Reimbursement Guidelines
2024 Coding and Reimbursement Guidelines for Percutaneous Atherectomy (Auryon System) EFFECTIVE OCTOBER 1, 2023

AURYON

Introducing the Next Generation of Peripheral Atherectomy Technology

angiodynamics

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Background

This document contains reimbursement information for percutaneous peripheral vascular atherectomy for the treatment of infrainguinal stenoses and occlusions, including in-stent restenosis (ISR). As with all medical innovations, reimbursement (codes, payment, and coverage) varies widely from payor to payor. Hospitals and physicians should confirm with the patient's health payor the appropriate codes for claims submission. This reimbursement information is intended to help hospitals and physicians stay up to date with reimbursement policies and properly use codes related to percutaneous peripheral vascular atherectomy as performed with the Auryon System. Centers for Medicare and Medicaid Services (CMS) has assigned most of these codes under the Medicare hospital inpatient prospective payment system (IPPS), to specific MS-DRGs, reflecting the procedure along with the severity of the patient's condition and the presence of any complications and comorbidities. Continued refinement in reimbursement policies occurs on an annual basis. Percutaneous peripheral vascular atherectomy codes assigned to MS-DRGs and average Medicare payment levels are in the following charts.

Percutaneous Peripheral Vascular Procedure Codes

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 in which they are provided. 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 organization's coding and compliance teams. Coverage is determined by payors such as Medicare and private payors based on reasonable and necessary standards. Coverage policies for percutaneous cardiology and peripheral vascular interventions may vary. Check with your local Medicare Contractor or payor to confirm coverage for these procedures.

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Codes for Physician and Outpatient Procedures (JAN 1, 2024 – DEC 31, 2024)

Current Procedural Terminology (CPT®) Codes are used to document the procedures or medical services healthcare professionals provide[1]. Physicians report services using CPT® codes regardless of site of service. Below is a list of commonly reported CPT® codes for percutaneous peripheral vascular interventions, and Medicare national average payment rates.

Medicare 2024 National Average Payment (Not Geographically Adjusted)								
Service Provided		Physician Fee Schedule[2]				Hospital OPPS Payment[3]		ASC Payment *(Payment Indicator)*[4]
CPT® Code[1]	CPT® Description (Procedure Codes)[1,13]	Non-Facility		Facility		APC *(Status Indicator)*	Payment	
		RVU	Payment	RVU	Payment			
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	256.71	$8,545.23	17.41	$579.54	5193 (J1)[5]	$16,707.31	$11,686.55 (J8)[6]
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	327.81	$10,911.98	20.83	$693.38	5194 (J1)[5]	$16,707.31	$11,863.59 (J8)[6]
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	261.2	$8,694.70	20.15	$670.74	5194 (J1)[5]	$16,707.31	$11,088.29 (J8)[6]
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	345.41	$11,497.84	21.35	$710.69	5194 (J1)[5]	$16,707.31	$11,971.52 (J8)[6]
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed	31.01	$1,032.25	9.36	$311.57	Packaged (N)[7]	Packaged (N)[7]	Packaged (N)[7]

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CPT® Code[1]	CPT® Description (Procedure Codes)[1,13]	Non-Facility		Facility		APC (*Status Indicator*)	Payment	
		RVU	Payment	RVU	Payment			
+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	115.88	$3,857.36	10.69	$355.84	Packaged (N)[7]	Packaged (N)[7]	Packaged (N)[7]
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	237.79	$7,915.43	15.09	$502.31	5193 (J1)	$10,481.81	$7,024.02 (J8)[6]
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	261.62	$8,708.68	20.16	$671.08	5194 (J1)	$16,707.31	$10,728.29 (J8)[6]
37232	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	24.14	$803.56	5.79	$192.73	Packaged (N)[7]	Packaged (N)[7]	Packaged (N)[7]
37234	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	106.68	$3,551.11	8.18	$272.29	Packaged (N)[7]	Packaged (N)[7]	Packaged (N)[7]

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Service Provided		Physician Fee Schedule[2]				Hospital OPPS Payment[3]		ASC Payment *(Payment Indicator)*[4]
CPT® Code[1]	CPT® Description (Procedure Codes)[1,13]	Non-Facility		Facility		APC *(Status Indicator)*	Payment	
		RVU	Payment	RVU	Payment			
37186*	Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)	34.83	$1,159.40	7.1	$236.34	N/A	Packaged (N)[7]	Packaged (N)[7]
0234T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery	No national set payment				5193 J(1)	$10,481.81	Not a qualified ASC service

*Code (37186) for removal of thrombus is specific to catheters with aspiration tubing.

Payment Considerations for Category III CPT Codes

Category III codes are for emerging technologies, services, and procedures. They enable physicians and outpatient facilities to report accurately and gather data on the clinical efficacy, utilization, and outcomes of emerging technologies. According to the AMA CPT, a Category III code must be used in place of an unlisted procedure code[X].

Importantly, the approval of these Category III IRE codes does not:

- Guarantee coverage by third party health payors.
- Set a national or local payment level for physician services.

In fact, payors may not immediately update their claims processing systems to include new Category III codes. Payors that have implemented the new Category III IRE codes may request documentation of clinical efficacy to support coverage.

Reporting Category III codes can also initiate a dialogue between the payor and the physician on the payment level.

Third party health payors use different payment methodologies for Category III codes. Private payors that accept and cover Category III CPT codes can pay based on physician charges, a percentage of those charges, or if available, Medicare fee schedule amounts, as examples. Medicare/CMS does not set national physician payment levels for Category III CPT codes, so these codes are "carrier/contractor-priced". Check with the payor to see if they have guidelines for pricing Category III codes and if so, follow those guidelines.

Physicians should be prepared to submit information to the payor that helps coverage and payment decisions. For

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example, CGS, a Medicare contractor, requests information that includes progress notes, documentation of previous treatments and/or clinical trials. CGS also requests an operative or procedure report as well as documentation to support medical necessity6. Procedures performed in an office setting may also require data about office expenses, supplies and equipment. An evidence-based dialogue with the payor contributes to accurate and equitable payment levels. Payors may describe these payment methods as crosswalking or negotiated rate setting.

Crosswalk payment from a similar procedure to the Category III code

The physician may want to offer a crosswalk analysis in communicating with a payor about a new code. The crosswalk first identifies a reference procedure with an established payment level. Next, the physician suggests that payment for the new Category III CPT IRE code should be at the same rate as the reference procedure rate because both procedures require similar physician time, effort, and complexity. The payor may accept the "comparability" of the procedures and crosswalk payment from the reference procedure to the new Category III CPT IRE code.

Medicare has used the crosswalk process in various settings7. While the Medicare physician fee schedule establishes payment based on the relative values of physician work, practice expenses, and malpractice, these metrics may be part of a local contractor Category III CPT code payment crosswalk. Physician work value typically focuses on:

- Time (pre-, intra-, and post-operative time in the hospital),
- Mental effort,
- Professional judgment,
- Technical skill,
- Physical effort,
- Stress due to risk, and
- Number and complexity of follow up visits.

For example, if the time, effort, and complexity of an IRE procedure is like a standard pancreatic surgical procedure, the physician may suggest to the payor that the payment for the Category III CPT IRE code should be crosswalked from the payment for the standard pancreatic surgical procedure. There may be resource similarities as well as clinical similarities because of the unique challenges of treating pancreatic cancer. Because the Category III IRE CPT codes include imaging guidance, the reference codes should also include physician resources with imaging guidance.

Value-based Negotiated rates

Physicians may also consider a negotiated rate approach. This uses similar information from a crosswalk but with broader clinical and payment considerations, such as:

- Unique clinical value,
- Improved net health outcomes,
- Comparison of clinical impact to other treatments,
- Resource comparisons, including the relative complexity of the procedure to alternative treatment of the same condition (see discussion above on crosswalk),
- Time and professional skill to perform the procedure including pre-, intra-, and post-operative time,
- Limited number of patients who will qualify to receive the IRE treatment,
- Role of the physician in the hospital as a center of excellence.

Value-based payment can be a component of negotiated rates where the new IRE procedure offers the payor's subscribers a clinical breakthrough in treatment of a fatal disease. Since the Category III IRE CPT codes encompass the imaging guidance services, physician time and effort associated with imaging guidance should be part of the negotiated rate. It is important to inquire if the payor has guidelines on negotiated rate setting for physician services and if so, to follow those guidelines.

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HCPCS 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. HCPCS codes should be reported for all device-dependent Ambulatory Payment Classifications (APCs) for procedures conducted in the hospital outpatient setting. While HCPCS codes do not generally result in additional payment, it is important for hospitals to use HCPCS codes as a means of cost reporting which CMS uses to help determine future payment rates. The HCPCS codes listed below may be used for peripheral intervention procedures.

HCPCS Code[8]	HCPCS Description[8]	Auryon System Product
C1885	Catheter, transluminal angioplasty, laser	Auryon Atherectomy Catheter EXM-4002-0000 Auryon Atherectomy Catheter EXM-4002-H000
		Auryon Atherectomy Catheter EXM-4001-0000 Auryon Atherectomy Catheter EXM-4001-H000
		Auryon Atherectomy Catheter EXM-4003-0000/US Auryon Atherectomy Catheter EXM-4003-H000/US
		Auryon Atherectomy Catheter EXM-4004-0000/US Auryon Atherectomy Catheter EXM-4004-H000/US

*Part numbers with H000 indicate hydrophilic coated

ICD-10 Procedure Coding System (ICD-10-PCS) Codes (October 2023 to September 2024)

The following ICD-10-PCS codes are commonly reported for atherectomy of other non-coronary vessel 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 Codes[9]	ICD-10-PCS Code Description[9]	MS-DRG Mapping[10]
04CK3ZZ	Extirpation of Matter from Right Femoral Artery, Percutaneous Approach	270, 271, 272
04CL3ZZ	Extirpation of Matter from Left Femoral Artery, Percutaneous Approach	270, 271, 272
04CM3ZZ	Extirpation of Matter from Right Popliteal Artery, Percutaneous Approach	270, 271, 272
04CN3ZZ	Extirpation of Matter from Left Popliteal Artery, Percutaneous Approach	270, 271, 272
04CP3ZZ	Extirpation of Matter from Right Anterior Tibial Artery, Percutaneous Approach	270, 271, 272
04CQ3ZZ	Extirpation of Matter from Left Anterior Tibial Artery, Percutaneous Approach	270, 271, 272
04CR3ZZ	Extirpation of Matter from Right Posterior Tibial Artery, Percutaneous Approach	270, 271, 272
04CS3ZZ	Extirpation of Matter from Left Posterior Tibial Artery, Percutaneous Approach	270, 271, 272
04CT3ZZ	Extirpation of Matter from Right Peroneal Artery, Percutaneous Approach	270, 271, 272
04CU3ZZ	Extirpation of Matter from Left Peroneal Artery, Percutaneous Approach	270, 271, 272
04CV3ZZ	Extirpation of Matter from Right Foot Artery, Percutaneous Approach	270, 271, 272
04CW3ZZ	Extirpation of Matter from Left Foot Artery, Percutaneous Approach	270, 271, 272
04CY3ZZ	Extirpation of Matter from Lower Artery, Percutaneous Approach	270, 271, 272

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Medicare Severity Diagnosis Related Groups (MS-DRGs) (October 2023 to September 2024)

The following MS-DRGs may apply to peripheral atherectomy procedures for Medicare patients depending on the ICD-10-PCS code used[11]. ICD-10-PCS codes can group into different MS-DRGs depending upon all the procedures performed and the patient's diagnosis. This chart presents examples of the MS-DRGs and associated payment amounts for Medicare in 2024 (effective October 1, 2023). Payment amounts are based on a National Operating and Capital amount for 2024= $7,001.60[11]. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG	Description	Relative Weight[11]	2024 National Average Reimbursement[11]
270	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH MCC	5.0569	$35,406.39
271	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH CC	3.4562	$24,198.93
272	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITHOUT CC/MCC	2.4395	$17,080.40

ICD-10-CM Diagnosis Codes (October 2023 to September 2024)

Diagnosis codes are used by healthcare providers to document all patient conditions associated with the procedures performed. Secondary diagnosis codes corresponding to additional conditions at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay, should be reported. The ICD-10-CM codes below are examples of diagnosis codes that may apply for percutaneous peripheral atherectomy[11,13]. The provider should refer to a complete coding authority to check, confirm, and report all codes that accurately describe all the patient's conditions.

ICD-10-CM Code[12]	ICD-10-CM Description (Diagnosis Codes)[12]
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

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ICD-10-CM Code[12]	ICD-10-CM Description (Diagnosis Codes)[12]
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
I70.92	Chronic total occlusion of artery of the extremities

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2. Physician fee schedule rates were calculated using Conversion Factor (32.7375) multiplied by Total Facility & Non- Facility RVUs. CMS, CMS 1784-F: Medicare and Medicaid Programs; CY2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program https://public-inspection.federalregister.gov/2023-24184.pdf. Published November 16, 2023. Effective January 1, 2024. Accessed December 4, 2023.

3. CMS, CMS-1786-FC: Hospital Outpatient Prospective Payment Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Price Transparency of Hospital Standard Charges; Radiation Oncology Model https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc. Published November 16, 2023. Effective January 1, 2024. Accessed December 4, 2023.

4. CMS, CMS-1786-FC: Ambulatory Surgical Center Payment-Notice of Final Rulemaking with Comment Period (NFRM) https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc. Published November 16, 2023. Effective January 1, 2024. Accessed December 4, 2023.

5. APC (J1): 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 status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. CMS-1786-FC https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc.

6. ASC (J8): Device-intensive procedure; paid at adjusted rate. CMS-1786-FC https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc. No Valid APC Classification Assigned to this CPT® Code. APC Status indicator (N) signifies Items and Services Packaged into APC Rates. This code is paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment. CMS-1786-FC https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc. AAPC. 2022 HCPCS Level II Expert: Service Supply Codes for Caregivers and Suppliers. American Academy of Professional Coders; 2021.

7. CMS, 2023 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes/2023-icd-10-pcs. Accessed September 14, 2023.

8. AAPC Codify, Cross-Reference "ICD-10-PCS - MS-DRG" Accessed August 23, 2021.

9. CMS, [CMS-1785-F] 2024 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule; Federal Register. Accessed September 14, 2023. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page. Payment is calculated based on the national adjusted standardized amount $7,001.60. Actual Medicare payment rates will vary from adjustments by Wage Index and Geographic Adjustment Factor dependingon geographic locality. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown.

10. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS). 2022 release of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) . https://www.cdc.gov/nchs/icd/icd-10-cm.htm. Updated June 29, 2023. Accessed September 14, 2023.

11. Krol, Katharine L., Tutton, Sean M., & Hopkins, Dawn (January 2006). Mechanical Thrombectomy Coding. *Endovascular Today*. https://evtoday.com/articles/2006-jan/EVT0106_Coding_Krol.html.

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