Zilver® PTX®
Drug-Eluting Peripheral Stent

2021 CODING AND REIMBURSEMENT GUIDE

Coverage, coding and payment for medical procedures and devices can be confusing. This guide was developed to assist with Medicare reporting and reimbursement when performing transcatheter peripheral vascular stenting procedures of the superficial femoral artery using the Zilver PTX Drug-Eluting Stent. 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 carrier's medical directors (www.cms.hhs.gov/apps/contacts/), or commercial insurers to determine if a procedure is covered.

Coding

"The lower extremity endovascular revascularization codes all include 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."[1] The bundled codes are broken down into three territories: iliac, femoral/ popliteal, and tibial/peroneal. These codes are structured based on a progressive hierarchy with the more intensive service inclusive of the lesser intensive services. The following CPT® codes are used to report transcatheter peripheral vascular interventions in the superficial femoral artery.

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.

NOTE: "The entire femoral/popliteal territory in one lower extremity is considered a single vessel for CPT reporting specifically for the endovascular lower extremity revascularization codes 37224 - 37227."[1] If more than one lesion is treated in the femoral/popliteal territory, report one code based on the most extensive procedure(s) performed.

Outpatient Hospital

Medicare requires hospitals to report, if applicable, device(s) used in the hospital outpatient setting by using Level II HCPCS codes, or "C-codes." When reporting use of a Cook Zilver PTX Drug-Eluting stent in a hospital outpatient setting, we recommend the following C-code(s):

C1874	Stent, coated/covered, with delivery system

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.*

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Payment

2021 Medicare Reimbursement for Stenting of the Superficial Femoral Artery: Physician and Outpatient Facilities

		Ambulatory Surgery Center	*Outpatient Hospital*		*Physician Services*	
Code	Procedure Description	Facility Payment (National Medicare Avg[2])	APC	Facility Payment (National MedicareAvg[3])	Fee When Service Is Performed in the Hospital or ASC (National MedicareAvg[4])	Fee When Service Is Performed in the Office (National Medicare Avg[4])
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

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).

1. American Medical Association. *CPT 2021 Professional Edition*. Chicago, IL: American Medical Association; 2020:281.
2. 2021 Medicare Ambulatory Surgical Center Fee Schedule.
3. 2021 Medicare Hospital Outpatient Prospective Payment System Fee Schedule.
4. 2021 Medicare Physician Fee Schedule.

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2021 physician fees for your local area can be found at the following CMS links:

https://www.cms.gov/apps/physician-fee-schedule/

or

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

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