2024 Coding & Payment Quick Reference

SYNERGY™ Everolimus-Eluting Platinum Chromium Coronary Stent System

Coding and Payment for Medicare Reimbursement: The following are the 2024 codes and Medicare national average payment rates for coronary therapies procedures involving drug eluting stent placement performed in an inpatient or outpatient hospital setting. Actual rates will vary by hospital.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

PROCEDURES			OUTPATIENT		INPATIENT	
HCPCS Code[1]	Abbreviated Description[2]	Add-On Code for Additional Branch[3]	Possible C-APC[4]	National Average Payment[5]	Possible MS-DRG[6]	National Average Payment[7]
C9600	Drug Eluting Stent with PTCA	+C9601	**5193**	$10,493		
C9602	Drug Eluting Stent with Atherectomy	+C9603	**5194**	$16,725		
C9604	Drug Eluting Stent with Bypass Graft	+C9605	**5193**	$10,493	**321** **322**	$20,127 $12,767
C9606	Drug Eluting Stent with Acute Myocardial Infarction		Hospital Inpatient Only			
C9607	Drug Eluting Stent with CTO	+C9608	**5194**	$16,725		

PHYSICIAN					
CPT® Code	Abbreviated Description[2]	Add-On Code for Additional Branch[3]	Work RVU[8]	Total RVU[9]	National Average Payment[10]
92928	Stent with PTCA	+92929	10.96	17.16	$563
92933	Stent with Atherectomy	+92934	12.29	19.38	$631
92937	Stent with Bypass Graft	+92938	10.95	17.26	$563
92941	Stent with Acute Myocardial Infarction		12.31	19.42	$632
92943	Stent with CTO	+92944	12.31	19.42	$632

See important notes on the uses and limitations of this information on page 2.

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This coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

Resources for Interventional Cardiology: https://www.bostonscientific.com/en-US/reimbursement/interventional-cardiology.html
Reimbursement Help Desk: IC.Reimbursement@bsci.com

IMPORTANT INFORMATION

Health economic and reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is subject to change without notice as a result of complex and frequently changing laws, regulations, rules, and policies. This information is presented for illustrative purposes only and does not constitute reimbursement or legal advice. Boston Scientific encourages providers to submit accurate and appropriate claims for services. **It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any services, and to submit appropriate codes, charges, and modifiers for services rendered.** It is also always the provider's responsibility to understand and comply with Medicare national coverage determinations (NCD), Medicare local coverage determinations (LCD), and any other coverage requirements established by relevant payers which can be updated frequently. Boston Scientific recommends that you consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters. Boston Scientific does not promote the use of its products outside their FDA-approved label. Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options. This coding information may include codes for procedures for which Boston Scientific currently offers no cleared or approved products. In those instances, such codes have been included solely in the interest of providing users with comprehensive coding information and are not intended to promote the use of any Boston Scientific products for which they are not cleared or approved. The Health Care Provider (HCP) is solely responsible for selecting the site of service and treatment modalities appropriate for the patient based on medically appropriate needs of that patient and the independent medical judgement of the HCP.

Information included herein is current as of January 2024 but is subject to change without notice. Rates for services are effective January 1, 2024 and set to expire on December 31, 2024. MS-DRG rates are set to expire on September 30, 2024.

Sequestration Disclaimer: Rates referenced in these guides do not reflect Sequestration

See important notes on the uses and limitations of this information on page 2.

[1] AAPC. (2022). HCPCS Level II Expert 2023. [[VitalSource Bookshelf version]].

[2] Descriptions have been abbreviated. For full code descriptions, please consult the Procedural Payment Guide. https://www.bostonscientific.com/en-US/reimbursement/interventional-cardiology.html

[3] The '+' sign indicates Add-on Code (AOC), a service that is performed in conjunction with another primary service by the same practitioner. It is rarely eligible for payment if it is the only procedure reported by a practitioner. Add-on Code Edits | CMS. (n.d.). www.cms.gov. Retrieved December 1, 2022, from https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits?msclkid=8a7b29c1d16111eca39b085d713db80c

[4] Comprehensive Ambulatory Payment Classifications (C-APCs) provide a single payment for a primary procedure (status indicator = J1) and all related or adjunctive hospital items and services given to a patient. https://www.cms.gov/newsroom/fact-sheets/cms-finalizes-hospital-outpatient-and-ambulatory-surgical-centers-policy-and-payment-changes-2015

[5] Source: CMS. CY 2024 Hospital Outpatient Prospective Payment (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems Final Rule: CMS-1786-FC, including related addenda. Effective through December 31, 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc

[6] MS-DRG assignment is based on a combination of diagnoses and procedure codes reported. While MS-DRGs listed in this guide represent likely assignments, Boston Scientific cannot guarantee assignment to any one specific MS-DRG.

[7] Source: CMS. FY 2024 IPPS Final Rule: CMS-1785-F, including data files. National average (wage index greater than one) MS-DRG rates calculated using the national adjusted full update standardized labor, non-labor, and capital amounts. Actual reimbursement will vary for each provider and institution for a variety of reasons including geographic differences in labor and non-labor costs, hospital teaching status, and/or proportion of low-income patients). Effective through September 30, 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page#CMS1785F

[8] Work RVU (Relative Value Unit) is a measure of skill and intensity to perform a service.

[9] Total RVU (Relative Value Unit) is the sum of work, practice expense and malpractice RVU.

[10] Source: CMS CY 2024 Physician Fee Schedule (PFS) Final Rule: CMS 1784-F, including related PFS addenda. Conversion Factor used in calculations = $32.7442. Effective through December 31, 2024. https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f

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