AGENT™
Drug-Coated Balloon

Boston Scientific
Advancing science for life™

Transitional Pass-Through (TPT) Payment

Effective January 1, 2025, the U.S. Centers for Medicare & Medicaid Services (CMS) has established a **Transitional Pass-Through (TPT) payment category** for coronary drug-coated balloons (DCBs). AGENT™ DCB is the first and only U.S. coronary DCB and provides a new treatment option for patients with in-stent restenosis (ISR). TPT payments provide additional reimbursement under the Hospital Outpatient Prospective Payment System (OPPS) for new devices that are considered to be a substantial clinical improvement over existing technology. The intent of TPT payment is to facilitate Medicare beneficiary access to the advantages of innovative devices by allowing for adequate payment.

The following billing code for the device is effective January 1, 2025.[1]

TPT Code for Coronary DCB

HCPCS Code	Short Description
C9610	Cath coronary drug-delivery

The contractor instructions with guidance about the TPT category were released January 13, 2024.[2]

To receive the TPT payment, hospitals must report C9610 on outpatient claims for cases using AGENT DCB along with the code for the associated procedure. Medicare will provide TPT payment when the code is reported with one of the following CPT®/HCPCS procedure codes:

CPT/HCPCS Codes for Procedures Associated with Coronary DCB

Code	Descriptor	2025 APC Payment Rate
0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g., drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	$5,701.52

[1] CMS. CY2025 Hospital Outpatient Prospective Payment System, Final Rule: CMS-1809-FC, Addenda C.
[2] CMS Transmittal 13033, Change Request 13908, "January 2025 Integrated Outpatient Code Editor (I/OCE) Specifications Version 26.0," January 3, 2025.

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Code	Descriptor	2025 APC Payment Rate
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	$11,341
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	$17,957
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	$17,957
C9602	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	$17,957
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	$11,341
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	$11,341
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	$11,341
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$11,341
C9600	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	$11,341
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	$5,702

Individual coding decisions are the responsibility of the provider and should be based upon diagnosis and treatment of individual patients.

TPT Payment Amount

There is no fixed payment amount for TPT device codes. The TPT payment amount is determined by Medicare based on the charges reported on the hospital claim for C9610. The charges are multiplied by the hospital's outpatient device cost-to-charge ratio (CCR), which Medicare publishes, to estimate the hospital's cost for AGENT DCB. CMS has determined that coronary DCBs do not replace any of the device costs incurred by the hospital for furnishing the associated procedure. Therefore, no device offset is applied when calculating the total payment to the hospital for both the TPT device and the procedure payment.

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Beneficiaries do not pay coinsurance for TPT devices. The beneficiary is responsible for coinsurance of 20% of the Medicare payment for the procedure. The Outpatient Prospective Payment System (OPPS) beneficiary coinsurance amount is capped at the hospital inpatient deductible which in 2024 is $1,632. (All of the associated procedures shown in above list of procedure codes are subject to the cap on beneficiary coinsurance other than 92920).

Hypothetical Calculations of TPT Payment for an AGENT DCB Case

For illustrative purposes only

In this example, we assume that a hospital uses AGENT DCB during a PTCA procedure.

Step 1 - Determine charges for AGENT DCB

Hospitals determine the charges to report for an item or service, often by applying a usual and customary mark-up to the acquisition cost for the item. This example assumes an acquisition cost for AGENT DCB of $6,175 and a hospital-specific mark-up of 3.4 times acquisition cost.

Charge amount for C9610

AGENT DCB Cost	*	Hospital-specific mark-up	=	Charge for C9610
$6,175	*	3.4	=	$20,995

Step 2 - Determine Expected TPT Payment Amount

Charge for C9610	*	Hospital's Outpatient CCR	=	TPT Payment
$20,995	*	.30	=	$6,299

Step 3 - Determine Total Payment Amount Including PTCA Payment

TPT Payment	+	OPPS APC 5192 Payment Amount; 92920	=	Total Payment
$6,299	+	$5,701	=	$12,000

Note: Commercial payers are not required to follow CMS payment levels, however, some may choose to do so. It is recommended to reach out to commercial payers to understand commercial payer reimbursement for AGENT DCB.

IMPORTANT

Why is it important for a hospital to report appropriate charges for pass-through devices?
Proper setting of charges for pass-through devices is important not only for the hospital's payment for the device today, but also to ensure that the data CMS has for future rate setting under the OPPS is accurate and reflective of true procedure costs, including the true cost of the device.

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

FREQUENTLY ASKED QUESTIONS

How long is TPT effective for AGENT DCB?
CMS established TPT for AGENT DCB effective January 1, 2025, and allows payments for three years.

If multiple AGENT DCB devices are used in a procedure, how does the hospital appropriately report?
For procedures where multiple devices are used, the number of devices would be reported as the number of units of the device. The charges are then accurately multiplied to reflect the total number of units.
Please note, the safety and effectiveness of using more than one AGENT DCB to treat a single lesion or multiple lesions/vessels per procedure has not been established.

How can a hospital locate its hospital specific cost-to-charge-ratio (CCR) used in the payment calculation?
The hospital-specific CCRs are part of the CMS Outpatient Rate Setting Files. Boston Scientific can assist by providing hospital-specific CCRs upon request. Please contact us by emailing IC.Reimbursement@bsci.com.

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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.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements.

Boston Scientific does not promote the use of its products outside their FDA-approved label.

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 February 2025 but is subject to change without notice. Rates for services are effective January 1, 2025. TPT code and payment is effective January 1, 2025.

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