Venous Stenting
2026 Coding and Billing Guide

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 andfrequently changing laws, regulations, rules, and policies. This information is presented for illustrativepurposes only and does not constitute reimbursement or legal advice. Boston Scientific encouragesproviders 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 thatyou consult with your payers, reimbursement specialists, and/or legal counsel regarding coding, coverage, and reimbursement matters.

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This coding information may include codes for procedures for which Boston Scientific currently offersno 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 independentmedical judgment of the HCP.

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

Claims must contain the appropriate HCPCS/CPT/ICD-10 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 HCPCS/CPT/ICD-10 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 ® Copyright 2026 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

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.

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Physician Services CY 2026 (01/01/2026-12/31/2026)

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	5.89	$271	$3,277
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	2.90	$132	$1,661

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.

Hospital Outpatient CY 2026 (01/01/2026-12/31/2026)

Service Provided		Hospital Outpatient[2]		
CPT® Code	CPT® Description	Status Indicator	APC	Payment*
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	$11,794
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	Y	$0
37238 + 37239 Venous stent, open or perc, incl RS&I, incl angioplasty, two veins		J1[#]	5194	$18,729

#: 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.

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Ambulatory Surgical Center (ASC) CY 2026 (01/01/2026-12/31/2026)

Service Provided		ASC[3]		
CPT® Code	CPT® Description	Status Indicator	APC	Payment*
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	$7,562
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	Y	

See the CPT® 2026 Professional Edition Codebook for important instructions regarding the use of the codes shown above.

According to the 2026 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.

ICD-10-PCS[4] Procedure Codes FY 2026 (10/01/2025-09/30/2026)

ICD-10-PCS	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.

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Hospital Inpatient FY 2026 (10/01/2025-09/30/2026)

Service Provided		Hospital Inpatient[5]
MS-DRG[6]	MS-DRG Description	Payment*
252	Other vascular procedures w/ MCC (Major Complications or Comorbidities)	$25,384
253	Other vascular procedures w/ CC (Complications or Comorbidities)	$18,888
254	Other vascular procedures w/o MCC/CC	$12,965

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

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Sources

1. 2026 Physician Fee Schedule. CMS-CMS-1832-CN2. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-cn2
   2026 *Conversion Factor of 33.40*
2. 2026 OPPS Payment. CMS- CMS-1834-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc
3. 2026 ASC Payment. CMS- CMS-1834-FC. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1834-fc
4. FY 2026 ICD-10 Procedure Coding System (ICD-10-PCS). https://www.cms.gov/medicare/coding-billing/icd-10-codes
5. FY 2026 IPPS Payment. CMS-CMS-1833-F. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page#CMS-1833-F
6. FY 2026 MS-DRG V43.0 Definitions Manual. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software
   Not intended as an all-inclusive list of MS-DRGs

Endnotes & Legend

* Payment refers to the Medicare Allowable Amount published by the Centers for Medicare & Medicaid Services (CMS) for the calendar or fiscal year.

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