Penumbra

Vascular Reimbursement Guide

Mechanical Thrombectomy and Embolization

EFFECTIVE JANUARY 2025

Reimbursement Inquiries: reimbursement@penumbrainc.com

For USA only.

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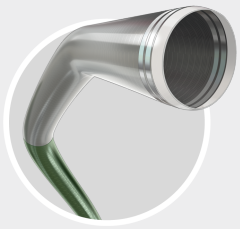
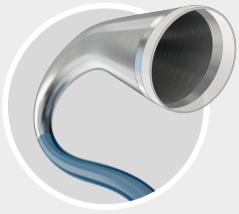
Lightning Flash **2.0**

Lightning Bolt **6X with TraX**



Lightning Bolt **12**



Lightning Bolt **7**

Lightning **12**

Lightning **7**

CAT™**8**

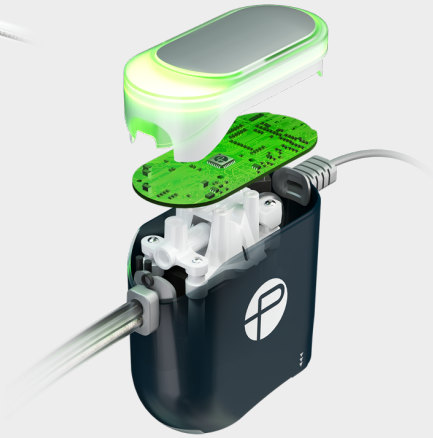
CAT**D**

CAT**6**

CAT **RX**

LIGHTNING BOLT®

LIGHTNING FLASH® 2.0



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.

Physician and Outpatient Coding and Payment

Coverage

Medicare carriers issue local coverage decisions (LCDs) listing coverage criteria for certain procedures.

Physicians are urged to review their local carrier coverage policies (http://www.cms.hhs.gov/mcd/search.asp?) and/or contact their local carrier medical directors (http://www.cms.hhs.gov/apps/contacts/).

Coding

Mechanical Thrombectomy Coding Tips

- Code(s) for catheter placement(s), diagnostic studies, and other percutaneous interventions (e.g., transluminal balloon angioplasty, stent placement) provided are separately reportable, unless for lower extremity revascularization.
- Current Procedural Terminology (CPT®) codes 37184–37188 and 37211–37214 specifically include intraprocedural fluoroscopic radiological supervision and interpretation services for guidance of the procedure.
- Intraprocedural injection(s) of a thrombolytic agent is an included service and not separately reportable in conjunction with mechanical thrombectomy. However, subsequent or prior continuous infusion of a thrombolytic is not an included service.
- Effective 10/1/2021, there are new ICD-10-PCS codes for Computer-aided Mechanical Aspiration. They should be used for the Indigo System when used with the Lightning Aspiration Tubing.
- 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.

Physician and Outpatient Coding and Payment

CPT® Code[1]	Description
Arterial Mechanical Thrombectomy and Thrombolysis Codes	
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
(+) 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 (List separately in addition to code for primary mechanical thrombectomy procedure)
(+) 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 (List separately in addition to code for primary procedure)
37211*	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day
Venous Mechanical Thrombectomy and Thrombolysis Codes	
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance
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
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method
Dialysis Circuit Mechanical Thrombectomy Codes	
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)
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
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 intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit
Manual Aspiration Codes	
37799	Unlisted procedure, vascular surgery

(+) in front of a procedure code denotes an add-on code. Add-on codes allow reporting of additional work associated with a primary procedure(s) and must never be reported alone. In addition, physician add-on codes are exempt from multiple procedure reduction.

* For continued transcatheter therapy (arterial infusion for thrombolysis other than coronary or intracranial) beyond the initial treatment day, please report CPT 37213.

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Venous Mechanical Thrombectomy Coding Tips

- CPT® 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. Any additional percutaneous interventions provided to treat underlying pathology(ies) are separately reportable.
- Fluoroscopy is considered an inclusive service in arterial and venous thrombectomy. Therefore, **DO NOT** report CPT 37187-37188 in conjunction with CPT 76000, 76001, or 96375.
- Report CPT 37212-37214 once per date of treatment.
- **DO NOT** report CPT 37212-37214 in conjunction with 75898.
- **DO NOT** report CPT 37187 in conjunction with 37214.

Arterial Mechanical Thrombectomy Coding Tips

- 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 modifier 51 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. See CPT 37186 for these procedures.
- Secondary mechanical thrombectomy is reported using CPT 37186. **DO NOT** report CPT 37186 in conjunction with CPT 37184–37185.

Physician and Outpatient Coding and Payment

		Ambulatory Surgery Center (ASC)	Hospital Outpatient Department (HOPD)		Physician Services[a]		
CPT® Code[1]	Description	Facility Payment[2]	APC	Facility Payment[3]	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU
Medicare Reimbursement for Arterial Percutaneous Mechanical Thrombectomy							
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	**$11,942.98**	**5194**	**$17,956.72**	**$408.26**	**$1,577.06**	**8.41**
(+) 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 (List separately in addition to code for primary mechanical thrombectomy procedure)	$ – (Packaged service/ item; no separate payment made)	$ – (Items and services are packaged into APC rate)	$ – (Items and services are packaged into APC rate)	**$153.99**	**$441.25**	**3.28**
(+) 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 (List separately in addition to code for primary procedure)	$ – (Packaged service/ item; no separate payment made)	$ – (Items and services are packaged into APC rate)	$ – (Items and services are packaged into APC rate)	**$1,094.72**	**$231.63**	**4.92**
37211	Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	**$3,987.18**	**5184**	**$5,405.70**	**$366.20**	$ – (Surgical procedure not performed in office setting)	**7.75**

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1. CPT 2025. American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.
2. 2025 Medicare Ambulatory Surgical Center (ASC) Payment System.
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4. 2025 Medicare Physician Fee Schedule (MPFS).

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Medicare Reimbursement for Venous Percutaneous Mechanical Thrombectomy							
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	**$7,800.37**	**5193**	**$11,340.57**	**$373.00**	**$1,549.24**	**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**	**$267.86**	**$1,330.56**	**5.46**
37212	Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	**$1,588.69**	**5183**	**$3,147.50**	**$319.94**	**$ –** (Surgical procedure not performed in office setting)	**6.81**
37213	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	**$ (Surgical procedure excluded from payment under ASC)**	**5183**	**$3,147.50**	**$218.69**	**$ –** (Surgical procedure not performed in office setting)	**4.75**
37214	Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	**$ (Surgical procedure excluded from payment under ASC)**	**5183**	**$3,147.50**	**$116.14**	**$ –** (Surgical procedure not performed in office setting)	**2.49**

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CPT® Code[1]	Description	Facility Payment[2]	APC	Facility Payment[3]	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU
Medicare Reimbursement for Dialysis Circuit Mechanical Thrombectomy *(continued)*							
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	**$528.22**	**5182**	**$1,553.34**	**$159.81**	**$653.79**	**3.36**

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CPT® Code[1]	Description	Facility Payment[2]	APC	Facility Payment[3]	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU
Medicare Reimbursement for Dialysis Circuit Mechanical Thrombectomy *(continued)*							
36902	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; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	**$2,629.62**	**5192**	**$5,701.52**	**$226.77**	**$1,113.16**	**4.83**
36903	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; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment	**$7,351.35**	**5193**	**$11,340.57**	**$298.27**	**$3,845.12**	**6.39**

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Medicare Reimbursement for Dialysis Circuit Mechanical Thrombectomy *(continued)*							
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)	**$3,515.82**	**5192**	**$5,701.52**	**$348.09**	**$1,667.00**	**7.50**
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	**$6,491.10**	**5193**	**$11,340.57**	**$418.93**	**$2,087.55**	**9.00**
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	**$11,783.21**	**5194**	**17,956.72**	**$482.34**	**$4,905.23**	**10.42**
(+) 36909	Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (List separately in addition to code for primary procedure)	**$ –** (Packaged service/ item; no separate payment made)	**$ –** (Items and services are packaged into APC rate)	**$ –** (Items and services are packaged into APC rate)	**$189.57**	**$1,719.08**	**4.12**

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CPT® Code[1]	Description	Facility Payment[2]	APC	Facility Payment[3]	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU
Medicare Reimbursement for Manual Aspiration							
37799	Unlisted procedure, vascular surgery	**$ –** (Surgical procedure excluded from payment under ASC)	**5181**	**$618.26**	**Carrier Priced**	**Carrier Priced**	**–**
Medicare Reimbursement for Percutaneous Transluminal Coronary Mechanical Thrombectomy*							
(+) 92973	Percutaneous transluminal coronary thrombectomy mechanical (List separately in addition to code for primary procedure) Notes: (Use 92973 in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975, 93454-93461, 93563, 93564) (Do not report 92973 for non-mechanical aspiration thrombectomy)	**$ –** (Packaged service/ item; no separate payment made)	(Items and services are packaged into APC rate)	**$ –** (Items and services are packaged into APC rate)	**$166.60**	**$ –** (Surgical procedure not performed in office setting)	**3.28**
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	**$3,628.13**	**5192**	**$5,701.52**	**$501.10**	**N/A**	**9.85**
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	**$6,994.16**	**5193**	**$11,340.57**	**$556.74**	**N/A**	**10.96**
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	**$ –** (Surgical procedure excluded from payment under ASC)	**5193**	**$11,340.57**	**$596.86**	**N/A**	**11.74**
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	**$ –** (Surgical procedure excluded from payment under ASC)	**5194**	**$17,956.72**	**$625.00**	**N/A**	**12.29**
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	**$ –** (Surgical procedure excluded from payment under ASC)	**5193**	**$11,340.57**	**$556.42**	**N/A**	**10.95**
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel	**$ –** (Surgical procedure excluded from payment under ASC)	**5193**	**$11,340.57**	**$625.65**	**N/A**	**12.31**

***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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Medicare Reimbursement for Percutaneous Transluminal Coronary Mechanical Thrombectomy* *(continued)*							
93454	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation	**$1,655.71**	**5191**	**$3,216.41**	**N/A**	**$835.92**	**4.54**
93455	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography	**$1,655.71**	**5191**	**$3,216.41**	**N/A**	**$933.30**	**5.29**
93456	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization	**$1,655.71**	**5191**	**$3,216.41**	**N/A**	**$1,040.70**	**5.90**
93457	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization	**$1,655.71**	**5191**	**$3,216.41**	**N/A**	**$1,135.81**	**6.64**
93458	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	**$1,655.71**	**5191**	**$3,216.41**	**N/A**	**$963.06**	**5.60**
93459	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	**$1,655.71**	**5191**	**$3,216.41**	**N/A**	**$1,036.82**	**6.35**

***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.**

a. The 2025 physician payment rates are reflective of the Calendar Year 2025 Medicare Physician Fee Schedule (MPFS) Final Rule, which was published in Federal Register, Vol. 89, No. 236, Monday, December 9, 2024. 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 to physicians may also vary based on locality.

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3. 2025 Medicare Outpatient Prospective Payment System (OPPS).
4. 2025 Medicare Physician Fee Schedule (MPFS) when billed with -26 modifier.

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

Reimbursement Inquiries: reimbursement@penumbrainc.com

Physician and Outpatient Coding and Payment

		Ambulatory Surgery Center (ASC)	Hospital Outpatient Department (HOPD)		Physician Services[a]		
CPT® Code[1]	Description	Facility Payment[2]	APC	Facility Payment[3]	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU
Medicare Reimbursement for Percutaneous Transluminal Coronary Mechanical Thrombectomy* *(continued)*							
93460	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed	**$1,655.71**	**5191**	**$3,216.41**	**N/A**	**$1,150.37**	**7.10**
93461	Catheter placement in coronary artery(ies) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography	**$1,655.71**	**5191**	**$3,216.41**	**N/A**	**$1,269.09**	**7.85**

***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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Hospital Inpatient Coding and Payment

ICD-10-PCS Computer-Aided Mechanical Aspiration Coding*

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 Arteriovenous Fistula Procedural Coding

03WY3JZ	Revision of Synthetic Substitute of Upper Artery, Percutaneous Approach
03WY37Z	Revision of Autologous Tissue Substitute of Upper Artery, Percutaneous Approach
03WY3KZ	Revision of Non-Autologous Tissue Substitute of Upper Artery, Percutaneous Approach

ICD-10-PCS Arterial Procedure Coding

02CP3ZZ	Extirpation of Matter from Pulmonary Trunk
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
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

*To be used for the Indigo System when used with the Lightning Aspiration Tubing.

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

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 Procedure Coding

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
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

Hospital Inpatient Coding and Payment

MS-DRG and 2025 Payment Rates: Arterial/ Venous Procedure Reimbursement

MS-DRG	Description	2025 National Medicare Payment
163	Major Chest Procedures w MCC	**$32,802**
164	Major Chest Procedures w CC	**$17,912**
165	Major Chest Procedures w/o CC/MCC	**$13,265**
252	Other Vascular Procedures w/ MCC	**$24,413**
253	Other Vascular Procedures w/ CC	**$18,169**
254	Other Vascular Procedures w/o CC/MCC	**$12,450**
270	Other Major Cardiovascular Procedures w/ MCC	**$36,530**
271	Other Major Cardiovascular Procedures w/ CC	**$24,514**
272	Other Major Cardiovascular Procedures w/o CC/MCC	**$17,807**

2025 Inpatient rates in effect from October 1, 2024 – September 30, 2025
(M)CC = (major) complications and/or comorbidities. Complete list available at: http://www.cms.hhs.gov/AcuteInpatientPPS
Rates reflect FY 2025 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 for hospital outpatient procedures. However, the Centers for Medicare & Medicaid Services (CMS) requires outpatient hospitals to bill the appropriate HCPCS codes for devices used as part of a procedure. CMS no longer requires procedures to have specific device edits as CMS has determined hospitals are experienced enough with this practice and are capable of applying the appropriate HCPCS codes on claims with the related procedures.

It is the responsibility of the provider to determine the appropriate coding when billing a claim.

References & Sources

- HIPPS (Inpatient) Federal Register / Vol. 89, No. 192 / Thursday, October 3, 2024.
- OPPS/ASC (Outpatient) Federal Register/ Vol. 89, No. 229 / Wednesday, November 27, 2024.
- MPFS (Physician) Federal Register/ Vol. 89, No. 236/ Monday, December 9, 2024
- ICD-10-PCS 2025 ICD-10-PCS Complete Official Codebook. American Medical Association. Copyright ©2025 Optum360.
- HCPCS 2025 Level II Professional Edition. American Medical Association. Copyright ©2025 Optum360.

DRG and 2025 Payment Rates: Percutaneous Coronary Intervention (PCI) Procedures

DRG	Description	2025 National Medicare Payment
250	Percutaneous Cardiovascular Procedure w/ Drug-Eluting Stent w/ MCC	**$16,460**
251	Percutaneous Cardiovascular Procedure w/ Drug-Eluting Stent	**$11,120**
321	Percutaneous Cardiovascular Procedures w/ Intraluminal Device w/ MCC Or 4+ Arteries/Intraluminal Devices	**$20,260**
322	Percutaneous Cardiovascular Procedures w/ Intraluminal Device w/o MCC Percutaneous Cardiovascular Procedure w/o Coronary Artery Stent	**$12,875**

2025 inpatient rates in effect from October 1, 2024 - September 30, 2025
(M)CC = (major) complications and/or comorbidities. Complete list available at: http://www.cms.hhs.gov/AcuteInpatientPPS
Rates reflect FY 2025 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.

Peripheral Embolization System

***NOW!* — Ruby Coil LP & Packing Coil LP**
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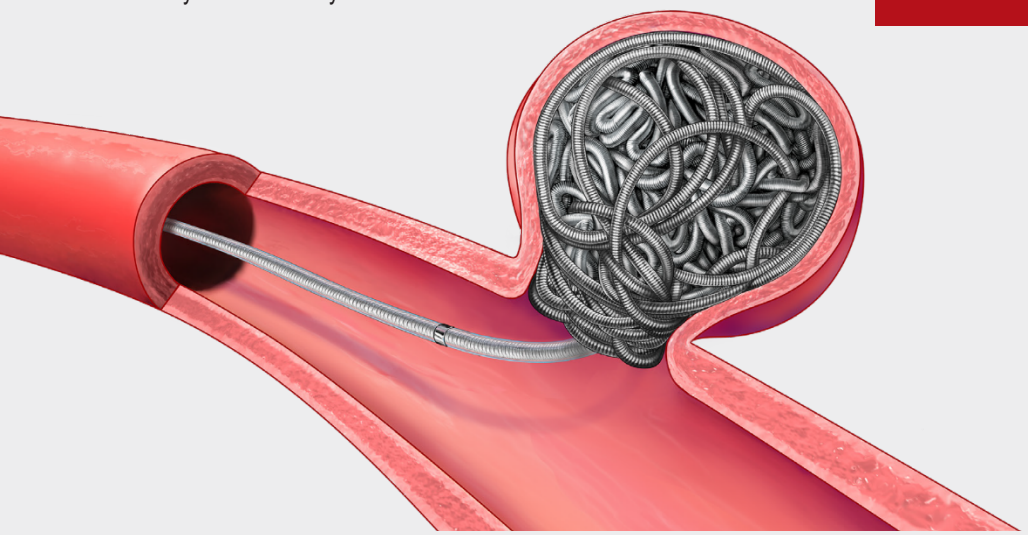

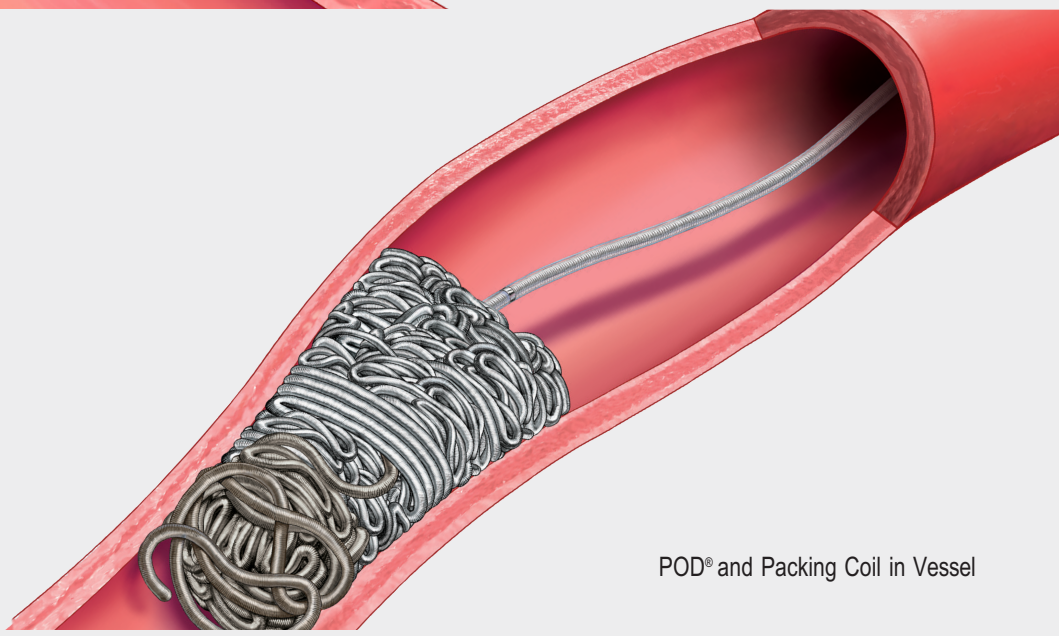

POD® and Packing Coil in Vessel

Renderings for illustrative purposes only. Individual results may vary depending on patient-specific attributes and other factors.

LANTERN® Microcatheter

Physician and Outpatient Coding and Payment

Coverage, coding, and reimbursement for medical procedures and devices can be confusing. This guide was developed to assist you in correctly reporting and obtaining appropriate Medicare reimbursement for peripheral coil embolization procedures. If you have any questions, please contact our reimbursement team at 1.866.808.1645 or by email at reimbursement@penumbrainc.com.

Coverage

Medicare carriers issue local coverage decisions (LCDs) listing coverage criteria for certain procedures. Physicians are urged to review their local carrier coverage policies (http://www.cms.hhs.gov/mcd/search.asp?) and/or contact their local carrier medical directors (http://www.cms.hhs.gov/apps/contacts/).

Coding Tips for Vascular Embolization

Effective January 1, 2017, prior moderate sedation codes CPT® 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 37241-37244) should now separately report new moderate sedation codes (CPT 99151-99157) with proper medical documentation.

Physician and Outpatient Coding and Payment

Embolization		Physician Services			Hospital Outpatient Department (HOPD)		Ambulatory Surgical Center (ASC)[a]
CPT® Code[1]	Description	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU	APC	Facility Payment[3]	Facility Payment[2]
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, 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)	$403.73	$4,198.38	8.75	5193	$11,340.57	$6,454.19
37242	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, 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)	$449.34	$6,467.09	9.80	5194	$17,956.72	$11,860.98
37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	$530.54	$7,841.96	11.74	5193	$11,340.57	$6,530.20
37244	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation	$624.03	$5,993.48	13.75	5193	$11,340.57	$ (Surgical procedure excluded from payment under ASC)

Catheter Access		Physician Services			Hospital Outpatient Department (HOPD)[a]	
CPT Code[1]	Description	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU	APC	Facility Payment[3]
36140	Introduction of needle or intracatheter, extremity artery	$84.11	$468.75	1.76	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
36160	Introduction of needle or intracatheter, aortic, translumbar	$116.78	$519.86	2.52	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
36200	Introduction of catheter, aorta	$132.64	$545.10	2.77	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)

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"TC" modifier identifies the technical component of the procedure.
"26" modifier identifies the professional component of the procedure.

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

Physician and Outpatient Coding and Payment

Catheter Placement		Physician Services			Hospital Outpatient Department (HOPD)[a]	
CPT® Code[1]	Description	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU	APC	Facility Payment[3]
36215	Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family	$203.16	$964.35	4.17	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
36216	Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family	$259.45	$994.76	5.27	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
36217	Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family	$322.53	$1,738.49	6.29	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
(+) 36218	Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)	$50.14	$198.31	1.01	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family	$1,144.22	$224.19	4.65	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
36246	Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family	$769.61	$238.74	5.02	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family	$1,309.85	$281.77	6.04	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
(+) 36248	Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (list in addition to code for initial second or third order vessel as appropriate)	$109.67	$45.94	1.01	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)

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"26" modifier identifies the professional component of the procedure.

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(+) in front of a procedure code denotes an add-on code. Add-on codes allow reporting of additional work associated with a primary procedure(s) and must never be reported alone. In addition, physician add-on codes are exempt from multiple procedure reduction.

Physician and Outpatient Coding and Payment

Catheter Placement *(continued)*

		Physician Services			Hospital Outpatient Department (HOPD)[a]	
CPT® Code[1]	Description	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU	APC	Facility Payment[3]
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	$241.33	$1,182.72	5.10	5183	$3,147.50
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	$338.06	$1,285.91	6.74	5183	$3,147.50
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	$334.82	$1,858.51	7.30	5184	$5,405.70
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	$395.32	$1,804.16	7.90	5183	$3,147.50

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"26" modifier identifies the professional component of the procedure.

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

(+) in front of a procedure code denotes an add-on code. Add-on codes allow reporting of additional work associated with a primary procedure(s) and must never be reported alone. In addition, physician add-on codes are exempt from multiple procedure reduction.

Physician and Outpatient Coding and Payment

Imaging

			Physician Services			Hospital Outpatient Department (HOPD) [a]	
CPT® Code[1]	Modifier	Description	Fee When Service is Performed in the HOPD or Inpatient Setting[4]	Fee When Service is Performed in the Physician Office[4]	Work RVU	APC	Facility Payment[3]
75710	N/A	Angiography, extremity, unilateral, radiological supervision and interpretation	No Modifier - N/A	No Modifier - $143.63	1.75	5183	$3,147.50
	TC		TC - N/A	TC - $65.35	0.00		
	26		26 -$78.29	26 - $78.29	1.75		
75716		Angiography, extremity, bilateral, radiological supervision and interpretation	No Modifier - N/A	No Modifier -$157.54	1.97	5183	$3,147.50
	TC		TC - N/A	TC - $69.23	0.00		
	26		26 - $88.32	26 - $88.32	1.97		
75726		Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation	No Modifier - N/A	No Modifier - $165.63	2.05	5184	$5,405.70
	TC		TC - N/A	TC - $75.05	0.00		
	26		26 - $90.58	26 - $90.58	2.05		
75731		Angiography, adrenal, unilateral, selective, radiological supervision and interpretation	No Modifier - N/A	No Modifier - $149.78	1.14	5183	$3,147.50
	TC		TC - N/A	TC - $97.70	0.00		
	26		26 - $52.08	26 - $52.08	1.14		
75733		Angiography, adrenal, bilateral, selective, radiological supervision and interpretation	No Modifier - N/A	No Modifier - $167.57	1.31	5183	$3,147.50
	TC		TC - N/A	TC - $109.34	0.00		
	26		26 -$58.23	26 -$58.23	1.31		
75736		Angiography, pelvic, selective or supraselective, radiological supervision and interpretation	No Modifier - N/A	No Modifier - $140.08	1.14	5184	$5,405.70
	TC		TC - N/A	TC - $90.58	0.00		
	26		26 - $49.50	26 - $49.50	1.14		
(+) 75774		Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure	No Modifier - N/A	No Modifier - $92.84	1.01	$ – (Items and services are packaged into APC Rate)	$ – (Items and services are packaged into APC Rate)
	TC		TC - N/A	TC - $48.85	0.00		
	26		26 - $44.00	26 - $44.00	1.01		

a. The 2025 physician payment rates are reflective of the Calendar Year 2025 Medicare Physician Fee Schedule (MPFS) Final Rule, which was published in Federal Register, Vol. 89, No. 236, Monday, December 9, 2024. 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 to physicians may also vary based on locality.

1. CPT®2025. American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.
2. 2025 Medicare Ambulatory Surgical Center (ASC) Payment System.
3. 2025 Medicare Outpatient Prospective Payment System (OPPS).
4. 2025 Medicare Physician Fee Schedule (MPFS).

"TC" modifier indicates the technical component of the procedure.
"26" modifier indicates the professional component of the procedure.

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

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
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

ICD-10-PCS Arterial Procedure Coding

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
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

ICD-10-PCS Arterial Procedure Coding

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
06LY3DZ	Occlusion of Lower Vein with Intraluminal Device, Percutaneous Approach
06LJ3DZ	Occlusion of Left Hypogastric 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

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
06VY3DZ	Restriction of Lower Vein with Intraluminal Device, Percutaneous Approach
06VJ3DZ	Restriction of Left Hypogastric 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

MS-DRG and 2025 Payment Rates: Arterial/ Venous Procedure Reimbursement

MS-DRG	Description	2025 National Medicare Payment
270	Other Major Cardiovascular Procedures w/ MCC	**$36,530**
271	Other Major Cardiovascular Procedures w/ CC	**$24,514**
272	Other Major Cardiovascular Procedures w/o CC/MCC	**$17,807**
252	Other Vascular Procedures	**$24,413**
253	Other Vascular Procedures	**$18,169**
254	Other Vascular Procedures	**$12,450**

Because MS-DRG reimbursement may vary based on actual procedures performed, this table does not represent all possible MS-DRG assignments.
2025 Inpatient rates in effect from October 1, 2024 – September 30, 2025.
(M)CC = (major) complications and/or comorbidities. Complete list available at: http://www.cms.hhs.gov/AcuteInpatientPPS
Rates reflect FY 2025 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.

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

Product	Suggested HCPCS
Penumbra Coils and POD	**C1889** - Implantable/insertable device, not otherwise classified
Penumbra Large Volume System Detachment Handle	NONE

HCPCS Codes are not separately reimbursed for hospital outpatient procedures. However, the Centers for Medicare & Medicaid Services (CMS) requires outpatient hospitals to bill the appropriate HCPCS codes for devices used as part of a procedure. CMS no longer requires procedures to have specific device edits as CMS has determined hospitals are experienced enough with this practice and are capable of applying the appropriate HCPCS codes on claims with the related procedures.

It is the responsibility of the provider to determine the appropriate coding when billing a claim.

References & Sources

- HIPPS (Inpatient) Federal Register / Vol. 89, No. 192 / Thursday, October 3, 2024.
- OPPS/ASC (Outpatient) Federal Register/ Vol. 89, No. 229 / Wednesday, November 27, 2024.
- MPFS (Physician) Federal Register/ Vol. 89, No. 236/ Monday, December 9, 2024
- ICD-10-PCS 2025 ICD-10-PCS Complete Official Codebook. American Medical Association. Copyright ©2025 Optum360.

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