

CMS Complexity Adjustment Methodology for Lower Extremity Revascularization Code Combinations

CMS Hospital Outpatient Payment (HOP) Panel Meeting

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Summary of Presentation

CPT Codes Involved

Obsolete codes as of Dec. 31, 2025: 37220-37235

Current codes as of Jan. 1, 2026: 37254-37295

Description of the Issue

When the predecessor lower-extremity revascularization codes were discontinued for CY 2026, CMS used the available predecessor-code claims data both to establish APC assignments for the replacement codes and to evaluate code combinations for complexity-adjustment eligibility. In the CY 2027 OPPS proposed rule, CMS again relied on predecessor-code cost data to determine APC placement for the new LER codes but did not apply the same methodology when evaluating the corresponding code combinations for complexity adjustments under either the hospital outpatient or ASC payment systems. Although many predecessor-code combinations satisfied CMS's applicable frequency and cost criteria, those codes are now obsolete and cannot be reported on claims. Consequently, the replacement codes may lose complexity-adjustment recognition solely because of the coding transition, even though the underlying procedures, clinical complexity, resource requirements, and cost profiles remain comparable.

Recommendation

Philips respectfully requests that the HOP Panel recommend CMS use predecessor-code claims history when evaluating the new lower extremity revascularization codes for CY 2027 complexity-adjustment eligibility. Consistent with the methodology applied for CY 2026, CMS should crosswalk the new codes to the appropriate predecessor CPT/HCPCS codes and preserve complexity-adjustment for combinations that previously satisfied CMS's applicable frequency and cost criteria.

Rationale

- **Aligns with CMS policy:** Predecessor-code claims provide reliable historical data when new HCPCS codes lack sufficient direct claims experience.
- **Supports accurate payment:** The coding transition should not eliminate recognition of complex, resource-intensive lower extremity revascularization procedures that previously met CMS's criteria.
- **Protects patient access:** Inadequate payment for complex cases could create financial pressure on hospitals and affect access for high-acuity Medicare beneficiaries.
- **Promotes continuity and stability:** Applying the crosswalk would prevent coding changes alone from disrupting payment for clinically comparable procedures.

The 2026 CPT Overhaul Replaced 16 Lower Extremity Revascularization Codes With 46 New Codes

Codes Deleted in CY2026		Crosswalked Codes
37220	➡	37254, 37256
37221	➡	37258, 37260
37222	➡	37255, 37257
37223	➡	37259, 37261
37224	➡	37263, 37265
37225	➡	37271, 37273
37226	➡	37267, 37269
37227	➡	37275, 37277
37228	➡	37280, 37282
37229	➡	37288, 37290

Codes Deleted in CY2026		Crosswalked Codes
37230	➡	37284, 37286
37231	➡	37292, 37294
37232	➡	37281, 37283
37233	➡	37289, 37291
37234	➡	37285, 37287
37235	➡	37293, 37295

The AMA's 2026 CPT code set includes a comprehensive overhaul of lower extremity revascularization (LER) codes, replacing 16 previous codes with 46 new ones, numbered 37254–37299.

The code crosswalk above does not include all 46 new codes including add-on codes that were created as part of the new code set.

In CY 2026, CMS Used Predecessor-Code Crosswalks for Both APC Assignment and Complexity-Adjustment Evaluation

Avoided payment disruption by recognizing that the new LER code set describes the same service as those previously reported under the predecessor code set.

Promoted coding continuity and payment stability by ensuring hospitals were not disadvantaged solely because of a coding transition when the underlying procedures, resource use, and patient care remain the same.

Example of CY 2026 Complexity Adjustments Using the New Code Set*

Primary HCPCS Code	Primary Short Descriptor	Primary SI	Primary APC Assignment	Secondary J1 or Add-on HCPCS Code	Secondary Short Descriptor	Secondary SI	Secondary APC Assignment	Complexity Adjusted APC Assignment
37254	Revsc evasc ivt angio sf 1st	J1	5192	37263	Revsc evasc fpvt angio sf 1	J1	5192	5193
37254	Revsc evasc ivt angio sf 1st	J1	5192	37265	Revsc evsc fpvt angio cplx 1	J1	5192	5193
37256	Revsc evasc ivt angio cplx 1	J1	5192	37263	Revsc evasc fpvt angio sf 1	J1	5192	5193
37256	Revsc evasc ivt angio cplx 1	J1	5192	37265	Revsc evsc fpvt angio cplx 1	J1	5192	5193
37263	Revsc evasc fpvt angio sf 1	J1	5192	37263	Revsc evasc fpvt angio sf 1	J1	5192	5193
37263	Revsc evasc fpvt angio sf 1	J1	5192	37265	Revsc evsc fpvt angio cplx 1	J1	5192	5193
37263	Revsc evasc fpvt angio sf 1	J1	5192	37265	Revsc evsc fpvt angio cplx 1	J1	5192	5193
37265	Revsc evsc fpvt angio cplx 1	J1	5192	37265	Revsc evsc fpvt angio cplx 1	J1	5192	5193

*Note this is not a complete list of all the new LER code set that qualified for complexity adjustment in CY 2026

In the CY 2027 OPPS Proposed Rule, CMS Used Predecessor Code Data to Establish APC Placement but Did Not Apply the Same Methodology to Complexity-Adjustment Eligibility

The CY 2027 OPPS Proposed Rule Addendum J includes only the obsolete predecessor codes and does not include the current LER code set used to report lower extremity revascularization procedures.

Although the predecessor combinations remain eligible for complexity adjustments hospitals can no longer report them, effectively eliminating all complexity-adjustment recognition for lower extremity revascularization procedures under the current coding structure.

Example of CY 2027 Proposed Complexity Adjustments for Predecessor Codes*

Primary HCPCS Code	Primary Short Descriptor	Primary SI	Primary APC Assignment	Secondary J1 or Add-on HCPCS Code	Secondary Short Descriptor	Secondary SI	Secondary APC Assignment	Complexity Adjusted APC Assignment
37224	Fem/popl revas w/tla	J1	5192	37220	Iliac revasc	J1	5192	5193
37224	Fem/popl revas w/tla	J1	5192	37224	Fem/popl revas w/tla	J1	5192	5193
37224	Fem/popl revas w/tla	J1	5192	37252	Intrvasc us noncoronary 1st	N		5193
37226	Fem/popl revasc w/stent	J1	5193	37221	Iliac revasc w/stent	J1	5193	5194

*This is not a complete list of all the predecessor codes that are proposed to qualify for complexity adjustment in CY 2027 that are not reportable effective Jan 2026

Example: Without Complexity Adjustments, Hospitals May Be Significantly Underpaid for the Resources Required to Perform Complex Lower Extremity Revascularization Procedures

In the CY 2027 OPPS Proposed Rule, CMS calculated a geometric mean cost of \$12,633 when predecessor codes 37224 and 37220 are performed during the same surgical encounter.

CY 2027 OPPS Proposed Rule Addendum J

Primary HCPCS Code	Primary Short Descriptor	Primary SI	Secondary J1 or Add-on HCPCS Code	Secondary Short Descriptor	Secondary SI	Complexity Adjusted APC Assignment	Evaluation Subset Combination Geometric Mean Cost
37224	Fem/popl revas w/tla	J1	37220	Iliac revasc	J1	5193	\$12,633.24

Predecessor code 37224 crosswalks to either 37263 or 37265 depending on the extent of the occlusion. As the codes above can not be reported on a claim, hospitals will report the procedure with 37263 or 37265. Both codes are comprehensive APCs therefore only one payment is made to the facility, and the secondary procedure is packaged.

HCPCS Code	Description	Status Indicator	APC	APC Payment
37263 OR 37265	Revasc evasc fpvt angio sf OR Revasc evasc fpvt angio cplx 1	J1	5192	\$6,710.86

The APC payment of \$6,710.86 results in a \$5,922.38 shortfall relative to the documented cost of furnishing the combined service.

Overall Recommendation and Rationale

As proposed for CY 2027, the absence of complexity adjustment for any of the current LER code set results in a single comprehensive APC payment that does not adequately reflect hospital costs when multiple lower-extremity revascularization procedures are performed during the same encounter. This is particularly concerning considering over 36% of patients have multi-level disease.^{1,2}

Recommendation

As CMS used predecessor-code crosswalks to determine both APC placement and complexity-adjustment eligibility for CY 2026, Philips respectfully requests that the HOP Panel recommend CMS apply the same methodology to the new lower extremity revascularization code set for CY 2027.

Philips also requests that the HOP Panel recommend using the same predecessor-code claims data to evaluate complexity-adjustment eligibility for these procedures in the ambulatory surgical center setting.

Rationale

- **Consistent with CMS policy:** Predecessor-code claims provide reliable data when new HCPCS codes lack sufficient direct claims experience.
- **Supports accurate payment:** The coding transition should not eliminate recognition of complex, resource-intensive lower extremity revascularization procedures that previously satisfied CMS's criteria.
- **Protects beneficiary access:** Adequate payment helps preserve access to complex lower extremity revascularization services, particularly for high-acuity and medically complex Medicare beneficiaries.
- **Promotes continuity and stability:** Applying the crosswalk would prevent changes in code structure rather than changes in clinical complexity or resource use from disrupting payment.

1. Vogel TR, Braet DJ, Kruse RL, et al. Level of disease and association with health status in patients presenting with claudication from the PORTRAIT registry. J Vasc Surg. 2020;72(6):2017-2026. doi:10.1016/j.jvs.2020.03.042.

2. Zimmermann A, Holstein DJ, Stürzebecher P, et al. Outcomes at Patient and Limb Levels in Peripheral Artery Disease by the Location of Atherosclerotic Lower Limb Lesions: An Observational Study from a High-Volume German Center. Journal of Clinical Medicine. 2025 Oct 4;14(19):7037.

Appendix

Example: Recommendation for code pairs 37224 and 37220

2027 Proposed LER Complexity Adjustment

Primary CPT Code				AND	Secondary CPT Code				2027(P) APC Complexity Adjustment	
Primary CPT Code	Shortened Description	SI	Primary APC		Secondary CPT Code	Shortened Description	SI	Secondary APC	APC	Payment
37224	Fem/popl revas w/tla	J1	5192		37220	Iliac revasc	J1	5192	5193	\$13,311.23

To address this payment deficiency, CMS should update Addendum J by crosswalking the predecessor LER codes to the corresponding new code set.

Correct Crosswalk to New LER Code Set Complexity Adjustment

Primary CPT Code				AND	Secondary CPT Code				2027(P) APC Complexity Adjustment	
Primary CPT Code	Shortened Description	SI	Primary APC		Secondary CPT Code	Shortened Description	SI	Secondary APC	APC	Payment
37263	Revsc evasc fpvt angio sf 1	J1	5192		37254	Revsc evasc ivt angio sf 1st	J1	5192	5193	\$13,311.23
37263	Revsc evasc fpvt angio sf 1	J1	5192		37256	Revsc evasc ivt angio cplx 1	J1	5192	5193	\$13,311.23
37265	Revsc evsc fpvt angio cplx 1	J1	5192		37254	Revsc evasc ivt angio sf 1st	J1	5192	5193	\$13,311.23
37265	Revsc evsc fpvt angio cplx 1	J1	5192		37256	Revsc evasc ivt angio cplx 1	J1	5192	5193	\$13,311.23

Clinical Rationale for Complexity Adjustments

Multilevel lower-extremity peripheral artery disease (PAD) is a well-recognized clinical presentation and may involve disease across multiple anatomic levels and arterial territories. The 2024 multisociety PAD guideline states that patients may have multilevel arterial disease across multiple segments and identifies aortoiliac, femoropopliteal, and infrapopliteal anatomic levels. The guideline's infrapopliteal definition includes the tibial-peroneal trunk, anterior tibial, posterior tibial and peroneal arteries, as well as the plantar pedal loop and pedal vessels. This framework supports consideration of the full lower-extremity arterial tree rather than limiting the analysis to any single combination of territories.¹

The distribution of PAD varies according to the patient's clinical presentation, disease severity, comorbidities, and limb status. Patients with chronic limb-threatening ischemia may have especially extensive or distal disease, and clinically significant lesions may be present at more than one level. Accordingly, a patient may require evaluation or treatment involving combinations of iliac, femoropopliteal, tibial/peroneal, or inframalleolar territories based on the individual's anatomy and clinical needs.

Clinical evidence demonstrates that multilevel disease is not unusual. In the international prospective PORTRAIT registry, 37.9 percent of patients with available anatomic data had multilevel disease, and this group had the poorest baseline PAD-related health-status scores among the anatomic categories evaluated.² In a retrospective analysis of 2,067 PAD patients with 2,633 affected limbs at a high-volume German center from (2018-2021) confirmed that 36.0% of patients had two levels of disease and 8.3% had three levels.³ A separate study of 1,454 patients with intermittent claudication found concurrent aortoiliac and femoropopliteal lesions in 33.6 percent of patients, further illustrating that disease commonly extends beyond a single arterial level.⁴ Although these studies describe particular patient populations and do not establish that every affected territory must be treated during the same encounter, they substantiate the broader clinical reality that lower-extremity PAD frequently spans multiple anatomic segments.

This clinical reality is directly relevant to CMS's complexity-adjustment analysis for the new lower limb revascularization codes. The revised coding structure separately identifies interventions performed in the iliac, femoropopliteal, tibial/peroneal, and inframalleolar territories. Because clinically significant disease may involve more than one of these territories, combinations of the new codes represent plausible and established patterns of care rather than artificial coding combinations.

The transition to the new code set does not change the underlying disease complexity, the potential need to address multiple arterial territories, or the resources required to perform multilevel revascularization. Where predecessor-code claims demonstrated that combinations of services met CMS's applicable frequency and cost criteria, the more anatomically specific coding structure should not eliminate recognition of that complexity solely because the procedures are now reported under replacement codes.

Accordingly, CMS should evaluate the full range of new lower limb revascularization code combinations, including combinations involving iliac, femoropopliteal, tibial/peroneal, and inframalleolar territories, using the relevant predecessor-code claims history. This approach would align the complexity-adjustment analysis with the recognized clinical presentation of multilevel PAD and help ensure that payment reflects the resources associated with treating disease across multiple arterial territories.

References

1. Gornik HL, Aronow HD, Goodney PP, et al. 2024 ACC/AHA/AACVPR/APMA/ABC/SCAI/SVM/SVN/SVS/SIR/VES Guideline for the Management of Lower Extremity Peripheral Artery Disease. *J Am Coll Cardiol.* 2024;83(24):2497-2604. doi:10.1016/j.jacc.2024.02.013.
2. Vogel TR, Braet DJ, Kruse RL, et al. Level of disease and association with health status in patients presenting with claudication from the PORTRAIT registry. *J Vasc Surg.* 2020;72(6):2017-2026. doi:10.1016/j.jvs.2020.03.042.
3. Zimmermann A, Holstein DJ, Stürzebecher P, et al. Outcomes at Patient and Limb Levels in Peripheral Artery Disease by the Location of Atherosclerotic Lower Limb Lesions: An Observational Study from a High-Volume German Center. *Journal of Clinical Medicine.* 2025 Oct 4;14(19):7037.
4. Gahide G, Banine A, Cossette M, et al. Reporting Peripheral Artery Disease in Claudicants: Lessons Learned From the TASC-Ability Study. *J Endovasc Ther.* 2023;30(2):259-268. doi:10.1177/15266028221081093.

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Thank you