Regence

Medicare Advantage Policy Manual **Policy ID:** M-SUR233

Intravascular Lithotripsy

Published: 04/01/2026

Next Review: 12/2026

Last Review: 12/2025

IMPORTANT REMINDER

The Medicare Advantage Medical Policy manual is not intended to override the member Evidence of Coverage (EOC), which defines the insured's benefits, nor is it intended to dictate how providers are to practice medicine. Physicians and other health care providers are expected to exercise their medical judgment in providing the most appropriate care for the individual member, including care that may be both medically reasonable and necessary.

The Medicare Advantage medical policies are designed to provide guidance regarding the decision-making process for the coverage or non-coverage of services or procedures in accordance with the member EOC and Centers of Medicare and Medicaid Services (CMS) policies and manuals, along with general CMS rules and regulations. In the event of a conflict, applicable CMS policy or EOC language will take precedence over the Medicare Advantage Medical Policy. In the absence of a specific CMS coverage determination for a requested service, item or procedure, the health plan may apply CMS regulations, as well as their Medical Policy Manual or other applicable utilization management vendor criteria developed with an objective, evidence-based process using scientific evidence, current generally accepted standards of medical practice, and authoritative clinical practice guidelines.

Some services or items may appear to be medically indicated for an individual but they may also be a direct exclusion of Medicare or the member's benefit plan. Medicare and member EOCs exclude from coverage, among other things, services or procedures considered to be investigational (experimental) or cosmetic, as well as services or items considered not medically reasonable and necessary under Title XVIII of the Social Security Act, §1862(a)(1)(A). In some cases, providers may bill members for these non-covered services or procedures. Providers are encouraged to inform members in advance when they may be financially responsible for the cost of non-covered or excluded services. Members, their appointed representative, or a treating provider can request coverage of a service or item by submitting a pre-service organization determination prior to services being rendered.

DESCRIPTION

Intravascular lithotripsy is used to prepare stenotic, calcified arteries for stent placement. Ultrasound waves are applied intravascularly to selectively break-up calcium deposits to aid with stent placement.

MEDICARE ADVANTAGE POLICY CRITERIA

CMS Coverage Manuals

None

National Coverage Determinations (NCDs)

For Medicare Coverage Determinations and Articles, see the Medicare Coverage Database

None

Noridian Healthcare Solutions (Noridian) Local Coverage Determinations (LCDs) and Articles

For Medicare Coverage Determinations and Articles, see the Medicare Coverage Database

None

Medical Policy Manual

Medicare coverage guidance is not available for Intravascular Lithotripsy. Therefore, the health plan's medical policy is applicable.

Coronary Intravascular Lithotripsy, Surgery, Policy No. 233 *(see "NOTE" below)*

NOTE: If a procedure or device lacks scientific evidence regarding safety and efficacy because it is investigational or experimental, the service is noncovered as not reasonable and necessary to treat illness or injury. (*Medicare IOM Pub. No. 100-04, Ch. 23, §30 A*). According to Title XVIII of the Social Security Act, §1862(a)(1)(A), only medically reasonable and necessary services are covered by Medicare. In the absence of a NCD, LCD, or other coverage guideline, CMS guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an ***objective, evidence-based process, based on authoritative evidence***. (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*). The Medicare Advantage Medical Policy - Medicine Policy No. M-149 - provides further details regarding the plan's evidence-assessment process (see Cross References).

POLICY GUIDELINES

REGULATORY STATUS

In 2021, The US Food and Drug administration (FDA) granted Premarket Approval (PMA) for the Shockwave Intravascular Lithotripsy (IVL) System with Shockwave C2 Coronary Intravascular Lithotripsy (IVL) Catheter (Product code QMG, PMA number P200039).(1)

The Shockwave Intravascular Lithotripsy (IVL) System with Shockwave C2 Coronary IVL Catheter is indicated for lithotripsy-enabled, low-pressure balloon dilatation of severely calcified, stenotic *de novo* coronary arteries prior to stenting.

The Peripheral IVL System (M5+) Shockwave Intravascular Lithotripsy (IVL) System with the Shockwave L6 Peripheral IVL Catheter received FDA clearance on April 22, 2021. This device is intended for lithotripsy-enhanced balloon dilatation of lesions, including calcified lesions, in the peripheral vasculature, including the iliac, femoral, ilio-femoral, popliteal, infra-popliteal, and renal arteries. Not for use in the coronary or cerebral vasculature. (K221852)

The Shockwave E8 Peripheral IVL Catheter received FDA clearance on September 2024 for treating calcified femoropopliteal and below-the-knee peripheral artery disease and chronic limb-threatening ischemia (CLTI).

Note, the fact a new service or procedure has been issued a CPT/HCPCS code or is FDA approved for a specific indication does not, in itself, make the procedure medically reasonable and necessary. The FDA determines safety and effectiveness of a device or drug, but does not establish medical necessity. While Medicare may adopt FDA determinations regarding safety

and effectiveness, Medicare or Medicare contractors evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A).

CROSS REFERENCES

None

REFERENCES

1. FDA (FDA). FDA. Food and Drug Administration; Premarket Approval - Shockwave Intravascular Lithotripsy (IVL) System with Shockwave C2 Coronary Intravascular Lithotripsy (IVL) Catheter (P200039). [cited 11/14/2025]. Available from: https://www.accessdata.fda.gov/cdrh_docs/pdf20/P200039A.pdf.

CODING

Codes	Number	Description
CPT	37262	Intravascular lithotripsy(ies), iliac vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)
	37279	Intravascular lithotripsy(ies), femoral and popliteal vascular territory, including all imaging guidance and radiological supervision and interpretation necessary to perform the intravascular lithotripsy(ies) within the same artery (List separately in addition to code for primary procedure)
	92972	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)
HCPCS	C1761	Catheter, transluminal intravascular lithotripsy, coronary
	C7571	Percutaneous transluminal coronary angioplasty, single major coronary artery or branch with percutaneous transluminal coronary lithotripsy
	C9764	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, includes angioplasty within the same vessel(s), when performed
	C9765	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed
	C9766	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel(s), when performed
	C9767	Revascularization, endovascular, open or percutaneous, any vessel(s); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel(s), when performed
	C9772	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies), with intravascular lithotripsy, includes angioplasty within the same vessel (s), when performed

Codes	Number	Description
	C9773	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy, and transluminal stent placement(s), includes angioplasty within the same vessel(s), when performed
	C9774	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and atherectomy, includes angioplasty within the same vessel (s), when performed
	C9775	Revascularization, endovascular, open or percutaneous, tibial/peroneal artery(ies); with intravascular lithotripsy and transluminal stent placement(s), and atherectomy, includes angioplasty within the same vessel (s), when performed