Penumbra

2026 Vascular Reimbursement Guide

Mechanical/Aspiration Thrombectomy and Embolization

Reimbursement Inquiries: reimbursement@penumbrainc.com

For USA only.

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Indigo® System CAVT™ Computer Assisted Vacuum Thrombectomy

Ruby® Embolization Platform

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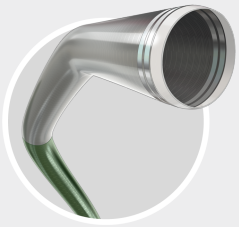
Indigo System · *CAVT*

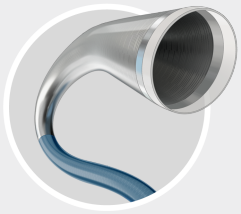
Computer Assisted Vacuum Thrombectomy

CAT™**16**

Lightning Bolt **6X with TraX**™



Lightning Bolt **12**



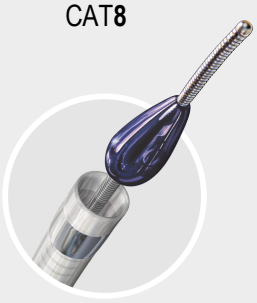
Lightning Bolt **7**

Lightning **12**

Lightning **7**

CAT**8**

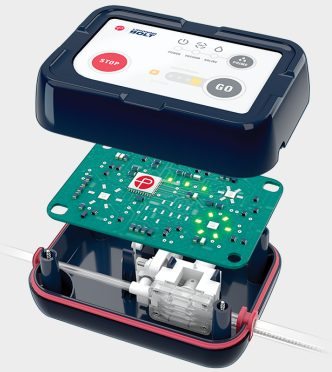
CAT**D**



CAT**6**

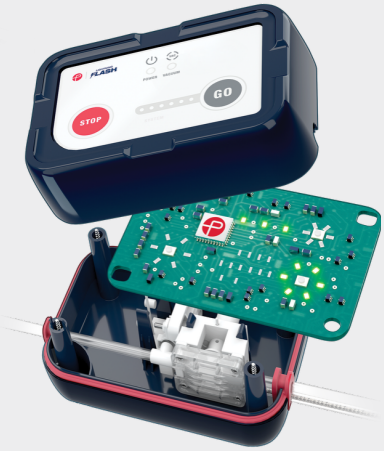
CAT **RX**

LIGHTNING BOLT®



ELEMENT™
Vascular Access System

LIGHTNING FLASH® 3.0



Select +™
Catheter

Penumbra ENGINE®

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The reimbursement information is provided for illustrative purposes only and does not constitute reimbursement or legal advice. Providers are responsible for consulting payers and reimbursement specialists regarding coding, coverage and reimbursement and for submitting appropriate coding and information for services provided.

Coding

Mechanical/Aspiration Thrombectomy Coding Notes

- Code(s) for selective catheter placement(s), diagnostic imaging studies, and other percutaneous interventions (e.g., transluminal balloon angioplasty, stent placement) may be separately reportable.
- Current Procedural Terminology (CPT®) codes 37184–37188 specifically include intraprocedural fluoroscopic guidance and intraprocedural injection(s) of a thrombolytic agent. DO NOT report CPT 37187-37188 in conjunction with CPT 76000 or 96375.
- Effective January 1, 2017, prior moderate sedation codes CPT 99143–99150 have been deleted and moderate sedation service have been unbundled from many interventional services. To receive full payment, providers performing moderate sedation for mechanical thrombectomy (CPT 37184–37188) should now separately report new moderate sedation codes (CPT 99151– 99157) with proper medical documentation.
- CPT code 37187 is used to report venous mechanical thrombectomy, either by itself or in conjunction with other percutaneous interventions. In certain circumstances, it may be necessary to repeat venous mechanical thrombectomy during the course of thrombolytic therapy. CPT code 37188 is used to report “repeat” venous mechanical thrombectomy on a subsequent day during the course of pharmacological thrombolysis.
- Primary mechanical thrombectomy is reported per vascular family using CPT 37184 for the initial vessel treated and CPT 37185 for second or all subsequent vessel(s) within the same vascular family. To report mechanical thrombectomy of an additional vascular family treated through a separate access site, use an appropriate modifier in conjunction with CPT 37184–37185.
- DO NOT report CPT 37184–37185 for mechanical thrombectomy performed for the retrieval of short segments of thrombus or embolus evident during other percutaneous interventional procedures. Secondary mechanical thrombectomy is reported using CPT 37186.
- DO NOT report CPT 37186 in conjunction with CPT 37184–37185.

References & Sources

- CPT Editorial Panel, *Current Procedure Terminology 2026 Professional Edition* codebook 4th edition, American Medical Association, Chicago, IL, 2025

Physician and Outpatient Facility Coding and Payment

National Medicare Reimbursement for Arterial Percutaneous Mechanical Thrombectomy

		Ambulatory Surgery Center (ASC)	Hospital Outpatient Department (HOPD)		Physician Services*		
CPT® Code	Description	Facility Payment	APC	Facility Payment	Fee When Service is Performed in the HOPD or Inpatient Setting	Fee When Service is Performed in the Physician Office	Work RVU
37184	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	**$12,459.00**	**5194**	**$18,729.00**	**$377.00**	**$1,631.00**	**8.20**
(+) 37185	Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (Add-on code: list separately in addition to code for primary mechanical thrombectomy procedure)	$ – (Packaged service/ item; no separate payment made)	**N/A**	$ – (Items and services are packaged into APC rate)	**$142.00**	**$459.00**	**3.20**
(+) 37186	Secondary percutaneous transluminal thrombectomy (e.g., nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (Add-on code: list separately in addition to code for primary procedure)	$ – (Packaged service/ item; no separate payment made)	**N/A**	$ – (Items and services are packaged into APC rate)	**$218.00**	**$1158.00**	**4.80**

* The 2026 physician payment rates and RVUs are reflective of the Calendar Year 2026 Medicare Physician Fee Schedule (MPFS) Final Rule, which was published in Federal Register, Vol. 90, No. 212, Wednesday, November 5, 2025. Payments listed are national unadjusted fee schedule rates and are subject to change due to CMS' quarterly fee schedule updates and correction notices. Actual payments may vary based on locality and setting of care.

Physician payment rates shown are based on RBRVS relative weights per CPT code × 2026 Qualifying APM conversion factor of $33.57.

This list may not be comprehensive or complete. These procedures may be subject to the CMS multiple procedure reduction rule. When applicable, a payment reduction of 50% is applied to all payment amounts except the procedure with the greatest RVUs, which is paid at 100% unless exempt by CPT instructions or payer policy.

Physician fees for your local area can be found at the following CMS link: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

References & Sources

- CPT Editorial Panel, *Current Procedure Terminology 2026 Professional Edition* codebook 4th edition, American Medical Association, Chicago, IL, 2025
- Centers for Medicare and Medicaid Services, Calendar Year 2026 Outpatient Prospective Payment System (OPPS/ASC) Final Rule CMS-1834-FC, Federal Register / Vol. 90, No. 225 / Tuesday, November 25, 2025
- Centers for Medicare and Medicaid Services, Calendar Year 2026 Medicare Physician Fee Schedule (MPFS) Final Rule CMS-1832-F, Federal Register, Vol. 90 No. 212, Wednesday, November 5, 2025

Physician and Outpatient Facility Coding and Payment

National Medicare Reimbursement for Venous Percutaneous Mechanical Thrombectomy

		Ambulatory Surgery Center (ASC)	Hospital Outpatient Department (HOPD)		Physician Services*		
CPT® Code	Description	Facility Payment	APC	Facility Payment	Fee When Service Is Performed in the HOPD or Inpatient Setting	Fee When Service Is Performed in the Physician Office	Work RVU
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	**$7,800.37**	**5193**	**$11,340.57**	**$346.00**	**$1,601.00**	**7.78**
37188	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	**$2,665.67**	**5183**	**$3,147.50**	**$251.00**	**$1,378.00**	**5.46**

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Physician and Outpatient Facility Coding and Payment

National Medicare Reimbursement for Dialysis Circuit Mechanical Thrombectomy

		Ambulatory Surgery Center (ASC)	Hospital Outpatient Department (HOPD)		Physician Services*		
CPT® Code	Description	Facility Payment	APC	Facility Payment	Fee When Service Is Performed in the HOPD or Inpatient Setting	Fee When Service Is Performed in the Physician Office	Work RVU
36901	Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiologic supervision and interpretation and image documentation and report	**$563.00**	**5182**	**$1,608.00**	**$148.00**	**$687.00**	**3.28**
36904	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	**$3,621.00**	**5192**	**$5,815.00**	**$321.00**	**$1,741.00**	**7.31**
36905	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	**$6,895.00**	**5193**	**$11,794.00**	**$386.00**	**$2,206.00**	**8.78**
36906	Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of an intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation to perform the stenting and all angioplasty within the peripheral dialysis circuit	**$12,365.00**	**5194**	**$18,729.00**	**$446.00**	**$5,915.00**	**10.16**

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National Medicare Reimbursement for Percutaneous Transluminal Coronary Mechanical Thrombectomy

2026 Update to CPT code 92973: The procedure description now includes “aspiration” to clarify definition of “mechanical.”

CPT code 92973 is an add-on code to a primary percutaneous coronary intervention (PCI), to use when reporting a thrombectomy being performed in conjunction with one of the interventions described by the CPT codes: 92920, 92924, 92928, 92930, 92933, 92937, 92941, 92943, 92975, 93454-93461, 93563, 93564.

Do not report 92973 for non-mechanical aspiration thrombectomy.

		Ambulatory Surgery Center (ASC)	Hospital Outpatient Department (HOPD)		Physician Services*		
CPT® Code	Description	Facility Payment	APC	Facility Payment	Fee When Service Is Performed in the HOPD or Inpatient Setting	Fee When Service Is Performed in the Physician Office	Work RVU
(+) 92973	Percutaneous transluminal coronary mechanical aspiration thrombectomy (Add-on code: list separately in addition to code for primary procedure)	**$ –** (Surgical procedure excluded from payment under ASC)	**N/A**	**$ –** (Items and services are packaged into primary procedure rate)	**$82.00**	**$ –** (Surgical procedure not performed in office setting)	**1.71**
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery and/or its branch(es)	**$3,849.00**	**5192**	**$5,815.00**	**$388.00**	**N/A**	**8.14**
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery and/or its branch(es); 1 lesion involving 1 or more coronary segments	**$7,309.00**	**5193**	**$11,794.00**	**$464.00**	**N/A**	**9.75**
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery and/or its branch(es)	**$ 8,448.00**	**5193**	**$11,794.00**	**$470.00**	**N/A**	**9.88**
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery and/or its branch(es)	**$12,965.00**	**5194**	**$18,729.00**	**$554.00**	**N/A**	**11.64**
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 branches	**$7,443.00**	**5193**	**$11,794.00**	**$524.00**	**N/A**	**11.02**
92943	Percutaneous transluminal revascularization 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	**$7,883.00**	**5193**	**$11,794.00**	**$634.00**	**N/A**	**13.35**

As part of the Indigo Aspiration System, the Indigo CAT RX Aspiration Catheters and Indigo Separator 4 are indicated for the removal of fresh, soft emboli and thrombi from vessels in the coronary and peripheral vasculature.

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Modifier 59 - Distinct Procedural Service

- Modifier 59 is used to identify procedures/services, other than Evaluation and Management (E/M) services, not normally reported together, but are appropriate under the specific circumstances. These circumstances may include:
  - different session or patient encounter (including different patient encounters on the same day)
  - different procedure or surgery distinct from primary procedure being reported
  - different anatomic sites (such as different vascular territories)
  - separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician
  - timed services (e.g., codes for which unit of service is a measure of time, such as per hour) provided during the same encounter only when they are performed sequentially
- Modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes. For example, if procedures are performed on different sides of the body, modifiers RT or LT are more appropriate than modifier 59.

Examples of appropriate uses of modifier 59 and National Correct Coding Initiative (NCCI) guidelines:

Example	NCCI Guidelines
Failed percutaneous vascular procedure is followed by an open procedure by the same physician at the same patient encounter.	Only the HCPCS/CPT® code for the completed procedure may be reported.
Percutaneous procedure is performed on one lesion with a similar open procedure performed on a separate lesion.	The HCPCS/CPT code for the percutaneous procedure may be reported with modifier 59 only if the lesions are in distinct and separate, anatomically defined vessels.
Similar open and percutaneous procedures are performed on different lesions in the same anatomically defined vessel	Only the open procedure may be reported.
A diagnostic procedure is performed preceding a therapeutic procedure and the diagnostic procedure is the basis for performing the therapeutic procedure.	Modifier 59 may be reported with a procedure code for diagnostic angiography that has not been previously performed and is not considered an integral component of the primary procedure or service.
A diagnostic procedure is performed subsequent to a completed therapeutic procedure.	Modifier 59 may be reported for a diagnostic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure.

References & Sources

- CPT Editorial Panel, *Current Procedure Terminology 2026 Professional Edition* codebook 4th edition, American Medical Association, Chicago, IL, 2025
- Centers for Medicare and Medicaid Services, Calendar Year 2026 Outpatient Prospective Payment System (OPPS/ASC) Final Rule CMS-1834-FC, Federal Register / Vol. 90, No. 225 / Tuesday, November 25, 2025
- Modifier 59, MLN1783722 Fact Sheet March 2022 Proper Use of Modifiers 59 & –X{EPSU}. https://www.cms.gov/files/document/mln1783722-proper-use-modifiers-59-xepsu.pdf

Computer-Aided Mechanical Aspiration Thrombectomy ICD-10-PCS Procedure Codes (Inpatient Setting)

- Effective 10/1/2021, there are new ICD-10-PCS codes for Computer-Aided Mechanical Aspiration Thrombectomy. These can be used to report the use of the Indigo® System Aspiration Catheters.

The procedure codes listed below are examples of appropriate codes to use when reporting the different elements of mechanical/aspiration thrombectomy procedures in an inpatient setting. This is not a complete or exhaustive list; there may be additional codes that could be used. AMA coding instructions state that providers should select the code that most accurately describes the procedure or service performed and should avoid using an approximate code if a more specific one exists. It is the responsibility of the provider to determine the appropriate coding when billing a claim.

ICD-10-PCS Coding Note: If a thrombus extends through two distinct tubular body parts and the thrombectomy is performed on a continuous section of one vessel into another, code the body part value corresponding to the farthest anatomical site from the point of entry.

ICD-10-PCS Computer-Aided Mechanical Aspiration Thrombectomy (CAVT) Coding (Inpatient)

X2CP3T7	Extirpation of Matter from Abdominal Aorta using Computer-aided Mechanical Aspiration, Percutaneous Approach
X2CQ3T7	Extirpation of Matter from Upper Extremity Vein, Right using Computer-aided Mechanical Aspiration, Percutaneous Approach
X2CR3T7	Extirpation of Matter from Upper Extremity Vein, Left using Computer-aided Mechanical Aspiration, Percutaneous Approach
X2CS3T7	Extirpation of Matter from Lower Extremity Artery, Right using Computer-aided Mechanical Aspiration, Percutaneous Approach
X2CT3T7	Extirpation of Matter from Lower Extremity Artery, Left using Computer-aided Mechanical Aspiration, Percutaneous Approach
X2CU3T7	Extirpation of Matter from Lower Extremity Vein, Right using Computer-aided Mechanical Aspiration, Percutaneous Approach
X2CV3T7	Extirpation of Matter from Lower Extremity Vein, Left using Computer-aided Mechanical Aspiration, Percutaneous Approach
X2CY3T7	Extirpation of Matter from Great Vessel using Computer-aided Mechanical Aspiration, Percutaneous Approach

ICD-10-PCS Arterial Mechanical Thrombectomy Procedure Coding (Inpatient)

02CP3ZZ	Extirpation of Matter from Pulmonary Trunk, Percutaneous Approach
02CQ3ZZ	Extirpation of Matter from Right Pulmonary Artery, Percutaneous Approach
02CR3ZZ	Extirpation of Matter from Left Pulmonary Artery, Percutaneous Approach
03C33ZZ	Extirpation of Matter from Right Subclavian Artery, Percutaneous Approach
03C43ZZ	Extirpation of Matter from Left Subclavian Artery, Percutaneous Approach
03C53ZZ	Extirpation of Matter from Right Axillary Artery, Percutaneous Approach
03C63ZZ	Extirpation of Matter from Left Axillary Artery, Percutaneous Approach
03C73ZZ	Extirpation of Matter from Right Brachial Artery, Percutaneous Approach
03C83ZZ	Extirpation of Matter from Left Brachial Artery, Percutaneous Approach
03C93ZZ	Extirpation of Matter from Right Ulnar Artery, Percutaneous Approach
03CA3ZZ	Extirpation of Matter from Left Ulnar Artery, Percutaneous Approach
03CB3ZZ	Extirpation of Matter from Right Radial Artery, Percutaneous Approach
03CC3ZZ	Extirpation of Matter from Left Radial Artery, Percutaneous Approach
03CY3ZZ	Extirpation of Matter from Upper Artery, Percutaneous Approach

References & Sources

- CPT Editorial Panel, *Current Procedure Terminology 2026 Professional Edition* codebook 4th edition, American Medical Association, Chicago, IL, 2025
- Centers for Medicare and Medicaid Services, ICD-10 Procedure Coding System (ICD-10-PCS) 2026 Tables and Index, https://www.cms.gov/medicare/coding-billing/icd-10-codes https://www.cms.gov/medicare/coding-billing/icd-10-codes

ICD-10-PCS Arterial Mechanical Thrombectomy Procedure Coding (Inpatient) *(continued)*

04C53ZZ	Extirpation of Matter from Superior Mesenteric Artery, Percutaneous Approach
04C93ZZ	Extirpation of Matter from Right Renal Artery, Percutaneous Approach
04CA3ZZ	Extirpation of Matter from Left Renal Artery, Percutaneous Approach
04CB3ZZ	Extirpation of Matter from Inferior Mesenteric Artery, Percutaneous Approach
04CC3ZZ	Extirpation of Matter from Right Common Iliac Artery, Percutaneous Approach
04CD3ZZ	Extirpation of Matter from Left Common Iliac Artery, Percutaneous Approach
04CE3ZZ	Extirpation of Matter from Right Internal Iliac Artery, Percutaneous Approach
04CF3ZZ	Extirpation of Matter from Left Internal Iliac Artery, Percutaneous Approach
04CH3ZZ	Extirpation of Matter from Right External Iliac Artery, Percutaneous Approach
04CJ3ZZ	Extirpation of Matter from Left External Iliac Artery, Percutaneous Approach
04CK3ZZ	Extirpation of Matter from Right Femoral Artery, Percutaneous Approach
04CL3ZZ	Extirpation of Matter from Left Femoral Artery, Percutaneous Approach
04CM3ZZ	Extirpation of Matter from Right Popliteal Artery, Percutaneous Approach
04CN3ZZ	Extirpation of Matter from Left Popliteal Artery, Percutaneous Approach
04CP3ZZ	Extirpation of Matter from Right Anterior Tibial Artery, Percutaneous Approach
04CQ3ZZ	Extirpation of Matter from Left Anterior Tibial Artery, Percutaneous Approach
04CR3ZZ	Extirpation of Matter from Right Posterior Tibial Artery, Percutaneous Approach
04CS3ZZ	Extirpation of Matter from Left Posterior Tibial Artery, Percutaneous Approach
04CT3ZZ	Extirpation of Matter from Right Peroneal Artery, Percutaneous Approach
04CU3ZZ	Extirpation of Matter from Left Peroneal Artery, Percutaneous Approach
04CV3ZZ	Extirpation of Matter from Right Foot Artery, Percutaneous Approach
04CW3ZZ	Extirpation of Matter from Left Foot Artery, Percutaneous Approach
04CY3ZZ	Extirpation of Matter from Lower Artery, Percutaneous Approach

ICD-10-PCS Venous Mechanical Thrombectomy Procedure Coding (Inpatient)

02CS3ZZ	Extirpation of Matter from Right Pulmonary Vein, Percutaneous Approach
02CT3ZZ	Extirpation of Matter from Left Pulmonary Vein, Percutaneous Approach
02CV3ZZ	Extirpation of Matter from Superior Vena Cava, Percutaneous Approach
05C53ZZ	Extirpation of Matter from Right Subclavian Vein, Percutaneous Approach
05C63ZZ	Extirpation of Matter from Left Subclavian Vein, Percutaneous Approach
05C73ZZ	Extirpation of Matter from Right Axillary Vein, Percutaneous Approach
05C83ZZ	Extirpation of Matter from Left Axillary Vein, Percutaneous Approach
05C93ZZ	Extirpation of Matter from Right Brachial Vein, Percutaneous Approach
05CA3ZZ	Extirpation of Matter from Left Brachial Vein, Percutaneous Approach
05CB3ZZ	Extirpation of Matter from Right Basilic Vein, Percutaneous Approach
05CC3ZZ	Extirpation of Matter from Left Basilic Vein, Percutaneous Approach
05CD3ZZ	Extirpation of Matter from Right Cephalic Vein, Percutaneous Approach
05CF3ZZ	Extirpation of Matter from Left Cephalic Vein, Percutaneous Approach
06C93ZZ	Extirpation of Matter from Right Renal Vein, Percutaneous Approach
06CB3ZZ	Extirpation of Matter from Left Renal Vein, Percutaneous Approach

ICD-10-PCS Venous Mechanical Thrombectomy Procedure Coding (Inpatient) *(continued)*

06CC3ZZ	Extirpation of Matter from Right Common Iliac Vein, Percutaneous Approach
06CD3ZZ	Extirpation of Matter from Left Common Iliac Vein, Percutaneous Approach
06CF3ZZ	Extirpation of Matter from Right External Iliac Vein, Percutaneous Approach
06CG3ZZ	Extirpation of Matter from Left External Iliac Vein, Percutaneous Approach
06CH3ZZ	Extirpation of Matter from Right Hypogastric Vein, Percutaneous Approach
06CJ3ZZ	Extirpation of Matter from Left Hypogastric Vein, Percutaneous Approach
06CM3ZZ	Extirpation of Matter from Right Femoral Vein, Percutaneous Approach
06CN3ZZ	Extirpation of Matter from Left Femoral Vein, Percutaneous Approach
06CP3ZZ	Extirpation of Matter from Right Greater Saphenous Vein, Percutaneous Approach
06CQ3ZZ	Extirpation of Matter from Left Greater Saphenous Vein, Percutaneous Approach
06CR3ZZ	Extirpation of Matter from Right Lesser Saphenous Vein, Percutaneous Approach
06CS3ZZ	Extirpation of Matter from Left Lesser Saphenous Vein, Percutaneous Approach
06CT3ZZ	Extirpation of Matter from Right Foot Vein, Percutaneous Approach
06CV3ZZ	Extirpation of Matter from Left Foot Vein, Percutaneous Approach
06CY3ZZ	Extirpation of Matter from Lower Vein, Percutaneous Approach

Relevant Medicare Severity Diagnosis Related Groups: Arterial & Venous Procedures

MS-DRG	Description	2026 National Medicare Payment
163	Major Chest Procedures w MCC	**$32,613.00**
164	Major Chest Procedures w CC	**$18,367.00**
165	Major Chest Procedures without CC/MCC	**$13,929.00**
252	Other Vascular Procedures w/ MCC	**$25,384.00**
253	Other Vascular Procedures w/ CC	**$18,888.00**
254	Other Vascular Procedures without CC/MCC	**$12,965.00**
270	Other Major Cardiovascular Procedures w/ MCC	**$38,394.00**
271	Other Major Cardiovascular Procedures w/ CC	**$25,878.00**
272	Other Major Cardiovascular Procedures without CC/MCC	**$18,578.00**

2026 Inpatient rates in effect from October 1, 2025 – September 30, 2026
(M)CC = (major) complications and/or comorbidities. Complete list available at:
https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page#DataFiles

Rates reflect FY 2026 National Medicare payment rates for hospitals submitting quality data and meaningful EHR users. Hospitals that do not submit quality data or are not meaningful EHR users may see decreased payment rates.

Charges for the Indigo System may be assigned to the following revenue codes:

- 0270 Medical/surgical supply
- 0272 Sterile supply
- 0279 Other supplies/devices

HCPCS

Product	Suggested HCPCS
Penumbra Aspiration Catheters	**C1757** – Catheter, thrombectomy/embolectomy
Penumbra Aspiration Catheters with Lightning	**C1757** – Catheter, thrombectomy/embolectomy
Penumbra Separators (with or without Separator™)	NONE
Sterile Aspiration Tubing	NONE
Non-Sterile System Supplies	NONE
Penumbra Sheath	**C1894** – Introducer/Sheath

HCPCS Codes are not separately reimbursed. However, they may be used for reporting and other administrative processes.

References & Sources

- Centers for Medicare and Medicaid Services, Fiscal Year 2026, Hospital Inpatient Prospective Payment System (IPPS) Final Rule, CMS-1833-F, Federal Register/ Vol. 90, No. 147/ Monday, August 4, 2025.
- Centers for Medicare and Medicaid Services, ICD-10 Procedure Coding System (ICD-10-PCS) 2026 Tables and Index, https://www.cms.gov/medicare/coding-billing/icd-10-codes
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System (HCPCS) Quarterly Update, effective January 2026,


Ruby®
Embolization
Platform

Physician and Outpatient Coding and Payment

Coding

Vascular Embolization Coding Notes

Effective January 1, 2017, prior moderate sedation CPT® codes 99143-99150 have been deleted, and moderate sedation services have been unbundled from many interventional services. To receive full payment, providers performing moderate sedation for vascular embolization (CPT codes 37241-37244) should now separately report new moderate sedation codes (CPT codes 99151-99157) with proper medical documentation.

CPT codes 37241–37244 include all radiological supervision and interpretation, intra-procedural guidance and road-mapping, and imaging necessary to document completion of the procedure.

Selective catheterization and diagnostic angiography in untreated vessels may be separately reportable using appropriate modifiers.

The procedure codes listed below are examples of appropriate codes to use when reporting the different elements of neurovascular coil embolization procedures in an inpatient setting. This is not a complete or exhaustive list; there may be additional codes that could be used. AMA coding instructions state that providers should select the code that most accurately describes the procedure or service performed and should avoid using an approximate code if a more specific one exists. It is the responsibility of the provider to determine the appropriate coding when billing a claim.

National Medicare Reimbursement for Vascular Embolization

		Hospital Outpatient Department (HOPD)		Ambulatory Surgical Center (ASC)	Physician Services		
CPT® Code	Description	APC	Facility Payment	Facility Payment	Fee When Service Is Performed in the HOPD or Inpatient Setting	Fee When Service Is Performed in the Physician Office	Work RVU
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (e.g., congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)	5193	$11,795.00	$6,867.00	$371.00	$4,394.00	8.53
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (e.g., congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)	5194	$18,729.00	$11,449.00	$414.00	$6,676.00	9.56
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	5193	$11,795.00	$5,419.00	$483.00	$7,996.00	11.45
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	5193	$11,795.00	$6,867.00	$567.00	$6,107.00	13.41
(+) 36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (Add-on code: list separately in addition to code for primary procedure)	N/A	$ – (Items and services are packaged into APC rate for primary procedure)	N/A	$176.00	$1,817.00	4.02

References & Sources

- CPT Editorial Panel, *Current Procedure Terminology 2026 Professional Edition* codebook 4th edition, American Medical Association, Chicago, IL, 2025

Reimbursement Inquiries: reimbursement@penumbrainc.com

Physician and Outpatient Coding and Payment

National Medicare Reimbursement for Selective Catheterization

		Hospital Outpatient Department (HOPD)		Ambulatory Surgical Center (ASC)	Physician Services*		
CPT® Code	Description	APC	Facility Payment	Facility Payment	Fee When Service Is Performed in the HOPD or Inpatient Setting	Fee When Service Is Performed in the Physician Office	Work RVU
36011	Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$137.00	$782.00	3.06
36012	Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$154.00	$809.00	3.42
36013	Introduction of catheter, right heart or main pulmonary artery	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$113.00	$776.00	2.46
36014	Selective catheter placement, left or right pulmonary artery	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$131.00	$751.00	2.94
36015	Selective catheter placement, segmental or subsegmental pulmonary artery	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$149.00	$795.00	3.42
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$188.00	$1,065.00	4.07
36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$244.00	$1,081.00	5.14
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$302.00	$1,976.00	6.13
(+) 36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (Add-on code: list in addition to code for initial second or third order vessel as appropriate)	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$47.00	$230.00	0.98
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$207.00	$1,199.00	4.53
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$222.00	$798.00	4.89
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	N/A	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$ – (Items and services are packaged into APC Rate for Primary Procedure)	$259.00	$1,356.00	5.89

* The 2026 physician payment rates and RVUs are reflective of the Calendar Year 2026 Medicare Physician Fee Schedule (MPFS) Final Rule, which was published in Federal Register, Vol. 90, No. 212, Wednesday, November 5, 2025. Payments listed are national unadjusted fee schedule rates and are subject to change due to CMS' quarterly fee schedule updates and correction notices. Actual payments may vary based on locality and setting of care.

Physician payment rates shown are based on RBRVS relative weights per CPT code × 2026 Qualifying APM conversion factor of $33.57

This list may not be comprehensive or complete. These procedures may be subject to the CMS multiple procedure reduction rule. When applicable, a payment reduction of 50% is applied to all payment amounts except the procedure with the greatest RVUs, which is paid at 100% unless exempt by CPT instructions or payer policy.

Physician fees for your local area can be found at the following CMS link: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

National Medicare Reimbursement for Selective Catheterization *(continued)*

(+) 36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (Add-on code: list in addition to code for initial second or third order vessel as appropriate)	**N/A**	**$ –** (Items and services are packaged into APC Rate for Primary Procedure)	**$ –** (Items and services are packaged into APC Rate for Primary Procedure)	**$42.00**	**$113.00**	**0.98**
36251	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	**5183**	**$3,226.00**	**$ –** (Items and services are packaged into APC Rate for Primary Procedure)	**$225.00**	**$1,227.00**	**4.97**
36252	Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	**5183**	**$3,226.00**	**$ –** (Items and services are packaged into APC Rate for Primary Procedure)	**$310.00**	**$1,344.00**	**6.57**
36253	Superselective catheter placement (one or more second order or higher renal artery branches), renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral	**5184**	**$5,685.00**	**$ –** (Items and services are packaged into APC Rate for Primary Procedure)	**$305.00**	**$1,898.00**	**7.12**
36254	Superselective catheter placement (one or more second order or higher renal artery branches), renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral	**5183**	**$3,226.00**	**$ –** (Items and services are packaged into APC Rate for Primary Procedure)	**$363.00**	**$1,910.00**	**7.70**

* The 2026 physician payment rates and RVUs are reflective of the Calendar Year 2026 Medicare Physician Fee Schedule (MPFS) Final Rule, which was published in Federal Register, Vol. 90, No. 212, Wednesday, November 5, 2025. Payments listed are national unadjusted fee schedule rates and are subject to change due to CMS' quarterly fee schedule updates and correction notices. Actual payments may vary based on locality and setting of care.

Physician payment rates shown are based on RBRVS relative weights per CPT code × 2026 Qualifying APM conversion factor of $33.57

This list may not be comprehensive or complete. These procedures may be subject to the CMS multiple procedure reduction rule. When applicable, a payment reduction of 50% is applied to all payment amounts except the procedure with the greatest RVUs, which is paid at 100% unless exempt by CPT instructions or payer policy.

Physician fees for your local area can be found at the following CMS link: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

References & Sources

- CPT Editorial Panel, Current Procedure Terminology 2026 Professional Edition codebook 4th edition, American Medical Association, Chicago, IL, 2025
- Centers for Medicare and Medicaid Services, Calendar Year 2026 Outpatient Prospective Payment System (OPPS/ASC) Final Rule CMS-1834-FC, Federal Register / Vol. 90, No. 225 / Tuesday, November 25, 2025
- Centers for Medicare and Medicaid Services, Calendar Year 2026 Medicare Physician Fee Schedule (MPFS) Final Rule CMS-1832-F, Federal Register, Vol. 90 No. 212, Wednesday, November 5, 2025

Vascular Embolization ICD-10-PCS Procedure Codes (Inpatient Setting)

The procedure codes listed below are examples of appropriate codes to use when reporting the different elements of vascular embolization procedures in an inpatient setting. This is not a complete or exhaustive list; there may be additional codes that could be used. AMA coding instructions state that providers should select the code that most accurately describes the procedure or service performed and should avoid using an approximate code if a more specific one exists. It is the responsibility of the provider to determine the appropriate coding when billing a claim.

ICD-10-PCS Arterial Procedure Coding

03V03DZ	Restriction of Right Internal Mammary Artery with Intraluminal Device, Percutaneous Approach
03V13DZ	Restriction of Left Internal Mammary Artery with Intraluminal Device, Percutaneous Approach
03V23DZ	Restriction of Innominate Artery with Intraluminal Device, Percutaneous Approach
03V33DZ	Restriction of Right Subclavian Artery with Intraluminal Device, Percutaneous Approach
03V43DZ	Restriction of Left Subclavian Artery with Intraluminal Device, Percutaneous Approach
03V53DZ	Restriction of Right Axillary Artery with Intraluminal Device, Percutaneous Approach
03V63DZ	Restriction of Left Axillary Artery with Intraluminal Device, Percutaneous Approach
03V73DZ	Restriction of Right Brachial Artery with Intraluminal Device, Percutaneous Approach
03V83DZ	Restriction of Left Brachial Artery with Intraluminal Device, Percutaneous Approach
03V93DZ	Restriction of Right Ulnar Artery with Intraluminal Device, Percutaneous Approach
03VA3DZ	Restriction of Left Ulnar Artery with Intraluminal Device, Percutaneous Approach
03VB3DZ	Restriction of Right Radial Artery with Intraluminal Device, Percutaneous Approach
03VC3DZ	Restriction of Left Radial Artery with Intraluminal Device, Percutaneous Approach
03VD3DZ	Restriction of Right-Hand Artery with Intraluminal Device, Percutaneous Approach
03VF3DZ	Restriction of Left-Hand Artery with Intraluminal Device, Percutaneous Approach
03VR3DZ	Restriction of Face Artery with Intraluminal Device, Percutaneous Approach
03VS3DZ	Restriction of Right Temporal Artery with Intraluminal Device, Percutaneous Approach
03VT3DZ	Restriction of Left Temporal Artery with Intraluminal Device, Percutaneous Approach
03VU3DZ	Restriction of Right Thyroid Artery with Intraluminal Device, Percutaneous Approach
03VV3DZ	Restriction of Left Thyroid Artery with Intraluminal Device, Percutaneous Approach
03VY3DZ	Restriction of Upper Artery with Intraluminal Device, Percutaneous Approach
03L03DZ	Occlusion of Right Internal Mammary Artery with Intraluminal Device, Percutaneous Approach
03L13DZ	Occlusion of Left Internal Mammary Artery with Intraluminal Device, Percutaneous Approach
03L23DZ	Occlusion of Innominate Artery with Intraluminal Device, Percutaneous Approach
03L33DZ	Occlusion of Right Subclavian Artery with Intraluminal Device, Percutaneous Approach
03L43DZ	Occlusion of Left Subclavian Artery with Intraluminal Device, Percutaneous Approach
03L53DZ	Occlusion of Right Axillary Artery with Intraluminal Device, Percutaneous Approach
03L63DZ	Occlusion of Left Axillary Artery with Intraluminal Device, Percutaneous Approach
03L73DZ	Occlusion of Right Brachial Artery with Intraluminal Device, Percutaneous Approach

References & Sources

- CPT Editorial Panel, *Current Procedure Terminology 2026 Professional Edition* codebook 4th edition, American Medical Association, Chicago, IL, 2025
- Centers for Medicare and Medicaid Services, ICD-10 Procedure Coding System (ICD-10-PCS) 2026 Tables and Index, https://www.cms.gov/medicare/coding-billing/icd-10-codes https://www.cms.gov/medicare/coding-billing/icd-10-codes

ICD-10-PCS Arterial Procedure Coding *(continued)*

03L83DZ	Occlusion of Left Brachial Artery with Intraluminal Device, Percutaneous Approach
03L93DZ	Occlusion of Right Ulnar Artery with Intraluminal Device, Percutaneous Approach
03LA3DZ	Occlusion of Left Ulnar Artery with Intraluminal Device, Percutaneous Approach
03LB3DZ	Occlusion of Right Radial Artery with Intraluminal Device, Percutaneous Approach
03LC3DZ	Occlusion of Left Radial Artery with Intraluminal Device, Percutaneous Approach
03LD3DZ	Occlusion of Right-Hand Artery with Intraluminal Device, Percutaneous Approach
03LF3DZ	Occlusion of Left-Hand Artery with Intraluminal Device, Percutaneous Approach
03LR3DZ	Occlusion of Face Artery with Intraluminal Device, Percutaneous Approach
03LS3DZ	Occlusion of Right Temporal Artery with Intraluminal Device, Percutaneous Approach
03LT3DZ	Occlusion of Left Temporal Artery with Intraluminal Device, Percutaneous Approach
03LU3DZ	Occlusion of Right Thyroid Artery with Intraluminal Device, Percutaneous Approach
03LV3DZ	Occlusion of Left Thyroid Artery with Intraluminal Device, Percutaneous Approach
03LY3DZ	Occlusion of Upper Artery with Intraluminal Device, Percutaneous Approach
04V03DZ	Restriction of Abdominal Aorta with Intraluminal Device, Percutaneous Approach
04V13DZ	Restriction of Celiac Artery with Intraluminal Device, Percutaneous Approach
04V23DZ	Restriction of Gastric Artery with Intraluminal Device, Percutaneous Approach
04V33DZ	Restriction of Hepatic Artery with Intraluminal Device, Percutaneous Approach
04V43DZ	Restriction of Splenic Artery with Intraluminal Device, Percutaneous Approach
04V53DZ	Restriction of Superior Mesenteric Artery with Intraluminal Device, Percutaneous Approach
04V63DZ	Restriction of Right Colic Artery with Intraluminal Device, Percutaneous Approach
04V73DZ	Restriction of Left Colic Artery with Intraluminal Device, Percutaneous Approach
04V83DZ	Restriction of Middle Colic Artery with Intraluminal Device, Percutaneous Approach
04V93DZ	Restriction of Right Renal Artery with Intraluminal Device, Percutaneous Approach
04VA3DZ	Restriction of Left Renal Artery with Intraluminal Device, Percutaneous Approach
04VB3DZ	Restriction of Inferior Mesenteric Artery with Intraluminal Device, Percutaneous Approach
04VC3DZ	Restriction of Right Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04VD3DZ	Restriction of Left Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04VE3DZ	Restriction of Right Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04VF3DZ	Restriction of Left Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04VH3DZ	Restriction of Right External Iliac Artery with Intraluminal Device, Percutaneous Approach
04VJ3DZ	Restriction of Left External Iliac Artery with Intraluminal Device, Percutaneous Approach
04VK3DZ	Restriction of Right Femoral Artery with Intraluminal Device, Percutaneous Approach
04VL3DZ	Restriction of Left Femoral Artery with Intraluminal Device, Percutaneous Approach
04VM3DZ	Restriction of Right Popliteal Artery with Intraluminal Device, Percutaneous Approach
04VN3DZ	Restriction of Left Popliteal Artery with Intraluminal Device, Percutaneous Approach
04VP3DZ	Restriction of Right Anterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04VQ3DZ	Restriction of Left Anterior Tibial Artery with Intraluminal Device, Percutaneous Approach

ICD-10-PCS Arterial Procedure Coding *(continued)*

04VR3DZ	Restriction of Right Posterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04VS3DZ	Restriction of Left Posterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04VT3DZ	Restriction of Right Peroneal Artery with Intraluminal Device, Percutaneous Approach
04VU3DZ	Restriction of Left Peroneal Artery with Intraluminal Device, Percutaneous Approach
04VV3DZ	Restriction of Right Foot Artery with Intraluminal Device, Percutaneous Approach
04VW3DZ	Restriction of Left Foot Artery with Intraluminal Device, Percutaneous Approach
04VY3DZ	Restriction of Lower Artery with Intraluminal Device, Percutaneous Approach
04L13DZ	Occlusion of Celiac Artery with Intraluminal Device, Percutaneous Approach
04L23DZ	Occlusion of Gastric Artery with Intraluminal Device, Percutaneous Approach
04L33DZ	Occlusion of Hepatic Artery with Intraluminal Device, Percutaneous Approach
04L43DZ	Occlusion of Splenic Artery with Intraluminal Device, Percutaneous Approach
04L53DZ	Occlusion of Superior Mesenteric Artery with Intraluminal Device, Percutaneous Approach
04L63DZ	Occlusion of Right Colic Artery with Intraluminal Device, Percutaneous Approach
04L73DZ	Occlusion of Left Colic Artery with Intraluminal Device, Percutaneous Approach
04L83DZ	Occlusion of Middle Colic Artery with Intraluminal Device, Percutaneous Approach
04L93DZ	Occlusion of Right Renal Artery with Intraluminal Device, Percutaneous Approach
04LA3DZ	Occlusion of Left Renal Artery with Intraluminal Device, Percutaneous Approach
04LB3DZ	Occlusion of Inferior Mesenteric Artery with Intraluminal Device, Percutaneous Approach
04LC3DZ	Occlusion of Right Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04LD3DZ	Occlusion of Left Common Iliac Artery with Intraluminal Device, Percutaneous Approach
04LE3DZ	Occlusion of Right Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04LF3DZ	Occlusion of Left Internal Iliac Artery with Intraluminal Device, Percutaneous Approach
04LH3DZ	Occlusion of Right External Iliac Artery with Intraluminal Device, Percutaneous Approach
04LJ3DZ	Occlusion of Left External Iliac Artery with Intraluminal Device, Percutaneous Approach
04LK3DZ	Occlusion of Right Femoral Artery with Intraluminal Device, Percutaneous Approach
04LL3DZ	Occlusion of Left Femoral Artery with Intraluminal Device, Percutaneous Approach
04LM3DZ	Occlusion of Right Popliteal Artery with Intraluminal Device, Percutaneous Approach
04LN3DZ	Occlusion of Left Popliteal Artery with Intraluminal Device, Percutaneous Approach
04LP3DZ	Occlusion of Right Anterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04LQ3DZ	Occlusion of Left Anterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04LR3DZ	Occlusion of Right Posterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04LS3DZ	Occlusion of Left Posterior Tibial Artery with Intraluminal Device, Percutaneous Approach
04LT3DZ	Occlusion of Right Peroneal Artery with Intraluminal Device, Percutaneous Approach
04LU3DZ	Occlusion of Left Peroneal Artery with Intraluminal Device, Percutaneous Approach
04LV3DZ	Occlusion of Right Foot Artery with Intraluminal Device, Percutaneous Approach
04LW3DZ	Occlusion of Left Foot Artery with Intraluminal Device, Percutaneous Approach
04LY3DZ	Occlusion of Lower Artery with Intraluminal Device, Percutaneous Approach

ICD-10-PCS Venous Procedure Coding

06L13DZ	Occlusion of Splenic Vein with Intraluminal Device, Percutaneous Approach
06L23DZ	Occlusion of Gastric Vein with Intraluminal Device, Percutaneous Approach
06L33DZ	Occlusion of Esophageal Vein with Intraluminal Device, Percutaneous Approach
06L43DZ	Occlusion of Hepatic Vein with Intraluminal Device, Percutaneous Approach
06L53DZ	Occlusion of Superior Mesenteric Vein with Intraluminal Device, Percutaneous Approach
06L63DZ	Occlusion of Inferior Mesenteric Vein with Intraluminal Device, Percutaneous Approach
06L73DZ	Occlusion of Colic Vein with Intraluminal Device, Percutaneous Approach
06L83DZ	Occlusion of Portal Vein with Intraluminal Device, Percutaneous Approach
06L93DZ	Occlusion of Right Renal Vein with Intraluminal Device, Percutaneous Approach
06LB3DZ	Occlusion of Left Renal Vein with Intraluminal Device, Percutaneous Approach
06LC3DZ	Occlusion of Right Common Iliac Vein with Intraluminal Device, Percutaneous Approach
06LD3DZ	Occlusion of Left Common Iliac Vein with Intraluminal Device, Percutaneous Approach
06LF3DZ	Occlusion of Right External Iliac Vein with Intraluminal Device, Percutaneous Approach
06LG3DZ	Occlusion of Left External Iliac Vein with Intraluminal Device, Percutaneous Approach
06LH3DZ	Occlusion of Right Hypogastric Vein with Intraluminal Device, Percutaneous Approach
06LJ3DZ	Occlusion of Left Hypogastric Vein with Intraluminal Device, Percutaneous Approach
06LY3DZ	Occlusion of Lower Vein with Intraluminal Device, Percutaneous Approach
06LM3DZ	Occlusion of Right Femoral Vein with Intraluminal Device, Percutaneous Approach
06LN3DZ	Occlusion of Left Femoral Vein with Intraluminal Device, Percutaneous Approach
06LP3DZ	Occlusion of Right Greater Saphenous Vein with Intraluminal Device, Percutaneous Approach
06LQ3DZ	Occlusion of Left Greater Saphenous Vein with Intraluminal Device, Percutaneous Approach
06LR3DZ	Occlusion of Right Lesser Saphenous Vein with Intraluminal Device, Percutaneous Approach
06LS3DZ	Occlusion of Left Lesser Saphenous Vein with Intraluminal Device, Percutaneous Approach
06LT3DZ	Occlusion of Right Foot Vein with Intraluminal Device, Percutaneous Approach
06LV3DZ	Occlusion of Left Foot Vein with Intraluminal Device, Percutaneous Approach
06V13DZ	Restriction of Splenic Vein with Intraluminal Device, Percutaneous Approach
06V23DZ	Restriction of Gastric Vein with Intraluminal Device, Percutaneous Approach
06V33DZ	Restriction of Esophageal Vein with Intraluminal Device, Percutaneous Approach
06V43DZ	Restriction of Hepatic Vein with Intraluminal Device, Percutaneous Approach
06V53DZ	Restriction of Superior Mesenteric Vein with Intraluminal Device, Percutaneous Approach
06V63DZ	Restriction of Inferior Mesenteric Vein with Intraluminal Device, Percutaneous Approach
06V73DZ	Restriction of Colic Vein with Intraluminal Device, Percutaneous Approach
06V83DZ	Restriction of Portal Vein with Intraluminal Device, Percutaneous Approach
06V93DZ	Restriction of Right Renal Vein with Intraluminal Device, Percutaneous Approach
06VB3DZ	Restriction of Left Renal Vein with Intraluminal Device, Percutaneous Approach

Hospital Inpatient Coding and Payment

ICD-10-PCS Venous Procedure Coding *(continued)*

06VC3DZ	Restriction of Right Common Iliac Vein with Intraluminal Device, Percutaneous Approach
06VD3DZ	Restriction of Left Common Iliac Vein with Intraluminal Device, Percutaneous Approach
06VF3DZ	Restriction of Right External Iliac Vein with Intraluminal Device, Percutaneous Approach
06VG3DZ	Restriction of Left External Iliac Vein with Intraluminal Device, Percutaneous Approach
06VH3DZ	Restriction of Right Hypogastric Vein with Intraluminal Device, Percutaneous Approach
06VJ3DZ	Restriction of Left Hypogastric Vein with Intraluminal Device, Percutaneous Approach
06VY3DZ	Restriction of Lower Vein with Intraluminal Device, Percutaneous Approach
06VM3DZ	Restriction of Right Femoral Vein with Intraluminal Device, Percutaneous Approach
06VN3DZ	Restriction of Left Femoral Vein with Intraluminal Device, Percutaneous Approach
06VP3DZ	Restriction of Right Greater Saphenous Vein with Intraluminal Device, Percutaneous Approach
06VQ3DZ	Restriction of Left Greater Saphenous Vein with Intraluminal Device, Percutaneous Approach
06VR3DZ	Restriction of Right Lesser Saphenous Vein with Intraluminal Device, Percutaneous Approach
06VS3DZ	Restriction of Left Lesser Saphenous Vein with Intraluminal Device, Percutaneous Approach
06VT3DZ	Restriction of Right Foot Vein with Intraluminal Device, Percutaneous Approach
06VV3DZ	Restriction of Left Foot Vein with Intraluminal Device, Percutaneous Approach

Relevant Medicare Severity Diagnosis Related Groups

MS-DRG	Description	2026 National Medicare Payment
270	Other Major Cardiovascular Procedures w/ MCC	**$38,394**
271	Other Major Cardiovascular Procedures w/ CC	**$25,878**
272	Other Major Cardiovascular Procedures w/o CC/MCC	**$18,578**
252	Other Vascular Procedures	**$25,384**
253	Other Vascular Procedures	**$18,888**
254	Other Vascular Procedures	**$12,965**

2026 Inpatient rates in effect from October 1, 2025 – September 30, 2026

(M)CC = (major) complications and/or comorbidities. Complete list available at:
https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page#DataFiles

* Rates reflect FY 2026 National Medicare payment rates for hospitals submitting quality data and meaningful EHR users. Hospitals that do not submit quality data or are not meaningful EHR users may see decreased payment.

Costs for the Ruby Coil System, POD™ System, and LANTERN™ Microcatheter can be categorized into the following revenue codes:

- 0270 Medical/surgical supply
- 0272 Sterile supply
- 0278 Other implants
- 0279 Other supplies/devices

Relevant HCPCS Level II Codes

Product	Suggested HCPCS
Coils	C1889 - Implantable/insertable device, not otherwise classified
Detachment Handle	NONE

HCPCS Codes are not separately reimbursed. However, they may be used for reporting and other administrative processes.

References & Sources

- Centers for Medicare and Medicaid Services, Fiscal Year 2026, Hospital Inpatient Prospective Payment System (IPPS) Final Rule, CMS-1833-F, Federal Register/ Vol. 90, No. 147/ Monday, August 4, 2025.
- Centers for Medicare and Medicaid Services, ICD-10 Procedure Coding System (ICD-10-PCS) 2026 Tables and Index, https://www.cms.gov/medicare/coding-billing/icd-10-codes
- Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System (HCPCS) Quarterly Update, effective January 2026, https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system/quarterly-update

For the complete Penumbra IFU Summary Statements, please scan QR code or visit: peninc.info/risk

Reimbursement Inquiries: reimbursement@penumbrainc.com

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