

Reimbursement Guidelines
2025 Coding and Reimbursement Guidelines
for Percutaneous Atherectomy (Auryon
System) EFFECTIVE JANUARY 1, 2025

AURYON

Introducing the Next Generation of Peripheral Atherectomy Technology



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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.

This is general reimbursement information only and is intended to assist in compliance with complex and changing reimbursement policies. It is not legal advice, nor is it advice about how to code, complete, or submit any particular claim for payment, nor is it intended to increase or maximize reimbursement by any third-party payor. This information has been gathered from third-party sources and was correct at the time of publication and is subject to change without notice. It is the provider’s responsibility to exercise independent clinical judgment to determine appropriate coding and charges that accurately reflect all the patient’s conditions and services provided. These should be recorded in the patient’s medical record. The information provided here is for informational purposes only and represents no statement, promise or guarantee by AngioDynamics concerning levels of reimbursement, payment, or charges. Payors may have their own coding and reimbursement requirements and policies. If reimbursement questions arise for a particular patient, providers should contact the payor to confirm current requirements and billing policies. All decisions related to reimbursement, including amounts to bill, are exclusively that of the provider. Providers should check and confirm coding from complete and authoritative coding sources to ensure accuracy. This document is not intended to promote the off-label use of medical devices and physicians should use medical devices fully consistent with all government requirements. The content is not intended to instruct hospitals and/or physicians on how to use medical devices or bill for healthcare procedures. CPT codes © 2025 American Medical Association. All Rights Reserved. CPT is a trademark of the AMA. Applicable FARS/DFARS restrictions apply to Government Use. US/PA/MS/497 Rev 23 02/2025

Codes for Physician and Outpatient Procedures (JAN 1, 2025 – DEC 31, 2025)

Current Procedural Terminology (CPT®) Codes are used to document the procedures or medical services healthcare professionals provide¹. 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 2025 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	244.26	\$7,900.96	17.39	\$562.51	5193 (J1) ⁵	\$17,956.72	\$12,444.93 (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	311.96	\$10,090.81	20.86	\$674.75	5194 (J1) ⁵	\$17,956.72	\$12,539.67 (J8) ⁶
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	249.50	\$8,070.45	20.19	\$653.08	5194 (J1) ⁵	\$17,956.72	\$11,855.35 (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	327.58	\$10,596.07	21.60	\$698.68	5194 (J1) ⁵	\$17,956.72	\$12,261.12 (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	30.26	\$978.81	9.39	\$303.73	Packaged (N) ⁷	Packaged (N) ⁷	Packaged (N) ⁷

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Medicare 2025 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			
+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	112.49	\$3,638.66	10.89	\$352.25	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	226.00	\$7,310.31	15.13	\$489.40	5193 (J1)	\$11,340.57	\$7,578.93 (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	249.67	\$8,075.95	20.27	\$655.66	5194 (J1)	\$16,724.70	\$11,438.92 (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)	23.23	\$751.41	5.80	\$187.61	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)	101.51	\$3,283.49	8.21	\$265.56	Packaged (N) ⁷	Packaged (N) ⁷	Packaged (N) ⁷

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Medicare 2025 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			
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)	33.84	\$1,094.61	7.16	\$231.60	N/A	Packaged (N) ⁷	Packaged (N) ⁷

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

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	Aurion System Product
C1885	Catheter, transluminal angioplasty, laser	Aurion Atherectomy Catheter EXM-4001-H000 Aurion Atherectomy Catheter EXM-4002-H000 Aurion Atherectomy Catheter EXM-4003-H000/US Aurion Atherectomy Catheter EXM-4004-H000/US Aurion Atherectomy Catheter EXM-4012-H000 Aurion Atherectomy Catheter EXM-4010-H000 Aurion Atherectomy Catheter EXM-4011-H000

*Part numbers with H000 indicate hydrophilic coated

ICD-10 Procedure Coding System (ICD-10-PCS) Codes (October 2024 to September 2025)

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

Medicare Severity Diagnosis Related Groups (MS-DRGs) (October 2024 to September 2025)

The following MS-DRGs may apply to peripheral atherectomy procedures for Medicare patients depending on the ICD-10-PCS code used¹¹. 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 2025 (effective October 1, 2024). Payment amounts are based on a National Operating and Capital amount for 2025= \$7,116.03¹¹. If significant additional procedures are performed during the same inpatient admission, other MS-DRGs may apply.

MS-DRG	Description	Relative Weight ¹¹	2025 National Average Reimbursement ¹¹
270	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH MCC	5.1330	\$36,526.53
271	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH CC	3.4444	\$24,507.60
272	OTHER MAJOR CARDIOVASCULAR PROCEDURES WITHOUT CC/MCC	2.5022	\$17,805.73

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ICD-10-CM Diagnosis Codes (October 2024 to September 2025)

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
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 (32.3465) multiplied by Total Facility & Non- Facility RVUs. CMS, CMS 1807-F: Medicare and Medicaid Programs; CY2025 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://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-F>. Published December 09, 2024. Effective January 1, 2025. Accessed December 9, 2024.
3. CMS, CMS-1809-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/ambulatory-surgical-center-asc-asc-regulations-and-notices/cms-1809-fc>. Published November 16, 2023. Effective January 1, 2024. Accessed December 11, 2024.
4. CMS, CMS-1809-FC: Ambulatory Surgical Center Payment-Notice of Final Rulemaking with Comment Period (NFRM) <https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-fc>. Published December 09, 2024. Effective January 1, 2025. Accessed December 11, 2024.
5. APC (J1): Paid under OPPTS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPTS 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-1809-fc>.
6. ASC (J8): Device-intensive procedure; paid at adjusted rate. CMS-1809-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 OPPTS; 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-1809-fc>. AAPC. 2022 HCPCS Level II Expert: Service Supply Codes for Caregivers and Suppliers. American Academy of Professional Coders; 2024.
7. CMS, 2024 ICD-10 Procedure Coding System (ICD-10-PCS). <https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10-pcs>. Accessed September 3, 2024.
8. AAPC Codify, Cross-Reference "ICD-10-PCS - MS-DRG" Accessed September 6, 2024.
9. CMS, [CMS-1808-F] 2025 Medicare Hospital Inpatient Prospective Payment System (IPPS) Final Rule; Federal Register <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page>. Payment is calculated based on the national adjusted standardized amount \$7,116.03. Actual Medicare payment rates will vary from adjustments by Wage Index and Geographic Adjustment Factor depending on geographic locality. Also note that any applicable coinsurance, deductible, and other amounts that are patient obligations are included in the payment amount shown. Accessed October 7, 2024.
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 7, 2024. Accessed September 3, 2024.
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.

Reimbursement Support

For questions regarding coding, payment, coverage, and other reimbursement information, please contact us at Reimbursement@Angiodynamics.com.

Other Resources

For other reimbursement educational materials, guides, and resources, please visit: AngioDynamics' [Reimbursement Resources](#) website.

Indications for Use

The Auryon Atherectomy System and Auryon Atherectomy Catheters with aspiration are indicated for use as atherectomy devices for arterial stenoses, including in-stent restenosis (ISR), and to aspirate thrombus adjacent to stenoses in native and stented infra-inguinal arteries.

The Auryon Atherectomy System and Auryon Atherectomy Catheters without aspiration are indicated for use in the treatment, including atherectomy, of infra-inguinal stenoses and occlusions.

Refer to Directions for Use and/or User Manual provided with the product for complete Instructions, Warnings, Precautions, Possible Adverse Effects and Contraindications prior to use of the product.

CAUTION: Federal (USA) law restricts the sale of the device by or on the order of a physician.

USA > 14 Plaza Drive, Latham, NY 12110 > tel: 800-772-6446 or 518-798-1215 > fax: 518-798-1360

International > Haaksbergweg 75 (Margrietoren), 1101 BR, Amsterdam Z-O > The Netherlands >

tel: +31 (0)20 753 2949 > fax: +31 (0)20 753 2939

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