SHOCKWAVE | IVL

CORONARY INTRAVASCULAR LITHOTRIPSY (IVL) & PERCUTANEOUS CORONARY INTERVENTION (PCI)

2025 Medicare Hospital and Ambulatory Surgery Center (ASC) Coding & Payment Guide

HOSPITAL INPATIENT OVERVIEW

The Medicare Inpatient Prospective Payment System (IPPS) Fiscal Year 2025 (FY2025) Final Rule contains several updates regarding PCI procedures for Medicare patients within the hospital inpatient setting effective October 1, 2024.

The three Medicare Severity Diagnosis Related Groups (MS-DRG) specific to Coronary Intravascular Lithotripsy (C-IVL) which were established in Fiscal Year 2024 (FY2024) remain in effect with updated payment rates for FY2025. Assignment to these C-IVL specific MS-DRGs will be based on the patient's diagnosis and the C-IVL specific International Classification of Diseases Procedure Code (ICD-10-PCS) included on the claim form (see table below). The standard PCI with stent MS-DRG codes which were consolidated from four separate codes to two codes in FY2024 also remain in place with updated payment rates for FY2025.

HOSPITAL INPATIENT CODING & PAYMENTS FOR CORONARY IVL

Medicare reimburses inpatient care under the FY2025 IPPS which utilizes the MS-DRG system for payment. Effective FY2024, when Coronary IVL is performed in the hospital inpatient setting with or without stent placement (any type), facilities are assigned one of the MS-DRG codes listed below. Performance of additional procedures may change the MS-DRG assignment. The below FY2025 payments for Coronary IVL MS-DRGs are effective starting October 1, 2024.

As compared to FY2024, the updated FY2025 payments associated with Coronary IVL procedures have increased by ~$1,650 on a volume weighted average basis.

MS-DRG	Descriptor	FY2025 Medicare National Base Payment[2]
323	Coronary IVL **with** Intraluminal Device **with MCC**[1]	$30,313
324	Coronary IVL **with** Intraluminal Device **without MCC**[1]	$22,793
325	Coronary IVL **without** Intraluminal Device **without CC/MCC**[1]	$20,369

[1]MCC: Major Complications and Comorbidities; CC: Complications and Comorbidities.
[2]CMS-1808-IFC; National Average MS-DRG rates shown are based on Medicare Inpatient Prospective Payment System FY2025 Final Rule, Table 1 & Table 5. National average payment rates assume full update amount for hospitals which have submitted quality data and hospitals have a wage index greater than 1. Site specific payment rates will vary based on regional area wage differences, teaching hospital status, indirect medical education costs, quality data, additional payments to hospitals that treat a large percentage of low-income patients ("disproportionate share payments"), etc. MS-DRG payment rates shown do not include sequestration reduction.

The following ICD-10-PCS codes are specific to procedures involving the use of C-IVL on one or more coronary arteries. Codes associated with stent procedures as well any other procedures performed may also be applicable.

ICD-10-PCS Code	Descriptor
02F03ZZ	Fragmentation in coronary artery, one artery, percutaneous approach
02F13ZZ	Fragmentation in coronary artery, two arteries percutaneous approach
02F23ZZ	Fragmentation in coronary artery, three arteries, percutaneous approach
02F33ZZ	Fragmentation in coronary artery, four or more arteries, percutaneous approach

HOSPITAL INPATIENT CODING & PAYMENTS FOR PCI

The consolidated, two code structure of standard PCI procedures with stent procedures established in FY2024 remain in place with updated payments for FY2025. PCI procedures involving atherectomy within the hospital inpatient setting will continue to map to these MS-DRG codes. The FY2025 IPPS rule includes the same MS-DRG for PCI without stent as FY2024 with updated payments. The below FY2025 payments for standard PCI with and without stent procedures are effective starting October 1, 2024.

As compared to FY2024, the updated FY2025 payments associated with standard PCI procedures have increased by ~$100 on a volume weighted average basis.

MS-DRGs FOR PCI WITH STENT PLACEMENT

MS-DRG	Descriptor	FY2025 Medicare National Base Payment[2]
321	PCI with intraluminal device **with MCC**[1] or 4+ arteries	$20,260
322	PCI with intraluminal device **without MCC**[1]	$12,875

MS-DRGs FOR PCI WITHOUT STENT PLACEMENT

MS-DRG	Descriptor	FY2025 Medicare National Base Payment[2]
250	PCI **without** intraluminal device **with MCC**[1]	$16,460
251	PCI **without** intraluminal device **without MCC**[1]	$11,120

[1]MCC: Major Complications and Comorbidities; CC: Complications and Comorbidities.
[2]CMS-1808-IFC; National Average MS-DRG rates shown are based on Medicare Inpatient Prospective Payment System FY2025 Final Rule, Table 1 & Table 5. National average payment rates assume full update amount for hospitals which have submitted quality data and hospitals have a wage index greater than 1. Site specific payment rates will vary based on regional area wage differences, teaching hospital status, indirect medical education costs, quality data, additional payments to hospitals that treat a large percentage of low-income patients ("disproportionate share payments"), etc. MS-DRG payment rates shown do not include sequestration reduction.

HOSPITAL OUTPATIENT OVERVIEW

 Hospital outpatient claims must contain the appropriate Healthcare Common Procedure Coding System (HCPCS) Level I and Level II 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, 2024, CMS released the 2025 Medicare Final Rule for the Hospital Outpatient Prospective Payment System (OPPS). As part of the 2025 Final Rule, the Coronary IVL Healthcare Common Procedure Coding System (HCPCS) Code C1761 and CPT® add-on code +92972 should be billed in combination with a designated primary procedure code when Coronary IVL is performed. Payment rates for these designated APCs are intended to provide payment under the OPPS for complete services or procedures. All changes are effective January 1, 2025.

HOSPITAL OUTPATIENT CODING & PAYMENTS FOR CORONARY IVL

CPT® code +92972 is an add-on code that must be used in conjunction with a designated primary procedure CPT® code as well as with the Coronary IVL HCPCS code C1761. While both codes are packaged with the primary procedure, both must be billed in conjunction with the primary procedure(s) performed. A list of primary procedure codes commonly used with Coronary IVL can be found in the table on the next page.

Primary (J1) Procedure Code(s)

Example: C9600
(PCI with Stent)

+

C1761

Coronary IVL HCPCS Code
Catheter, transluminal intravascular lithotripsy, coronary (Coronary IVL)

+

+92972

Coronary IVL CPT® Add-on Code
Percutaneous transluminal coronary lithotripsy
(List separately in addition to code for primary procedure)

Primary CPT® Procedure Codes Commonly used with Coronary IVL			
CPT®[1] Code	Description	APC/Status Indicator[2]	2025 National Average Payment[3]
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	5192/J1	$5,702
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	5193/J1	$11,341
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	5193/J1	$11,341
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	5194/J1	$17,957
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	5193/J1	$11,341
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	Inpatient Only	NA
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	5193/J1	$11,341
92975	Thrombolysis, coronary; by intracoronary infusion, including selective coronary angiography	Inpatient Only	NA
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	5193/J1	$11,341
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	5194/J1	$17,957
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	5193/J1	$11,341
C9606	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel	Inpatient Only	NA
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	5194/J1	$17,957

[1]CPT® only copyright 2024 American Medical Association. All rights Reserved.
[2]Per Addendum D1, CY2025 OPPS Final Rule, Status Indicator J1 = Hospital Part B Services Paid Through a Comprehensive APC with the following payment status: 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.
[3]CMS-1809-FC; Medicare Hospital Outpatient Prospective Payment System (OPPS) Calendar Year 2025 Final Rule, Addendum B, 11122024. Payment rates do not take into account geographical or additional adjustments. Providers should contact their local Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates vary by region.
Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of November 2024 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.

AMBULATORY SURGERY CENTER OVERVIEW

Ambulatory Surgery Center (ASC) claims must contain the appropriate Healthcare Common Procedure Coding System (HCPCS) Level I and Level II code(s) to indicate the items and services that are furnished to the patient.

The Centers for Medicare and Medicaid Services (CMS) reimburses the ASC using a percentage of Ambulatory Payment Classification assignment (APC). On November 1, 2024, CMS released the 2025 Medicare Final Rule for the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Payment System,. As part of the 2025 Final Rule, the Coronary IVL Healthcare Common Procedure Coding System (HCPCS) Code C1761 and CPT® add-on code +92972 should be billed in combination with a designated primary procedure code (approved for Medicare ASC billing) when Coronary IVL is performed. Payment rates for these designated primary codes are intended to provide payment to the ASC for complete services or procedures. All changes are effective January 1, 2025.

ASC CODING & PAYMENTS FOR CORONARY IVL

CPT® code +92972 is an add-on code that must be used in conjunction with a designated primary procedure CPT® code as well as with the Coronary IVL HCPCS code C1761. While both codes are packaged with the primary procedure, both must be billed in conjunction with the primary procedure(s) performed. The below table identifies primary CPT® procedure codes commonly used with Coronary IVL as allowed by Medicare in the ASC setting. Commercial payers may allow coverage and payment for additional codes in the ASC setting and should be contacted for their requirements.

Primary (J1) Procedure Code(s)

Example: C9600
(PCI with Stent)

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C1761

Coronary IVL HCPCS Code
Catheter, transluminal intravascular lithotripsy, coronary (Coronary IVL)

\+

+92972

Coronary IVL CPT® Add-on Code
Percutaneous transluminal coronary lithotripsy
(List separately in addition to code for primary procedure)

Primary CPT® Procedure Codes Commonly used with Coronary IVL as Allowed by Medicare in the ASC Setting

CPT® Code[1]	Description	2025 National Average Payment[2]
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$3,628
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$6,994
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$7,062

[1] CPT® only copyright 2024 American Medical Association. All rights Reserved.
[2] CMS-1809-FC; Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Payment System, Calendar Year 2025 Final Rule, Addenda AA, 11142024. Payment rates do not take into account geographical or additional adjustments. Providers should contact their local Medicare Administrative Contractor (MAC) or CMS for specific information as payment rates vary by region.
Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of November 2024 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.

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QUESTIONS?

CONNECT WITH A SHOCKWAVE MEDICAL REIMBURSEMENT SPECIALIST BY PHONE AT **(877) 273-4628** OR EMAIL AT **REIMBURSEMENT@SHOCKWAVEMEDICAL.COM**

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 theprovider'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.

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