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MedTech

FY2027 CY2026 Coronary Intravascular Lithotripsy (IVL)

Hospital and ambulatory surgery center (ASC) coding and reimbursement guide

The below information is provided to assist in the accurate coding of intravascular lithotripsy (IVL) procedures with shockwave ivl catheters. IVL is the energy-based generation of ultrasonic acoustic pressure waves for modification, fracture, and fragmentation of vascular calcification.

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.

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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.

2027 Hospital inpatient coding & payments for Coronary IVL

The Medicare Inpatient Prospective Payment System (IPPS) Fiscal Year 2027 (FY2027) Final Rule contains several updates regarding PCI procedures for Medicare patients within the hospital inpatient setting effective October 1, 2026. There are three Medicare Severity Diagnosis Related Groups (MS-DRGs) specific to Coronary Intravascular Lithotripsy (C-IVL) when utilized in Percutaneous Coronary Interventions (PCIs). 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).

Medicare reimburses acute inpatient care under the FY2027 IPPS, which utilizes the MS-DRG system for payment. When Coronary IVL is performed in the hospital inpatient setting the hospital discharge is typically assigned to one of the MS-DRGs listed below. Performance of additional procedures may change the MS-DRG assignment.

MS-DRG	Descriptor	FY2027 Medicare base payment[2]
323	Coronary IVL **with** intraluminal device **with MCC**[1]	$32,760
324	Coronary IVL **with** intraluminal device **without MCC**[1]	$23,571
325	Coronary IVL **without** intraluminal device[1]	$24,653

[1]MCC: Major Complications and Comorbidities; CC: Complications and Comorbidities.
[2]CMS-1849-CN3; MS-DRG Base Rates shown are based on Medicare Inpatient Prospective Payment System FY2027 Final Rule and Correction Notice, Table 1 & Table 5. National base 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 may be reported when C-IVL is utilized on one or more coronary arteries. Additional ICD-10-PCS codes may be warranted if other procedures are performed during the hospital admission.

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

2026 Hospital outpatient coding & payments for Coronary IVL

The Centers for Medicare and Medicaid Services (CMS) reimburses hospital outpatient departments using Ambulatory Payment Classification assignments (APCs). As part of the 2026 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.

A list of primary procedure codes commonly used with Coronary IVL can be found in the table below. While both codes are packaged with the primary procedure, both must be billed in conjunction with the primary procedure(s) performed. Payment rates for these designated APCs are intended to provide payment under the OPPS for complete services or procedures and are effective January 1, 2026.

Primary (J1) procedure code(s)

Example: C9600
(PCI with Stent)

+

+92972

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

+

C1761

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

Primary CPT® procedure codes commonly used with Coronary IVL

CPT®[1] code	Description	APC/status indicator[2]	2026 national base payment[2]
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery and/or its branch(es).	5192/J1	$5,815
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery and/or its branch(es).	5193/J1	$11,794
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery and/or its branch(es); one lesion involving one or more coronary segments.	5193/J1	$11,794
92930	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); into two or more distinct coronary lesions with two or more coronary stents deployed into or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch.	5194/J1	$18,729
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery and/or its branch(es).	5194/J1	$18,729
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 major coronary artery and/or its branch(es).	5193/J1	$11,794
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single major coronary artery and/or its branches or single bypass graft and/or its subtended branches.	Inpatient only	
92943	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; antegrade approach.	5193/J1	$11,794
92945	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approach.	5193/J1	$11,794
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch.	5193/J1	$11,794
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch.	5194/J1	$18,729
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	$11,794
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	
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	$18,729

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[2]CMS-1834-FC, Addenda D1, J1 = Comprehensive APC, All covered services on the claim are packaged with the primary "J1" service on the claim.

2026 ASC coding & payments for Coronary IVL

As part of the 2026 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. While both codes are packaged with the primary procedure, both should 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. Payment rates for these designated primary codes are intended to provide payment to the ASC for complete services or procedures and are effective January 1, 2026.

Primary (J1) procedure code(s)

Example: C9600
(PCI with stent)

+

+92972

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

+

C1761

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

Primary CPT® procedure codes commonly used with Coronary IVL as allowed by Medicare in the ASC setting

CPT® code[1]	Description	2026 national base payment[2]
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery and/or its branch(es).	$3,849
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery and/or its branch(es).	$8,448
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery and/or its branch(es); one lesion involving one or more coronary segments.	$7,309
92930	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); into two or more distinct coronary lesions with two or more coronary stents deployed into or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch.	$12,842
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery and/or its branch(es).	$12,965
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 major coronary artery and/or its branch(es).	$7,423
92943	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; antegrade approach.	$7,883
92945	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approach.	$7,438
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch.	$7,500
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch.	$13,206
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.	$7,354
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	$12,790
C7571	Percutaneous transluminal coronary angioplasty, single major coronary artery or branch with percutaneous transluminal coronary lithotripsy	$6,542

[1]CPT® 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
[2]CMS-1834-FC; Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Payment System Calendar Year 2026 Final Rule Addenda AA, 11242025.

Questions?

Connect with your reimbursement specialist at **shockwavereimbursement@its.jnj.com**

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Contact your local Medicare Administrative Contractor (MAC) or relevant payer for specific coding and coverage guidelines. Circulatory Restoration cannot guarantee medical benefit coverage or reimbursement with the codes listed in this guide. Information included in this material was obtained from third-party sources and is accurate as of the time of publication but is subject to change without notice.

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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