RANGER™ DRUG-COATED BALLOON

2024 CODING & PAYMENT GUIDE

The procedure codes listed below are applicable to Femoral/Popliteal cases utilizing the Ranger™ Drug-Coated Balloon.

Claims must contain the appropriate CPT/HCPCS/ICD-10-PCS code(s) for the specific site of service to indicate the items and services that are furnished. The tables below contain a list of possible CPT/HCPCS/ICD-10-PCS codes that may be used to bill for Ranger™ Drug-Coated Balloon. Providers should select the most appropriate code(s) and modifier(s) with the highest level of detail to describe the service(s) actually rendered.

PHYSICIAN SERVICES CY 2024 (01/01/2024-12/31/2024)

Service Provided		Physician Fee Schedule			
CPT® Code	CPT® Description	Work RVU[1]	Total RVU[1]	Facility Payment[1]	Non Facility Payment[1]
		Rates are for Physician work performed in a facility setting (hospital — inpatient or outpatient, and ASC)			
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	8.75	12.94	$431	$2,850
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	11.75	17.41	$580	$8,545
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed	10.24	15.09	$502	$7,915
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	14.25	20.83	$693	$10,912

CPT Codes are used to report medical services and procedures performed by or under the direction of physicians in the office or facility setting. The MPFS is based on Relative Value Units (RVUs) assigned to each CPT code. RVUs represent the physician's work, practice expenses and malpractice costs associated with each procedure or service. Reimbursement for commercial payers may be based on the Medicare RVUs or by a contractually negotiated rate. C-Codes are used to report devices used in combination with device-related procedures for hospital outpatient services.

See important notes on the uses and limitations of this information on page 3.

HOSPITAL OUTPATIENT CY 2024 (01/01/2024-12/31/2024)

Service Provided		Hospital Outpatient	
CPT® Code	CPT® Description	APC	Payment[3]
37224	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty	5192	$5,452
37225	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed	5194	$16,725
37226	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed		
37227	Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed	5194	$16,725

HOSPITAL INPATIENT FY 2024 (10/01/2023-09/30/2024)

Service Provided		Hospital Inpatient
MS-DRG[4]	MS-DRG Description	Payment[2]
• 252	Other Vascular Procedures with MCC	$23,482
• 253	Other Vascular Procedures with CC	$17,862
• 254	Other Vascular Procedures without CC/MCC	$12,148

- Denotes DRG assigned to patient w/ MCC (Major Comorbidities or Complications)
- Denotes DRG assigned to patient w/ CC (Comorbidities or Complications)
- Denotes DRG assigned to patient w/o MCC or CC

Medicare reimburses facilities for inpatient stays based on the Medicare Severity Diagnosis Related Group (MS-DRG). The MS-DRG is a system of classifying patients based on principal diagnosis, complications, and comorbidities managed and the procedures performed during an inpatient stay. A single MS-DRG payment is intended to cover all hospital costs associated with treating a patient for a hospital stay. Private payers may use MS-DRG-based systems or other payer-specific systems.

ICD-10 PCS CODES

ICD-10-PCS[5]	Description
047K3Z1	Dilation of Right Femoral Artery using Drug-Coated Balloon, Percutaneous Approach
047L3Z1	Dilation of Left Femoral Artery using Drug-Coated Balloon, Percutaneous Approach
047M3Z1	Dilation of Right Popliteal Artery using Drug-Coated Balloon, Percutaneous Approach
047N3Z1	Dilation of Left Popliteal Artery using Drug-Coated Balloon, Percutaneous Approach

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.

C CODE:

The applicable C-Code to report the use of Ranger™ is **C2623**, defined as “catheter, transluminal angioplasty, drug-coated, non-laser.”

See important notes on the uses and limitations of this information on page 3.

SOURCES:

1. FY 2024 IPPS Payment. CMS-1785-F. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2024-ipps-final-rule-home-page
2. CMS 2024 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes/2024-icd-10-pcs
3. CMS ICD-10-CM/PCS MS-DRG V41.0 Definitions Manual. https://www.cms.gov/files/zip/icd-10-ms-drg-definitions-manual-files-v41.zip
   Not intended as an all-inclusive list of MS-DRGs
4. 2024 Physician Fee Schedule. CMS-1784-F. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1784-f
   2024 *Conversion Factor of $33.2875*
5. 2024 OPPS Payment. CMS-1786-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc

IMPORTANT INFORMATION

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