a Comprehensive Ambulatory Payment Classification (C-APC), which packages hospital outpatient payment for services and supplies rather than providing separate multiple payments for each individual service. Comprehensive APCs will provide a single all-inclusive payment for the primary service with no additional reimbursement for adjunctive services and supplies used during delivery of the primary service. Listed below are commonly reported CPT and HCPCS codes for percutaneous coronary atherectomy and stent interventions, C-APC assignment, and the Medicare national average payment rate when performed in a hospital outpatient setting.

Percutaneous Coronary Atherectomy and Stent Interventions

Effective Dates: January 1, 2021 – December 31, 2021

CPT CODE[1]	DESCRIPTION	2021 C-APC	STATUS INDICATOR*	MEDICARE NATIONAL AVERAGE PAYMENT[3]
Percutaneous Transluminal Coronary Angioplasty				
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	5192	J1	$4,957
+92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery	Packaged	N	Packaged
Atherectomy with Angioplasty				
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	5193	J1	$10,043
+92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery	Packaged	N	Packaged
Bare Metal or Drug-Eluting Stent and Angioplasty				
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	5193	J1	$10,043
+92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery	Packaged	N	Packaged
HCPCS[7] C9600	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; a single major coronary artery or branch	5193	J1	$10,043
HCPCS +C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery	Packaged	N	Packaged
Atherectomy with Bare Metal Stent and Angioplasty				
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	5194	J1	$16,064
+92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery	Packaged	N	Packaged
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	5193	J1	$10,043
+92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	Packaged	N	Packaged
Atherectomy with Drug-Eluting Stent and Angioplasty				
HCPCS C9602	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	5194	J1	$16,064
HCPCS +C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery	Packaged	N	Packaged
HCPCS C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	5194	J1	$16,064
HCPCS +C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	Packaged	N	Packaged

+Add-on code. Each add on code description includes: "(List separately in addition to code for primary procedure.)" Add-on codes represent procedures always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. They are not subject to multiple procedure discount rules.

*OPPS Payment Status Indicators (SI) for CY 2021:
J1 = Hospital Part B services paid through a comprehensive APC. Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
N = Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.

HOSPITAL INPATIENT FACILITY SERVICES

HOSPITAL INPATIENT REIMBURSEMENT

Medicare reimburses hospitals for inpatient services based on the MS-DRG (Medicare Severity Diagnosis Related Group). Only one DRG is assigned to a patient per admission and is determined by the combination of the primary procedure performed and the severity of the patient's diagnosis and comorbidities. Listed below are MS-DRGs and the Medicare national average payment for percutaneous coronary atherectomy and stent interventions.

Percutaneous Coronary Atherectomy and Stent Interventions

Effective Dates: October 1, 2020 – September 30, 2021

MS-DRG[4]	DESCRIPTION	MEDICARE NATIONAL AVERAGE PAYMENT[5,***]
PCI with Drug-Eluting Stent		
246	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with MCC or 4+ Arteries or Stents	$20,090
247	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent without MCC	$12,779
PCI with non Drug-Eluting Stent		
248	Percutaneous Cardiovascular Procedures with Non Drug-Eluting Stent with MCC or 4+ Arteries or Stents	$20,400
249	Percutaneous Cardiovascular Procedures with Non Drug-Eluting Stent without MCC	$12,079
PCI without Stent		
250	Percutaneous Cardiovascular Procedures without Coronary Artery Stent with MCC	$16,215
251	Percutaneous Cardiovascular Procedures without Coronary Artery Stent without MCC	$10,668

MCC = Major Complications and Comorbidities

***The national average payment amount is calculated by multiplying the DRG relative weight for each DRG listed, by the national average hospital Medicare base rate. The national average hospital Medicare base rate used in these calculations is the labor and non labor rates for a particular type of hospital, as an example. In this case, the hospital has a wage index greater than one, has submitted quality data and is a "meaningful EHR user" as determined by CMS. The calculation also includes the capital standard federal payment rate. Please note that hospital rates can vary greatly depending on a variety of factors including location, teaching status and proportion of indigent patients served.

AMBULATORY SURGICAL CENTER

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT

Under Medicare, only select procedures and services can be administered to Medicare beneficiaries in an ASC. Payment for these procedures is determined under the Ambulatory Surgical Center fee schedule established by CMS. Listed below are CMS-approved percutaneous coronary atherectomy and stent intervention procedures, the corresponding CPT code, and the Medicare national payment indicator and average payment rate.

Percutaneous Coronary Atherectomy and Stent Interventions

Effective Dates: January 1, 2021 – December 31, 2021

CPT CODE[1]	DESCRIPTION	MEDICARE NATIONAL PAYMENT INDICATOR**	MEDICARE NATIONAL AVERAGE PAYMENT[6]
Percutaneous Transluminal Coronary Angioplasty			
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	J8	$3,067
+92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery	N1	Packaged
Bare Metal or Drug-Eluting Stent and Angioplasty			
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J8	$5,997
+92929	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery	N1	Packaged
HCPCS[7] C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	J8	$6,276
HCPCS[7] +C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery	N1	Packaged
Atherectomy with Drug-Eluting Stent and Angioplasty			
HCPCS C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	J8	$11,371
HCPCS C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)	N/A	Packaged
HCPCS C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	J8	$11,286
HCPCS +C9608	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)	N/A	Packaged

**ASC Payment Indicators for CY 2021; Addendum 2021 NFRM ASC DD1 of CMS-1736-FC:
J8 = Device-intensive procedure; paid at adjusted rate
N1 = Packaged service item; no separate payment made

+Add-on code. Each add on code description includes: "(List separately in addition to code for primary procedure.)" Add-on codes represent procedures always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. They are not subject to multiple procedure discount rules.

HOSPITAL ICD-10 CODE SETS

Hospitals use ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes to identify patient conditions and therapeutic interventions which result in the most appropriate MS-DRG assignment. Examples are provided below of the commonly reported ICD-10-CM diagnosis and ICD-10-PCS procedure codes for coronary therapeutic services and procedures.

ICD-10 CLINICAL MODIFICATION (CM)/DIAGNOSIS CODES

The following ICD-10-CM diagnosis codes are commonly reported to support medical necessity for coronary therapeutic services and procedures. This is not an exhaustive list and other patient conditions may support medical necessity of a procedure.

ICD-10-CM DIAGNOSIS[8]	DESCRIPTION
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
I25.111	Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
I25.82	Chronic total occlusion of coronary artery
I25.83	Coronary atherosclerosis due to lipid rich plaque
I25.84	Coronary atherosclerosis due to calcified coronary lesion

ICD-10 PROCEDURE CODING SYSTEM (PCS)/PROCEDURE CODES

Section X Orbital Atherectomy PCS Codes

In 2015, CMS created New Technology PCS codes to specifically describe **orbital** atherectomy procedures performed with the Diamondback 360 Coronary Orbital Atherectomy System. Please note that X-codes are standalone codes that fully represent the complete procedure. They do not require additional codes from other sections of the ICD-10-PCS coding book. Other codes are available within PCS to describe procedures performed utilizing non-orbital atherectomy systems.

ICD-10-PCS PROCEDURE[9]	DESCRIPTION
X2C0361	Extirpation of matter from coronary artery, one artery using orbital atherectomy technology, percutaneous approach, new technology group 1
X2C1361	Extirpation of matter from coronary artery, two arteries, using orbital atherectomy technology, percutaneous approach, new technology group 1
X2C2361	Extirpation of matter from coronary artery, three arteries, using orbital atherectomy technology, percutaneous approach, new technology group 1
X2C3361	Extirpation of matter from coronary artery, four or more arteries, using orbital atherectomy technology, percutaneous approach, new technology group 1

Additional ICD-10-PCS Codes

The following ICD-10-PCS codes are commonly reported for stent placement and angioplasty procedures. This is a list of possible procedure codes and is not an exhaustive list of ICD-10-PCS procedure codes. Physicians are responsible for selecting the most appropriate code(s) to reflect services performed.

ICD-10-PCS PROCEDURE[9]	DESCRIPTION
02703ZZ	Dilation of Coronary Artery, One Artery, Percutaneous Approach
02713ZZ	Dilation of Coronary Artery, Two Arteries, Percutaneous Approach
02723ZZ	Dilation of Coronary Artery, Three Arteries, Percutaneous Approach
02733ZZ	Dilation of Coronary Artery Four or More Arteries, Percutaneous Approach
02703DZ	Dilation of Coronary Artery, One Artery, Intraluminal Device, Percutaneous Approach
02713DZ	Dilation of Coronary Artery, Two Arteries, with Intraluminal Device, Percutaneous Approach
02723DZ	Dilation of Coronary Artery, Three Arteries, with Intraluminal Device, Percutaneous Approach
02733DZ	Dilation of Coronary Artery Four or More Arteries, with Intraluminal Device, Percutaneous Approach
027034Z	Dilation of Coronary Artery, One Artery, with Drug-Eluting Intraluminal Device, Percutaneous Approach
027134Z	Dilation of Coronary Artery, Two Arteries, with Drug-Eluting Intraluminal Device, Percutaneous Approach
027234Z	Dilation of Coronary Artery, Three Arteries, with Drug-Eluting Intraluminal Device, Percutaneous Approach
027334Z	Dilation of Coronary Artery Four or More Arteries, Drug-Eluting Intraluminal Device, Percutaneous Approach

PHYSICIAN SERVICES

PHYSICIAN FACILITY REIMBURSEMENT

Current Procedural Terminology (CPT) Codes are used to document the procedures or medical services health care professionals provide. Physicians always report CPT codes regardless of site of service. Relative Value Units (RVU) assigned to CPT codes determine procedure payment under Medicare. Below is a list of commonly reported CPT codes for percutaneous peripheral vascular interventions, the total procedure RVUs, and Medicare national average payment rates in a facility setting.

Percutaneous Peripheral Vascular Interventions

Effective Dates: January 1, 2021 – December 31, 2021

CPT CODE[1]	DESCRIPTION	TOTAL FACILITY RVUS[2]	MEDICARE NATIONAL AVERAGE PAYMENT[2]
Iliac Vascular Territory			
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	11.65	$407
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	14.37	$501
+37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty	5.38	$188
+37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	6.19	$216
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	0.00	Determined by Payer
Femoral/Popliteal Vascular Territory			
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	12.94	$452
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	17.52	$611
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	15.13	$528
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	20.99	$732
Tibial/Peroneal Territory			
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	15.75	$550
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	20.29	$708
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) includes angioplasty within the same vessel, when performed	20.27	$707
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	21.81	$761
+37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty	5.80	$202
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed	9.46	$330
+37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placements(s), includes angioplasty within the same vessel, when performed	8.30	$290
+37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	11.46	$400

CY 2021 conversion factor is $34.8931.

+Add-on code. Each add on code description includes: "(List separately in addition to code for primary procedure.)" Add-on codes represent procedures always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. They are not subject to multiple procedure discount rules.

PHYSICIAN SERVICES

PHYSICIAN NON-FACILITY (OBL) SITE OF SERVICE 11

CPT codes are used to document the procedures or medical services health care professionals provide. Below is a list of commonly reported CPT codes for percutaneous peripheral vessel interventions, the associated relative value unit of work associated with the codes, and Medicare national average payment rates in a non-facility setting, for procedures conducted in an office-based setting.

Percutaneous Peripheral Vascular Interventions

Effective Dates: January 1, 2021 – December 31, 2021

CPT CODE[1]	DESCRIPTION	TOTAL NON-FACILITY RVUS[2]	MEDICARE NON-FACILITY NATIONAL AVERAGE PAYMENT[2]
Iliac Vascular Territory			
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	83.83	$2,925
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	108.70	$3,793
+37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty	20.68	$722
+37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	49.23	$1,718
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	0.00	Determined by Payer
Femoral/Popliteal Vascular Territory			
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	99.12	$3,459
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	314.02	$10,957
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	285.70	$9,969
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	402.50	$14,044
Tibial/Peroneal Territory			
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	141.95	$4,953
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	315.86	$11,021
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) includes angioplasty within the same vessel, when performed	300.50	$10,485
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	403.82	$14,091
+37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty	28.34	$989
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed	34.97	$1,220
+37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placements(s), includes angioplasty within the same vessel, when performed	118.41	$4,132
+37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	125.83	$4,391

CY 2021 conversion factor is $34.8931.

+Add-on code. Each add on code description includes: "(List separately in addition to code for primary procedure.)" Add-on codes represent procedures always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. They are not subject to multiple procedure discount rules.

HOSPITAL OUTPATIENT FACILITY SERVICES

HOSPITAL OUTPATIENT REIMBURSEMENT

Many of the hospital outpatient procedures in this guide are assigned to a Comprehensive Ambulatory Payment Classification (C-APC). A C-APC packages hospital outpatient payment for services and supplies rather than providing separate multiple payments for each individual service. Comprehensive APCs will provide a single all-inclusive payment for the primary service with no additional reimbursement for adjunctive services and supplies used during delivery of the primary service. Listed below are commonly reported CPT and HCPCS codes for percutaneous peripheral vascular interventions, C-APC assignment, and the Medicare national average payment rate when performed in a hospital outpatient setting.

Percutaneous Peripheral Vascular Interventions

Effective Dates: January 1, 2021 – December 31, 2021

CPT CODE[1]	DESCRIPTION	2021 C-APC	STATUS INDICATOR*	MEDICARE NATIONAL AVERAGE PAYMENT[3]
Iliac Interventions				
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	5192	J1	$4,957
37221	Revascularization, endovascular, open or percutaneous,iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	5193	J1	$10,043
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	5194	J1	$16,064
Additional Vessels Treated within Iliac Territory				
+37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty	Packaged	N	Packaged
+37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	Packaged	N	Packaged
Femoral/Popliteal Interventions				
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	5192	J1	$4,957
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	5193	J1	$10,043
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	5193	J1	$10,043
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	5194	J1	$16,064
Tibial/Peroneal Interventions				
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	5193	J1	$10,043
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	5194	J1	$16,064
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) includes angioplasty within the same vessel, when performed	5194	J1	$16,064
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	5194	J1	$16,064
Additional Vessels Treated within Tibial/Peroneal Territory				
+37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty	Packaged	N	Packaged
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed	Packaged	N	Packaged
+37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placements(s), includes angioplasty within the same vessel, when performed	Packaged	N	Packaged
+37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	Packaged	N	Packaged

+Add-on code. Each add on code description includes: "(List separately in addition to code for primary procedure.)" Add-on codes represent procedures always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. They are not subject to multiple procedure discount rules.

*OPPS Payment Status Indicators (SI) for CY 2021:
J1 = Hospital Part B services paid through a comprehensive APC. Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
N = Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.

AMBULATORY SURGICAL CENTER

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT

Under Medicare, only select procedures and services can be administered to Medicare beneficiaries in an ASC. Payment for these procedures is determined under the Ambulatory Surgical Center fee schedule established by CMS. Listed below are CMS-approved percutaneous peripheral vascular intervention procedures, the corresponding CPT code, and the Medicare national average payment indicator and payment rate.

Percutaneous Peripheral Vascular Interventions

Effective Dates: January 1, 2021 – December 31, 2021

CPT CODE[1]	DESCRIPTION	MEDICARE NATIONAL PAYMENT INDICATOR**	MEDICARE NATIONAL AVERAGE PAYMENT[6]
Iliac Interventions			
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	G2	$2,167
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	J8	$6,247
+37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty	N1	Packaged
+37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	N1	Packaged
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation, iliac artery, each vessel	J8	$9,319
Femoral/Popliteal Interventions			
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	J8	$3,081
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	J8	$6,763
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	J8	$6,540
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	J8	$11,301
Tibial/Peroneal Interventions			
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	J8	$5,822
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	J8	$10,556
37230	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) includes angioplasty within the same vessel, when performed	J8	$10,408
37231	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	J8	$10,592
+37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty	N1	Packaged
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed	N1	Packaged
+37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placements(s), includes angioplasty within the same vessel, when performed	N1	Packaged
+37235	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	N1	Packaged

+Add-on code. Each add on code description includes: "(List separately in addition to code for primary procedure.)" Add-on codes represent procedures always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. They are not subject to multiple procedure discount rules.

**ASC Payment Indicators for CY 2021:
G2 = Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
J8 = Device-intensive procedure; paid at adjusted rate
N1 = Packaged service item; no separate payment made

PHYSICIAN FACILITY AND NON-FACILITY CATEGORY III CPT CODES

Category III CPT codes have been established to report atherectomy procedures when performed in the supra-inguinal arteries. These codes include the radiological supervision and interpretation of the atherectomy. Final determination of coverage and payment will be made at the discretion of the individual carrier. Please contact your carrier for additional information.

Atherectomy Procedures for Supra-Inguinal Arteries

CPT CODE[1]	ATHERECTOMY (OPEN OR PERCUTANEOUS) FOR SUPRA-INGUINAL ARTERIES
0234T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery
0235T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation, visceral artery (except renal), each vessel
0236T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation, abdominal aorta
0237T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation, brachiocephalic trunk and branches, each vessel
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation, iliac artery, each vessel

HOSPITAL INPATIENT FACILITY SERVICES

HOSPITAL INPATIENT REIMBURSEMENT

Medicare reimburses hospitals for inpatient services based on the MS-DRG (Medicare Severity Diagnosis Related Group). Only one DRG is assigned to a patient per admission and is determined by the combination of the primary procedure performed and the severity of the patient's diagnosis and comorbidities. Listed below are MS-DRGs and the Medicare national average payment for percutaneous peripheral vascular interventions.

Percutaneous Peripheral Vascular Interventions

Effective Dates: October 1, 2020 – September 30, 2021

MS-DRG[4]	DESCRIPTION	MEDICARE NATIONAL AVERAGE PAYMENT[5,***]
252	Other Vascular Procedures with MCC	$21,344
253	Other Vascular Procedures with CC	$17,057
254	Other Vascular Procedures without CC/MCC	$11,631
270	Other Major Cardiovascular Procedures with MCC	$33,305
271	Other Major Cardiovascular Procedures with CC	$22,912
272	Other Major Cardiovascular Procedures without MCC/CC	$17,282

MCC = Major Complications and Comorbidities

CC = Complications and Comorbidities

***The national average payment amount is calculated by multiplying the DRG relative weight for each DRG listed, by the national average hospital Medicare base rate. The national average hospital Medicare base rate used in these calculations is the labor and non labor rates for a particular type of hospital, as an example. In this case, the hospital has a wage index greater than one, has submitted quality data and is a "meaningful EHR user" as determined by CMS. The calculation also includes the capital standard federal payment rate. Please note that hospital rates can vary greatly depending on a variety of factors including location, teaching status and proportion of indigent patients served.

HOSPITAL ICD-10 CODE SETS

Hospitals use ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes to identify patient conditions and therapeutic interventions which result in the most appropriate MS-DRG assignment. Examples are provided below of the commonly reported ICD-10-CM diagnosis and ICD-10-PCS procedure codes for peripheral vascular interventions and procedures.

ICD-10 CLINICAL MODIFICATION (CM)/DIAGNOSIS CODES

The following ICD-10-CM diagnosis codes are commonly reported for coronary therapeutic services and procedures. This is not an exhaustive list and other patient conditions may support medical necessity of a procedure. Physicians are responsible for selecting the most appropriate code(s) to reflect the patient's medical condition.

ICD-10-CM DIAGNOSIS[8]	DESCRIPTION
I70.211	Atherosclerosis of native arteries of extremities with intermittent claudication, right leg
I70.212	Atherosclerosis of native arteries of extremities with intermittent claudication, left leg
I70.213	Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs
I70.218	Atherosclerosis of native arteries of extremities with intermittent claudication, other extremity
I70.219	Atherosclerosis of native arteries of extremities with intermittent claudication, unspecified extremity
I70.221	Atherosclerosis of native arteries of extremities with rest pain, right leg
I70.222	Atherosclerosis of native arteries of extremities with rest pain, left leg
I70.223	Atherosclerosis of native arteries of extremities with rest pain, bilateral legs
I70.228	Atherosclerosis of native arteries of extremities with rest pain, other extremity
I70.229	Atherosclerosis of native arteries of extremities with rest pain, unspecified extremity
I70.231	Atherosclerosis of native arteries of right leg with ulceration of thigh
I70.232	Atherosclerosis of native arteries of right leg with ulceration of calf
I70.233	Atherosclerosis of native arteries of right leg with ulceration of ankle
I70.234	Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot
I70.235	Atherosclerosis of native arteries of right leg with ulceration of other part of foot
I70.238	Atherosclerosis of native arteries of right leg with ulceration of other part of lower right leg
I70.239	Atherosclerosis of native arteries of right leg with ulceration of unspecified site
I70.241	Atherosclerosis of native arteries of left leg with ulceration of thigh
I70.242	Atherosclerosis of native arteries of left leg with ulceration of calf
I70.243	Atherosclerosis of native arteries of left leg with ulceration of ankle
I70.244	Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot
I70.245	Atherosclerosis of native arteries of left leg with ulceration of other part of foot
I70.248	Atherosclerosis of native arteries of left leg with ulceration of other part of lower left leg
I70.249	Atherosclerosis of native arteries of left leg with ulceration of unspecified site
I70.25	Atherosclerosis of native arteries of other extremities with ulceration
I70.261	Atherosclerosis of native arteries of extremities with gangrene, right leg
I70.262	Atherosclerosis of native arteries of extremities with gangrene, left leg
I70.263	Atherosclerosis of native arteries of extremities with gangrene, bilateral legs
I70.268	Atherosclerosis of native arteries of extremities with gangrene, other extremity
I70.269	Atherosclerosis of native arteries of extremities with gangrene, unspecified extremity
I70.82	Chronic total occlusion of artery of the extremities

Note, as of October 1, 2020, Chronic Limb Ischemia/Chronic Limb-Threatening Ischemia has formally been assigned to 144 existing codes. All changes are found within category I70, Atherosclerosis, including some of the codes listed above. For more detail, please visit the CLI Global Society website: https://www.cliglobalsociety.org/wp-content/uploads/2020/10/Summary-ICD-10-CLI-Changes-final.pdf

ICD-10 PROCEDURE CODING SYSTEM (PCS)/PROCEDURE CODES

Atherectomy of Peripheral Vasculature

The following ICD-10-PCS codes are commonly reported for atherectomy of other non-coronary vessels procedures. This is not an exhaustive list of ICD-10-PCS procedure codes. Physicians are responsible for selecting the most appropriate code(s) to reflect services performed.

ICD-10-PCS PROCEDURE[9]	DESCRIPTION
047C3ZZ	Dilation of Right Common Iliac Artery, Percutaneous Approach
047D3ZZ	Dilation of Left Common Iliac Artery, Percutaneous Approach
047E3ZZ	Dilation of Right Internal Iliac Artery, Percutaneous Approach
047F3ZZ	Dilation of Left Internal Iliac Artery, Percutaneous Approach
047H3ZZ	Dilation of Right External Iliac Artery, Percutaneous Approach
047J3ZZ	Dilation of Left External Iliac Artery, Percutaneous Approach
047K3ZZ	Dilation of Right Femoral Artery, Percutaneous Approach
047L3ZZ	Dilation of Left Femoral Artery, Percutaneous Approach
047M3ZZ	Dilation of Right Popliteal Artery, Percutaneous Approach
047N3ZZ	Dilation of Left Popliteal Artery, Percutaneous Approach
047P3ZZ	Dilation of Right Anterior Tibial Artery, Percutaneous Approach
047Q3ZZ	Dilation of Left Anterior Tibial Artery, Percutaneous Approach
047R3ZZ	Dilation of Right Posterior Tibial Artery, Percutaneous Approach
047S3ZZ	Dilation of Left Posterior Tibial Artery, Percutaneous Approach
047T3ZZ	Dilation of Right Peroneal Artery, Percutaneous Approach
047U3ZZ	Dilation of Left Peroneal Artery, Percutanous Approach
047V3ZZ	Dilation of Right Foot Artery, Percutaneous Approach
047W3ZZ	Dilation of Left Foot Artery, Percutaneous Approach
047Y3ZZ	Dilation of Lower Artery, Percutaneous Approach
04CC3ZZ	Extirpation of Matter from Right Common Iliac Artery, Percutaneous Approach
04CD3ZZ	Extirpation of Matter from Left Common Iliac Artery, Percutaneous Approach
04CE3ZZ	Extirpation of Matter from Right Internal Iliac Artery, Percutaneous Approach
04CF3ZZ	Extirpation of Matter from Left Internal Iliac Artery, Percutaneous Approach
04CH3ZZ	Extirpation of Matter from Right External Iliac Artery, Percutaneous Approach
04CJ3ZZ	Extirpation of Matter from Left External Iliac Artery, Percutaneous Approach
04CK3ZZ	Extirpation of Matter from Right Femoral Artery, Percutaneous Approach
04CL3ZZ	Extirpation of Matter from Left Femoral Artery, Percutaneous Approach
04CM3ZZ	Extirpation of Matter from Right Popliteal Artery, Percutaneous Approach
04CN3ZZ	Extirpation of Matter from Left Popliteal Artery, Percutaneous Approach
04CP3ZZ	Extirpation of Matter from Right Anterior Tibial Artery, Percutaneous Approach
04CQ3ZZ	Extirpation of Matter from Left Anterior Tibial Artery, Percutaneous Approach
04CR3ZZ	Extirpation of Matter from Right Posterior Tibial Artery, Percutaneous Approach
04CS3ZZ	Extirpation of Matter from Left Posterior Tibial Artery, Percutaneous Approach
04CT3ZZ	Extirpation of Matter from Right Peroneal Artery, Percutaneous Approach
04CU3ZZ	Extirpation of Matter from Left Peroneal Artery, Percutaneous Approach
04CV3ZZ	Extirpation of Matter from Right Foot Artery, Percutaneous Approach
04CW3ZZ	Extirpation of Matter from Left Foot Artery, Percutaneous Approach
04CY3ZZ	Extirpation of Matter from Lower Artery, Percutaneous Approach

PRODUCT DESCRIPTIONS

Diamondback 360® Peripheral Orbital Atherectomy System

The Diamondback 360 Peripheral Orbital Atherectomy System is a percutaneous orbital atherectomy system indicated for use as therapy in patients with occlusive atherosclerotic disease in peripheral arteries and stenotic material from artificial arteriovenous dialysis fistulae. Contraindications for the system include for use in coronary arteries, bypass grafts, stents, or where thrombus or dissections are present. Although the incidence of adverse events is rare, potential events that can occur with atherectomy include: pain, hypotension, CVA/TIA, death, dissection, perforation, distal embolization, thrombus formation, hematuria, abrupt
or acute vessel closure, or arterial spasm.

Diamondback 360® Peripheral Orbital Atherectomy System, Exchangeable Series

The Diamondback 360 Peripheral Orbital Atherectomy System Exchangeable Series is a percutaneous orbital atherectomy system indicated for use as therapy in patients with occlusive atherosclerotic disease in peripheral arteries and stenotic material from artificial arteriovenous dialysis fistulae. Important Safety Information: The System is contraindicated for use in coronary arteries, bypass grafts, stents, or where thrombus or dissections are present. Although the incidence of adverse events is rare, potential events that can occur with atherectomy include: pain, hypotension, CVA/TIA, death, dissection, perforation, distal embolization, thrombus formation, hematuria, abrupt or acute vessel closure, or arterial spasm.

Diamondback 360® Coronary Orbital Atherectomy System

The Diamondback 360 Coronary Orbital Atherectomy System is a percutaneous orbital atherectomy system indicated to facilitate stent delivery in patients with coronary artery disease (CAD) who are acceptable candidates for PTCA or stenting due to *de novo,* severely calcified coronary artery lesions. **Contraindications:** The OAS is contraindicated when the ViperWire Advance® Coronary guide wire cannot pass across the coronary lesion or the target lesion is within a bypass graft or stent. The OAS is contraindicated when the patient is not an appropriate candidate for bypass surgery, angioplasty, or atherectomy therapy, or has angiographic evidence of thrombus, or has only one open vessel, or has angiographic evidence of significant dissection at the treatment site and for women who are pregnant or children. **Warnings/Precautions:** Performing treatment in excessively tortuous vessels or bifurcations may result in vessel damage; The OAS was only evaluated in severely calcified lesions, A temporary pacing lead may be necessary when treating lesions in the right coronary and circumflex arteries; On-site surgical back-up should be included as a clinical consideration; Use in patients with an ejection fraction (EF) of less than 25% has not been evaluated. See the instructions for use before performing Diamondback 360 coronary orbital atherectomy procedures for detailed information regarding the procedure, indications, contraindications, warnings, precautions, and potential adverse events. For further information call CSI at 1-877-274-0901 and/or consult CSI's website at www.csi360.com. Caution: Federal law (USA) restricts this device to sale by or on the order of a physician.

Stealth 360® Peripheral Orbital Atherectomy System

The Stealth 360 Peripheral Orbital Atherectomy System is a percutaneous orbital atherectomy system indicated for use as therapy in patients with occlusive atherosclerotic disease in peripheral arteries and stenotic material from artificial arteriovenous dialysis fistulae. Contraindications for the system include use in coronary arteries, bypass grafts, stents, or where thrombus or dissections are present. Although the incidence of adverse events is rare, potential events that can occur with atherectomy include: pain, hypotension, CVA/TIA, death, dissection, perforation, distal embolization, thrombus formation, hematuria, abrupt or acute vessel closure, or arterial spasm.

VIPERCATH™ XC Peripheral Exchange Catheter

The VIPERCATH XC Peripheral Exchange Catheter is designed to support use of the guide wire during access of the peripheral vasculature. The exchange catheter allows for exchanges of guide wires, up to diameters of 0.035" during interventional and diagnostic peripheral arterial procedures.

WIRION® Embolic Protection System

WIRION is indicated for use as an embolic protection system to contain and remove embolic material (thrombus/debris) while performing atherectomy in calcified lesions of the lower extremities. The diameter of the vessel at the site of filter basket placement should be between 3.5mm to 6.0mm. WIRION may be used with commercially available 0.014" guide wires.

Zilient® Peripheral Guidewire (distributed by CSI)

The Zilient Peripheral Guidewire is intended to facilitate the placement and exchange of balloon catheters or other interventional devices within the peripheral vasculatures during Percutaneous Transluminal Angioplasty (PTA) or other intravascular interventional procedures.

JADE® PTA Balloon Catheter†

The Jade PTA Balloon Dilatation Catheter is indicated for Percutaneous Transluminal Angioplasty in the peripheral vasculature, including iliac, femoral, ilio-femoral, popliteal, infra-popliteal, and renal arteries, and for the treatment of obstructive lesions of native or synthetic arteriovenous dialysis fistulae. This device is also indicated for post-dilation of balloon expandable and self-expanding stents in the peripheral vasculature.

†This product is distributed by CSI and manufactured by OrbusNeich Medical Company Limited or its affiliates.

PRODUCT DESCRIPTIONS (continued)

Sapphire® NC Plus Coronary Balloon Dilatation Catheter†
The Sapphire NC Plus Coronary Balloon Dilatation Catheter is indicated for balloon dilatation of the stenotic portion of a coronary artery or bypass graft stenosis in patients evidencing coronary ischemia for the purpose of improving myocardial perfusion, balloon dilatation of a coronary artery occlusion for the treatment of acute myocardial infarction, in-stent restenosis, or post-delivery expansion of balloon expandable coronary stents.

Sapphire® II PRO Balloon Dilatation Catheter†
(Ø 1.0–1.25 mm configurations) is indicated for:
- balloon pre-dilatation of a stenotic portion of a coronary artery or bypass graft stenosis (≥70% stenosis) for the purpose of improving myocardial perfusion

Sapphire® II PRO Balloon Dilatation Catheter†
(Ø 1.5–4.0 mm configurations) is indicated for:
- balloon dilatation of the stenotic portion of a coronary artery or bypass graft stenosis in patients evidencing coronary ischemia for the purpose of improving myocardial perfusion
- balloon dilatation of a coronary artery occlusion for the treatment of acute myocardial infarction

Sapphire® II PRO Balloon Dilatation Catheter†
is also indicated for:
- percutaneous transluminal angioplasty in the peripheral vasculature, including renal, femoral, popliteal, infra-popliteal, tibial, and peroneal arteries

Scoreflex® NC Coronary Scoring Dilatation Catheter†
The Scoreflex NC Coronary Scoring Dilatation Catheter is indicated for balloon dilatation of a stenotic portion of a coronary artery or bypass graft stenosis in patients evidencing coronary ischemia for the purpose of improving myocardial perfusion. It is also indicated for in-stent restenosis.

Teleport® Microcatheter†
The Teleport Microcatheter is indicated for supporting and facilitating the placement of guidewires in the coronary and peripheral vasculature, exchanging guidewires in the coronary and peripheral vasculature, and the delivery of contrast media into the coronary, peripheral and abdominal vasculature.

†This product is distributed by CSI and manufactured by OrbusNeich Medical Company Limited or its affiliates.

Resources

1. Current Procedural Terminology (CPT) Professional Edition 2021. Copyright 2020 American Medical Association. All rights reserved.
2. Centers for Medicare and Medicaid Services (CMS). CY2021 Physician Fee Schedule (PFS) Final Rule and Correction Notice: CMS-1734-F and CMS-1734-CN, including related PFS addenda. The Conversion Factor used in calculations = $34.8931. Conversion Factor Source: H.R. 133 (116th): H.R. 133: Consolidated Appropriations Act, 2021 [Including Coronavirus Stimulus & Relief]. Effective through December 31, 2021.
3. Centers for Medicare and Medicaid Services (CMS). CY2021 Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems Final Rule: CMS-1736-FC, including related OPPS Addenda and January 2021 Addendum B.· Final OPPS Payment by HCPCS Code for CY 2021. Effective through December 31, 2021.
4. DRG Expert 2021. Optum360°, LLC.
5. Centers for Medicare and Medicaid Services (CMS). FY2021 Hospital Inpatient Prospective Payment (IPPS) Final Rule and Correction Notice: CMS 1735-F and CMS 1735-CN, including relevant data tables. Effective through September 30, 2021.
6. Centers for Medicare and Medicaid Services (CMS). CY2021 Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems Final Rule: CMS-1736-FC, including related ASC Addenda. Effective through December 31, 2021.
7. Healthcare Common Procedure Coding System (HCPCS) Level II Expert, 2021. Centers for Medicare and Medicaid Services (CMS). Optum360°, LLC.
8. ICD-10-CM Expert for Physicians and Hospitals, 2021. Optum360°, LLC.
9. ICD-10-PCS Expert for Hospitals, 2021. Optum360°, LLC.

Notes

+Add-on code. Each add on code description includes: "(List separately in addition to code for primary procedure.)" Add-on codes represent procedures always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. They are not subject to multiple procedure discount rules.

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N = Items and Services Packaged into APC Rates. Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.

**ASC Payment Indicators for CY 2021:
G2 = Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight
J8 = Device-intensive procedure; paid at adjusted rate
N1 = Packaged service item; no separate payment made

***The national average payment amount is calculated by multiplying the DRG relative weight for each DRG listed, by the national average hospital Medicare base rate. The national average hospital Medicare base rate used in these calculations is the labor and non labor rates for a particular type of hospital, as an example. In this case, the hospital has a wage index greater than one, has submitted quality data and is a "meaningful EHR user" as determined by CMS. The calculation also includes the capital standard federal payment rate. Please note that hospital rates can vary greatly depending on a variety of factors including location, teaching status and proportion of indigent patients served.

For additional reimbursement information, please visit www.csi360.com/reimbursement or email csireimbursement@csi360.com.

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