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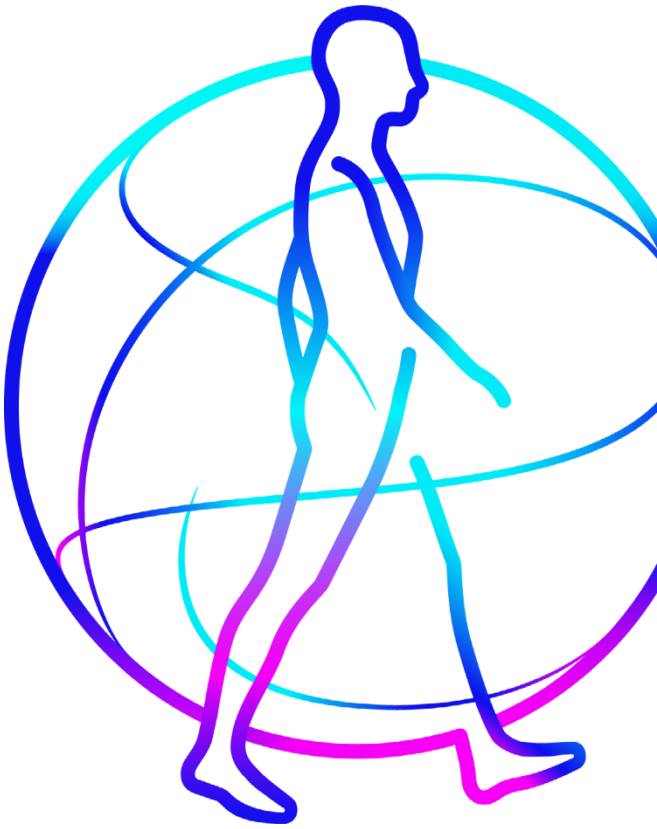

Peripheral mechanical thrombectomy

2026 coding and payment guide

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Hospital Inpatient Coding and Payment

Effective October 1, 2025 – September 30, 2026

ICD-10-PCS procedure codes

ICD-10-PCS codes are used by hospitals to report surgeries and procedures performed in the inpatient setting. They are a factor in Medicare DRG payment for hospital inpatient services. Note: Below are commonly assigned ICD-10-PCS codes. However, the codes listed below are not exhaustive, as other codes may apply.

Peripheral mechanical thrombectomy - arterial

Procedure code[1]	Procedure code description
03C33ZZ	Extirpation of Matter from Right Subclavian Artery, Percutaneous Approach
03C43ZZ	Extirpation of Matter from Left Subclavian Artery, Percutaneous Approach
03C53ZZ	Extirpation of Matter from Right Axillary Artery, Percutaneous Approach
03C63ZZ	Extirpation of Matter from Left Axillary Artery, Percutaneous Approach
03C73ZZ	Extirpation of Matter from Right Brachial Artery, Percutaneous Approach
03C83ZZ	Extirpation of Matter from Left Brachial Artery, Percutaneous Approach
03C93ZZ	Extirpation of Matter from Right Ulnar Artery, Percutaneous Approach
03CA3ZZ	Extirpation of Matter from Left Ulnar Artery, Percutaneous Approach
03CB3ZZ	Extirpation of Matter from Right Radial Artery, Percutaneous Approach
03CC3ZZ	Extirpation of Matter from Left Radial Artery, Percutaneous Approach
03CY3ZZ	Extirpation of Matter from Upper Artery, Percutaneous Approach
04C53ZZ	Extirpation of Matter from Superior Mesenteric Artery, Percutaneous Approach
04C93ZZ	Extirpation of Matter from Right Renal Artery, Percutaneous Approach
04CA3ZZ	Extirpation of Matter from Left Renal Artery, Percutaneous Approach
04CB3ZZ	Extirpation of Matter from Inferior Mesenteric Artery, Percutaneous Approach
04CC3ZZ	Extirpation of Matter from Right Common Iliac Artery, Percutaneous Approach
04CD3ZZ	Extirpation of Matter from Left Common Iliac Artery, Percutaneous Approach
04CE3ZZ	Extirpation of Matter from Right Internal Iliac Artery, Percutaneous Approach
04CF3ZZ	Extirpation of Matter from Left Internal Iliac Artery, Percutaneous Approach
04CH3ZZ	Extirpation of Matter from Right External Iliac Artery, Percutaneous Approach
04CJ3ZZ	Extirpation of Matter from Left External Iliac Artery, Percutaneous Approach
04CK3ZZ	Extirpation of Matter from Right Femoral Artery, Percutaneous Approach
04CL3ZZ	Extirpation of Matter from Left Femoral Artery, Percutaneous Approach
04CM3ZZ	Extirpation of Matter from Right Popliteal Artery, Percutaneous Approach
04CN3ZZ	Extirpation of Matter from Left Popliteal Artery, Percutaneous Approach
04CP3ZZ	Extirpation of Matter from Right Anterior Tibial Artery, Percutaneous Approach
04CQ3ZZ	Extirpation of Matter from Left Anterior Tibial Artery, Percutaneous Approach
04CR3ZZ	Extirpation of Matter from Right Posterior Tibial Artery, Percutaneous Approach

Procedure code[1]	Procedure code description
04CS3ZZ	Extirpation of Matter from Left Posterior Tibial Artery, Percutaneous Approach
04CT3ZZ	Extirpation of Matter from Right Peroneal Artery, Percutaneous Approach
04CU3ZZ	Extirpation of Matter from Left Peroneal Artery, Percutaneous Approach
04CV3ZZ	Extirpation of Matter from Right Foot Artery, Percutaneous Approach
04CW3ZZ	Extirpation of Matter from Left Foot Artery, Percutaneous Approach
04CY3ZZ	Extirpation of Matter from Lower Artery, Percutaneous Approach

Peripheral mechanical thrombectomy - venous

Procedure code[1]	Procedure code description
02CV3ZZ	Extirpation of Matter from Superior Vena Cava, Percutaneous Approach
05C53ZZ	Extirpation of Matter from Right Subclavian Vein, Percutaneous Approach
05C63ZZ	Extirpation of Matter from Left Subclavian Vein, Percutaneous Approach
05C73ZZ	Extirpation of Matter from Right Axillary Vein, Percutaneous Approach
05C83ZZ	Extirpation of Matter from Left Axillary Vein, Percutaneous Approach
05C93ZZ	Extirpation of Matter from Right Brachial Vein, Percutaneous Approach
05CA3ZZ	Extirpation of Matter from Left Brachial Vein, Percutaneous Approach
05CB3ZZ	Extirpation of Matter from Right Basilic Vein, Percutaneous Approach
05CC3ZZ	Extirpation of Matter from Left Basilic Vein, Percutaneous Approach
05CD3ZZ	Extirpation of Matter from Right Cephalic Vein, Percutaneous Approach
05CF3ZZ	Extirpation of Matter from Left Cephalic Vein, Percutaneous Approach
06C93ZZ	Extirpation of Matter from Right Renal Vein, Percutaneous Approach
06CB3ZZ	Extirpation of Matter from Left Renal Vein, Percutaneous Approach
06CC3ZZ	Extirpation of Matter from Right Common Iliac Vein, Percutaneous Approach
06CD3ZZ	Extirpation of Matter from Left Common Iliac Vein, Percutaneous Approach
06CF3ZZ	Extirpation of Matter from Right External Iliac Vein, Percutaneous Approach
06CG3ZZ	Extirpation of Matter from Left External Iliac Vein, Percutaneous Approach
06CH3ZZ	Extirpation of Matter from Right Hypogastric Vein, Percutaneous Approach
06CJ3ZZ	Extirpation of Matter from Left Hypogastric Vein, Percutaneous Approach
06CM3ZZ	Extirpation of Matter from Right Femoral Vein, Percutaneous Approach
06CN3ZZ	Extirpation of Matter from Left Femoral Vein, Percutaneous Approach
06CP3ZZ	Extirpation of Matter from Right Saphenous Vein, Percutaneous Approach
06CQ3ZZ	Extirpation of Matter from Left Saphenous Vein, Percutaneous Approach
06CT3ZZ	Extirpation of Matter from Right Foot Vein, Percutaneous Approach
06CV3ZZ	Extirpation of Matter from Left Foot Vein, Percutaneous Approach
06CY3ZZ	Extirpation of Matter from Lower Vein, Percutaneous Approach

MS-DRG Assignments

FY 2026 Inpatient Prospective Payment System (IPPS) payment rates are effective for inpatient services on October 1, 2025. This is not an all-inclusive list of possible MS-DRGs. MS-DRG assignment is based on many factors including documented patient conditions, as well as services rendered during an inpatient admission.

Note: For certain procedures, DRG assignment varies depending on the primary diagnosis.

MS-DRG[2]	MS-DRG title[2]	Relative weight[3]	2026 Medicare National Average Payment[4]
270	Other Major Cardiovascular Procedures with MCC	5.2763	$38,394
271	Other Major Cardiovascular Procedures with CC	3.5563	$25,878
272	Other Major Cardiovascular Procedures without CC or MCC	2.5530	$18,578
252	Other Vascular Procedures with MCC	3.4883	$25,384
253	Other Vascular Procedures with CC	2.5956	$18,888
254	Other Vascular Procedures without CC/MCC	1.7817	$12,965

MCC = major complication or comorbidity

Hospital Outpatient Coding and Payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[5]	APC[6]	Status Indicator[6]	Medicare national average[6]
Arterial mechanical thrombectomy [a, b, c, d, q, r]	**37184**[e, f] Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	5194	J1	$18,729
	+37185[e, f] Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)		N	
	+37186[g, h, i] Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)		N	

Procedure	CPT procedure code and description[5]	APC[6]	Status Indicator[6]	Medicare national average[6]
Venous mechanical thrombectomy	**37187**[j] Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	5193	J1	$11,794
	37188[j] Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	5183	J1	$3,226
Dialysis circuit mechanical thrombectomy[l, m, q]	**36904** Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	5192	J1	$5,815
	36905[n, o, p] Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	5193	J1	$11,794
	36906[o, p] Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	5194	J1	$18,729
Manual aspiration thrombectomy	**37799** Unlisted procedure, vascular surgery	5181	T	$641
Arterial and venous thrombolysis[r, s, t, u, v]	**37211**[w, y] Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	5184	J1	$5,685
	37212[w, y] Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	5183	J1	$3,226

Procedure	CPT procedure code and description[5]	APC[6]	Status Indicator[6]	Medicare national average[6]
	37213[x] Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	5183	J1	$3,226
	37214[x] Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	5183	J1	$3,226

Complexity-adjusted APCs[7]

Comprehensive APC (C-APC) claims may be eligible for a complexity adjustment in certain situations. This complexity adjustment promotes the claim to the next higher cost APC within the primary procedure's clinical family. The complexity adjustments are developed for frequently occurring combinations that significantly increase the cost of the primary procedure claim.

Primary CPT®	Primary CPT® Description	Primary APC Assigned	Secondary or add-on CPT®	Secondary or add-on CPT® Description	Secondary APC Assigned	Complexity Adjusted APC Assignment
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	5193	37238	Intravascular stent, initial vein	5193	5194
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	5193	37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	5193	5194
37187	Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	5193	37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein	5193	5194

HCPCS II device codes

Effective January 1, 2025 – December 31, 2025

HCPCS II device codes[9]	HCPCS II code description
C1757	Catheter, thrombectomy/embolectomy
C1769	Guidewire
C1894	Introducer/sheath, other than guiding, other than intracardiac electrophysiological, nonlaser
C1887	Catheter, guiding (may include infusion/perfusion capability)
C1760	Closure device, vascular (implantable/insertable)

Note: This list is not exhaustive. Additional codes may apply, and not all codes listed will be relevant to every procedure. Not every component of these procedures has a separate C-code.

Physician coding and payment

Effective January 1, 2025 – December 31, 2025

Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

Mechanical thrombectomy and thrombolysis codes

Procedure	CPT procedure code and description[5]	Multiple procedure discounting[8]	Medicare work RVUs (facility setting)[8]	Medicare national average for physician services provided in facility setting[8]
Arterial mechanical thrombectomy [a, b, c, d, q, r]	**37184**[e, f] Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel	Yes	8.20	$376
	+37185[e, f] Primary percutaneous transluminal mechanical thrombectomy, noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)	Yes	3.20	$141
	+37186[g, h, i] Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, non-intracranial, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)	Yes	4.80	$218

Procedure	CPT procedure code and description[5]	Multiple procedure discounting[8]	Medicare work RVUs (facility setting)[8]	Medicare national average for physician services provided in facility setting[8]
Venous mechanical thrombectomy	**37187**[j, k] Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance	Yes	7.59	$346
	37188[j, k] Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy	No	5.32	$251
Dialysis circuit mechanical thrombectomy[l, m, q]	**36904** Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s)	Yes	7.31	$321
	36905[n, o, p] Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty	Yes	8.78	$386
	36906[o, p] Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit	Yes	10.16	$445
Manual aspiration thrombectomy	**37799** Unlisted procedure, vascular surgery		1.71	n/a
Arterial and venous thrombolysis[r, s, t, u, v, z]	**37211**[w, y] Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day	Yes	7.56	$338
	37212[w, y] Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day	Yes	6.64	$295

Procedure	CPT procedure code and description[5]	Multiple procedure discounting[8]	Medicare work RVUs (facility setting)[8]	Medicare national average for physician services provided in facility setting[8]
	37213[x] Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed	Yes	4.63	$202
	37214[x] Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method	Yes	2.43	$107

Coding Footnotes[5]

a. Thrombectomy codes 37184-37188 include intraprocedural fluoroscopic guidance, all radiological supervision and interpretation for fluoroscopic imaging, and completion angiography (CPT Assistant September 2019, p. 5).

b. Codes 37184-37188 do not include selective catheterization (eg, 36011-36015, 36245-36247) or other interventions, eg, angioplasty, stenting. These may be coded separately.

c. Diagnostic angiography cannot be coded separately with 37184-37188 if a prior study was performed unless it is medically necessary to repeat the prior study (2026 NCCI Policy Manual, Chapter V, D-13). Modifier -59 can be used to override NCCI edits in this scenario.

d. Intraprocedural injection of thrombolytics is included in codes 37184-37188.

e. Arterial thrombectomy codes 37184, +37185 are primary procedures in which the focus is on performing the thrombectomy. The diagnosis is usually established and the procedure planned in advance, although occasionally, a primary thrombectomy may follow another intervention.

f. Code 37184 is assigned for the initial vessel within a vascular family and code +37185 is assigned once for any and all additional vessels within the vascular family (CPT Assistant September 2019 p. 5 and April 2015 p. 10). Medicare's Medically Unlikely Edits (MUE) published 1/1/2026 state that in bilateral thrombectomy, code +37185 can be reported twice, ie, once per side.

g. Secondary arterial thrombectomy code +37186 is assigned for removal of short segments of thrombus performed either before or after another intended intervention, eg, removing a small amount of thrombus prior to performing a planned angioplasty or removing distal thrombus after planned angioplasty. This scenario should never be assigned to 37184, +37185.

h. National Correct Coding Initiative (NCCI) edits prohibit coding +37186 with primary thrombectomy code 37184.

i. Do not assign secondary thrombectomy code +37186 for removal of thrombus associated with an atherectomy (2026 NCCI Policy Manual, Chapter V, D-26, see also CPT Assistant, July 2011 p.9-11).

j. Venous thrombectomy code 37187 is assigned for the initial procedure day. Code 37188 is assigned when it is necessary to perform repeat venous thrombectomy on a subsequent day during the course of treatment. This may occur when initial venous thrombectomy 37187 followed by continuous thrombolytic infusion 37212, 37213 does not resolve the thrombus (CPT Assistant, February 2013 p.4).

k. Bilateral modifier -50 can be used with primary arterial thrombectomy code 37184 and with venous thrombectomy codes 37187 and 37188. It cannot be used with +37185, +37186[8].

l. Codes 36904-36906 include fistulogram, ie, contrast injection and diagnostic imaging from arterial anastomosis through venous outflow to the vena cava. These codes also include catheterization, fluoroscopic guidance, roadmapping, angiography, radiologic supervision and interpretation, and access closure by any means.

m. Intraprocedural injection of thrombolytics is included in dialysis circuit thrombectomy codes 36904-36906. However, subsequent or prior continuous infusion of a thrombolytic is not included and can be separately coded with 36904-36906.

n. Do not assign code 36905 for thrombectomy with angioplasty for removal of the anastomotic plug via balloon. This constitutes a thrombectomy and is included in 36904 (AMA CPT Changes 2017: An Insider's View, p.67).
o. Code 36906 includes all services in code 36905, and code 36905 includes all services in code 36904.
p. Codes 36905 and 36906 are reported only once per session, regardless of the number of lesions treated, the number of balloons used, or the number of stents placed (2026 NCCI Policy Manual, Chapter V, G-3). Code 36905 is not reported separately with 36906 even if the angioplasty is performed on a separate lesion from the stent placement (CPT Assistant, March 2017, p. 5).
q. General thrombectomy codes 37184-37188 cannot be assigned together with dialysis circuit thrombectomy codes 36904-36906 as they are considered mutually exclusive (NCCI edits).
r. Although intraprocedural injection of thrombolytics is included in general thrombectomy codes 37184-37188, subsequent or prior continuous infusion of a thrombolytic is not included and can be separately coded with 37211-37214. There are NCCI edits for 37211-37214 with the general thrombectomy codes, but the edits allow an override for this scenario.
s. Thrombolytic infusion codes 37211-37214 include fluoroscopic guidance, all radiological supervision and interpretation for fluoroscopic imaging, and completion angiography (AMA CPT Changes 2013: An Insider's View, p.140-141).
t. Codes 37211-37214 do not include selective catheterization (eg, 36011-36015, 36245-36247) or other interventions, eg, angioplasty, stenting. These may be coded separately.
u. Diagnostic angiography cannot be coded separately with 37211-37214 if a prior study was performed unless it is medically necessary to repeat the prior study (2026 NCCI Policy Manual, Chapter V, D-13). Modifier -59 can be used to override NCCI edits in this scenario.
v. Codes 37211-37214 are assigned once per treatment day (AMA CPT Changes 2013: An Insider's View, p.141, MUE edits 1st Q 2026).
w. Arterial thrombolytic infusion code 37211 and venous code 37212 are assigned for the initial treatment day and include any follow-up angiography, catheter repositioning, and catheter exchange when performed.
x. Code 37213 is assigned for continued infusion on a subsequent treatment day and code 37214 is used for the day when infusion is discontinued. Both include catheter exchange when performed (AMA CPT Changes 2013: An Insider's View, p.141).
y. When initiation and discontinuation of thrombolytic infusion occur on the same day, only 37211 or 37212 is reported.
z. Bilateral modifier -50 can be used with thrombolytic infusion codes 37211 and 37212. It cannot be used with 37213, 37214 (2026 National Physician Fee Schedule Relative Value File).

Annual References

1. AAPC. ICD-10-PCS Code Book 2026. AAPC; 2025.
2. CMS. ICD-10-CM/PCS MS-DRG v43.0 Definitions Manual. Cms.gov. Published 2025. https://www.cms.gov/icd10m/FY2026-fr-v43-fullcode-cms/fullcode_cms/P0001.html
3. FY 2026 IPPS Final Rule Home Page | CMS. Cms.gov. Published July 31, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page
4. Rates shown reflect the unadjusted IPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
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6. OPPS 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc
   Rates shown reflect the unadjusted OPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
7. 2026 NPRM OPPS Addenda. Cms.gov. Published November 21, 2025. https://www.cms.gov/license/ama?file=/files/zip/2026-nprm-opps-addenda.zip
8. PFS 2026 Final Rule CMS-1832-F | CMS. Cms.gov. Published October 31, 2025. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f
   Local physician rates will vary based on location specific factors not reflected in this document.
9. HCPCS 2025 Level II Professional Edition. American Medical Association; 2024. These codes are used by the entity that purchased and supplied the medical device. For Medicare hospital outpatient claims, C-Codes are required. For Medicare ASC claims C-Codes are not

reported for packaged items, yet may be reported for non-packaged items such as items with transitional pass-through status. C1826 has Medicare pass transitional passthrough status effective 1/1/23-12/31/25. For non- Medicare hospital or ASC claims, please consult payer specific contracts for whether C or L codes would be billed.

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