

2026 CODING & PAYMENT REFERENCE GUIDE IN-STENT RESTENOSIS (ISR) INDICATION

SELUTION SLR™
DRUG-ELUTING BALLOON



SELUTION SLR™ Drug-eluting Balloon (DEB) is the first sirolimus-approved DEB for treatment of coronary in-stent restenosis (ISR).

The following guide is intended to capture the 2026 coding and payment guidance to facilitate accurate and appropriate billing.

The following are 2026 codes and Medicare national average payment rates for coronary therapy procedures involving coronary drug-eluting balloons. Actual rates will vary by hospital. Information provided represents Center for Medicare & Medicaid Services (CMS) guidance, commercial payer policies may vary and should be verified prior to treatment.

The codes outlined in this guide are commonly used procedural codes, we recommend consulting your relevant internal guidance for appropriate coding options.

INDICATION FOR USE

The SELUTION SLR™ PTCA Drug-Eluting Balloon is intended to be used after appropriate vessel preparation in patients undergoing percutaneous coronary intervention (PCI) in coronary arteries 2.25 mm to 4.50 mm in diameter and lesions ≤ 26 mm in length for the purpose of improving myocardial perfusion when treating in-stent restenosis (ISR).

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Hospital Outpatient Coding Reference

EMERGING PROCEDURE CODING: CORONARY DRUG-ELUTING BALLOONS

Effective January 1, 2025, CMS established Category III codes 0913T and +0914T for coronary drug-coated/eluting balloons.

Category III codes are common for new procedures and technologies. Category III codes are payable when medically necessary and reported with the appropriate documentation. Follow this link for more details on [the AMA CAT III codes](#).

CPT® Codes	Description	APC	2026 Payment Rate
0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g., drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using IVUS or OCT when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	5193	\$11,794
+0914T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting) performed on a separate target lesion from the target lesion treated with balloon angioplasty, coronary stent placement or coronary atherectomy, including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using IVUS or OCT when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	N/A	Packaged

Transitional Pass-Through Payment Guide

TPT CODE FOR CORONARY DEB

Effective January 1, 2025, Center for Medicare & Medicaid Services (CMS) has established a Transitional Pass-Through (TPT) payment category for coronary drug-coated and drug-eluting balloons (DCB and DEB). SELUTION SLR™ Drug Eluting Balloon (DEB) is the first sirolimus based DEB to be approved by the FDA as a treatment option for patients with in-stent restenosis (ISR). When utilized in procedures performed in the hospital outpatient setting, the TPT provides incremental payment in addition to the applicable Ambulatory Payment Classification (APC) payment to offset the cost of SELUTION SLR™ DEB for outpatient services.

HCPCS Code	Description
C9610	Catheter, transluminal drug delivery with or without angioplasty, coronary, non-laser (insertable)

This billing code for Coronary DEB is effective from January 1, 2025 through December 31, 2027.

CPT®/HCPCS Codes for Procedures Associated with Coronary DEB

To receive the TPT payment, hospitals must report C9610 on outpatient claims for cases where SELUTION SLR™ DEB along with the code for the associated procedure. Medicare will provide TPT when the code is reported with one of the following CPT®/HCPCS procedure codes.

Individual coding decisions are the responsibility of the provider and should be based upon diagnosis and treatment of individual patients.

Code	Description	2026 APC Payment Rate
0913T	Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (e.g., drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using IVUS or OCT when performed, imaging supervision, interpretation, and report, single major coronary artery or branch	\$11,794
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	\$5,815
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch	\$11,794
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	\$11,794
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	\$11,794
92930	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed, single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch	\$18,729
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	\$18,729
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch	\$18,729
92937	Percutaneous transluminal revascularization of a single coronary artery bypass graft using angioplasty, atherectomy, and/or stent placement.	\$11,794
92943	Percutaneous transluminal revascularization of a chronic total occlusion (CTO) in a coronary artery, branch, or bypass graft using angioplasty, stent placement, and/or atherectomy for a single vessel.	\$11,794
92945	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approaches	\$11,794
C9604	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel	\$11,794
C9607	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty; single vessel	\$18,729

TPT Payment Amount and Illustration

CMS will determine the incremental TPT payment amount for SELUTION SLR™ DEB on a case-by-case basis for each hospital. The TPT payment is not a set amount as it is calculated based on:

- A hospital's charge for SELUTION SLR™ DEB, which includes a hospital charge adjustment to account for operating and capital costs.
- A hospital cost -charge-ratio (CCR) for implantable medical devices, typically reported under Revenue Center 278, which CMS publishes. CMS applies this CCR to the charges a hospital submits to determine the cost of the DEB to the hospital.
- The device-related portion of the relevant HCPCS procedure code, which is referred to as the device offset.

CMS has determined the costs associated with C9610 are not reflected in the current APC assignment. Therefore, there is no offset device cost when using C9610.

Commercial payers are not required to follow CMS payment levels. It is recommended to reach out to commercial payers to understand their policy for reimbursement for SEULTION SLR™ DEB.

IMPORTANT:

Using TPT code C9610 with SELUTION SLR™ DEB is important not only for current hospital reimbursement, but also to ensure CMS captures the full procedural cost for future rate setting

OVERVIEW OF THE TPT PAYMENT CALCULATION

- Determine the APC payment amount for the procedure.
- Multiply the SELUTION SLR™ DEB acquisition costs by your hospitals charge adjustment - this is the billed amount using C9610.
- Determine your hospital specific implantable device cost to charge ratio.
- Determine the device offset amount for your CPT® procedure (no device offset for SELUTION SLR™ DEB).
- Calculate your TPT payment amount by multiplying your DEB charges by the CCR. Subtract the device offset.
- Calculate the total hospital payment by adding the APC amount to the calculated TPT payment.

For illustrative purposes only. In this example, we'll evaluate the hospital outpatient setting use of SELUTION SLR™ DEB during a percutaneous coronary procedure.

	Step	Description	Action	Calculation
Procedure Payment	1	0913T		\$11,794
	2	Acquisition cost for SELUTION SLR™ DEB		\$6,175
	3	Hospital Charge Adjustment		300% (or 3.0x)
TPT Calculation	4	Total DEB Charges (C9610)	multiply row 2 x 3	\$18,525
	5	Hospital Specific Implantable Device Charged to Patients (CCR)		0.333
	6	Device Offset		\$0
	7	CMS Calculated TPT Payment	multiply row 4 x 5 and subtract 6	\$6,169
DEB Procedure Payment	8	Total Hospital Payment	add row 1 and 7	\$17,963

Hospital Inpatient Coding Reference

Use of SELUTION SLR™ Drug-Eluting Balloons is bundled within the existing Medicare Severity Diagnosis Related Groups (MS-DRGs). MS-DRGs listed in this guide are commonly used to report coronary percutaneous interventions (PCI), we recommend consulting internal guidance for appropriate coding options within your facility.

Therapy	MS-DRG	Severity	Description	2026 Payment Rate
PCI with an intraluminal device	321	MCC	PCI with intraluminal device or 4+ arteries	\$11,794
	322	CC/None	PCI with intraluminal device	\$12,829
Coronary IVL with an intraluminal device	323	MCC	C-IVL with intraluminal device	\$31,489
	324	CC/None		\$22,929
Coronary IVL Only	325		C-IVL w/o intraluminal device	\$23,361
PCI without intraluminal device	250	MCC	Percutaneous cardiovascular procedures without coronary artery stent	\$15,882
	251	CC/None		\$10,875
Coronary Atherectomy with an intraluminal device	359	MCC	Percutaneous coronary atherectomy with intraluminal device	\$25,022
	390	CC/None		\$17,568
Coronary Atherectomy	318	N/A	Percutaneous coronary atherectomy without intraluminal device	\$17,626

Physician Coding Reference

This guide is to assist with crosswalk or process options to assign billing charges for Category III codes for SELUTION SLR™ DEB. Category III codes allow data collection of emerging technologies. CMS does not establish relative value units (RVUs) for Category III codes. To facilitate payment associated with Category III codes, additional documentation is often required.

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 codes. It is recommended that providers check with their specific MAC for additional information related to payment levels of CPT® code 0913T and +0914T. Similarly, commercial payers may use different methodologies for calculating fee schedules. We recommend checking with commercial payers to determine their guidelines for pricing and billing of Category III codes.

IMPORTANT

Category I codes for Coronary DCB/DEBs are authorized and will go into effect January 1, 2027. Details on coding and payment information will be made available ahead of the effective date.

DETERMINING CHARGES FOR USE OF SELUTION SLR™ DEB

When reporting charges for CPT® code 0913T, physicians should provide a crosswalk to an existing Category I CPT® code with comparable procedures in complexity and time.

In creating a crosswalk consider including:

- A selection of a comparable procedure relative to time, medical decision making, and expense.
- A comparison statement of similarities and differences in time, resources, effort and complexity.
- Documenting any differences in work for the service associated with 0913T.
- A statement explaining the crosswalk code (e.g., comparison of drug-eluting balloon to drug-eluting stent or plain balloon angioplasty).
- Indicating the normal charge for the comparison service code and the relative charge for the 0913T procedure.

SAMPLE CROSSWALK

Cat III CPT® Code	Description	Physician Work RVUs	Total Physician RVUs	Medicare 2026 PFS Payment Rate
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch	8.14	11.58	\$387
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch	9.75	13.87	\$463

Frequently Asked CPT Questions

Do we need pre-authorization for Category III codes?

Prior authorization may be required for commercial and Medicare Advantage coverage. Consult payers directly to determine if prior authorization is required or available.

Traditional Medicare fee-for-service does not require prior authorization.

Can we bill unlisted codes?

Per AMA guidance, if an appropriate Category III code exists, it must be utilized. 0913T should be used when stand-alone SELUTION SLR™ DEB procedures are performed. +0914T should be used when reporting SELUTION SLR™ DEB in conjunction with another primary PCI procedure.

If multiple SELUTION SLR™ DEB devices are used in a procedure, how should the hospital report?

If multiple SELUTION SLR™ DEB devices are used in a single procedure, the device charges are then multiplied by the total number used in that procedure.

What if a hospital encounter claims edits/issues regarding submission of claims with C9610?

Providers should contact the appropriate payer to seek clarification on the claims issue. Please contact the Cordis Reimbursement Hotline at (866) 379-3367 or by emailing us at [SELUTION SLR™ DEB Reimbursement](#) with the details of the issue for additional support and guidance.

How should a hospital bill procedures that include the use of SELUTION SLR™ DEB in the outpatient setting?

We suggest the best practices for billing a percutaneous coronary procedure that utilizes SELUTION SLR™ DEB in the hospital outpatient setting:

- Ensure the correct CPT®/HCPCS procedure code(s) for the procedure performed is submitted with C9610.
- Specify the number of SELUTION SLR™ DEB units in the procedure.
- Ensure the charges reflect the number of SELUTION SLR™ DEB devices used in the procedure.

How are physician payments impacted by the C-Code for Coronary DEB?

Physicians do not bill C9610 when utilizing Coronary DCB/DEB devices in percutaneous coronary interventions. C9610 is specifically designated for use in the hospital outpatient setting for the purposes of providing incremental payments.

Frequently Asked TPT Questions

How long is the TPT in place for SELUTION SLR™ DEB?

CMS established the TPT for coronary DCB/DEB effective January 1, 2025 through December 31, 2027.

Where can a hospital find its specific cost-to-charge ratio (CCR) used in the TPT payment calculation?

The provider specific CCR is part of the Outpatient Rate setting files provided by CMS. Hospital specific CCR are available by calling the Cordis Reimbursement Hotline at (866) 379-3367 or by emailing us at [SELUTION SLR™ DEB Reimbursement](#). Please provide your Medicare provider number. If you do not know this number, please provide the name and location of your hospital.

If multiple SELUTION SLR™ DEB devices are used in a procedure, how should the hospital report?

If multiple SELUTION SLR™ DEB devices are used in a single procedure, the device charges should be multiplied to reflect the total number used in that procedure.

What if a hospital experiences edits/issues regarding submission of claims with C9610?

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- Ensure the correct CPT®/HCPCS procedure code(s) for the procedure performed is submitted with C9610.
- Specify the number of SELUTION SLR™ DEB units in the procedure.
- Ensure the charges reflect the number of SELUTION SLR™ DEB devices used in the procedure.

Does the TPT apply to non-Medicare patients?

TPT payment only applies to Medicare FFS claims that include the C-Code for Coronary DCB/DEB. While commercial and Medicare Advantage plans often use Medicare FFS payment rates as a reference when establishing their own payment rates, the coding and payment policies may vary. Providers should contact these payers to ensure appropriate coding and billing for non-Medicare FFS patients.

Reference:
American Medical Association CPT® Professional 2026. Chicago, IL: American Medical Association; 2025

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CORDIS recommends consulting with reimbursement professionals, applicable payers, and/or legal counsel regarding coding, coverage, and reimbursement specifics.

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