Veryan

AN OTSUKA MEDICAL DEVICES COMPANY

CODING & REIMBURSEMENT GUIDE 2024

Disclaimer: The information provided herein reflects Veryan's understanding of the procedure(s) and/or device(s) from sources that may include, but are not limited to, the CPT coding system; Medicare payment systems; commercially available coding guides; professional societies; and research conducted by independent coding and reimbursement consultants. This information should not be construed as authoritative. The entity billing Medicare and/or third party payers is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Veryan does not, and should not, have access to medical records, and therefore cannot recommend codes for specific cases. When you are making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims. Veryan does not promote the off-label use of its devices.

CMS Physician Fee Schedule

Coverage

Medicare carriers may issue local coverage decisions (LCDs) listing criteria that must be met prior to coverage. Physicians are urged to review these policies (http://www.cms.hhs.gov/mcd/search.asp?) and contact their carriers' medical directors (http://www.cms.hhs.gov/apps/contacts/) or commercial insurers to determine if a procedure is covered.

Coding

The following CPT® codes are used to report transcatheter peripheral vascular interventions for occlusive disease in the lower extremities. The codes are structured as a progressive hierarchy in which the more intensive services are inclusive of the lesser services. The work of accessing and selectively catheterizing the vessel, traversing the lesion, radiological supervision and interpretation directly related to the intervention(s) performed, embolic protection if used, closure of the arteriotomy by pressure and application of an arterial closure device or standard closure of the puncture by suture, and imaging performed to document completion of the intervention in addition to the intervention(s) performed are included.[1]

Femoral/Popliteal Vascular Territory

The femoral/popliteal territory in one extremity is treated as one vessel. If more than one lesion is treated, report one code based on the most intensive procedure(s) performed.

37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
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

Payment

2024 Medicare Reimbursement for Peripheral Vascular Interventions of the Lower Extremities—Physician and Outpatient

		Ambulatory Surgery Center	Outpatient Hospital		Physician Services	
CPT Code	Procedure Description	Facility Payment (National Medicare Avg[2])	APC	Facility Payment (National Medicare Avg[3])	Fee When Service Is Performed in the Hospital or ASC (National Medicare Avg[4])	Fee When Service Is Performed in the Office (National Medicare Avg[4])
Femoral/Popliteal Vascular Territory						
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	$3,450.04	5192	$5,451.51	$451.52	$3,458.60
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$11,686.17	5194	$16,724.70	$611.33	$10,957.13
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$7,023.76	5193	$10,492.72	$527.93	$9,968.96
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	$11,863.24	5194	$16,724.70	$732.41	$14,044.47

Note: Alternative payment policies may apply when multiple services are performed at the same encounter, including but not limited to, multiple procedure payment reductions and comprehensive ambulatory payment classifications (C-APC).

2. 2021 Medicare Ambulatory Surgery Center Fee Schedule
3. 2021 Medicare Hospital Outpatient Prospective Payment System (OPPS) Fee Schedule
4. 2021 Medicare Physician Fee Schedule

2024 physician fees for your local area can be found at the following CMS links:
http://www.cms.hhs.gov/pfslookup
or
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

For additional information please contact your local representative.

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