Optum

Complete Guide for Interventional Radiology

An in-depth guide to interventional radiology coding, billing and reimbursement

2027

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Contents

Introduction

The purpose of the *Complete Guide for Interventional Radiology* is to provide a reference for hospitals and physicians to accurately report interventional radiology and cardiology procedures in the context of today's complex requirements for coding, billing, and reimbursement. Coding for these types of procedures is widely recognized as one of the most complex and challenging under Medicare's reimbursement programs, especially the ambulatory payment classification (APC) program.

This guide is intended to help the technical, professional, and coding staff select the appropriate codes to accurately report the services performed in the interventional radiology and cardiology settings.

CPT and Medicare have continued to revise reporting requirements for interventional radiology services to keep up with technological changes, techniques, and methods for performing procedures. Certain components of an interventional procedure, such as contrast media, supplies and devices, or additional imaging procedures, have increased both the complexity and cost. In order for Medicare to keep up with these changes in terms of billing and payment, specific HCPCS codes and other unique coding requirements such as surgical component codes may be required.

Accuracy in reporting interventional radiology procedures requires a good basic understanding of CPT® coding. Providers are expected to report each procedure component by revenue code, CPT/HCPCS code, modifiers if applicable, and the number of units used or performed.

The most common components of an interventional radiology procedure are the surgical intervention, imaging, supplies, contrast media, and pharmacy. Complexity of a procedure may require reporting several CPT codes. Where appropriate, this book includes CPT codes that are not necessarily cardiovascular or radiology-related.

Case examples of procedures are provided in this publication as a guide to learning and understanding the various aspects of the service. The case examples in this publication follow basic Medicare guidance for reporting; however, many payers accept these guidelines. Standardized reporting should be the goal of all providers with specific exceptions from individual payers on a case-by-case basis. With few exceptions, coding for the professional components should match the coding submitted for the technical components.

Documentation for each procedure must be in the medical record and must include detailed descriptions of each component of the procedure, such as advancement and exact placement of catheters, surgical component descriptors, the type and amount of low osmolar contrast media, all medications given, and the special devices used. These documentation requirements hold true for both radiology and cardiology interventions.

Providers should review their process for reporting interventional services at least semi-annually and in conjunction with newly released Medicare notices to ensure proper claims processing.

Coding described throughout this publication is for normal anatomy and transfemoral percutaneous approach unless otherwise specified.

CPT Codes and Descriptions

Physicians' Current Procedural Terminology (CPT) was developed by the American Medical Association and is used to report medical services and procedures performed by physicians and some allied health providers. The codes are updated every year. The CPT code set is used by both hospitals and physicians.

Indented Procedures

CPT descriptions are developed to stand alone, but sometimes they appear to be incomplete. The format is employed to conserve space on the printed page. Some CPT codes that share a common procedure are grouped together and the common procedure is listed fully only with the first code. The codes that follow are indented to indicate that a portion of their description is found in a previous code.

CPT code descriptions appear in bold text followed by the lay description of the service provided.

For example:

37224 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**

37225 **with atherectomy, includes angioplasty within the same vessel, when performed**

The common portion of these codes precedes the semicolon (;) in the full description of 37224. The complete description of 37225 is:

37225 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral with atherectomy, includes angioplasty within the same vessel, when performed**

When the information for an indented code is the same as the information for the code with the full description, these codes will be grouped together in a range. When the information varies greatly, they will be listed separately.

Revenue Code	Description	Guidelines
0480	Cardiology, general	Use for electrophysiology procedures.
0481	Cardiac cath lab	Recommended for procedures performed in the cath lab.
0610	MRI, general	Use for MRI guidance.
0621	Supplies incident to radiology	May be used to report radiology supplies. Do not use with pass-through status devices.
0622	Supplies incident to other diagnostic services	May be used to report cath lab supplies. Do not use with pass-through status devices.
0624	FDA investigational devices	Use to report investigational devices and procedures for FDA approved clinical trials.
0636	Drugs requiring detailed coding	Use to report drugs and biologicals requiring specific HCPCS code including LOCM.
0972	Professional fees, radiology, diagnostic	Use to report the professional component for diagnostic imaging procedures when billed by hospitals.
0973	Professional fees, radiology, therapeutic	Use to report the professional component for therapeutic procedures when billed by hospitals.

General Interventional Radiology Coding Guidelines for Selective and Nonselective Catheter Placements

Interventional radiology procedures are coded using a mixture of comprehensive procedure codes and the component coding methodology. There are several *components* to an interventional radiology procedure. There is the procedure of placing the catheter into the vascular system known as catheter placement. There is often a *surgical* component to the procedure, and there is the *imaging* or radiologic supervision and interpretation portion of the procedure. Most interventional radiology procedures have two of these components, and many include all three. More recently, interventional radiology coding is returning to comprehensive codes. These codes include all components of the procedure, namely the catheter placement, imaging, and surgical procedure. It is important to note there is often not a one-to-one coding correlation with the surgical and the radiology supervision and interpretation components. It is also important to note this component coding methodology is not applied consistently. Comprehensive codes have replaced component coding for some diagnostic procedures. Please review the appropriate sections in chapters 2–14 carefully.

Nonselective catheter placement is defined as the final placement of the tip of the catheter either into the aorta or vena cava from the point of origin, or placement of the catheter so that the tip is not advanced beyond the vessel of original access.

Selective catheter placement means the catheter tip is advanced from the vessel of origin into the aorta or vena cava and then *beyond* into another vessel.

There are specific and special rules guiding coding of interventional radiology procedures.

Nonselective Coding

- Regardless of the access site (femoral, axillary, or brachial) or the number of injections made in the aorta, if the catheter tip does not advance beyond the aorta and into a branch vessel, it is considered a nonselective catheter placement, catheter stays in the aorta; report CPT code 36200.
- Regardless of the access site, if the catheter tip is not advanced beyond the access vessel, the access is considered nonselective.
- Code a nonselective and selective catheter placement CPT code only if there are two puncture sites or there are two separate patient encounters on the same date of service.

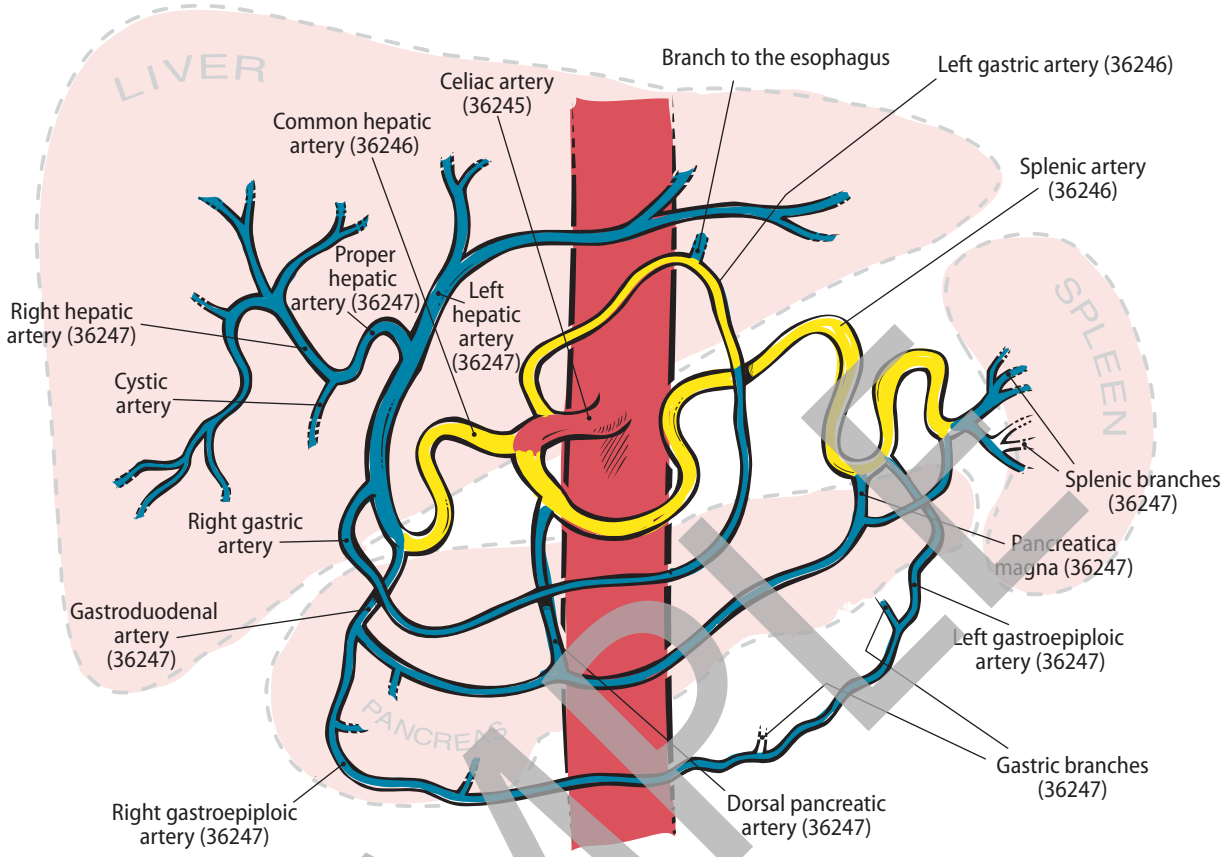
Selective Coding

The intent of the catheterization determines the degree of selectivity of the code assigned for the procedure performed. If the catheter tip is unintentionally placed into a vessel, this placement is not coded. Catheterizations to assist with forming loops in the catheter in order to assist in placement are also not coded.

General Rules:

- Know each puncture site.
- Know each final catheter placement.
- Place precedence on selective CPT codes over nonselective CPT codes.
- Code each vascular family separately.
- Code each vascular family to the highest degree of selectivity within that vascular family.
- Code only one second- or third-order selective catheter placement code within each vascular family.
- Code each additional second- or third-order catheter placement within a vascular family with the appropriate CPT code.
- Code each diagnostic (vessels visualized with documented interpretation) and therapeutic procedure when performed together.

Celiac Artery and Branches



*Coding may vary upon patient anatomy

Coding Tips

1. Report both components of the procedure: the catheter placement code and the radiology S&I codes.
2. If multiple vessels are studied during the same session, CPT code 75774 is reported for each vessel after the initial vessel. Catheter placement is coded for each vascular family. Any of the arteries in the group listed can be studied by themselves. CPT code 75726 and one catheter placement code would be reported in this situation. It is more common to study multiple vessels during the same session.
3. Do not report CPT code 75625 in addition to 75726 if the aorta is injected during the exam. The aorta imaging is included as part of this procedure.
4. These vessels can have many congenital variations in their location and take off from the aorta. This affects catheter placement coding. Anatomy should be detailed in the dictated report.
5. When multiple branches of the celiac are catheterized be sure to report 36248 instead of 36246 or 36247 as appropriate. The celiac and its branches are one vascular family.
6. Abdominal radiographic images are included. Do not separately report codes 74018–74022.
7. Conscious sedation is not included in these codes. Separately report 99151–99157 per payer policy and coding guidelines. Hospitals may choose to include the costs associated with the service as part of the procedure rather than reporting them separately.
8. Report all applicable HCPCS Level II codes. Refer to the HCPCS section for possible codes.
9. Hospitals are requested to continue reporting LOCM separately with HCPCS codes Q9965–Q9967. Report contrast media by milliliter rather than by bottle or other unit.
10. Diagnostic angiography performed during the same surgical encounter as an interventional procedure may be reported separately if no previous catheter-based angiogram has been performed. A complete diagnostic exam must also be performed and the decision to perform an interventional procedure should be based on diagnostic exam results. When a previous diagnostic exam was performed, documentation must indicate the condition of the patient changed since that exam, anatomy was not optimally identified in the previous exam, or a change during the surgical encounter required another evaluation beyond the area being treated during the intervention. Under these circumstances, append modifier 59 (or appropriate Xx [XE, XS, etc.] modifier for CMS) to the diagnostic evaluation.
11. Physician Reporting: These radiology S&I codes have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier.

Transcatheter Endovascular Revascularization—Femoral/Popliteal Vascular Territory

The femoral/popliteal territory consists of the following segments:

- Common femoral artery
- Deep femoral artery
- Superficial femoral artery
- Popliteal artery

Angioplasty, only

37224 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**

Atherectomy, with or without angioplasty

37225 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**

Stent placement, with or without angioplasty

37226 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Stent placement and atherectomy, with or without angioplasty

37227 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Lithotripsy including angioplasty

C9764 **Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed**

Lithotripsy and stent placement, including angioplasty

C9765 **Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed**

Lithotripsy and atherectomy, including angioplasty

C9766 **Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed**

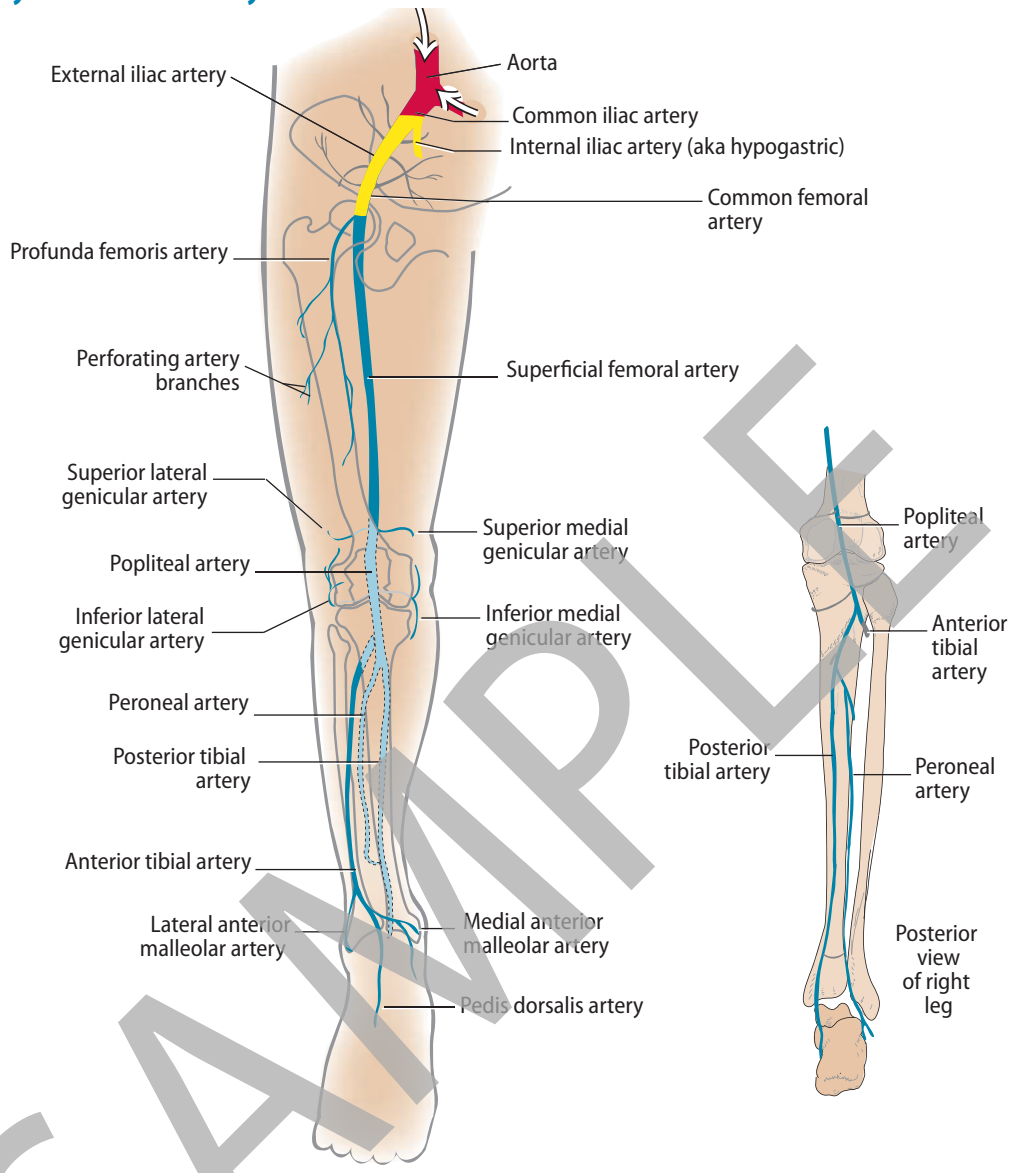
Lithotripsy, stent placement, and atherectomy, including angioplasty

C9767 **Revascularization, endovascular, open or percutaneous, lower extremity artery(ies), except tibial/peroneal; with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed**

Coding Tips—Femoral/Popliteal Territory

1. For endovascular revascularization CPT coding the entire femoral/popliteal territory is considered to be a single vessel.
2. The number of separate lesions treated within this defined territory does not impact coding. Report only one code describing the complexity of the therapy performed. For example, if a stent is placed in one lesion in the common femoral and atherectomy is performed on a lesion in the superficial femoral, only 37227 is reported.
3. HCPCS codes C9764–C9767 are reported once per vascular territory. (Not appropriate for physician reporting.)

Extremity Arterial Anatomy



Facility HCPCS Coding

Some applicable codes may include but are not limited to:

C1714	Catheter, transluminal atherectomy, directional	C1876	Stent, non-coated/non-covered, with delivery system
C1724	Catheter, transluminal atherectomy, rotational	C1877	Stent, non-coated/non-covered, without delivery system
C1725	Catheter, transluminal angioplasty, non-laser	C1885	Catheter transluminal angioplasty, laser
C1760	Closure device vascular (implantable/insertable), if used	G0269	Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioSeal plug, vascular plug), if performed
C1769	Guidewire	Q9965	LOCM, 100-199 mg/ml iodine concentration, per ml
C1874	Stent, coated/covered, with delivery system	Q9966	LOCM, 200-299 mg/ml iodine concentration, per ml
C1875	Stent, coated/covered, without delivery system	Q9967	LOCM, 300-399 mg/ml iodine concentration, per ml

Note: See appendix B for a complete listing of reportable HCPCS Level II codes.

ICD-10-CM Coding

The application of these codes is too broad to adequately present ICD-10-CM diagnosis code links here. Refer to the current ICD-10-CM book.

Ventricular Assist Device—Repositioning of Percutaneous Device

33993 **Repositioning of percutaneous right or left heart ventricular assist device with imaging guidance at separate and distinct session from insertion**
The physician uses fluoroscopic or ultrasound guidance to change the position of a previously placed ventricular assist device.

Coding Tips

1. This code is assigned inpatient-only status under OPPS. There will be no payment if reported on an outpatient hospital claim. Check other payers for their payment policies.
2. Repositioning performed during the insertion session is not separately reportable. When performed during distinct, separate sessions, append modifier 59 to the repositioning code.
3. Repositioning that does not require imaging guidance is not a reportable service.
4. Conscious sedation is not included in these codes. Separately report 99151–99157 per payer policy and coding guidelines. Hospitals may choose to include the costs associated with the service as part of the procedure rather than reporting them separately.
5. Hospitals are requested to continue reporting the procedure to place a vascular closure device with HCPCS code G0269. Report the closure device separately with HCPCS code C1760; however, other third-party payers may not accept this code. Hospitals should verify how each payer wants this service reported. Medicare does not provide separate payment, but the costs and charges should be reported separately, when allowed.
6. Hospitals should continue to report separately low osmolar contrast media (LOCM) with HCPCS codes Q9965–Q9967. Report contrast media by milliliter. Refer to the HCPCS code section for applicable codes.

Facility HCPCS Coding

Report any applicable supplies and HCPCS codes. Refer to appendix B for a complete current list.

C1760	Closure device, vascular (implantable/insertable)
C1769	Guidewire
Q9965	LOCM, 100–199 mg/ml iodine concentration, per ml
Q9966	LOCM, 200–299 mg/ml iodine concentration, per ml
Q9967	LOCM, 300–399 mg/ml iodine concentration, per ml

ICD-10-CM Coding

T82.528A	Displacement of other cardiac and vascular devices and implants, initial encounter
T82.897A	Other specified complication of cardiac prosthetic devices, implants and grafts, initial encounter
Z45.Ø9	Encounter for adjustment and management of other cardiac device
Z95.811	Presence of heart assist device

ICD-10-PCS Coding

Section:	Ø Medical and Surgical
Body System:	2 Heart and Great Vessels
Operation:	W Revision
Body Part:	A Heart
Approach:	3 Percutaneous
Device:	Q Implantable Heart Assist System
Qualifier:	Z No Qualifier

Comprehensive EP with Arrhythmia Induction and Left Ventricular Pacing and Recording (Add-On Code)

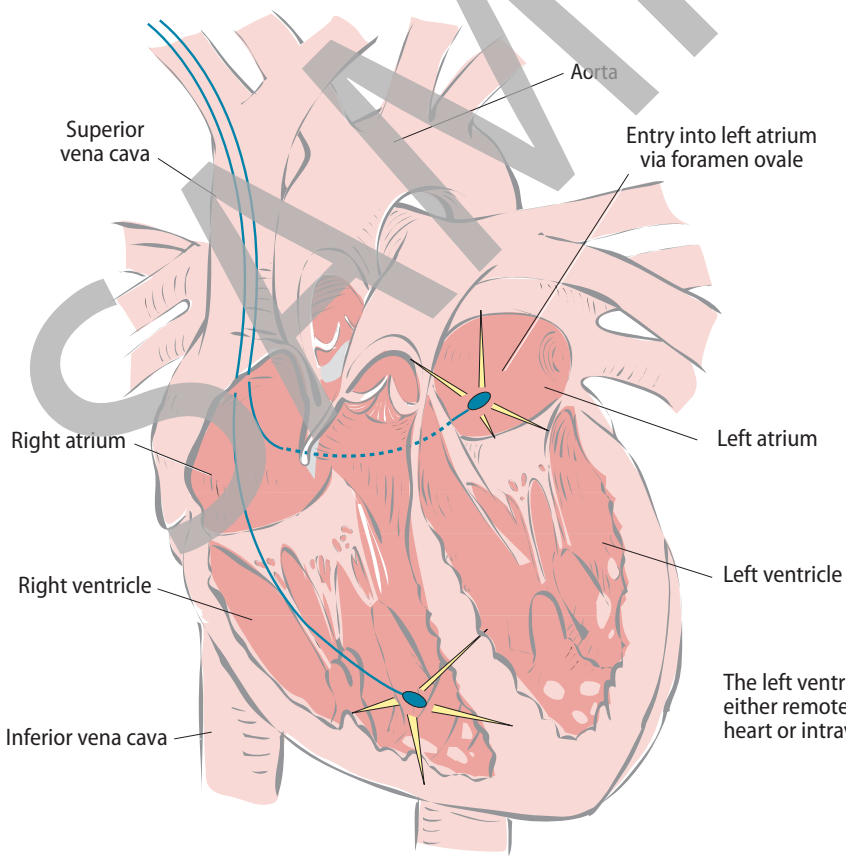
93622 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left ventricular pacing and recording (List separately in addition to code for primary procedure)**

The physician places three central venous sheaths and an arterial sheath using standard techniques. The physician advances four electrical catheters through these sheaths and into the heart under fluoroscopic guidance. The physician attaches the four catheters to an electrical recording device to allow depiction of the intracardiac electrograms obtained from electrodes on the catheter tips. The physician moves the tips of the four catheters to the right atrium, the bundle of His, the right ventricle, and the left ventricle and obtains recordings. The physician may attach the catheters to an electrical pacing device to allow transmission of pacing impulses through the catheters to the different heart chambers. The physician may stimulate the heart with rapid pacing or programmed electrical stimulation in an attempt to induce an arrhythmia.

Coding Tips

1. CPT code 93622 is an add-on code. Report in addition to 93620, 93653, and 93656.
2. Report 93622 when left ventricular recording and pacing are also performed as part of an electrophysiology study.
3. Do not report 93622 with 93654.
4. Conscious sedation is not included in these codes. Separately report 99151–99157 per payer policy and coding guidelines. Hospitals may choose to include the costs associated with the service as part of the procedure rather than reporting them separately.
5. Physician Reporting: This code has both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier.
6. Add-on codes are flagged for RAC (recovery audit contractor) review. Facilities and professional providers should take extra steps to make sure the coding meets guidelines.

Electrophysiology Study



Facility HCPCS Coding

HCPCS Level II codes are used to report the supplies provided during the procedure. Hospitals should separately report supplies used during cardiac invasive procedures. Refer to chapter 1 for more information regarding appropriate billing of supplies. Refer to the list of current codes in appendix B.

C1730 Catheter, electrophysiology, diagnostic, other than 3D mapping (19 or fewer electrodes)
C1731 Catheter, electrophysiology, diagnostic, other than 3D mapping (20 or more electrodes)
C1732 Catheter, electrophysiology, diagnostic/ablation, 3D or vector mapping
C1733 Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, other than cool-tip
C1766 Introducer sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away
C1892 Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, peel-away
C1893 Introducer/sheath, guiding, intracardiac electrophysiological, fixed-curve, other than peel-away
C1894 Introducer/sheath, other than guiding, intracardiac, electrophysiological, non-laser
C2629 Introducer/sheath, other than guiding, intracardiac
C2630 Catheter, electrophysiology, diagnostic/ablation, other than 3D or vector mapping, cool tip

ICD-10-CM Coding

This is an add-on code. Refer to the corresponding primary procedure code for ICD-10-CM diagnosis code links.

ICD-10-PCS Procedure Codes

Section:	4 Measurement and Monitoring
Body System:	A Physiological Systems
Operation:	Ø Measurement
Body Part:	2 Cardiac
Approach:	3 Percutaneous
Function/Device:	4 Electrical Activity
Qualifier:	Z No Qualifier

Appendix A: 2026 APCs and Payment Rates

Following is information for the addendum B table from the 2026 OPPS proposed rule, crosswalking CPT®/HCPCS codes to their associated APCs and payment rates.

CPT/HCPCS Code	Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
0042T	Ct perfusion w/contrast cbf		N					
0054T	Bone srgry cmptr fluor image		N					
0055T	Bone srgry cmptr ct/mri imag		N					
0071T	Us leiomyomata ablate <200		J1	5414	35.6573	$3,179.53		$635.91
0072T	Fcsd us abltj leiomyom>=200		J1	5414	35.6573	$3,179.53		$635.91
0075T	Perq stent/chest vert art		C					
0076T	S&i stent/chest vert art		C					
0095T	Rmvl artific disc addl crvcl		C					
0098T	Rev artific disc addl		C					
0100T	Prosth retina receive&gen		E2					
0101T	Esw muscskel sys nos		T	5111	2.6902	$239.88		$47.98
0102T	Esw phy anes lat hmrl epcndl		J1	5113	36.3872	$3,244.61		$648.93
0106T	Touch quant sensory test		Q1	5732	0.4402	$39.25		$7.85
0107T	Vibrate quant sensory test		Q1	5732	0.4402	$39.25		$7.85
0108T	Cool quant sensory test		Q1	5733	0.6661	$59.40		$11.88
0109T	Heat quant sensory test		Q1	5732	0.4402	$39.25		$7.85
0110T	Nos quant sensory test		Q1	5734	1.4456	$128.90		$25.78
0164T	Remove lumb artif disc addl		C					
0165T	Revise lumb artif disc addl		C					
0174T	Cad cxr with interp		N					
0175T	Cad cxr remote		N					
0184T	Exc rectal tumor endoscopic		J1	5331	66.7587	$5,952.81		$1,190.57
0198T	Ocular blood flow measure		Q1	5734	1.4456	$128.90		$25.78
0200T	Perq sacral augmt unilat inj		J1	5114	80.1145	$7,143.73		$1,428.75
0201T	Perq sacral augmt bilat inj		J1	5114	80.1145	$7,143.73		$1,428.75
0202T	Post vert arthrplst 1 lumbar		C					
0207T	Clear eyelid gland w/heat		Q1	5734	1.4456	$128.90		$25.78
0208T	Audiometry air only		Q1	5732	0.4402	$39.25		$7.85
0209T	Audiometry air & bone		Q1	5732	0.4402	$39.25		$7.85
0210T	Speech audiometry threshold		Q1	5732	0.4402	$39.25		$7.85
0211T	Speech audiom thresh & recog		Q1	5732	0.4402	$39.25		$7.85
0212T	Compre audiometry evaluation		Q1	5721	1.7546	$156.46		$31.30
0213T	Njx paravert w/us cer/thor		T	5443	9.9843	$890.29		$178.06
0214T	Njx paravert w/us cer/thor		N					
0215T	Njx paravert w/us cer/thor		N					
0216T	Njx paravert w/us lumb/sac		T	5443	9.9843	$890.29		$178.06
0217T	Njx paravert w/us lumb/sac		N					
0218T	Njx paravert w/us lumb/sac		N					
0219T	Plmt post facet implt cerv		C					
0220T	Plmt post facet implt thor		C					
0221T	Plmt post facet implt lumb		J1	5114	80.1145	$7,143.73		$1,428.75

* Copayments capped at inpatient deductible of $1,632.00.

Appendix B: HCPCS Level II Device Codes

The following is a list of HCPCS Level II device codes current as of November 2026 for interventional radiology and cardiology. These codes are appropriate for hospital providers to report with the associated procedures.

Device Code	Description
C1600	Catheter, transluminal intravascular lesion preparation device, bladed, sheathed (insertable)
C1603	Retrieval device, insertable, laser (used to retrieve intravascular inferior vena cava filter)
C1604	Graft, transmural transvenous arterial bypass (implantable), with all delivery components
C1605	Pacemaker, leadless, dual chamber (right atrial and right ventricular implantable components), rate-responsive, including all necessary components for implantation
C1714	Catheter, transluminal atherectomy, directional
C1721	Cardioverter-defibrillator, dual chamber (implantable)
C1722	Cardioverter-defibrillator, single chamber (implantable)
C1724	Catheter, transluminal atherectomy, rotational
C1725	Catheter, transluminal angioplasty, non-laser (may include guidance, infusion/perfusion capability)
C1726	Catheter, balloon dilatation, non-vascular
C1727	Catheter, balloon tissue dissector, non-vascular (insertable)
C1729	Catheter, drainage
C1730	Catheter, electrophysiology, diagnostic, other than 3d mapping (19 or fewer electrodes)
C1731	Catheter, electrophysiology, diagnostic, other than 3d mapping (20 or more electrodes)
C1732	Catheter, electrophysiology, diagnostic/ablation, 3d or vector mapping
C1733	Catheter, electrophysiology, diagnostic/ablation, other than 3d or vector mapping, other than cool-tip
C1735	Catheter(s), intravascular for renal denervation, radiofrequency, including all single use system components
C1736	Catheter(s), intravascular for renal denervation, ultrasound, including all single use system components
C1739	Tissue marker, imaging and non-imaging device (implantable)
C1750	Catheter, hemodialysis/peritoneal, long-term
C1751	Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)
C1752	Catheter, hemodialysis/peritoneal, short-term
C1753	Catheter, intravascular ultrasound
C1754	Catheter, intradiscal
C1755	Catheter, intraspinal
C1756	Catheter, pacing, transesophageal
C1757	Catheter, thrombectomy/embolectomy
C1758	Catheter, ureteral
C1759	Catheter, intracardiac echocardiography
C1760	Closure device, vascular (implantable/insertable)
C1761	Catheter, transluminal intravascular lithotripsy, coronary
C1766	Introducer/sheath, guiding, intracardiac electrophysiological, steerable, other than peel-away
C1768	Graft, vascular
C1769	Guide wire
C1772	Infusion pump, programmable, implantable
C1773	Retrieval device, insertable (used to retrieve fractured medical devices)
C1777	Lead, cardioverter-defibrillator, endocardial single coil (implantable)
C1779	Lead, pacemaker, transvenous vdd single pass
C1785	Pacemaker, dual chamber, rate-responsive (implantable)
C1786	Pacemaker, single chamber, rate-responsive (implantable)
C1788	Port, indwelling (implantable)

Appendix E: 2026 Status Indicators for OPPS Payment

Indicator	Item/Code/Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Separately payable clinical diagnostic laboratory services • Separately payable non-implantable prosthetics and orthotics • Physical, Occupational, and Speech Therapy • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS. Services are subject to deductible or coinsurance unless indicated otherwise. Not subject to deductible or coinsurance. Not subject to deductible.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E1	Items and Services: • Not covered by any Medicare outpatient benefit category • Statutorily excluded by Medicare • Not reasonable and necessary	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
E2	Items and Services: For which pricing information and claims data are not available	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; separate APC payment.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; not subject to copayment.
J1	Hospital Part B services paid through a comprehensive APC	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 SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
J2	Hospital Part B Services That May Be Paid Through a Comprehensive APC	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services. (2) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "J1." (3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.