SHOCKWAVE MEDICAL INC

# 2022 CODING AND REIMBURSEMENT GUIDE

# PERIPHERAL INTRAVASCULAR LITHOTRIPSY (IVL)

*The coding, coverage, and payment information contained herein is gathered from various resources and is subject to change without notice. Shockwave Medical cannot guarantee success in obtaining third-party insurance payments. Third-party payment for medical products and services is affected by numerous factors. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that are rendered. Providers should contact their third-party payers for specific information on their coding, coverage, and payment policies.*

SHOCKWAVE | IVL

SHOCKWAVE MEDICAL INC

# 2022 HOSPITAL OUTPATIENT

## IVL Hospital Outpatient Ambulatory Payment Classification (APC) Assignment

Hospital outpatient claims must contain the appropriate Healthcare Common Procedure Coding System (HCPCS) code(s) to indicate the items and services that are furnished to the patient.

The Centers for Medicare and Medicaid Services (CMS) reimburses hospital outpatient departments using Ambulatory Payment Classification assignments (APCs). On November 2, 2021 , CMS released the 2022 Medicare Final Rule for Hospital Outpatient Payment. As part of the 2022 final rule, CMS has announced new APC assignments for three Healthcare Common Procedure Coding System (HCPCS) codes that describe peripheral IVL procedures performed in lower extremity arteries in the outpatient hospital setting. The three HCPCS codes affected describe procedures in iliac, femoral and popliteal arteries when IVL is performed by itself or adjunctively with percutaneous transluminal angioplasty (PTA), drug coated balloons (DCB), stents or atherectomy. The new APC assignments will increase the payments hospitals receive for these procedures. All changes are effective January 1, 2022. Payment rates for these designated APCs are intended to provide payment under the Hospital Outpatient Prospective Payment System (OPPS) for complete services or procedures.

**The table below contains a list of possible HCPCS codes that may be used to bill for IVL:**

| Code* | Description | Status Indicator[3] | 2021 APC[1] | 2021 Medicare Natl Payment[4] | 2022 APC[2] | 2022 Medicare Natl Payment[5] |
|---|---|---|---|---|---|---|
| C9764 | Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed | J1 | 5192 | $4,957 | 5193 | $10,258 |
| C9765 | Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed | J1 | 5193 | $10,043 | 5194 | $16,402 |
| C9766 | Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed | J1 | 5193 | $10,043 | 5194 | $16,402 |
| C9767 | Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed | J1 | 5194 | $16,064 | 5194 | $16,402 |
| C9772 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed | J1 | 5193 | $10,043 | 5193 | $10,258 |
| C9773 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed | J1 | 5194 | $16,064 | 5194 | $16,402 |
| C9774 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed | J1 | 5194 | $16,064 | 5194 | $16,402 |
| C9775 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed | J1 | 5194 | $16,064 | 5194 | $16,402 |

[1] Medicare 2021 OPPS Final Rule is available for download here: https://www.cms.gov/files/document/12220-opps-final-rule-cms-1736-fc.pdf

[2] Medicare 2022 OPPS Final Rule is available for download here: https://public-inspection.federalregister.gov/2021-24011.pdf

[3] According to Appendix D1, of the OPPS Payment System for 2021, Status Indicator J1 stands for "Hospital Part B Services Paid Through a Comprehensive APC" with the following payment status:

Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services.

Appendix D1 is available for download here: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates]

Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of November 4, 2021 but is subject to change without notice. Amounts do not reflect any subsequent changes in payment since publication. To confirm reimbursement rates, you should consult with your local MAC for specific codes.

Providers should select the most appropriate HCPCS code(s) with the highest level of detail to describe the service(s) rendered to the patient. Any questions should be directed to the pertinent local payer.

**It is important to note that the C-codes are designed to identify the entire procedure, and not just the IVL catheter, when IVL is performed in revascularization procedures. Hospital and ASC charges for the HCPCS codes should reflect charges for the entire procedure similar to other lower extremity revascularization procedures, including charges associated with the IVL catheter.*

## 2022 Ambulatory Surgery Center (ASC)

Effective January 1, 2021, Medicare added all 8 IVL codes to the ASC list of approved procedures. These 8 codes remain approved for 2022. The table below contains a list of possible HCPCS codes that may be used to bill for IVL in the ASC setting:

| Code | Description | Medicare 2021 National Payment[4] | Medicare 2022 National Payment[5] |
|---|---|---|---|
| C9764 | Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed | $2,167 | $4,369 |
| C9765 | Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed | $5,572 | $11,308 |
| C9766 | Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed | $4,285 | $7,233 |
| C9767 | Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed | $9,223 | $11,988 |
| C9772 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed | $5,822 | $5,940 |
| C9773 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed | $10,408 | $10,625 |
| C9774 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed | $10,556 | $10,776 |
| C9775 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed | $10,592 | $10,814 |

[4] Addendum B of the OPPS Payment System for 2021 is available for download here: https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-fc

[5] Addendum B of the OPPS Payment System for 2022 is available for download here: https://www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-data-addendum-b-and-2-times-rule.zip

# HOSPITAL INPATIENT

Effective October 1, 2020, CMS published new International Classification of Diseases, Tenth Revision, Procedural Coding System (ICD-10-PCS) codes specifically identifying IVL. These codes are used for hospital reporting of inpatient procedures, which are assigned to Medicare-Severity Diagnosis Related Groups (MS-DRGs) for payment for the hospital admission.

## Coding: Possible ICD-10-PCS codes for IVL procedures[6]

Hospital inpatient claims must contain the appropriate ICD-10 code(s) to indicate the items and services that are furnished to the patient. The table below contains a list of possible ICD 10-PCS codes that may be used to bill for IVL.

Providers should select the most appropriate ICD-10 code(s) with the highest level of detail to describe the service(s) rendered to the patient. Any questions should be directed to the pertinent local payer.

| Code | Description |
|---|---|
| 04FC3ZZ | Fragmentation of Right Common Iliac Artery, Percutaneous Approach |
| 04FE3ZZ | Fragmentation of Right Internal Iliac Artery, Percutaneous Approach |
| 04FH3ZZ | Fragmentation of Right External Iliac Artery, Percutaneous Approach |
| 04FK3ZZ | Fragmentation of Right Femoral Artery, Percutaneous Approach |
| 04FM3ZZ | Fragmentation of Right Popliteal Artery, Percutaneous Approach |
| 04FP3ZZ | Fragmentation of Right Anterior Tibial Artery, Percutaneous Approach |
| 04FR3ZZ | Fragmentation of Right Posterior Tibial Artery, Percutaneous Approach |
| 04FT3ZZ | Fragmentation of Right Peroneal Artery, Percutaneous Approach |
| 04FD3ZZ | Fragmentation of Left Common Iliac Artery, Percutaneous Approach |
| 04FF3ZZ | Fragmentation of Left Internal Iliac Artery, Percutaneous Approach |
| 04FJ3ZZ | Fragmentation of Left External Iliac Artery, Percutaneous Approach |
| 04FL3ZZ | Fragmentation of Left Femoral Artery, Percutaneous Approach |
| 04FN3ZZ | Fragmentation of Left Popliteal Artery, Percutaneous Approach |
| 04FQ3ZZ | Fragmentation of Left Anterior Tibial Artery, Percutaneous Approach |
| 04FS3ZZ | Fragmentation of Left Posterior Tibial Artery, Percutaneous Approach |
| 04FU3ZZ | Fragmentation of Left Peroneal Artery, Percutaneous Approach |
| 04FY3ZZ | Fragmentation of Lower Artery, Percutaneous Approach |

[6]These ICD-10 procedure codes are available here: https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs.

## Payment: Medicare 2022 Hospital Inpatient MS-DRGs

The ICD-10 procedure codes listed above group to MS-DRGs 252-254. When other procedures are performed in addition to IVL, other MS-DRGs may apply.

| MS-DRG | Description | Medicare 2021 National Payment[7] | Medicare 2022 National Payment[8] |
|---|---|---|---|
| 252 | Other Vascular Procedures with MCC | $21,344 | $21,931 |
| 253 | Other Vascular Procedures with CC | $17,056 | $17,499 |
| 254 | Other Vascular Procedures w/o CC/MCC | $11,630 | $11,975 |

Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of November 4, 2021 but is subject to change without notice. Amounts do not reflect any subsequent changes in payment since publication. To confirm reimbursement rates, you should consult with your local Medicare Administrative Contractor (MAC) for specific codes.

*This document includes possible codes that might be used to bill for the Shockwave device. Each provider must verify the appropriate codes for each patient. It is the provider's sole responsibility to determine and submit appropriate codes, charges, and modifiers for services rendered. Providers should contact insurers to verify correct coding procedures prior to submitting claims related to IVL. Shockwave Medical cannot guarantee coverage or reimbursement with the codes listed in this billing guide. In all cases, providers will need to follow local payer policies for billing and reimbursement.*

[7] Source: CMS-1735-CN

[8] Source: CMS-1752-F

All rates shown are national averages for operating and capital payments, not adjusted for geographic variations in costs, disproportionate share hospital payments, or graduate medical education payments. All these factors can have a significant impact on a hospital's payment rates.