2025 Outpatient Coding & Payment Quick Reference

AGENT™ Drug-Coated Balloon

Coding and Payment for Medicare Reimbursement: The following are the 2025 codes and Medicare national average payment rates for coronary therapies procedures involving coronary drug-coated balloon performed in an 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.

Indications for Use

The AGENT Drug-Coated Balloon (DCB) is intended to be used after appropriate vessel preparation in adult patients undergoing percutaneous coronary intervention (PCI) for the purpose of improving myocardial perfusion when treating in-stent restenosis (ISR).

Category III CPT Codes

Effective January 1, 2025, Category III CPT codes 0913T and +0914T were established for procedures involving coronary DCB.

The American Medical Association (AMA) guidelines for Category III CPT codes allow for data collection for emerging technologies, services, procedures, and service paradigms. Use of unlisted codes does not offer the opportunity for the collection of specific data. If a Category III code is available, this code must be reported instead of a Category I unlisted code. Physicians are required to use the most appropriate code to describe the service provided.

Category III codes are very common for new procedures and technologies. Category III CPT codes may be payable when medically necessary and reported with appropriate documentation. CPT AMA Category 3 codes

CPT Code	Code Description
0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g. drug-coated, drug-eluting), including mechanical dilation by non-drug 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
+0914T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g. drug-coated, drug-eluting), preformed on a separate target lesion from the target lesion treated with the balloon angioplasty, coronary stent placement or coronary atherectomy, including mechanical dilation by non-drug 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 (list separately in addition to code for percutaneous coronary stent or atherectomy intervention)

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

HCPCS C-Code

HCPCS Code	Code Description
C9610	Catheter transluminal drug delivery, coronary, non-laser (insertable)

Hospital Outpatient Payment – Medicare

Hospital outpatient claims must contain the appropriate CPT and HCPCS code(s) to indicate the items and services that are furnished. The tables below contain a list of possible codes that may be used to bill for AGENT DCB procedures.

All rates shown are 2025 Medicare national averages; actual rates will vary geographically and/or by individual facility.

CPT Code	Description	APC	2025 Payment Rate
0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g. drug-coated, drug-eluting), including mechanical dilation by non-drug 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	5192	$5,702
+0914T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g. drug-coated, drug-eluting), preformed on a separate target lesion from the target lesion treated with the balloon angioplasty, coronary stent placement or coronary atherectomy, including mechanical dilation by non-drug 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 (list separately in addition to code for percutaneous coronary stent or atherectomy intervention)	N/A	N/A

Append appropriate location modifiers to CPT code(s)

Modifiers	Description
LC	Left Circumflex Coronary
LD	Left Anterior Descending Coronary
LM	Left Main Coronary
RC	Right Coronary
RI	Ramus Intermedius

HCPCS Code	Short Description	Revenue Code	Transitional Pass-Through Payment (TPT) Eligible?
C9610	Cath coronary drug-delivery	0278-Other Implant	Y

CMS has established a **Transitional Pass-Through payment (TPT)** for coronary drug-coated balloons. To receive TPT payment, hospitals must report C9610 on outpatient claims. TPT is calculated using a formula including the hospital's device(s) cost, cost-to-charge ratio (CCR) and hospital-specific mark-up. TPT payment amounts vary by each hospital. Additional information regarding TPT can be found here: CMS TPT

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

Hospital Outpatient Payment – Commercial

For commercial payers, individual payer guidelines and contracts should be referenced to identify reporting requirements and reimbursement for Category III CPT codes.

Frequently Asked Questions

Q: Can we bill an unlisted code instead of the new Category III code?

A: Per CPT guidance from AMA, if an appropriate Category III code exists, it must be utilized in lieu of an unlisted procedure code. 0913T is used when performing a stand-alone AGENT DCB procedure. +0914T is used when reporting AGENT DCB in conjunction with another primary PCI procedure.

Q: Is the new Category III CPT code covered by payers?

A: Category III codes may be reimbursed by payers on a case-by-case basis. Coverage and payment will be based on physician documentation of medical necessity. AGENT DCB is indicated for in-stent restenosis which should be documented during the pre-authorization process.

Q: Do we need to pre-authorize the Category III code?

A: Prior authorization may be required. Providers should seek prior authorization from commercial payers. Consult with payers directly to determine if prior authorization is required or available. Traditional fee-for-service Medicare does not require prior authorization.

Denials and Appeals

Q: Are there resources available to assist with prior authorization or claims denials?

A: Yes, Boston Scientific is pleased to support customers with prior authorization and claims denial appeals. To access support, contact AGENTDCB@pinnaclehealthgroup.com or visit www.thepinnaclehealthgroup.com.

If you have questions or would like additional information, please email: IC.Reimbursement@bsci.com

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

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.

References

1. CMS. CY2025 Physician Fee Schedule, Final Rule. CMS-1807-F. CMS-4201-F5
2. CMS. CY2025 Hospital Outpatient Prospective Payment System, Final Rule: CMS-1809-FC, Addenda A, Addenda AA

Sequestration Disclaimer

Rates referenced in these guides do not reflect Sequestration, automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2025.

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