# AGENT

## New Category III CPT® Code Approved for AGENT™ Drug-coated balloon procedures

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.

## AGENT indications for Use:

The AGENT™Paclitaxel-Coated AGENT 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.

To facilitate payment associated with Category III codes, additional documentation is often required as CMS does not establish relative value units (RVU’s) for category III codes. 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

For Medicare claims the Medicare Administrative Contractors (MAC’s) establish RVU’s and payment rates. Each MAC will determine their own payment rates, and they may not be public.

This guide is to help with crosswalk or process options to assign billing charges for the new Category III CPT codes for AGENT.

| 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) |

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Append appropriate site modifiers:

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

## REPORTING CATEGORY III CPT CODES

Category III codes are not nationally valued and therefore payers use different payment methodologies to determine physician reimbursement associated with the code. For Medicare claims, associated RVUs and payment rates for Category III codes are established by the Medicare Administrative Contractors (MACs). Each MAC establishes their own payment rates and coverage policies for Category III CPT codes.[2] It is recommended that providers check with their specific MAC for additional information related to the payment levels for CPT code 0913T and +0914T.

Private payors determine coverage and payment for procedures described by Category III CPT codes individually and may pay based on a percentage of physician charges, a percentage of Medicare fee schedule amounts, or by some other methodology. We recommend checking with your payer contracts to determine if they have specific guidelines for pricing and billing of Category III codes.

## DETERMINING CHARGES

When reporting charges for CPT codes 0913T physicians should provide a crosswalk to an existing Category I CPT code with comparable resources for the service.

In the absence of established RVUs, payers rely on the use of a comparator code to set an RVU rate for codes without established payment. Payers will require supporting documentation to assign payment. It will be important to document the services provided regarding resources and time for appropriate payment valuation. Physicians should be prepared to submit information to assist in coverage and payment decisions. Recommended items to support your Category III claims submissions include:

- Copy of operative or procedure report with clinical notes (Indication for procedure)
- Letter of medical necessity
- Relevant crosswalk CPT code with anticipated payment indicated


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## CATEGORY III CROSSWALK CODE

Physicians should provide a coding crosswalk to an existing Category I code procedure, similar in complexity and time. The crosswalk code should be a comparable add-on code in terms of complexity and time.

To select a coding crosswalk:

- Select a comparable procedure with an established payment level that involves similar physician time, medical decision making and practice expense as the AGENT DCB procedure
- Include a comparison statement of similarities and differences in time, training and resources;
- both require similar physician time, effort and complexity;
- Document any differences in work for the service associated with the 0913T
- Include a brief statement explaining the crosswalk code e.g. comparison of Drug Coated Balloon to Drug Eluting Stent
- Indicate the normal charge for the comparison service code, and the charge for the 0913T CPT code based on the percentage increase or decrease

Example: Potential Options for CPT Code crosswalks for 0913T:

| Category 1 CPT Code | Brief Description | Physician Work RVUs | Total Physician RVUs | Medicare 2025 PFS rate | Physician Intraoperative Service Time |
|---|---|---|---|---|---|
| 92928 | Percutaneous transcatheter placement of intracoronary stent, with angioplasty when performed; single artery or branch | 10.96 | 17.21 | $572 | 135 Minutes |
| +92978 | Endoluminal Imaging of coronary vessel using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) | 1.80 | 2.76 | $92 | 25 Minutes |
| **OR** | | | | | |
| 92920 | Percutaneous transluminal coronary angioplasty; single major coronary artery or branch | 9.85 | 15.49 | $501 | 127 Minutes |
| +92978 | Endoluminal Imaging of coronary vessel using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) | 1.80 | 2.76 | $92 | 25 Minutes |

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Example: Potential CPT Code crosswalks for +0914T:

| Category 1 CPT Code | Brief Description | Physician Work RVUs | Total Physician RVUs | Medicare 2025 PFS rate | Physician Intraoperative Service Time |
|---|---|---|---|---|---|
| +33904 | Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (List separately in addition to code for primary procedure) | 5.53 | 8.78 | $281 | 45 Minutes |
| +37234 | Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure) | 5.50 | 8.21 | $266 | 62 Minutes |
| +92998 | Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure) | 5.99 | 9.33 | $302 | 58 Minutes |

**Physician Work Relative Value Units (RVUs)** = Work RVUs account for the provider's work when performing a procedure or service. Variables factored into this value include technical skills, physical effort, mental effort and judgement, stress related to patient risk, and the amount of time required to perform the service or procedure.

**Total RVUs** = The Total RVUs are a combination of Physician Work, Practice Expense and Malpractice RVUs.

**Intraoperative Service time**= is limited to intraoperative work only and does not include time for pre-evaluation, pre-positioning, pre-service scrub time or immediate post service time.

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## 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

## Physician Claims Checklist

- ✓ Confirm payer billing requirements for all claims with Category III CPT codes
- ✓ Ensure appropriate medical record documentation including prior-authorization approval, if required
- ✓ Report CPT code 0913T per encounter and include a crosswalk of the appropriate Category I CPT code along with a separate letter describing the service, identifying RVUs and charges for the comparable service, and its similarities and differences to the percutaneous drug-coated balloon procedure described by 0913T
- ✓ If requested, provide additional documentation and plan to appeal the payer's decision if not covered

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## Physician Billing

Physician claims must contain the appropriate CPT codes to report procedures furnished in the physician office or facility

For Medicare claims, Category III CPT codes are considered Medicare Administrative Contractor (MAC) priced and therefore no RVUs are assigned. Each MAC establishes their own payment rates for Category III CPT codes. It is recommended that providers check with their MAC for additional information related to the payment levels for CPT code 0913T and +0914T. For commercial payers, payer guidelines and provider contracts should be referenced to identify reporting requirements and reimbursement for Category III CPT codes.

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

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

## Patient Consent and Copay

For Medicare beneficiaries, services are subject to a 20% beneficiary copay.

For commercial payers, it is recommended that each individual payer's guidelines be referenced as consent and copay policies may vary.

## 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.


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**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.



## 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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