New Category III CPT® Code Approved for AGENT™ Drug-coated Balloon PCI procedures

AGENT™ Drug-Coated Balloon Procedure Billing Guide

Effective January 1, 2025, Category III CPT codes 0913T and 0914T have been established for AGENT Drug-coated balloon coronary interventions. This document is intended to provide coding support to physicians and staff for use of the new codes.

Indications for Use:

The AGENT™ Paclitaxel-Coated Balloon Catheter 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

The American Medical Association (AMA) guidelines for Category III CPT codes include the following “Category III codes allow 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 1 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)

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

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

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Hospital Outpatient Payment – Medicare

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

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

CPT Code	Brief Description	APC	2025 Reimbursement Rate
0913T	Percutaneous transcatheter placement of intracoronary stent, with angioplasty when performed; single artery or branch	5192	$5,702
+0914T	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with angioplasty if performed, single artery or branch	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	Description	Revenue Code	Transitional Pass-Through Payment (TPT) Eligible?
C9610	Catheter transluminal drug delivery, coronary, non-laser (insertable)	0278-Other Implant	Y

AGENT™ Drug-Coated Balloon qualifies for transitional pass-through payment under HCPCS code C9610. Report each balloon used during the coronary intervention include cost and units used. TPT is calculated using a formula including the facility cost to charge ration (CCR), device charge, APC payment and device offset, the TPT reimbursement amount varies by each facility. Additional information on TPT can be found here: CMS TPT

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

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

FAQ's:

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. Category III CPT code(s) 0913T must be used when performing an AGENT DCB procedure. +0914T must be used when reporting AGENT DCB procedures when performed in conjunction with another PCI primary procedure on or after January 1, 2025.

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: The prior authorization process does not change when using Category III codes. Providers should see prior authorization from private payers. Consult with local payers to determine if prior authorization is required. Traditional Medicare does not require prior authorization.

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

A: yes, Boston Scientific has partnered with Pinnacle Health Group to assist with prior authorization and claims denial appeals, Pinnacle Health Group contact information: AGENTDCB@pinnaclehealthgroup.com or www.thepinnaclehealthgroup.com

Denials and Appeals

Providers may experience denials, either during the prior authorization process or as a claim denial. Boston Scientific has partnered with Pinnacle Health Care to assist providers with prior authorization and claims denial appeals. Additional information on Pinnacle Health Care services can be found here.

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

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.

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

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.

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