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MEDICAL POLICY – 2.02.508

Percutaneous Coronary Intervention, Angioplasty, Non-Emergent in Adults

Effective Date:	**Nov. 7, 2025**	RELATED MEDICAL POLICIES:
Last Revised:	Jul. 8, 2025	Not Applicable
Replaces:	N/A	

Select a hyperlink below to be directed to that section.

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Percutaneous coronary intervention (PCI), also known as angioplasty, is a procedure used to open narrowed or blocked arteries in the heart. In non-emergency situations, PCI is often done in adults who have stable chest pain or other symptoms caused by reduced blood flow to the heart. During the procedure, a thin tube with a small balloon on the end is guided through a blood vessel to the blocked area. The balloon is then inflated to widen the artery, and in most cases, a small mesh tube called a stent is placed to help keep the artery open. This is intended to improve blood flow, relieve symptoms like chest pain, and reduce the risk of future heart problems. This policy describes when PCI may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Note: **This policy only applies to individuals aged 19 and older.**

Surgery	Medical Necessity

Percutaneous coronary intervention (PCI)/Angioplasty	**Percutaneous coronary intervention (PCI)/Angioplasty may be considered medically necessary only for the following conditions when criteria are met:**
	• Acute coronary syndrome as indicated by **1 or more** of the following:
	  ○ Unstable angina, indicated by 1 or more of the following
	  ▪ New onset
	  ▪ Nocturnal
	  ▪ Prolonged at rest
	  ▪ Progressive
	  ○ Myocardial infarction (MI) (non-ST-elevation or ST-elevation)
	• Survivors of sudden cardiac death with presumed ischemia-mediated ventricular tachycardia or ventricular fibrillation due to coronary artery disease (CAD) amenable to PCI
	• Significant left main coronary artery stenosis (50% diameter stenosis or greater) and **ALL** of the following:
	  ○ Anatomic conditions associated with low to intermediate risk of PCI procedural complications and intermediate to high likelihood of good long-term outcome (e.g., SYNTAX score of less than 33, bifurcation left main CAD) (See **Calculator**)
	  ○ Clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate to severe COPD, disability from previous stroke or cardiac surgery, STS-predicted risk of operative mortality greater than 2%) (See **Related Information**)
	  ○ Individual is able to tolerate dual antiplatelet therapy (e.g., clopidogrel and aspirin)
	• Significant non-left main coronary artery disease (70% diameter stenosis or greater, or fractional flow reserve (FFR) less than or equal to 80) (See **Definition of Terms**) in one or more vessels and **ALL** of the following:
	  ○ Revascularization indicated by **1 or more** of the following:

Surgery	Medical Necessity
	▪ Unacceptable angina despite optimized medical therapy (e.g., treatment with therapeutic doses of at least 2 classes of antianginal medication*) ▪ Unacceptable angina and optimized medical therapy (e.g., treatment with therapeutic doses of at least 2 classes of antianginal medication) cannot be implemented due to **1 or more** of the following: ▪ Absolute medication contraindications ▪ Clinically significant adverse effects ▪ Other individual situation preventing optimal medical treatment ○ Stenosis amendable to PCI ○ Individual is able to tolerate dual antiplatelet therapy (e.g., clopidogrel and aspirin) ***Note**: Classes of anti-anginal medications: Beta blockers, calcium channel blockers, sodium channel blockers (i.e. Ranolazine), nitrates
Percutaneous coronary intervention (PCI)/Angioplasty	**Percutaneous coronary intervention (PCI)/Angioplasty is considered not medically necessary for individuals without a documented clinical indication that meets the medical necessity criteria for this procedure noted above.**

Documentation Requirements

The patient's medical records submitted for review for all conditions should document that medical necessity criteria are met. The record should include the following:

- Office visit notes that contain the relevant history and physical and one of the following conditions for which a PCI is considered medically necessary:
  - Acute coronary syndrome as indicated by **1 or more** of the following:
    - Unstable angina, indicated by 1 or more of the following
      - New onset
      - Nocturnal
      - Prolonged at rest
      - Progressive
  - Myocardial infarction (MI) (non-ST-elevation or ST-elevation)

Documentation Requirements

OR

- Survivors of sudden cardiac death with presumed ischemia-mediated ventricular tachycardia or ventricular fibrillation due to coronary artery disease (CAD) amenable to PCI

OR

- Significant left main coronary artery stenosis (50% diameter stenosis or greater) and ALL of the following
  - Anatomic conditions associated with low to intermediate risk of PCI procedural complications and intermediate to high likelihood of good long-term outcome (e.g., SYNTAX score of less than 33, bifurcation left main CAD) (See Related Information)
  - Clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate to severe COPD, disability from previous stroke or cardiac surgery, STS-predicted risk of operative mortality greater than 2%) (See Related Information)
  - Individual able to tolerate dual antiplatelet therapy (e.g., clopidogrel and aspirin)

OR

- Significant non-left main coronary artery disease (70% diameter stenosis or greater, or fractional flow reserve (FFR) less than or equal to 80) in one or more vessels and ALL of the following:
  - Revascularization indicated by 1 or more of the following:
    - Unacceptable angina despite optimized medical therapy (e.g., treatment with therapeutic doses of at least 2 classes of antianginal medication*)
    - Unacceptable angina and optimized medical therapy (e.g., treatment with therapeutic doses of at least 2 classes of antianginal medication) cannot be implemented due to 1 or more of the following:
    - Absolute medication contraindications
    - Clinically significant adverse effects
    - Other individual situation preventing optimal medical treatment
  - Stenosis amendable to PCI
  - Individual able to tolerate dual antiplatelet therapy (e.g., clopidogrel and aspirin)

Coding

Code	Description
CPT	

Code	Description
92920	Percutaneous transluminal coronary angioplasty; single major coronary artery or branch
92921	Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92924	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch
92925	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92928	Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
92929	Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92933	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch
92934	Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (List separately in addition to code for primary procedure)
92937	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel
92938	Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (List separately in addition to code for primary procedure)
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel
92943	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel
92944	Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery,

Code	Description
	coronary artery branch, or bypass graft (List separately in addition to code for primary procedure)
92980	Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
92982	Percutaneous transluminal coronary balloon angioplasty; single vessel
HCPCS	
C9600	Percutaneous transcatheter placement of drug eluting intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
C9601	Percutaneous transcatheter placement of drug-eluting intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)
C9602	Percutaneous transluminal coronary atherectomy, with drug eluting intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch
C9603	Percutaneous transluminal coronary atherectomy, with drug-eluting intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Definition of Terms

SYNTAX Score: The Synergy Between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery (SYNTAX) score is based upon coronary anatomic characteristics such as number of lesions, total or partial occlusion, presence of bifurcations or trifurcations, and aorto-ostial stenosis as well as lesion length, tortuosity, and degree of calcification. A higher SYNTAX score indicates increased anatomic complexity and correlates with higher rates of PCI-related morbidity and mortality. Calculator available at **https://syntaxscore.org/calculator/start.htm**.

STS Risk Score: The Society of Thoracic Surgeons (STS) risk score can be used to predict the likelihood of postoperative mortality and complications (e.g., renal failure, stroke, reoperation) following cardiac surgery. The score is based upon clinical factors such as patient age and the

presence of comorbidities (e.g., peripheral vascular disease, diabetes) as well as cardiac-specific variables such as valvular disease, heart failure, or recent MI. Calculator available at: http://www.sts.org/quality-research-patient-safety/quality/risk-calculator-and-models/risk-calculator.

Fractional Flow Reserve: The Fractional Flow Reserve (FFR) is the ratio of maximal blood flow in a stenotic artery to normal maximal flow.

Evidence Review

Description

Percutaneous coronary intervention (PCI), also known as coronary angioplasty, is a non-surgical procedure used to treat the narrowed coronary arteries of the heart found in coronary artery disease. The goal of PCI is to open up a coronary artery and restore blood flow. PCI refers to both non-stent procedures on one or more coronary arteries such as balloon angioplasty or atherectomy, as well as stent interventions.

Alternatives to PCI include but are not limited to:

- Optimal medical therapy with anti-anginal and anti-ischemic medications, and risk-reduction therapy, including statin medications and antiplatelet and antihypertensive therapy,
- Minimally invasive coronary bypass surgery or
- Coronary artery bypass graft.

Summary of Evidence

Several randomized trials, meta-analyses, and guidelines have concluded that for patients with stable angina, including diabetics, the addition of percutaneous coronary intervention (PCI) to optimal medical therapy does not reduce mortality or risk of cardiovascular events.

Wijeysundera and colleagues performed a meta-analysis of 14 randomized trials, including more than 7800 patients, examining the addition of PCI to medical therapy in the treatment of stable angina. They found that, overall; the addition of PCI increased achievement of the end point of freedom from angina by 14% (73% vs. 64%). However, in this same meta-analysis, no benefit to the addition of PCI was found when limiting examination to the 5 trials and more than 2000

individuals who were recruited after the year 2000, thought to be due to improved implementation of more intensive and evidence-based medical therapy

In studies by Hochman (2006/2011) and Cantor (2009), opening an occluded infarct-related artery via PCI 3 or more days after a MI did not reduce subsequent death, MI, or chronic heart failure, including in the subset of individuals with inducible ischemia on postinfarct stress testing.

In 2009, Tonino and colleagues conducted a randomized trial to determine if routine measurement of fractional flow reserve (FFR), in addition to angiography, would improve outcomes for those patients with multivessel coronary artery disease undergoing PCI. In their study of 1005 patients in 20 medical centers, they compared the angiography-guided PCI group that underwent stenting of all indicated lesions to the FFR-guided PCI group that underwent stenting only if the FFR was 0.80 or less. The primary endpoint was the rate of death, nonfatal myocardial infarction, and repeat revascularization at 1 year. They found that the 1-year event rate was significantly less in the FFR group, with 78% of the patients in the angiography group being free from angina, as compared with 81% of patients in the FFR group. They concluded that routine measurement of FFR in patients with multivessel coronary artery disease who are undergoing PCI with stents significantly reduces the rate of the composite end point of death, nonfatal myocardial infarction, and repeat vascularization at 1 year.

In a systematic review and meta-analysis by Post and colleagues (2010) which included 10 studies, over 1.3 million patients, and 1746 hospitals, they found that higher hospital PCI procedural volume was associated with lower in-hospital mortality.

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

American College of Cardiology Foundation/American Heart Association and Society for Cardiovascular Angiography and Interventions

Guidelines from both the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions (2011) and the update of the American College of Cardiology/American Heart Association on the management of patients with chronic stable angina (2007) issued

recommendations on PCI in patients with stable angina. Considering the risks of PCI (procedural and need for long-term dual antiplatelet therapy), both groups felt that PCI is not recommended for patients with stable angina unless they are intolerant of optimal medical therapy or optimal medical therapy is not sufficient.

A guideline from the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions recommends against the performance of non-emergent PCI by low-volume operators (fewer than 75 procedures a year) at low-volume centers (less than 400 procedures a year).

American College of Cardiology Appropriate Use Criteria Task Force, American Association for Thoracic Surgery, American Heart Association, American Society of Echocardiography, American Society of Nuclear Cardiology, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, and Society of Thoracic Surgeons

In 2017 ACC/AATS/AHA/ASE/ASNC/SCAI/SCCT/STS Appropriate Use Criteria for Coronary Revascularization in Patients with Stable Ischemic Heart Disease[21] recommended the following for revascularization to improve survival compared with medical therapy:

Anatomic Setting	COR	LOE
PCI	IIa—For SIHD when *both* of the following are present: ■ Anatomic conditions associated with a low risk of PCI procedural complications and a high likelihood of good long-term outcome (e.g., a low SYNTAX score of ≤22, ostial or trunk left main CAD) ■ Clinical characteristics that predict a significantly increased risk of adverse surgical outcomes (e.g., STS-predicted risk of operative mortality ≥5%)	B
	IIa—For UA/NSTEMI if not a CABG candidate	B
	IIa—For STEMI when distal coronary flow is TIMI flow grade <3 and PCI can be performed more rapidly and safely than CABG	C
	IIb—For SIHD when *both* of the following are present: ■ Anatomic conditions associated with a low to intermediate risk of PCI procedural complications and an intermediate to high likelihood of good long-term outcome (e.g., low-intermediate SYNTAX score of <33, bifurcation left main CAD) ■ Clinical characteristics that predict an increased risk of adverse surgical outcomes (e.g., moderate–severe COPD, disability from prior stroke, or prior cardiac surgery; STS-predicted operative mortality >2%)	B
	III: Harm—For SIHD in patients (versus performing CABG) with unfavorable anatomy for PCI and who are good candidates for CABG	B

CABG: coronary artery bypass graft, CAD: coronary artery disease, COPD: chronic obstructive pulmonary disease, COR: class of recommendation, LOE: level of evidence, PCI: percutaneous coronary intervention, SIHD: stable ischemic heart disease, STEMI: ST-elevation myocardial infarction, STS: Society of Thoracic Surgeons, SYNTAX: Synergy between Percutaneous Coronary Intervention with TAXUS and Cardiac Surgery, TIMI: Thrombolysis In Myocardial Infarction, UA/NSTEMI, unstable angina/non–ST-elevation myocardial infarction

General assumptions as applicable for these clinical scenarios were summarized as the following:

- A significant coronary stenosis was defined as:
    - ≥70% luminal diameter narrowing, by visual assessment, of an epicardial stenosis measured by angiography
    - ≥ 50% luminal diameter narrowing, by visual assessment, of a left main stenosis measured by angiography
    - 40 to 70% luminal narrowing, by visual assessment, of an epicardial stenosis measured by angiography with an abnormal FFR
- An FFR ≤ 80 is abnormal and is consistent with downstream inducible ischemia. It is the reference standard for invasively assessing the physiological significance of a coronary artery stenosis before PCI.

American College of Cardiology, American Heart Association, Society for Cardiovascular Angiography and Interventions

In 2021, the ACC/AHA/SCAI Guideline for Coronary Artery Revascularization: Executive Summary. A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines[22] recommended the following:

- …"For patients with significant left main disease, surgical revascularization is indicated to improve survival relative to that likely to be achieved with medical therapy. Percutaneous revascularization is a reasonable option to improve survival, compared with medical therapy, in selected patients with low-to medium anatomic complexity of CAD and left main disease that is equally suitable for surgical or percutaneous revascularization.
- Updated evidence from contemporary trials supplement older evidence with regard to mortality benefit of revascularization in patients with stable ischemic heart disease, normal left ventricular ejection fraction, and triple-vessel CAD. Surgical revascularization may be reasonable to improve survival. A survival benefit with percutaneous revascularization is uncertain.

- The use of a radial artery as a surgical revascularization conduit is preferred versus the use of a saphenous vein conduit to bypass the second most important target vessel with significant stenosis after the left anterior descending coronary artery. Benefits include superior patency, reduced adverse cardiac events, and improved survival.
- Radial artery access is recommended in patients undergoing percutaneous intervention who have acute coronary syndrome or stable ischemic heart disease, to reduce bleeding and vascular complications compared with a femoral approach. Patients with acute coronary syndrome also benefit from a reduction in mortality rate with this approach.
- A short duration of dual antiplatelet therapy after percutaneous revascularization in patients with stable ischemic heart disease is reasonable to reduce the risk of bleeding events. After consideration of recurrent ischemia and bleeding risks, select patients may safely transition to P2Y12 inhibitor monotherapy and stop aspirin after 1 to 3 months of dual antiplatelet therapy.
- Staged percutaneous intervention (while in hospital or after discharge) of a significantly stenosed nonculprit artery in patients presenting with an ST-segment–elevation myocardial infarction is recommended in select patients to improve outcomes. Percutaneous intervention of the nonculprit artery at the time of primary percutaneous coronary intervention is less clear and may be considered in stable patients with uncomplicated revascularization of the culprit artery, low-complexity nonculprit artery disease, and normal renal function. In contrast, percutaneous intervention of the nonculprit artery can be harmful in patients in cardiogenic shock.
- Revascularization decisions in patients with diabetes and multivessel CAD are optimized by the use of a Heart Team approach. Patients with diabetes who have triple-vessel disease should undergo surgical revascularization; percutaneous coronary intervention may be considered if they are poor candidates for surgery
- Treatment decisions for patients undergoing surgical revascularization of CAD should include the calculation of a patient's surgical risk with the Society of Thoracic Surgeons score. The usefulness of the SYNTAX (Synergy Between PCI With TAXUS and Cardiac Surgery) score calculation in treatment decisions is less clear because of the interobserver variability in its calculation and its absence of clinical variables."

Medicare National Coverage

There is no national coverage determination

Regulatory Status

Percutaneous coronary intervention is considered a surgical procedure and is therefore not regulated by the US Food and Drug Administration (FDA).

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History

Date	Comments
06/10/13	New policy. Add to Cardiology section. This policy is approved with a 90-day hold for provider notification and will be effective on October 1, 2013.
08/12/13	Clarification added to Guidelines that policy only applies to members age 19 and older.
10/14/13	Minor update. Title expanded to include “non-urgent”.
06/09/14	Annual Review. Policy extensively re-written. Policy statements reorganized but intent is unchanged. Policy updated with literature search. Reference to using MCG as a tool to guide determinations is removed. References 2-26 added. HCPCS codes G0290 and G0291 removed; they are deleted codes.
12/22/14	Interim Review. Reference #1 removed.
06/17/15	Annual Review. No changes to policy statements. ICD-9 and ICD-10 diagnosis and procedure codes removed; these are not utilized in adjudication. HCPCS codes C1874-C1877 removed; they do not suspend.
07/14/15	Archive Policy. This procedure will no longer stop for review. There is no sign of misuse and reviews are not cost effective at this time.
08/01/25	New policy, approved July 8, 2025, effective for dates of service on or after November 7, 2025, following 90-day provider notification. Percutaneous coronary intervention (PCI) is considered medically necessary for select conditions when criteria are met. Added CPT codes 92920, 92921, 92924, 92925, 92928, 92929, 92933, 92934, 92937,92938, 92941, 92943, 92944, 92980, 92982 and HCPCS codes C9600, C9601, C9602 and C9603 to match criteria following 90-day hold.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.