



2023

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.

2023 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 1, 2022, CMS released the 2023 Medicare Final Rule for Hospital Outpatient Payment. As part of the 2023 final rule, CMS has continued the 2022 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 described 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. All changes are effective January 1, 2023. 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	2022 APC ¹	2022 Medicare Natl Payment ⁴	2023 APC ²	2023 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	5193	\$10,258	5193	\$10,615
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	5194	\$16,402	5194	\$17,178
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	5194	\$16,402	5194	\$17,178
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	\$16,402	5194	\$17,178
C9772	Revascularization, endovascular, open or percutaneous, tibial/ peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	J1	5193	\$10,258	5193	\$10,615
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	\$16,402	5194	\$17,178
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	\$16,402	5194	\$17,178
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	\$16,402	5194	\$17,178

¹ Medicare 2022 OPPS Final Rule is available for download here: <https://public-inspection.federalregister.gov/2021-24011.pdf>.

² Medicare 2023 OPPS Final Rule is available for download here: www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf.

³ According to Appendix D1, of the OPPS Payment System for 2023, 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; services assigned to a new technology APC; self-administered drugs; all preventive services; and certain Part B inpatient services; and FDA-authorized or approved drugs and biologicals (including blood products) that are authorized or approved to treat or prevent COVID-19.

⁴ Addendum B of the OPPS Payment System for 2022 is available for download here: www.cms.gov/license/ama?file=/files/zip/2022-nfrm-opps-data-addendum-b-and-2-times-rule.zip.

⁵ Appendix D1 is available for download here: www.cms.gov/license/ama?file=/files/zip/2023-nfrm-opps-addenda.zip.

Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of November 1, 2022 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.*

2023 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 2023. Additionally, CMS has finalized a proposal to assign device-intensive status to HCPCS codes C9764 and C9766 resulting in significant increases in payments for these procedures compared to the previous year.

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 2022 National Payment ⁶	Medicare 2023 National Payment ⁷
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	\$4,369	\$7,055
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	\$11,308	\$11,951
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	\$7,233	\$12,267
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	\$11,968	\$12,620
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed	\$5,940	\$6,791
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	\$10,625	\$10,990
C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed	\$10,776	\$11,771
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	\$10,814	\$11,178

⁶ Addendum B of the OPSS Payment System for 2022 is available for download here: www.cms.gov/license/ama?file=/files/zip/2022-nfrm-ops-data-addendum-b-and-2-times-rule.zip

⁷ Addendum FF of the OPSS Payment System for 2023 is available for download here: www.cms.gov/license/ama?file=/files/zip/2023-nfrm-addendum-aa-bb-dd1-dd2-ee-and-ff.zip

HOSPITAL INPATIENT

Effective October 1, 2023, CMS has maintained the previously published 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 procedures⁸

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

⁸ These ICD-10 procedure codes are available here: www.cms.gov/medicare/icd-10/2021-icd-10-pcs.

Payment: Medicare 2023 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 2022 National Payment ⁹	Medicare 2023 National Payment ¹⁰
252	Other Vascular Procedures with MCC	\$21,931	\$22,933
253	Other Vascular Procedures with CC	\$17,499	\$18,342
254	Other Vascular Procedures w/o CC/MCC	\$11,975	\$12,543

⁹ Source: CMS-1752-F

¹⁰ Source: CMS-1771-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.

Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of November 4, 2022 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.

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See more information

