Peripheral Vascular Interventions of the Lower Extremities

2021 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and reimbursement for medical procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement when performing transcatheter peripheral vascular angioplasty, atherectomy and stenting procedures of the lower extremities. If you have any questions, please contact our reimbursement team at 800.468.1379 or by e-mail at Reimbursement@cookmedical.com.

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 bundled codes are broken down into three territories: iliac, femoral/popliteal and tibial/peroneal. 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]

Iliac Vascular Territory

The iliac territory is divided into three vessels: common iliac, internal iliac and external iliac.

37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
+37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)
+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 (List separately in addition to code for primary procedure)

Primary codes are reported for the initial iliac artery treated in each leg. Add-on codes within the iliac territory are reported if more than one vessel within the territory is treated. Do not report an add-on code for distinct lesions within the same vessel.

1. American Medical Association. *CPT 2021 Professional Edition.* Chicago, IL: American Medical Association; 2020:315.

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

Tibial/Peroneal Territory

The tibial/peroneal territory is divided into three vessels: anterior tibial, posterior tibial and peroneal arteries.

37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed
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
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
+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)
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)
+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)
+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 (List separately in addition to code for primary procedure)

Primary codes are reported for the initial tibial/peroneal artery treated in each leg. Add-on codes within the tibial/peroneal territory are reported if more than one vessel within the territory is treated. Do not report an add-on code for distinct lesions within the same vessel. The common tibioperoneal trunk is part of the tibial/peroneal territory and is not treated as a separate vessel.

Payment

2021 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])
Iliac Vascular Territory						
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$2,167.40	5192	$4,956.84	$380.49	$2,798.28
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$6,247.01	5193	$10,042.94	$468.97	$3,630.24
+37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure) (Use 37222 in conjunction with 37220, 37221)	*Packaged service No separate payment*		*Packaged service No separate payment*	$175.66	$687.42
+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 (List separately in addition to code for primary procedure) (Use 37223 in conjunction with 37221)	*Packaged service No separate payment*		*Packaged service No separate payment*	$201.59	$1,642.54
Femoral/Popliteal Vascular Territory						
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	$3,080.81	5192	$4,956.84	$421.65	$3,309.71

Continued on next page

		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])
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	$6,763.47	5193	$10,042.94	$572.04	$10,535.84
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	$6,540.11	5193	$10,042.94	$493.28	$9,561.60
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	$11,300.68	5194	$16,064.00	$685.80	$13,491.31
Tibial/Peroneal Territory						
37228	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty	$5,822.30	5193	$10,042.94	$513.70	$4,739.64
37229	Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed	$10,555.82	5194	$16,064.00	$662.78	$10,580.24
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	$10,408.09	5194	$16,064.00	$663.11	$10,094.42
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	$10,592.24	5194	$16,064.00	$713.34	$13,569.74
+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) (Use 37232 in conjunction with 37228-37231)	Packaged service *No separate payment*		Packaged service *No separate payment*	$189.27	$944.10

Continued on next page

		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])
+37233	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure) (Use 37233 in conjunction with 37229, 37231)	*Packaged service No separate payment*		*Packaged service No separate payment*	$308.22	$1,163.84
+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) (Use 37234 in conjunction with 37229, 37230, 37231)	*Packaged service No separate payment*		*Packaged service No separate payment*	$271.60	$3,983.51
+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 (List separately in addition to code for primary procedure) (Use 37235 in conjunction with 37231)	*Packaged service No separate payment*		*Packaged service No separate payment*	$373.69	$4,226.26

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

2021 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

COOK® MEDICAL

Disclaimer: The information provided herein reflects Cook'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. Cook 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. Cook does not promote the off-label use of its devices.