VENOUS STENTING
2024 CODING AND REIMBURSEMENT GUIDE

The procedure codes listed below are applicable to peripheral venous stenting cases involving venous stents.

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 venous stents. Providers should select the most appropriate code(s) and modifier(s) with the highest level of detail to describe the service(s) actually rendered.

CPT codes 37238 and 37239 do not include catheter placement, ultrasound guidance, or diagnostic intravascular ultrasound (IVUS). If performed, these services may be separately reported.

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

Service Provided		Physician Fee Schedule[1]		
CPT® Code	CPT® Description	RVUs	Facility	Non Facility
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	6.04	$293	$3,317
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein	2.97	$143	$1,658

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

Service Provided		Hospital Outpatient		
CPT® Code	CPT® Description	Status Indicator	APC	Payment[2]
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	J1	5193	$10,493
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein	N	NA	$0
37238 + 37239	Venous stent, open or perc, incl RS&I, incl angioplasty, two veins	J1*	5194	$16,725

*Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicators of "F", "G", ",", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; services assigned to a new technology APC; self-administered drugs; all preventive services; and certain Part B inpatient services.

See important notes on the uses and limitations of this information on page 4.

AMBULATORY SURGICAL CENTER (ASC) CY 2024 (01/01/2024-12/31/2024)

Service Provided		ASC		
CPT® Code	CPT® Description	Status Indicator	APC	Payment[3]
37238	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein	J8	Y	$6,699
37239	Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein	N1	NA	$0

See the CPT® 2023 Professional Edition Codebook for important instructions regarding the use of the codes shown above.

According to the 2023 AMA CPT® Professional Edition on page 316, multiple stents placed in a single vessel may only be reported with a single code. If a lesion extends across the margins of one vessel into another, but can be treated with a single therapy, the intervention should only be reported once.

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

ICD-10-PCS[4]	Description
067C3DZ	Dilation of Right Common Iliac Vein with Intraluminal Device, Percutaneous Approach
067D3DZ	Dilation of Left Common Iliac Vein with Intraluminal Device, Percutaneous Approach
067F3DZ	Dilation of Right External Iliac Vein with Intraluminal Device, Percutaneous Approach
067G3DZ	Dilation of Left External Iliac Vein with Intraluminal Device, Percutaneous Approach
067M3DZ	Dilation of Right Femoral Vein with Intraluminal Device, Percutaneous Approach
067N3DZ	Dilation of Left Femoral Vein with Intraluminal Device, Percutaneous Approach

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.

The following MS-DRGs are associated with procedures involving venous stenting:

Service Provided		Hospital Inpatient
MS-DRG	MS-DRG Description	Payment[1]
252	Other vascular procedures w/ MCC (Major Complications or Comorbidities)	$23,482
253	Other vascular procedures w/ CC (Complications or Comorbidities)	$17,862
254	Other vascular procedures w/o MCC/CC	$12,148

See important notes on the uses and limitations of this information on page 4.

C CODES

C-codes are tracking codes established by the Centers for Medicare & Medicaid Services (CMS) to assist Medicare in establishing future APC payment rates. C-codes only apply to Medicare hospital outpatient claims. They do not trigger additional payment to the facility today. It is very important that hospitals report C-codes as well as the associated device costs. This will help inform future outpatient hospital payment rates.

The C Code for Charger, Mustang, and Athletis is C1725 - Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability).

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

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 $32.7442*
5. 2024 ASC Payment. CMS-1786-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and/cms-1786-fc
6. 2024 OPPS Payment. CMS-1786-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc

See important notes on the uses and limitations of this information on page 4.

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