Zenith® AAA Endovascular Graft
Zenith® Iliac Branch

2026 CODING AND REIMBURSEMENT GUIDE

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 (Medicare Coverage Database) and contact their local carrier's medical director (CMS Contacts Directory) or commercial insurers to determine if a procedure is covered.

HOSPITAL INPATIENT CODING AND PAYMENT

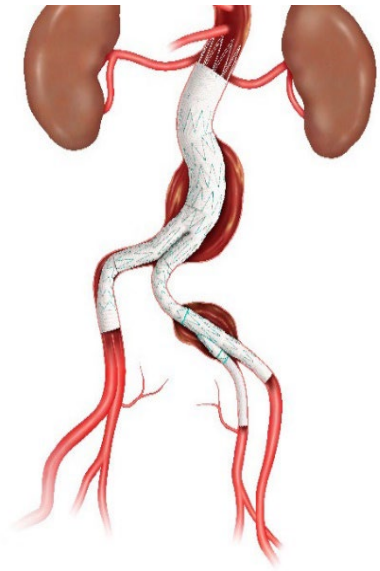
Procedures utilizing a Zenith® AAA Endovascular graft for the treatment of an abdominal aortic aneurysm should report only the abdominal code. If both an abdominal aortic aneurysm, and iliac branch repair utilizing a Zenith® Iliac Branch are performed, codes for both procedures should be reported.

AAA Endovascular Aortic Repair - EVAR	
ICD-10-PCS Code[1]	**Description**
04V03DZ	Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach

Endovascular Iliac Branch Repair	
ICD-10-PCS Code[1]	**Description**
04VC3EZ	Restriction of Right Common Iliac Artery with Branched or Fenestrated Intraluminal Device, One or Two Arteries, Percutaneous Approach
04VD3EZ	Restriction of Left Common Iliac Artery with Branched or Fenestrated Intraluminal Device, One or Two Arteries, Percutaneous Approach
04VC3DZ	Restriction of Right Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04VD3DZ	Restriction of Left Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04VE3DZ	Restriction of Right Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04VF3DZ	Restriction of Left Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04VH3DZ	Restriction of Right External Iliac Artery with Intraluminal Device, Percutaneous Approach
04VJ3DZ	Restriction of Left External Iliac Artery with Intraluminal Device, Percutaneous Approach

Abdominal aortic aneurysm repair procedures with a Zenith® AAA Endovascular graft, with or without iliac branch repair utilizing a Zenith® Iliac Branch, may map to one of several MS-DRGs, including the newly established MS-DRG 213 for endovascular abdominal aorta procedures with iliac branch. However, final MS-DRG assignment is based on factors such as primary and secondary diagnoses and procedures performed. Additionally, hospital payment will depend on factors like teaching status, location, and other hospital-specific characteristics.

MS-DRG National Average Reimbursement Rates		
DRG Code	**Description**	**Hospital Payment[2]**
213	Endovascular Abdominal Aorta with Iliac Branch Procedures	$43,207
268	Aortic and heart assist procedures except pulsation balloon with MCC	$52,963
269	Aortic and heart assist procedures except pulsation balloon without MCC	$31,473



One important distinction that must be made when reporting endovascular repair of aortic aneurysms is the landing zone of the graft. Placement of docking limb(s) is **NOT** an automatic trigger to report an add-on code (+34709) for extension prosthesis(es). If a graft lands below the iliac bifurcation, (+34709) is reportable.

Clinicians can use (34713) to report percutaneous access and closure of the femoral artery.

Access codes may only be reported once per side. For bilateral procedures, report the appropriate code twice.[3]

Zenith AAA Endograft

Physicians should use the following CPT® procedure codes for deployment of the Cook Zenith AAA device

2026 Physician Medicare Reimbursement for Zenith AAA Endograft and Adjunctive Procedures

CPT® Code	Description	Work RVUs	Physician Fees[4]
AAA Endovascular Procedures			
34705	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)	28.84	$1,381.64
34706	Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)	43.88	$2,060.71
+34717	Endovascular repair of iliac artery at the time of aorto-iliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption), unilateral (List separately in addition to code for primary procedure)	8.78	$398.78
+34709	Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (34709 may only be reported once per vessel treated [ie, multiple endograft extensions placed in a single vessel may only be reported once])	6.34	$290.02

PHYSICIAN CODING AND PAYMENT

2026 Physician Medicare Reimbursement for Zenith AAA Endograft and Adjunctive Procedures

CPT® Code	Description	Work RVUs	Physician Fees[4]
Open Procedures			
+34714	Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (List separately in addition to code for primary procedure)	5.12	$246.39
+34715	Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	5.85	$270.55
+34716	Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (List separately in addition to code for primary procedure)	7.01	$340.04
+34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)	4.03	$185.96
+34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	6.83	$305.80
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis	34.35	$1,609.56
34831	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis	37.03	$1,763.30
34832	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis	37.03	$1,729.40
+34833	Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (List separately in addition to code for primary procedure)	7.96	$356.82
+34834	Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (List separately in addition to code for primary procedure)	2.58	$117.15
Other Procedures			
+34808	Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)	4.02	$182.61
+34713	Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 French or larger), including ultrasound guidance, when performed, unilateral (List separately in addition to code for primary procedure)	2.44	$110.77
+34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure) (Use 34813 in conjunction with 34812)	4.67	$212.82

1. CMS 2026 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes
2. FY 2026 IPPS Payment. CMS-1785-F. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2027-ipps-final-rule-home-page
3. *CPT © 2025 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*
4. 2026 Medicare Physician Fee Schedule. The rates shown in this guide reflect the CY 2026 qualifying APM conversion factor of $33.57. For reference, the CY 2026 nonqualifying APM conversion factor is $33.40.
2026 physician fees for your local area can be found at the following CMS link:
https://www.cms.gov/medicare/physician-fee-schedule/search

If you have any questions, please contact our reimbursement team at:

833.585.2688

Or
By e-mail at:

reimbursement@cookmedical.com

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Disclaimer: The information provided herein reflects Cook's understanding of the procedure(s) and/or device(s) from sources which 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 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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