

2021 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.

2021 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.

CMS reimburses hospital outpatient departments using APCs. On December 2, 2020, CMS released the 2021 Medicare Final Rule for Hospital Outpatient Payment. Adding to the four IVL codes (C9764 – C9767) created on July 1, 2020, CMS added four additional HCPCS codes to describe tibial and peroneal IVL procedures for a total of eight IVL procedure codes. The long descriptors for HCPCS codes C9764, C9765, C9766, and C9767 were revised by deleting the words “any vessel(s)” and replacing with “lower extremity artery(ies), except tibial/peroneal.” All of these changes are effective January 1, 2021.

The APC assignment of the approved IVL procedure codes is consistent with other treatment alternatives used to treat peripheral arterial diseases including angioplasty, stenting, and/or atherectomy. 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 ²	2021 APC ¹	2021 Medicare Natl Payment ³
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
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
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
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
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
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
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
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

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

² 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>

³ Addendum B of the OPPS Payment System for 2021 is available for download here: <https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-fc>

Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of December 2, 2020 but is subject to change without notice. Amounts do not necessarily 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 the charges associated with the IVL catheter.*

2021 Ambulatory Surgery Center (ASC)

Effective January 1, 2021, Medicare added all 8 IVL codes to the ASC list of approved procedures.

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 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
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
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
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
C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed	\$5,822
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
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
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

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 procedures⁴

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

⁴These ICD-10 procedure codes are available here: <https://www.cms.gov/medicare/icd-10/2021-icd-10-pcs>.

Payment: Medicare 2021 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 ⁵
252	Other Vascular Procedures with MCC	\$21,344
253	Other Vascular Procedures with CC	\$17,056
254	Other Vascular Procedures w/o CC/MCC	\$11,630

Third party reimbursement amounts for specific procedures will vary by payer and by locality. This information is current as of September 2, 2020 but is subject to change without notice. Amounts do not necessarily 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.

⁵All 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.