SASCI
South African Society of Cardiovascular Intervention

SASCI Guidance:
Drug Coated Balloon (DCB) / Drug Eluting Balloon (DEB)

29 January 2026

1 Introduction

Drug Coated Balloon (DCB)/ Drug Eluting Balloon (DEB) is coded as a stent. This stems from historical information where **DCB/DEB** was introduced into the Interventional Cardiology realm.

2 Current Coding Practice

The **SASCI Coding Handbook 2025** defines the current coding practice under points 7.2 as follows:

> ***"7.2 Drug eluting balloon***
>
> *The issue of drug eluting balloons has been previously discussed with medical funders**. Application of a drug eluting balloon is regarded as an implant by funders and therefore the consensus with medical funders is that cardiologists should code for an intracoronary stent when coding for use of a drug eluting balloon.** Since application of drug eluting balloon is considered as a 'stent' the same rules regarding stenting apply."*

DCB/DEB is billed using code 1286 (Insertion of intravascular stent: First cardiologist) or 1287 (Insertion of intravascular stent: Second cardiologist). The review of this billing practice was requested by funders in view of possible incorrect coding for DCB/DEB. For the purpose of document drug coated balloon and drug eluting balloon are used interchangeably.

3 Review

The terminology "Drug Eluding Balloon" has been changed to "Drug Coated Balloon". It is worth looking at the clinical application for drug coated balloons.

The references below are two major reviews on the prevailing role of the DCB (Drug Coated Balloon) in PCI (Percutaneous Coronary Intervention).

One article was published in 2013, the second article in February 2025. Both articles contain excellent discussion on the published data at the time. The February 2025 article covers the history and contemporary information available in the literature.

Both articles acknowledge that in the setting of ISR (In-stent restenosis), the DCB (Drug Coated Balloon) has proven value in optimizing outcomes after PCI (Percutaneous Coronary Intervention). Both articles also acknowledge that DCBs (Drug Coated Balloons) may be utilized in the hope of improving the long-term outcome from inadequate multiple or complex stenting.

Despite the passage of time between these two articles, authors of both reviews emphasize that there are still little convincing data to justify the use of DCBs (Drug Coated Balloons) outside of the above-mentioned circumstances.

Deploying a DCB (Drug Coated Balloon) does not require much different skill to POBA (Percutaneous Old Balloon Angioplasty) apart from minimal handling and very careful positioning and deployment. However, the real skill required in preparing the sub-optimal stented vessel segment is getting the best result with multiple dilatations with or without imaging before deploying the DCB (Drug Coated Balloon).

In the most recent review below there is excellent discussion on the possible future roles of DCB (Drug Coated Balloon), but again we are reminded that the data is still not solid enough to mandate more extensive advantages of DCB (Drug Coated Balloon). In essence, while DCBs (Drug Coated Balloons) offer potential benefits, they also require interventional cardiologists to possess specialized skills and be prepared for potentially more time-consuming procedures. The average extra time spent when a DCB (Drug Coated Balloon) is used versus a POBA is estimated at about 20 minutes, as established in the SASCI realm. One should also take the risk of radiation exposure into consideration during the extended time.

(https://eurointervention.pcronline.com/article/the-current-status-of-drug-coated-balloons-in-percutaneous-coronary-and-peripheral-interventions/pdf)

(https://pmc.ncbi.nlm.nih.gov/articles/PMC11788978/)

(https://pmc.ncbi.nlm.nih.gov/articles/PMC10020262/)

3.1 "Future of drug-coated balloon angioplasty"

This article by Fernando Alfonso and Javier Cuesta discusses the evolving role and future directions of drug coated balloon (DCB) angioplasty in percutaneous coronary interventions (PCI) https://www.pcronline.com/Cases-resources-images/Tools-and-Practice/The-Essentials/DCB/Future-directions-of-drug-coated-balloon-angioplasty

- **Refining DCB Use Through Robust Clinical Studies:**
    - The authors emphasize the need for more well-designed clinical trials to identify optimal patient subsets and scenarios for DCB use, particularly in de novo lesions and in comparison, to drug eluting stents (DES).
    - Studies powered for clinical endpoints with long-term follow-up are essential.
- **Promoting "Hybrid" or "Blended" Procedures:**
    - Combining DCBs and DES to minimize metal burden in complex cases is a promising strategy.
    - DCB angioplasty should be viewed as a primary strategy, and the need for a later stent should be viewed as part of that strategy, not a failure.

Coding guidelines cannot be prescriptive. It is left to the discretion of the Cardiologist in correlation with the clinical presentation of the patient where and when the DCB is best suited. A detailed catheterisation laboratory report may be requested by the funders.

3.2 Technical and operational considerations

The use of drug coated balloons (DCBs) in coronary interventions brings specific technical considerations that can influence the skill required and the time taken during procedures.

Key Factors Affecting Skill and Time:

- Precise Lesion Preparation:
    - DCB efficacy heavily relies on meticulous lesion preparation. This often necessitates:
        - Careful pre-dilation with appropriately sized balloons.

        - In some cases, the use of specialized balloons like scoring or cutting balloons to optimize lesion preparation e.g. Rotablation/IVL.
        - Rotablation/IVL does not have a dedicated code in the Medical Doctor's Coding Manual (MDCM) and is currently coded using:
            - 1284 - Atherectomy: Single lesion: First cardiologist.
            - 1285 - Atherectomy: Single lesion: Second cardiologist.
    - This process demands skill and adds time to the procedure.

- DCB Deployment Technique:
    - DCBs require careful handling to preserve the drug coating.
    - Specific inflation times (typically 30-60 seconds) are crucial for optimal drug transfer, introducing a timed element.
    - Avoiding "geographic miss" is important, meaning ensuring the drug covers the entire lesion. This requires careful sizing and placement.

- Imaging Guidance:
    - Intra-coronary imaging (ICI), such as OCT or IVUS, is increasingly used to guide DCB procedures.
    - Intra-coronary imaging (ICI) adds complexity and time, but it can enhance precision and optimize outcomes.
    - The interpretation of Intra-coronary imaging (ICI) images requires specialized skills.

- Potential for Bailout Stenting:
    - Although the aim is a "leave nothing behind" approach, bailout stenting may be necessary if complications like dissections occur.
    - This possibility requires the operator to be prepared for additional steps, potentially prolonging the procedure.

- Drug Delivery Optimization:
    - Ensuring optimal drug delivery is paramount. This includes proper balloon sizing, inflation times, and pressure.
    - Factors that influence drug delivery, such as lesion characteristics and blood flow, must be carefully considered.

3.3 Current Coding

The Medical Doctor's Coding Manual list the following codes in relation to percutaneous coronary angioplasties and stents:

1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	**260,00**
1277	Percutaneous transluminal angioplasty: Second cardiologist: Single lesion	**140,00**
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	**60,00**
1279	Percutaneous transluminal angioplasty: Second cardiologist: Second lesion	**40,00**
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	**60,00**
1281	Percutaneous transluminal angioplasty: Second cardiologist: Third or subsequent lesions (each)	**40,00**
1286	Insertion of intravascular stent: First cardiologist	**100,00**
1287	Insertion of intravascular stent: Second cardiologist	**50,00**

There is no specific code for a drug coated balloon in MDCM or in CPT. There are 2 Category III CPT codes under review for DOB's (0913T and 0914T). No RVU's have been allocated.

It is also true that you cannot code per inflation of the balloon, but per lesion. Since the DCB has a range of steps, including when clinically necessary, normal balloon angioplasty, Rotablation or IVL as listed above in the review, a coding method for the usage of the DCB is necessary.

3.3.1 Coding method

SASCI would like to maintain the status quo of coding for a drug coated balloon, if the procedures were performed remains, however guidelines must be adhered to.

1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	**260,00**	**PTCA**
1286	Insertion of intravascular stent: First cardiologist	**100,00**	**DCB**

The usage of Rule J should be mentioned when dealing with disproportionately low procedure units. It is however a fact that most funders do not reimburse Rule J. This is not a viable reimbursement method.

3.3.2 Guidelines for billing a Drug Coated Balloon (DCB):

a) A Balloon (Non-Drug Coated) will be reimbursed **once per lesion**
b) A DCB will be reimbursed **once per vessel** (the same as for a stent) using code 1286 or 1287
c) A note must be added on the account next to code 1286 or 1287 that these codes were used for the insertion of a DCB. Only one of these codes can be used per vessel for the usage of a DCB.
d) Should it be clinically indicated to deploy a stent in the same vessel as where the DCB was used, it should be allowed using code 1286 or 1287 once per vessel without an additional description to clarify what device was used,
e) It is possible that code 1286 or 1287 could be used twice per vessel. Once for a DCB and once for a stent. This will however not be the norm.
f) Coding example:
   - Cath-lab case 1 entails a Percutaneous Transcatheter Coronary Angioplasty (PTCA) to the distal Right Coronary Artery (RCA) and Left Anterior Descending Artery (LAD) as well as a stent to the Left Anterior Descending Artery (LAD)

1252	Left heart catheterisation with coronary angiography (with or without biopsy)		140
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	LAD	260
1286	Insertion of intravascular stent: First cardiologist	LAD	100
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	RCA	60

   - Cath-lab case 2 entails a Percutaneous Transcatheter Coronary Angioplasty (PTCA) to the distal Right Coronary Artery (RCA) as well as a DCB to the distal Right Coronary Artery (RCA): 1252 + 1276 +1286(DCB)

1252	Left heart catheterisation with coronary angiography (with or without biopsy)	140

1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	RCA	260
1286	Insertion of intravascular stent: First cardiologist (Drug Coated Balloon // DCB)	RCA	100

- Bifurcation stent first diagonal branch arising from the Left Anterior Descending Artery (LAD-D1) (2 stent) and a PTCA to the distal Posterior Descending Artery (distal PDA) and distal Right Coronary Artery (distal RCA) and DEB on distal Left Circumflex Artery (distal LCX)

1252	Left heart catheterisation with coronary angiography (with or without biopsy)		140
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	LAD	260
1286	Insertion of intravascular stent: First cardiologist	LAD	100
1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	D1	60
1286	Insertion of intravascular stent: First cardiologist	D1	100
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	LCX	60
1286	Insertion of intravascular stent: First cardiologist (Drug Coated Balloon // DCB)	LCX	100
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	PDA	60
1280	Percutaneous transluminal angioplasty: First cardiologist: Third or subsequent lesions (each)	RCA	60

- Stent mid Left Main Coronary Artery (LMCA) and DEB and Stent mid Left Artery Descendance (LAD)

1252	Left heart catheterisation with coronary angiography (with or without biopsy)		140
1276	Percutaneous transluminal angioplasty: First cardiologist: Single lesion	LAD	260
1286	Insertion of intravascular stent: First cardiologist	LAD	100
1286	Insertion of intravascular stent: First cardiologist (Drug Coated Balloon // DCB)	LAD	100

1278	Percutaneous transluminal angioplasty: First cardiologist: Second lesion	LMCA	60
1286	Insertion of intravascular stent: First cardiologist	LMCA	100

It is imperative that the preparation of the vessel for DCB is reimbursed. This preparation may or may not include a POBA, Rotablation, IVL and/or IVUS.

4 Summary

It is true that DCB procedures necessitate a high level of operator skill and attention to detail. The emphasis on meticulous lesion preparation and precise drug delivery contributes to the time required for these interventions. The use of imaging guidance can further enhance precision but also adds to procedural time.

The proposed coding to reflect skill, time, effort and exposure is seen as reasonable.