Other Peripheral Vascular Stenting Procedures
Including Renal Stenting

2022 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 on peripheral vessels other than the coronary, carotid, vertebral, iliac and lower extremities. For lower extremity interventions, please see Cook Medical's Lower Extremity Coding and Reimbursement Guide. 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 encouraged to contact their local carrier medical directors (www.cms.hhs.gov/apps/contacts) or commercial insurers to determine if a procedure is covered.

Coding

The following CPT codes were created for transcatheter placement of intravascular stents. Included in this family of codes is any and all angioplasty(s) performed in the treated vessel (including pre-dilation whether performed as a primary or secondary angioplasty); post-dilation following stent placement, treatment of a lesion outside the stented segment but in the same vessel, or use of larger/smaller balloon to achieve therapeutic result. Radiological supervision and interpretation directly related to the intervention(s) performed, closure of the arteriotomy by pressure, 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 is also included in 37236-37237.[1]

37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery
+37237	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)

Angioplasty in a separate and distinct vessel; non-selective and/or selective catheterization(s) (eg, 36005,36010-36015, 36200,36215-36218, 36245- 36248); extensive repair or replacement of an artery (35226 or 35286); and intravascular ultrasound (37252-37253) may be reported separately.[1]

When a stent is placed for the purpose of providing a latticework for deployment of embolization coils, such as for embolization of an aneurysm, the embolization code (37241-37244) is reported and not the stent code (37236-37237). If a covered stent is deployed as the sole management of an aneurysm, pseudoaneurysm, or vascular extravasation, then the stent deployment code should be reported and not the embolization code.[1]

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 Cook peripheral vascular stent(s) in an outpatient hospital setting, we recommend the following C-code(s):

C1876	Stent, noncoated/noncovered, with delivery system

1. American Medical Association. CPT 2022 Professional Edition. Chicago, IL: American Medical Association; 2021:329.

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Payment

2022 Medicare Reimbursement for Peripheral Stent Placement – Physician and Outpatient Facilities

		Ambulatory Surgery Center	*Outpatient Hospital*		*Physician Services*	
CPT Code	Procedure Description	Facility Payment (National Medicare Avg)[1]	APC	Facility Payment (National Medicare Avg)[2]	Fee When Procedure Is Performed in Hospital or ASC (National Medicare Avg)[3]	Fee When Procedure Is Performed in Office (National Medicare Avg)[3]
37236	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel when performed; initial artery	$6,257.96	5193	$10,258.49	$446.42	$2,969.90
+37237	Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel when performed; each additional artery (List separately in addition to code for primary procedure)	Packaged service No separate payment		Packaged service No separate payment	$213.52	$1,390.48

[1] 2022 Medicare Ambulatory Surgery Center Fee Schedule
[2] 2022 Medicare Outpatient Hospital Fee Schedule
[3] 2022 Medicare Physician Services Fee Schedule

The reimbursement rates provided are national Medicare averages published by CMS at the time this guide was created. Reimbursement rates may change due to addendum updates Medicare publishes throughout the year and may not be reflected in the guide.

2022 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