



INTERVENTIONAL RADIOLOGY CODING UPDATE

2021

2021 Interventional Radiology Coding Update

Coding for Endovascular and Interventional Procedures and Services

Society of Interventional Radiology (SIR)

American College of Radiology (ACR)

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The Society of Interventional Radiology (SIR) and the American College of Radiology (ACR) are providing this coding update for educational and information purposes only. It is not intended to provide legal, medical or any other kind of advice. The update is meant to be an adjunct to the American Medical Association (AMA) Current Procedural Terminology (CPT®2021/©2020). It is not comprehensive and does not replace the *CPT® 2021 Professional Edition Manual*. Our intent is to assist physicians, business managers and coders. Therefore, a precise knowledge of the definitions of the CPT® descriptors and the appropriate services associated with each code is mandatory for proper coding of physician service.

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Preface

This 2021 edition of the *Interventional Radiology Coding Update* is intended to provide physicians and coders with practical advice and information on coding for common interventional radiological and endovascular procedures. When possible, the *Coding Update* provides patient care scenarios and FAQs to highlight how codes should be used and what codes may be appropriately reported.

In recent years, coding for IR has undergone major changes. Coding for interventional radiology procedures can be complex and often not easily decipherable. In this *Update*, we make our best effort to suggest accurate coding, but we are always open to questions or comments on scenarios that are not addressed in this document. We also encourage providers and coders to work with carriers on difficult coding issues.

In preparing this 2021 *Update*, the Society of Interventional Radiology and American College of Radiology gratefully acknowledge the time and expertise that our physician and clinical associate members volunteer to support the coding process and the education of our membership.

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Glossary of acronyms

AAA	Abdominal aortic aneurysm
ACR	American College of Radiology
AMA	American Medical Association
APC	Ambulatory payment classification
APM	Advanced alternative payment model
AV	Arteriovenous
CF	Conversion factor
CMD	Carrier medical director
CMS	Centers for Medicare and Medicaid Services
CPT	Current procedural terminology
E/M	Evaluation and management
EVLA	Endovenous laser ablation
FDA	U.S. Food and Drug Administration
GPCI	Geographic practice cost index
GSV	Great saphenous vein
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedure Coding System
HOPPS	Hospital Outpatient Prospective Payment System
IDE	Investigational device exemption
IVUS	Intravascular ultrasound
MAC	Medicare administrative contractor
MACRA	Medicare Reauthorization and Children's Health Act of 2015
MIPS	Merit-based incentive payment system
MOCA	Mechanicochemical ablation
MP	Malpractice
MPFS	Medicare Physician Fee Schedule
MPPR	Multiple-procedure payment reduction
MRgFUS	MR-guided focused ultrasound
MUE	Medically unlikely edit

NCCI	National Correct Coding Initiative
PE	Practice expense
PICC	Peripherally inserted central catheter
PQRS	Physician quality reporting system
PTA	Percutaneous transluminal angioplasty
QPP	Quality payment program
RAW	Relativity assessment workgroup
RBRVS	Resource-based relative value scale
RFA	Radiofrequency ablation
RS&I	Radiological supervision and interpretation
RS&I/S&I	Radiological supervision and interpretation/imaging supervision and interpretation
RUC	RVS Update Committee
RVS	Relative value scale
RVU	Relative value unit
SIR	Society of Interventional Radiology
US	Ultrasound
VAS	Visual analogue scale
VCSS	Venous clinical severity score

Categories of CPT® codes

CPT® code proposal requests submitted to the AMA CPT® Editorial Panel must identify what category of CPT® code is being sought; the panel reviews requests for three types of CPT® codes.

CATEGORY I CODES

These represent established services and procedures, performed by a variety of providers, in multiple geographical locations, with appropriate U.S. Food and Drug Administration (FDA) approval for all aspects of the procedure.

CATEGORY II CODES

These codes are used to track performance measures. They are intended solely to facilitate data collection. Category II codes also are used in the Physician Quality Reporting System (PQRS) to report quality measures related to services provided under the Medicare Physician Fee Schedule (MPFS). The Centers for Medicare and Medicaid Services (CMS) PQRS is a reporting program associated with a negative payment adjustment (penalty) for eligible professionals (EPs) who do not successfully submit measure data to CMS. The adjustments are applied to payments for covered MPFS services furnished to Medicare Part B fee-for-service beneficiaries.

A detailed overview of the new Medicare Reauthorization and Children's Health Act of 2015, or MACRA, is available on the SIR website. The Quality Payment Program (QPP) has two payment systems—the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). In 2017, CMS commenced data collection under MIPS. Detailing compliance with MIPS is beyond the scope of the Coding Update, but we encourage all SIR members to familiarize themselves with how to report quality metrics. See more at: <https://www.sirweb.org/practice-resources/toolkits/macra-matters-toolkit/>.

CATEGORY III CODES

These codes are issued for emerging technologies not meeting standards for a Category I code. Additional information regarding the different categories of CPT® codes can be found on the AMA website at <https://www.ama-assn.org/practice-management/cpt/criteria-cpt-category-i-and-category-iii-codes>.

HCPCS CODES

CMS operates a parallel coding system, known as the Healthcare Common Procedure Coding System (HCPCS). HCPCS codes are divided into three levels: Level I codes are five-digit numeric codes used to report physician services and are equivalent to CPT® Category I codes; Level II codes, which are five-digit alphanumeric codes (leading alpha character followed by four numeric characters) used to report products, supplies and services not included in the CPT® codes; and Level III codes were local codes, use of which was discontinued in 2003. More information may be found at <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo>.

A listing of current HCPCS Level II codes may be found at: <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCSCODINGPROCESS>.

Level II HCPCS codes include:

G-CODES—temporary codes issued by CMS to describe procedures and professional services and are principally used to be reimbursed for new technology.

S-CODES—temporary codes issued by CMS, often at the request of a commercial carrier. While S-codes are not eligible for use within the Medicare program, commercial carriers may elect to utilize these codes to facilitate claims processing.

The basics of coding and reimbursement

THE RESOURCE-BASED RELATIVE-VALUE SCALE PAYMENT SYSTEM

In 1992, Medicare adopted a national system of payment using the resource-based relative value scale (RBRVS). Under the RBRVS, procedures are weighted and assigned a value on the basis of their difficulty, intensity, time and resource utilization. In the RBRVS system, a procedure's RVU total is derived by summing the physician's work (time and intensity), the practice expense (PE) related to performing the service, and malpractice costs associated with the procedure.

Additionally, to take into account regional cost variations, CMS folds in what is termed the geographic practice cost index (GPCI). The GPCI rates are reviewed annually by CMS for their relevancy and accuracy.

CMS annually publishes a MPFS Final Rule, which contains a figure called the conversion factor (CF), a \$/RVU that will be paid for claims submitted during the year subject to the Final Rule.

With the budget neutrality adjustment to account for changes in RVUs, as required by law, the CY 2021 MPFS conversion factor is \$34.8931, in which reflects a 3.3 percent decrease from the CY 2020 MPFS conversion factor of \$36.0896. As part of CMS 2021 Final Rule for Part B services, total combined payments to interventional radiology (IR) and diagnostic radiology (DR) for the entire mix of services these specialties reported to Medicare (based on 2019 data) are estimated to increase CY 2021 relative to 2020.

In CY 2021, payments made to interventional radiologists, identified clinicians who report services with specialty code 94, are expected to decrease by about 2 percent, which is a change from the original final rule impact of minus 8 percent.

PART B PAYMENT

Determining how much a service is paid is not a straightforward task. In recent years, most of the Medicare administrative contractors (MACs) have published helpful tables on their websites that show the MPFS for the coming year for their covered region.

Depending on whether a provider practices in the non-facility (i.e., physician office) or facility (i.e., hospital) setting, or an ambulatory surgery center, the actual formula for provider payment is as follows:

2021 nonfacility pricing amount = [(work RVU * work GPCI) + (transitioned nonfacility PE RVU * PE GPCI) + (MP (malpractice) RVU * MP GPCI)] * CF

2021 facility pricing amount = [(work RVU * work GPCI) + (transitioned facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * CF

SIR has posted tables that display all the 2021 RVU component values for the common interventional radiology CPT® codes: <https://www.sirweb.org/practice-resources/coding-page/>.

Interventional Radiology practices can also obtain current data about any CPT® code by using the tool on the CMS website at [cms.gov/apps/physician-fee-schedule/overview.aspx](https://www.cms.gov/apps/physician-fee-schedule/overview.aspx).

CPT® PROCESS

CPT® codes are developed by the AMA CPT® Editorial Panel in consultation with CMS and the CPT® Advisory Committee, which includes representatives from numerous specialty and subspecialty societies and allied medical societies. CPT® Advisory Committee membership is limited to those national medical societies seated in the AMA House of Delegates. Seats in the AMA House of Delegates are determined by the percentage of each society's membership that are also members of the AMA.

Since the practice of medicine is dynamic, the need for new or modified CPT® codes to reflect changes in practice often arises. Code change proposals are submitted to the AMA through the medical specialty societies, or individuals, through a standard application process.

Assessment of the supporting scientific literature and informal survey by the societies of a number of individuals performing the procedure in question helps assess the need for the new procedural code, its validity and the language that will be proposed to describe it. After a case can be made to support editing CPT® to include a new procedure, the application is heard by the CPT® Editorial Panel, which is made up of representatives of approximately 20 medical and allied organizations. If the new or modified CPT® code is approved by the CPT® Editorial Panel, that code advances into the RUC process (see below) for valuation.

The AMA holds three CPT® Editorial Panel meetings per year, most commonly in February, May and October. The general public is allowed to register for and attend AMA CPT® Editorial Panel meetings. To ensure release of the updated CPT® manual each fall, all proposed additions or revisions to Category I CPT® codes for the upcoming calendar year must be considered by the Panel during the calendar year one year prior to the fall publication. For example, new Category I 2021 CPT® codes were approved by the Panel during CY 2019 CPT® Editorial Panel meetings. The CPT® cycle has stringent deadlines for submission of proposals that are well in advance of panel meetings to ensure all advisors from all representative societies have an opportunity to review and comment. Information regarding CPT® submission deadlines and panel meetings can be found on the AMA website, <https://www.ama-assn.org/system/files/2020-10/cpt-ruc-calendar.pdf>.

Typically, each July CMS issues a draft rule for the Medicare Physician Fee Schedule and the Hospital Outpatient Prospective Payment System (HOPPS) for the upcoming year. In the proposed rules, CMS will review new codes, proposed RVU and PE values recommended by the RUC (see below), while the HOPPS proposed rule focuses on policies related to services provided in the hospital outpatient setting. CMS allows a comment period of 60 days when specialty societies and interested parties respond to the proposed rules. CMS considers these comments, responds to them, and may alter the proposed rule in response to comments in the publication of the Final Rule in early November.

THE RELATIVE VALUE SCALE UPDATE COMMITTEE (RUC) PROCESS

Codes are submitted to the RUC for valuation if they are new or revised CPT® codes, potentially misvalued codes identified by CMS, or ongoing RUC review (screens).

NEW OR REVISED CPT® CODES

When the CPT® Editorial Panel approves a new Category I CPT® code, the Relative Value Scale (RVS) Update Committee (RUC) process is initiated, and a recommended relative value is developed. This provides Medicare and other payers a uniform scale on which to base payment. In the case of a revised code, depending on the nature of the change, the code's value may be re-evaluated through the RUC process. Category III codes are not referred to the RUC for valuation; instead, reimbursement levels are set directly by those insurance carriers electing to provide coverage for the performance of these "emerging technologies."

The RUC develops physician work RVU recommendations for CPT® codes. Specialties comprising the RUC Advisory Committee designate their “level of interest” for developing work RVU recommendations based on recent actions taken by the CPT® Editorial Panel. Developing work values for new procedures is determined utilizing a standardized random physician survey, with consideration given to time, intensity and relative risk of the procedure. The survey generates data on time and intensity of the procedure, and the necessary pre- and post-procedural work, comparing the proposed code to a group of similar recently valued codes. Each individual surveyed is asked to weight the procedure in comparison to a defined standard procedure with which they are familiar.

These data are collated and summarized for the valuation process. If more than one specialty is involved, a consensus value must be reached before recommendation can be made to the RUC.

In a process parallel to work RVU valuation, direct practice expenses—including supplies, equipment and clinical staff time—are also examined for both facility (hospital) and non-facility (office settings). For example, even for facility-based services there is often a direct practice expense for clinical staff time spent on the completion of pre-service diagnostic/referral forms, coordination of pre-surgery services, scheduling of facility space for a procedure, review of test and exam results, follow-up phone calls, and prescriptions. As with the physician work value, these data are also summarized for consideration by the RUC and, if more than one specialty is involved, consensus regarding these inputs must be reached before recommendation can be made.

Once the proposed work value and practice expense inputs are derived the recommendations are submitted for consideration to the RUC. After debate, the RUC will either adopt a recommendation, derive a new value through on-site negotiations, or reject the recommendation altogether. Rejected recommendations must start anew if the sponsoring society wants to pursue RUC valuation. Adopted physician work RVU and PE recommendations are then forwarded to CMS. CMS’ final decision on RVUs and other payment policies usually appear each November in the Federal Register to be implemented the following January. A copy of the MPFS is available to the general public for download via the CMS webpage, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched>.

In an environment of mandated “budget neutrality,” it is understood that additional new procedures and their derived RVU value may negatively impact the payment associated with RVUs of existing codes. The extent of any change is determined by the number of

RVUs assigned to the procedure and the number of times the procedure is performed annually, in the Medicare patient population. This provides a clear incentive to societies with representatives on the RUC to ensure that all valuations are fair and accurate.

It is the intent of Medicare RVS (also known as the RBRVS) to pay for services on the basis of the amount of work involved without regard to the specialty of the provider(s) performing the service. Since 1992, all physician specialty types use the same CPT® code(s) to report the procedural component(s) of an interventional radiology service.

Similarly, the supervision of imaging personnel and interpretation of images obtained during the procedure is reported using RS&I/S&I CPT® code(s) without regard to the specialty of the physician who performs the service. If a single physician performs both the procedure and supervision and interpretation of the service, that single physician utilizes both codes (i.e., procedural and RS&I/S&I). If several physicians perform portions of a service, each must report only those CPT® codes reflecting the procedure (or portion of the procedure) that they each specifically performed.

POTENTIALLY MISVALUED CODES

Upon the implementation of the Medicare RBRVS MPFS in January 1992, Congress, through the Omnibus Budget Reconciliation Act of 1990, required CMS to review the physician's work relative value units within the Medicare Fee Schedule (MFS). CMS was required to conduct these reviews at least once every five years. This process, known as the five-year review, was used to identify and reconsider the valuation of potentially misvalued codes. The results from the first five-year review were implemented on Jan. 1, 1997. Subsequent reviews were implemented every five years in 2002 and 2007.

Prompted by concerns raised by the Medicare Payment Advisory Commission (MedPAC), legislators, CMS and others in 2006, the AMA established the Five-year Review Identification Workgroup as a subcommittee under the RUC. The Five-year Review Identification Workgroup (since renamed as the Relativity Assessment Workgroup [RAW]) engages in an ongoing iterative process to identify potentially misvalued codes, replacing the traditional, formal five-year review process. RAW identifies groups of potentially misvalued codes through 12 different screens including: services reported together, new technology services to rereview, high-volume growth, fastest growing procedures and old Harvard-valued codes with utilization of more than 30,000. Since its inception, RAW has targeted more than 1,800 services for further

review by the RUC, including many radiology and interventional radiology codes. For additional information on the RUC screening process, see: <https://www.ama-assn.org/about/rvs-update-committee-ruc>.

CMS also identifies potentially misvalued codes through its screening processes and requests these codes be reviewed by RUC.

NATIONAL CORRECT CODING INITIATIVE (NCCI)

In 1996, to prevent payment of perceived abuses in procedural reporting, Congress authorized the Health Care Financing Administration (HCFA, now CMS) to begin the National Correct Coding Initiative (NCCI). The primary intent of the NCCI is to promote correct coding through identification of code pairs that cannot or should not be reported in the same patient encounter (so called “procedure-to-procedure” or PTP edits). NCCI PTP edits also prevent erroneous independent reporting of one or more services inherent to (included in) a comprehensive procedure code (commonly referred to as “unbundling”).

NCCI edits are developed by CMS through a subcontract with Capitol Bridge LLC (ProfessionalSociety@CapitolBridgellc.com). Most proposed new NCCI edits are distributed by the AMA to specialty societies for comment. For all these NCCI edits, SIR’s and ACR’s coding advisers carefully review the proposed edits, and both societies frequently comment and submit opinion letters objecting to a proposed edit if clinical scenario and typical patient care practices indicate that the edit might be in error.

An NCCI modifier indicator of “0” indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of “1” indicates that NCCI-associated modifiers can be used to bypass an edit under appropriate circumstances (please see the Modifier chapter for additional information). Information about NCCI edits is available on the CMS webpage, cms.hhs.gov/nationalcorrectcodinitied/ncciep/list.asp#topofpage. The left side of the NCCI page has several links to specific NCCI policy pages.

MEDICALLY UNLIKELY EDITS (MUES)

In January 2007, CMS developed “medically unlikely edits” (MUEs) to reduce the claims error rate in Part B payments. These edits result in the limitation of the frequency (or number of units) of a particular service that can be reported for a beneficiary by the same provider/provider group on a single date of service. Although CMS

publishes most MUE values on its website (<https://www.cms.gov/medicare/coding/nationalcorrectcodinited/mue>), some MUE values are confidential and are for CMS' and CMS contractors' use only. The latter group of MUE values are not released by CMS.

Ongoing maintenance of MUEs is similar to PTP edits with specialty societies being given an opportunity to comment/challenge existing and proposed MUEs.

MODIFIER USAGE

Modifiers are two-character suffixes (alpha and/or numeric) that are used in conjunction with CPT® codes to justify, elaborate or further clarify the reporting of a particular service. Modifiers explain specifically how the service described by the code was rendered by the provider. Proper use of modifiers is critical, as incorrect modifier usage is often cited as a reason for lost or improper reimbursement. The following is a list of the most common modifiers used in interventional radiology. (Refer to Appendix A of the *CPT® 2021 Professional Edition* for a complete list of modifiers and descriptions.)

-22 (increased service): When an extraordinary amount of time, skill and effort were used to complete a procedure, a **-22** modifier may be appended to the base service. The documentation should support why this is considered above and beyond what is typically encountered during this procedure. Necessary documentation elements include a description of what technical aspects are different from the standard code, documentation of the increased time from what is typical for the given procedure and a description of the extenuating circumstance that made the overall service an increased effort. Some payers may increase reimbursement when this modifier is used, if appropriately documented.

-26 (professional component): Used most often in a hospital or ambulatory surgery center when a radiologist is only interpreting images and not providing the imaging equipment.

-TC (technical component): Used by the hospital or surgery center to cover the expense of the equipment, staff, etc. of the facility.

-50 (bilateral procedure): This is appended to surgical codes when an identical procedure is performed bilaterally (left and right) in the same body system. This is not used when the CPT® descriptor states the procedure is bilateral. Refer to the Medicare Physician Fee Schedule, which dictates when modifier **-50** can be used on a specific code. Modifier **-50** is not used for RS&I codes.

-LT/-RT (left/right): These modifiers may be used to further clarify the laterality, especially when multiple codes are being submitted in one encounter.

-52 (reduced service): When a service is partially performed, it may be appropriate to report this service using a **-52** modifier. Use of this modifier indicates that a service was completed but not all of the services required by a CPT® code descriptor were performed. Use this modifier only to clarify that not all aspects of the service were rendered. Some payers may reduce reimbursement when this modifier is used. Do not use this modifier for terminated procedures or exams that were terminated (discontinued) due to extenuating circumstances; instead use modifier **-53**.

-53 (discontinued procedure): When a procedure or service is terminated due to extenuating circumstances, or something that may threaten the well-being of the patient, the intended procedure code can be reported with this modifier. This modifier may only be used after the induction of anesthesia and should not be used for the cancellation of an elective procedure. The use of modifier **-53** indicates some level of effort was rendered to provide the service. Supporting documentation should state why the procedure was terminated and provide an approximate percentage of the procedure that was performed. (Note that hospital outpatient facilities would report modifier **-73** or **-74** for discontinued procedure).

-59 (distinct procedural service): This modifier indicates that a service was distinct or independent of another service that was also reported during the same encounter. This modifier is used when services that may typically be considered inherent to one another are actually performed on distinct sites, systems or at separate sessions. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. Modifier **-59** is known to be the most widely misused modifier. To counteract its misuse, in 2015, CMS introduced the HCPCS “X{EPSU} modifiers.” These modifiers are to be used to further clarify the reason for the distinct service.

The HCPCS modifiers are used in place of **-59** when the scenario fits the more specific definition modifier. Not all MACs have adopted the use of these modifiers, and providers should seek local guidance for recommended use.

- **-XE:** Separate encounter
- **-XP:** Separate practitioner
- **-XS:** Separate structure
- **-XU:** Unusual nonoverlapping service

-25 (significant E/M service by same physician on date of procedure): This modifier is required when an E/M service is provided on the same day as a procedure with a global fee period (**000** or **010**; most interventional radiology services). An E/M service should only be reported on the same day a procedure is performed if the E/M is a significant and separately identifiable service, above and beyond the usual pre- or postoperative work included in the procedure.

-57 (decision for surgery made within a global surgical period): Required when an E/M service is provided on the same-day-of or on-the-day-before a procedure with a **090** day global period. Similar to modifier **-25** above, the E/M service provided must be a significant and separately identifiable service, above and beyond the usual pre- or postoperative work of the procedure.

Each payer/MAC will have different rules and policies on appropriate modifier usage for claim submission. Reimbursement and reimbursement adjustments will differ by payer. Supporting documentation and justification for the use of some modifiers will also differ by payer.

ADD-ON CODE EDITS

Certain “add-on” codes (those codes identified with a “+” designation) can be reported in conjunction with only a limited number of particular codes, resulting in the rejection of the add-on code when reported in conjunction with a code not on the approved list. CMS has asserted that these edits are determined at the local level.

Evaluation and Management (E/M) codes

E/M CODING AND THE INTERVENTIONAL RADIOLOGIST

Evaluation and Management (E/M) services (CPT® 99202-99499) are fundamentally important and inherent to Interventional Radiology (IR) practices and should be understood by all Interventional Radiologists and used appropriately to describe services we render. Over the past several years, interventional radiology practices have encountered a handful of instances in which some hospital systems prohibit the coding or payers deny payment for E/M claims submitted by diagnostic and interventional radiologists. E/M services, when indicated and provided, may be reported by any physician or any qualified provider, independent of speciality.

We understand that some payers have denied payments for E/M services provided by all radiologists because they have assumed that the services being reported were not true E/M services but rather focused history and physicals to satisfy The Joint Commission (TJC) (formerly Joint Commission on Accreditation of Healthcare Organizations) requirements for current documentation on the chart for invasive procedures. However, Interventional Radiology is a clinical specialty, thus it is fully appropriate for interventional radiologists to document patient care activities with E/M codes.

Our societies have worked to educate several payers about the nature of E/M work provided by interventional radiologists and to differentiate these E/M services from the pre- and post-procedural work that is included in procedural valuations. Please notify the societies of denials so that we can track and continue to educate payers and point out errors when made by payers.

Many interventional radiology procedures require longitudinal care, identical to many other surgical and medical specialties. Upon consultation, patients are seen prior to procedure to determine the care plan, evaluate their state of health, assess the presenting illness and determine the appropriateness of different therapeutic options. Appropriate testing is ordered to fully diagnose their pathology. The patient is advised of all potential treatment options including, but not limited to, minimally invasive therapies provided by interventional radiologists. If the patient's condition is deemed suitable for treatment by the interventional radiologist, then he or she is scheduled

for treatment and the service is rendered. Follow-up care is given as appropriate, and patients are often followed in a clinical office to monitor the effectiveness of the therapy and the progress of the underlying condition. This is identical to services provided by medical and surgical specialists such as gastroenterologists, surgeons and cardiologists.

It is appropriate to perform and document consultations. If the consult is performed and fully documented on the same day as a major (090-day global) procedure one should add modifier **-57** to the E/M code. If performed and fully documented on the same day as a minor procedure (010-day global), one should add modifier **-25** to the E/M code. These modifiers are required to designate that the E/M service involved medical decision making and is a separate service, rendering it reportable. It is not appropriate to report an E/M service when the decision to perform a procedure has already been made, and the physician is merely evaluating the patient as appropriate prior to the planned procedure or for moderate sedation purposes. Following inpatients longitudinally (rounding) also frequently leads to changes in patient management. However, global period rules should be followed when reporting such services.

OFFICE OR OTHER OUTPATIENT SERVICES

The following codes are used to report evaluation and management services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs. Codes are established by new patient service, established patient service or consultation. Definitions for these categories are found below.

NEW AND ESTABLISHED PATIENT

A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

For 2021, the CPT® Editorial Panel updated the E/M code set for new and established outpatient visits (CPT® 99202-99215) as the first step in a comprehensive effort intended to allow providers to focus on the patient, to reduce paperwork, and to better reflect the value of the service. The updated codes have been re-valued by RUC, and CMS updated the Physician Fee Schedule effective 1/1/2021. The reporting criteria for Office and Outpatient E/M services have changed significantly.

Specifically, the 1995 and 1997 Guidelines are no longer applicable for the Office/outpatient visit E/M services. A medically appropriate history and/or physical examination is expected to be performed and documented for all services but is not used in code selection. Code selection for these services is now based on either 1) time OR 2) Medical Decision Making (MDM):

1. **Time-based reporting**

EXCEPT for **99211**, time alone may be used in the outpatient or office setting (**99202–99215**) for selecting a code level. The criteria for counting time have changed significantly for the office and outpatient E/M services in 2021. (This change in criteria is specific to the new and established patient office and outpatient visit codes and is not extended to other E/M services in 2021). In the past, only time spent face-to-face with the patient was counted, and for these services, more than 50% of the time had to be documented as spent on patient counseling and/or coordination of care. Beginning 1/1/2021, time is now calculated as all practitioner time spent for a patient's care on the calendar day the patient was seen, and non-face-to-face services (examples below) may be included in total time calculation. Support staff time is NOT included in the time calculation for these services. There is no longer a requirement that the majority of the time be spent on patient counseling and/or coordination of care. Documentation may be as simple as: "I spent a total of xx minutes reviewing the patient's diagnostic tests, seeing the patient, talking with the patient's caregivers, and documenting in the record."

Physician/other qualified health care professional time include the following activities, when performed:

- preparing to see the patient (eg, review of tests or other medical records)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation

- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver¹
- care coordination (not separately reported)

For joint or shared visits (one where a physician and another qualified health professional in the same practice jointly perform work related to the visit): 1) when time is used as the basis for selecting the appropriate code for distinct and separate visits by the providers, the total time spent by both individuals should be summed to determine the total time; and 2) if both individuals see the patient simultaneously, only the time of one individual should be counted for reporting purposes.

See **Table 1** below for criteria when using time as determining factor for LOS during office or outpatient new and established patient services.

2. Medical decision-making (MDM)

The criteria for MDM have not changed in 2021, and may be used as they have been in the past. If MDM is selected as the method to report the office or outpatient E/M (99202-99215) then 2 of 3 categories must be met, this is regardless of the visit is for new or established patients. The components which make up the MDM option are number and complexity of problems addressed at the encounter, amount and/or complexity of data to be reviewed and analyzed (each unique test, order, or document is counted as an individual piece data for separate and distinct data type), and risk of complications and/or morbidity or mortality of patient management.

¹ Since professional supervision and interpretation of x-ray exams is reimbursable standard of practice, this dot-point effectively excludes an IR from using the time to separately report an interpretation of an x-ray exam AND using the same time for time-based coding. When another individual separately reports the x-ray interpretation, the time the IR spends in review of the exam falls under the preparing to see the patient dot point).

See **Table 2** below for criteria when using MDM as determining factor for LOS during office or outpatient new and established patient services.

Key

The following symbols are used in this section:

- = **new CPT® code**
- + = **add-on code**
- ▲ = **revised code**
- # = **resequenced code**
- ★ = **Telemedicine**

NEW PATIENT, OFFICE OR OTHER OUTPATIENT

Code **99201** has been deleted. To report, use **99202**.

- ★▲ **99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for **99202**, 15-19 minutes of total time is spent on the date of encounter.

- ★▲ **99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for **99203**, 30-44 minutes of total time is spent on the date of the encounter.

- ★▲ **99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for **99204**, 45-59 minutes of total time is spent on the date of the encounter.

- ★▲ **99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for **99205**, 60-74 minutes of total time is spent in the date of the encounter.

ESTABLISHED PATIENT, OFFICE OR OTHER OUTPATIENT

- ▲ **99211** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

- ★▲ **99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for **99212**, 10-19 minutes of total time is spent on the date of the encounter.

- ★▲ **99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making.

When using time for **99213**, 20-29 minutes of total time is spent on the date of the encounter.

- ★▲ **99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making.

When using time for **99214**, 30-39 minutes of total time is spent on the date of the encounter.

★▲ **99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making.

When using time for **99215**, 40-54 minutes of total time is spent on the date of the encounter.

(For services 55 minutes of longer, use prolonged services code **99417**)

Table 1. Time as Determining Factor

NEW PATIENT	
CPT® CODE	TOTAL TIME ON DATE OF ENCOUNTER
99202	15-29 minutes
99203	30-44 minutes
99204	45-49 minutes
99205	60-74 minutes
ESTABLISHED PATIENT	
CPT® CODE	TOTAL TIME ON DATE OF ENCOUNTER
99211	N/A
99212	10-19 minutes
99213	20-29 minutes
99214	30-39 minutes
99215	40-54 minutes

Table 2. Medical Decision Making as Determining Factor

CODE	LEVEL OF MDM (BASED ON 2 OUT OF 3 ELEMENTS OF MDM)	ELEMENTS OF MEDICAL DECISION MAKING		
		NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED AT THE ENCOUNTER	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED <small>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</small>	RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT
99211	N/A	N/A	N/A	N/A
99202 99212	Straight-forward	Minimal 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low 2 or more self-limited or minor problems; OR 1 stable chronic illness; OR 1 acute, uncomplicated illness or injury	Limited <i>(Must meet the requirements of at least 1 of the 2 categories)</i> Category 1: Tests and documents Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* OR Category 2: Assessment requiring an independent historian(s) <i>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</i>	Low risk of morbidity from additional diagnostic testing or treatment

(continued)

Table 2. Medical Decision Making as Determining Factor (continued)

CODE	LEVEL OF MDM (BASED ON 2 OUT OF 3 ELEMENTS OF MDM)	ELEMENTS OF MEDICAL DECISION MAKING		
		NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED AT THE ENCOUNTER	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED <small>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</small>	RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT
99204 99214	Moderate	<p>Moderate</p> <p>1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;</p> <p>OR</p> <p>2 or more stable chronic illnesses;</p> <p>OR</p> <p>1 undiagnosed new problem with uncertain prognosis;</p> <p>OR</p> <p>1 acute illness with systemic symptoms;</p> <p>OR</p> <p>1 acute complicated injury</p>	<p>Moderate</p> <p><i>(Must meet the requirements of at least 1 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <p>Any combination of 3 from the following:</p> <ul style="list-style-type: none"> • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) <p>OR</p> <p>Category 2: Independent interpretation of tests</p> <p>Independent interpretation of a test performed by another physician/ other qualified healthcare professional (not separately reported);</p> <p>OR</p> <p>Category 3: Discussion of management or test interpretation</p> <p>Discussion of management or test interpretation with external physician/other qualified healthcare professional/ appropriate source (not separately reported)</p>	<p>Moderate risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <p>Prescription drug management</p> <p>Decision regarding minor surgery with identified patient or procedure risk factors</p> <p>Decision regarding elective major surgery without identified patient or procedure risk factors</p> <p>Diagnosis or treatment significantly limited by social determinants of health</p>

(continued)

Table 2. Medical Decision Making as Determining Factor (continued)

CODE	LEVEL OF MDM (BASED ON 2 OUT OF 3 ELEMENTS OF MDM)	ELEMENTS OF MEDICAL DECISION MAKING		
		NUMBER AND COMPLEXITY OF PROBLEMS ADDRESSED AT THE ENCOUNTER	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED <small>*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.</small>	RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT
99205 99215	High	<p>High</p> <p>1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;</p> <p>OR</p> <p>1 acute or chronic illness or injury that poses a threat to life or bodily function</p>	<p>Extensive</p> <p><i>(Must meet the requirements of at least 2 out of 3 categories)</i></p> <p>Category 1: Tests, documents, or independent historian(s)</p> <p>Any combination of 3 from the following:</p> <ul style="list-style-type: none"> • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) <p>OR</p> <p>Category 2: Independent interpretation of tests</p> <p>Independent interpretation of a test performed by another physician/ other qualified healthcare professional (not separately reported);</p> <p>OR</p> <p>Category 3: Discussion of management or test interpretation</p> <p>Discussion of management or test interpretation with external physician/other qualified healthcare professional/ appropriate source (not separately reported)</p>	<p>High risk of morbidity from additional diagnostic testing or treatment</p> <p><i>Examples only:</i></p> <p>Drug therapy requiring intensive monitoring for toxicity</p> <p>Decision regarding elective major surgery with identified patient or procedure risk factors</p> <p>Decision regarding emergency major surgery</p> <p>Decision regarding hospitalization</p> <p>Decision not to resuscitate or to de-escalate care because of poor prognosis</p>

CONSULTATIONS, OFFICE OR OTHER OUTPATIENT

Consultation codes (CPT® 99241–99245, 99251–99255), deserve special consideration given that there is a very real conflict between appropriate utilization according to

guidelines issued by the AMA CPT® Editorial Panel for use of these codes and how payers utilize these codes for physician reimbursement.

A consultation, as defined in the CPT® manual, is an evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. In order to minimize fraud and abuse exposure, it is critical that the provider requesting the consultation document the request in the medical record (either by a formal consultation order or progress note) and the consultation recipient document the request (requesting provider and reason) in his/her written summary of the consultation.

A consultation initiated by a patient or family member, not requested by a physician or other qualified health care provider, is reported using standard E/M service codes for the appropriate site of service.

The conclusions/opinion reached as the result of the consultation must be documented in the medical record and separately (by written report) communicated to the requesting provider. If a consultation is mandated by a third party (eg, insurance provider), the consultation code should be reported with modifier **-32** appended.

There is variable reimbursement for consultation services and we recommend you check with your commercial payers to determine their individual policies regarding consultation services. Medicare does not accept consultation codes (effective January 1, 2010), whether the patient is primarily or secondarily insured by Medicare. Consultation services for Medicare primarily insured patients should be converted to the analogous standard E/M code for the site of service. For secondarily insured Medicare patients, there are two options:

1. Report the standard E/M service to the primary insurer and to Medicare; or
2. Report the consultation code to the primary insurer. After receipt of reimbursement, convert the consultation code to a standard E/M code and report this code and reimbursement already received so that Medicare can determine if additional payment is due. Since consultation codes generally carry a higher reimbursement, if the commercial reimbursement is already greater than the standard E/M Medicare reimbursement, Medicare will decline additional payment.

★ **99241** Office consultation for a new or established patient, *which requires these 3 key components:*

- **A problem focused history;**
- **A problem focused examination; and**
- **Straightforward medical decision making.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.

★ **99242** Office consultation for a new or established patient, which requires these 3 key components:

- **An expanded problem focused history;**
- **An expanded problem focused examination; and**
- **Straightforward medical decision making.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.

★ **99243** Office consultation for a new or established patient, which requires these 3 key components:

- **A detailed history;**
- **A detailed examination; and**
- **Medical decision making of low complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital “observation status” are of low severity. Typically, 40 minutes are spent at the bedside and on the patient’s hospital floor or unit.

- ★ **99244** Office consultation for a new or established patient, which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of moderate complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to outpatient hospital “observation status” are of low severity. Typically, 60 minutes are spent at the bedside and on the patient’s hospital floor or unit.

- ★ **99245** Office consultation for a new or established patient, which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to outpatient hospital “observation status” are of low severity. Typically, 80 minutes are spent at the bedside and on the patient’s hospital floor or unit.

PROLONGED SERVICE WITH OR WITHOUT DIRECT PATIENT CONTACT ON THE DATE OF AN OFFICE OR OTHER OUTPATIENT SERVICE

The new add-on code +99417 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services.

For prolonged time-based services where total time exceeds that defined in the highest-level service (**99205** or **99215**), a new code (**99417**) may also be reported for each additional 15 minute increment of service provided each day. Note that to report **99417**, a full 15 minutes of service must be provided for each unit reported. Per CPT® definitions, **99417** is reported when an full 15 minutes of service is provided beyond the MINIMUM time required for **99205** (60 minutes + 15 minutes) or **99215** (40 minutes + 15 minutes).

CMS determined that they would not value or pay for code **99417** in 2021, and instead created code **G2212**. **G2212** is reported when a full additional 15 minutes of services is provided beyond the MAXIMUM time included in **99205** (74 minutes + 15 minutes) or **99215** (54 minutes + 15 minutes).

G2212 Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes **99205**, **99215** for office or other outpatient evaluation and management services

(Do not report **G2212** on the same date of service as **99354**, **99355**, **99358**, **99359**, **99415**, **99416**).

(Do not report **G2212** for any time unit less than 15 minutes)

At this time, it is unclear whether non-Medicare payers will require use of **99417** or **G2212**, so it will be important to check with carriers on their preference. CMS did not accept the RUC recommended value for code **99417**, and therefore it is not valued in the 2021 Physician Fee Schedule.

See Table 3 for examples of comparisons between AMA CPT® time guidelines & CMS time guidelines.

#★+● 99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in

addition to codes **99205, 99215** for office or other outpatient **Evaluation and Management** services)

(Use **99417** in conjunction with **99205, 99215**)

(Do not report **99417** on the same date of service as **99354, 99355, 99358, 99359, 99415, 99416**)

(Do not report **99417** for any time unit less than 15 minutes)

Table 3. Prolonged services reporting – comparison of CPT® and CMS instructions

AMA CPT		CMS	
Office E/M, new patient 60-74 minutes	99205	Office E/M, new patient 60-74 minutes	99205
Office E/M new patient 75-89 min	99205, 99417	Office E/M, new patient 75-88 minutes	99205
Office E/M, new patient 90-104 min	99205, 99417, 99417	Office E/M, new patient 89-103 min	99205, G2212
Office E/M, new patient ≥ 105 min	99205, 99417X3 (add 99417 for each additional 15 minutes)	Office E/M, new patient 104-118 minutes	99205, G2212, G2212 (add G2212 for each additional 15 minutes)
Office E/M, established patient 40-54 minutes	99215	Office E/M, established patient 40-54 minutes	99215
Office E/M, established patient 55-69 minutes	99215, 99417	Office E/M, established patient 55-68 minutes	99215
Office E/M, established patient 70-84 minutes	99215, 99417, 99417	Office E/M, established patient 69-83 minutes	99215, G2212
Office E/M, established patient ≥ 85 minutes	99215, 99417X3 (add 99417 for each additional 15 minutes)	Office E/M, established patient 84-98 min	99215, G2212, G2212 (add G2212 for each additional 15 minutes)

HOSPITAL INPATIENT SERVICES

The following codes are used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a “partial hospital” setting. These codes are to be used to report these partial hospitalization services.

For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient’s hospital unit and at the bedside rendering services for the patient. This includes the time to establish and/or review the patients chart, examine the patient, write notes, and communicate with other professionals and the patient’s family.

INITIAL HOSPITAL CARE (NEW OR ESTABLISHED PATIENT)

The following codes are used to report the first hospital inpatient encounter with the patient by the admitting physician.

For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (**99251–99255**) or subsequent hospital care codes (**99231–99233**) as appropriate.

For admission services for the neonate (28 days of age or younger) requiring intensive observation, frequent interventions, and other intensive care services, see **99477**.

When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (eg, hospital emergency department, observation status in the hospital, office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting.

Evaluation and management services including new or established patient office or other outpatient services (**99202–99215**), emergency department services (**99281–99285**), nursing facility services (**99304–99318**), domiciliary, rest home, or custodial care services (**99324–99337**), home services (**99341–99350**), and preventive medicine services (**99381–99397**) on the same date related to the admission to “observation status” should **not** be reported separately. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes **99234–99236** as appropriate.

99221

Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components:

- **A detailed or comprehensive history;**
- **A detailed or comprehensive examination; and**
- **Medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.

99222

Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making that is of moderate complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

99223

Initial hospital care, per day, for the evaluation and management of a patient which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making that is of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital “observation status” are of low severity. Typically, 70 minutes are spent at the bedside and on the patient’s hospital floor or unit.

SUBSEQUENT HOSPITAL CARE

All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient status (ie, changes in history, physical condition and response to management) since the last assessment.

★ **99231** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **A problem focused interval history;**
- **A problem focused examination;**
- **Medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to outpatient hospital “observation status” are of low severity. Typically, 15 minutes are spent at the bedside and on the patient’s hospital floor or unit.

★ **99232** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **An expanded problem focused interval history;**
- **An expanded problem focused examination;**
- **Medical decision making of moderate complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Usually, the problem(s) requiring admission to outpatient hospital “observation status” are of low severity. Typically, 25 minutes are spent at the bedside and on the patient’s hospital floor or unit.

★ **99233** Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **A detailed interval history;**
- **A detailed examination;**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

CONSULTATIONS, INPATIENT

NEW AND ESTABLISHED PATIENT

The following codes are used to report physician or other qualified health care professional consultations provided to the hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. Only one consultation should be reported by a consultant per admission. Subsequent services during the same admission are reported using subsequent hospital care codes (**99231-99233**) or subsequent nursing facility care codes (**99307-99310**), including services to complete the initial consultation, monitor progress, revise recommendations, or address a new problem. Use subsequent hospital care codes (**99231-99233**) or subsequent nursing facility care codes (**99307-99310**) to report transfer of care services.

When an inpatient consultation is performed on a date that a patient is admitted to a hospital or nursing facility, all evaluation and management services provided by the consultant related to the admission are reported with the inpatient consultation service code (**99251-99255**). If a patient is admitted after an outpatient consultation (office, emergency department, etc.) and the patient is not seen on the unit on the date of admission, only report the outpatient consultation code (**99241-99245**). If the patient is seen by the consultant on the unit on the date of admission, report all evaluation and management services provided by the consultant related to the admission with the inpatient consultation code (**99251-99255**). Do not report both an outpatient consultation (**99241-99245**) and inpatient consultation (**99251-99255**) for services

related to the same inpatient stay. When transfer of care services are provided on the date subsequent to the outpatient consultation, use the subsequent hospital care codes (99231–99233) or subsequent nursing facility care codes (99307–99310).

★ **99251** Inpatient consultation for a new or established patient, which requires these 3 key components:

- **A problem focused history;**
- **A problem focused examination; and**
- **Straightforward medical decision making.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.

★ **99252** Inpatient consultation for a new or established patient, which requires these 3 key components:

- **A expanded problem focused history;**
- **A expanded problem focused examination; and**
- **Straightforward medical decision making.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.

★ **99253** Inpatient consultation for a new or established patient, which requires these 3 key components:

- **A detailed history;**
- **A detailed examination; and**
- **Medical decision making of low complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.

★ 99254

Inpatient consultation for a new or established patient, which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of moderate complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.

★ 99255

Inpatient consultation for a new or established patient, which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.

HOSPITAL DISCHARGE SERVICES

The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes **99234–99236** as appropriate.

99238 Hospital discharge day management; 30 minutes or less

99239 more than 30 minutes

NON-FACE-TO-FACE SERVICES

TELEPHONE SERVICES

Telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services. These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) is considered part of that previous E/M service or procedure. (Do not report **99441–99443**, if **99421**, **99422** **99423** have been reported by the same provider in the previous seven days for the same problem.)

99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes if medical discussion

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

(Do not report **99441-99443** when using **99339-99340**, **99374-99380** for the same call[s])

(Do not report **99441-99443** for home and outpatient INR monitoring when reporting **93792**, **93793**)

(Do not report **99441-99443** during the same month with **99487-99489**)

(Do not report **99441-99443** when performed during the service time codes **99495** or **99496**)

For Medicare patients, once the public health emergency (PHE) ends, providers will be required to use the HCPCS codes for telephone services as CMS will no longer accept codes **99441-99443**. HCPCS code G2012 was created as an initial check-in code and **G2252** has been added on an interim basis for extended telephone services once the PHE ends.

G2012 – Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

G2251 – Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

(Reportable by NPPs who do not have separate privileges for services provided.)

HCPCS code **G2252** is not a replacement for in-person visit, instead it is meant to assess whether or not one is needed. The only technological requirement for this service is the communication technology must be synchronous, happening in real-time. As with other similarly defined services, if it results from an E/M service in previous seven days or in an E/M or other service within the next 24 hours or soonest available appointment, it is bundled into the in-person service.

G2252 Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

ONLINE DIGITAL ASSESSMENT SERVICES

Online digital evaluation and management (E/M) services (**99421, 99422, 99423**) are patient-initiated services with physicians or other qualified health care professionals (HPs). Online digital E/M services require physicians or other QHP's evaluation, assessment, and management of the patient. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. While the patient's problem may be new to the physician or other QHP, the patient is an established patient. Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms, such as electronic health record (EHR) portals, secure email, or other digital communication with the physician or other QHP.

Online digital E/M services are reported once for the physician's or other QHP's cumulative time devoted to the service during a seven-day period. The seven-day period begins with the physician's or other QHP's initial, personal review of the patient-generated inquiry. Physician's or other QHP's cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient's problem, personal physician or other QHP interaction with clinical staff focused on the patient's problem, development of management plans, including

physician or other QHP generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent a separately reported E/M service. All professional decision making, assessment, and subsequent management by physicians or other QHP's in the same group practice contribute to the cumulative service time of the patient's online digital E/M service. Online digital E/M service require permanent documentation storage (electronic or hard copy) of the encounter.

If within seven days of the initiation of an online digital E/M service, a separately reported E/M visit occurs, then the physician or other QHP work devoted to the online digital E/M service is incorporated into the separately reported E/M visit (eg, additive or visit time for a time-based E/M visit or additive of decision-making complexity for a key component-based E/M visit). This includes E/M visits and procedures that are provided through synchronous telemedicine visits using interactive audio and video telecommunications equipment, which are reported with modifier **95** appended to the E/M service code. If the patient initiates an online digital inquiry for the same or a related problem within seven days of a previous E/M service, then the online digital visit is not reported. If the online digital inquiry is related to a surgical procedure and occurs during the postoperative period of a previously completed procedure, then the online digital E/M service is not reported separately. If the patient generates the initial online digital inquiry of a new problem within seven days of a previous E/M visit that addressed a different problem, then the online digital E/M service may be reported separately. If the patient presents a new, unrelated problem during the seven-day period of an online digital E/M service, then the physician's or other QHP's time spent on evaluation, assessment, and management of the additional problem is added to the cumulative service time of the online digital E/M service for that seven-day period.

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

99422 11-20 minutes

99423 21 or more minutes

(Report **99421**, **99442**, **99423** once per 7 days)

(Clinical staff time is not calculated as part of cumulative service time less than 5 minutes)

(Do not report online digital E/M services for cumulative service time less than 5 minutes).

(Do not count **99421, 99422, 99423** time otherwise reported with other services)

(Do not report **99421, 99422, 99423** on the same day when the physician or other qualified health care professional reports E/M services [**99202, 99203, 99204, 99205, 99212, 9913, 99214, 99215, 99241, 99242, 99243, 99244, 99245**])

(Do not report **99421, 99422, 99423**, when using **99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489** for the same communications[s])

(Do not report **99421, 99422, 99423** for home and outpatient INR monitoring when reporting **93792, 93793**)

(**99444** has been deleted. To report, see **99421, 99422, 99423**)

Additional HCPCS codes for communication technology-based services (CTBS) include two codes available from CMS for their beneficiaries. These services include those reported to Medicare by practitioners and NPPs who may not have independent privileges for remote assessment of recorded video/or images submitted by an established patient.

G2010 – Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

G2250 – Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days

nor leading to a service or procedure within the next 24 hours or soonest available appointment

CONSULTATIONS BETWEEN PRACTITIONERS

This code family acknowledges the use of multiple methods whereby non-face-to-face consultations occur, which now include: telephone, internet or electronic health records consultations. The consultant should use codes **99446–99449** or **99451** to report this type of non-face-to-face service.

Interprofessional telephone/internet/electronic health record consultation is an assessment and management service in which a patient's treating (e.g., attending or primary) physician requests the opinion and/or treatment advice of a specific specialty physician, the consultant, to assist the treating physician in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant.

- 99446** Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
- 99447** 11–20 minutes of medical consultative discussion and review
- 99448** 21–30 minutes of medical consultative discussion and reviewx
- 99449** 31 minutes or more of medical consultative discussion and review
- 99451** Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
- 99452** Under Interprofessional Telephone/internet/Electronic Health Record Consultations. The Current Procedural Terminology (CPT) code **99452** as maintained by American Medical Association, is a medical procedural code under the range—Interprofessional Telephone/internet/Electronic Health Record Consultations.

Unlisted services

The CPT® manual dictates that you must “select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT® code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code.”¹ With the innovative nature of our specialty, it is fairly common that unlisted CPT® codes need to be used to report the procedures we perform. Unlisted CPT® codes do not describe a specific procedure, but are categorized by general anatomic regions, organs or body systems. Typically, the last two digits of the CPT® code end in “99”. For example; **27299 – Unlisted procedure, pelvis or hip**. A full and complete list of the unlisted procedural CPT® codes can be found on pages 85 & 86 of the *AMA CPT® 2021 Professional Edition Manual*.¹ One should choose an unlisted code based on most appropriate anatomic considerations.

Without a specific procedure described by an unlisted code, relative value units (RVUs) are not assigned, therefore, reimbursement is not typically predetermined. Providers need to work closely with their coding and reimbursement teams to ensure adequate reimbursement. This process will likely require sharing clinical documentation, including detailed information on the procedure (intended to be) performed, along with supporting literature to justify the efficacy and medical necessity for the procedure. Additionally, it may also be helpful to submit information on a comparable, listed Category I CPT® code when the claim is submitted. When determining which listed code to use for a comparison, give consideration to not only general procedural techniques involved, but also the time, intensity, effort and equipment needed to perform the procedure. All of these elements should also be captured and supported in the documentation of your procedural report when describing the procedure performed to further justify the work performed.

When giving consideration to reporting listed CPT® codes, in combination with an unlisted CPT® code, one should consider what separate and distinct services were provided as described by the listed code(s) versus what would be considered inherent to the procedure being described as unlisted. For example, if a metastatic bone lesion of the pelvis is being treated with radiofrequency ablation, followed by osteoplasty to stabilize the region, one could report **20982** for the ablation and **27299** to represent the osteoplasty. This is justified since the ablation is a stand-alone procedure, separate from the osteoplasty. In this scenario, one could consider using CPT® code **22511** (*Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral*) as the

comparator code for justification and reimbursement purposes. Furthermore, if a bone biopsy was performed as well, one should give consideration to the fact that a bone biopsy is not separately reportable with **22511**, therefore the bone biopsy (**20225**) should NOT be reported and would be considered a part of reported unlisted code **27299**.

While reimbursement for unlisted codes is challenging and requires a team of people working on your behalf, providers are encouraged to report unlisted codes because they provide a means of tracking services until a more specific code is established.

Deleted interventional radiology codes

The following is a list of codes used in interventional radiology practices that were deleted effective Jan. 1, 2021. For further information and a detailed listing of all code changes, refer to the *CPT® 2021 Professional Edition Manual*.

- 32405** Biopsy, lung or mediastinum, percutaneous needle
- 99201** Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

Interventional radiology procedure codes

The following list of code ranges is provided to assist the user of this update in identifying those services that may be frequently performed by a physician practicing interventional radiology. Most code descriptors presented are the “short descriptors” established by CMS. Almost all descriptors presented in this update are truncated in some manner. For a full description of these procedures, please refer to the complete text of the AMA *CPT® 2021 Professional Edition Manual*. No code should ever be used without consulting the complete text of that particular code, including introductory language, parenthetical notes, subcategory notes, and overall category and section notes.

Key

The following symbols are used in this section:

- = **new CPT® code**
- + = **add-on code**
- ▲ = **revised code**
- # = **resequenced code**
- ★ = **Telemedicine**

New and revised 2021 interventional radiology procedure codes: A brief introduction

(Additional information is found in the numerical section of this update.)

Please consult the accompanying introductory language describing the codes and reporting instructions in the *CPT® 2021 Professional Edition Manual*.

LUNG BIOPSY

32408 Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed

NEW AND EMERGING TECHNOLOGY

● **0600T** Ablation, irreversible electroporation; 1 or more tumors per organ, including imaging guidance, when performed, percutaneous

(Do not report **0600T** in conjunction with **76940**, **77002**, **77013**, **77002**)

● **0601T** Ablation, irreversible electroporation; 1 or more tumors per organ, including fluoroscopic and ultrasound guidance, when performed, open

(Do not report **0601T** in conjunction with **76940**, **77002**)

#● **0620T** Endovascular venous arterialization, tibial or peroneal vein, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to complete the intervention, all associated radiological supervision and interpretation, when performed

(**0620T** includes all ipsilateral selective arterial and venous catheterization, all diagnostic imaging for ipsilateral, lower extremity arteriography, and all related radiological supervision and interpretation)

(Do not report **0620T** in conjunction with **37228**, **37229**, **37230**, **37231**, **37238**, **37239**, **37248**, **37249** within the tibial-peroneal segment)

Interventional radiology/radiology procedure codes

FINE NEEDLE ASPIRATION CODES

- 10021** Fine needle aspiration biopsy, without imaging guidance; first lesion
- 10022** has been deleted. To report, see **10005**, **10006**, **10007**, **10008**, **10009**, **10010**, **10011**, **10012**.
- +#10004** each additional lesion (List separately in addition to code for primary procedure)
- (Use **10004** in conjunction with **10021**)
- (Do not report **10004**, **10021** in conjunction with **10005**, **10006**, **10007**, **10008**, **10009**, **10010**, **10011**, **10012** for the same lesion)
- (For evaluation of fine needle aspirate, see **88172**, **88173**, **88177**)
- #10005** Fine needle aspiration biopsy, **including ultrasound guidance**; first lesion
- +#10006** each additional lesion (List separately in addition to code for primary procedure)
- (Use **10006** in conjunction with **10005**)
- (Do not report **10005**, **10006** in conjunction with **76942**)
- (For evaluation of fine needle aspirate, see **88172**, **88173**, **88177**)

#10007 Fine needle aspiration biopsy, **including fluoroscopic guidance**; first lesion

+#10008 each additional lesion (List separately in addition to code for primary procedure)

(Use **10008** in conjunction with **10007**)

(Do not report **10007**, **10008** in conjunction with **77002**)

(For evaluation of fine needle aspirate, see **88172**, **88173**, **88177**)

#10009 Fine needle aspiration biopsy, **including CT guidance**; first lesion

+#10010 each additional lesion (List separately in addition to code for primary procedure)

(Use **10010** in conjunction with **10009**)

(Do not report **10009**, **10010** in conjunction with **77012**)

(For evaluation of fine needle aspirate, see **88172**, **88173**, **88177**)

#10011 Fine needle aspiration biopsy, **including MR guidance**; first lesion

+#10012 each additional lesion (List separately in addition to code for primary procedure)

(Use **10012** in conjunction with **10011**)

(Do not report **10011**, **10012** in conjunction with **77021**)

(For evaluation of fine needle aspirate, see **88172**, **88173**, **88177**)

For percutaneous needle biopsy other than fine needle aspiration biopsy, see **19081–19086** for breast, **20216** for muscle, **20220–20225** for bone, **32400** for pleura, **32408** for lung or mediastinum, **38505** for lymph node(s), **42400** for salivary gland, **47000–47001** for liver, **48102** for pancreas, **49180** for abdominal or retroperitoneal mass, **50200** for kidney, **54500** for testis, **55700** for prostate, **54800** for epididymis, **60100** for thyroid, **62267** for nucleus pulposus, intervertebral disc, or paravertebral tissue, **62269** for spinal cord.

(For percutaneous image-guided fluid collection drainage by catheter of soft tissue [e.g., extremity, abdominal wall, neck], use **10030**)

Please refer to *CPT® 2021 Professional Edition Manual* for complete instructions on how to report FNA and core biopsy procedures.

SOFT-TISSUE MARKER

Percutaneous placement of a soft tissue-marker (e.g., clip, metallic pellet, wire/needle, radioactive seeds) with imaging guidance is reported with **10035** and **10036**. If a more specific site descriptor than soft tissue is applicable (e.g., breast), use the site-specific codes for marker placement at that site. Report **10035** and **10036** only once per target, regardless of how many markers are placed to mark that target. It would be appropriate to report the add-on code **10036** for a second procedure or site, on the same side or contralateral side.

10035 Placement of soft-tissue localization device(s) (percutaneous), first lesion, including imaging guidance

+10036 Placement of soft-tissue localization device(s) (percutaneous), each additional lesion, including imaging guidance Use **10036** in conjunction with **10035**.

Do not report **10035**, **10036** in conjunction with **76942**, **77002**, **77012**, **77021**.

To report a second procedure or site on the same side or contralateral side, use **10036**.

ASPIRATION/INJECTION OF INTEGUMENTARY SYSTEM

10160 Aspiration via puncture of abscess, hematoma, bulla, or cyst.

Imaging guidance is separately reported with code **10160**; use **77002**, **77012**, **77021** or **76942** to report appropriate modality-specific guidance.

19000 Aspiration via puncture of cyst of breast (single cyst).

+19001 Aspiration via puncture of cyst of breast (each additional cyst).

(For drainage of breast abscess, SIR and ACR recommend code **10160**).

Imaging guidance is separately reportable with code **19000**; use **77002**, **77012**, **77021** or **76942** to report appropriate modality-specific guidance.

19030 Injection for mammary galactogram or ductogram.

For RS&I/S&I, see **77053**, **77054**.

BREAST BIOPSIES AND PLACEMENT OF LOCALIZATION DEVICES

There are introductory guidelines in the Breast subsection of *CPT® 2021 Professional Edition Manual* to clarify breast biopsy, percutaneous or open approach, procedures with or without imaging. The guidelines instructions include how to report breast biopsies with placement of localization device(s), imaging services and bilateral procedures.

Percutaneous breast biopsies without imaging guidance are reported with **19100**.

Please refer to *CPT® 2021 Professional Edition Manual* for complete instructions on breast biopsies code set.

Breast biopsies can be performed using a variety of imaging guidance techniques. Choose the code (**19081–19086**) that describes the imaging modality used for the biopsy. If more than one lesion is biopsied in the same setting (either same breast or contralateral breast), use the add-on code(s) to describe each additional lesion biopsied. The percutaneous placement of a localization device (e.g., clip, metallic pellet, wire/needle, radioactive seeds) is included in the biopsy codes when performed; as well as the imaging of the biopsy specimen, when performed. For reporting placement of localization device in the breast under imaging guidance but without concurrent biopsy, see codes **19281–19288**.

19081 Breast biopsy (percutaneous), first lesion, **using stereotactic guidance**, with placement of localization device(s), when performed, and imaging of the biopsy specimen, when performed.

+19082 Breast biopsy (percutaneous), each additional lesion, **using stereotactic guidance**, with placement of localization device(s), when performed, and imaging of the biopsy specimen, when performed.

(Use **19082** in conjunction with **19081**).

19083 Breast biopsy (percutaneous), first lesion, **using ultrasound guidance**, with placement of localization device(s), when performed, and imaging of the biopsy specimen, when performed.

- +19084** Breast biopsy (percutaneous), each additional lesion, **using ultrasound guidance**, with placement of localization device(s), when performed, and imaging of the biopsy specimen, when performed.
- (Use **19084** in conjunction with **19083**).
- 19085** Breast biopsy (percutaneous), first lesion, **using magnetic resonance guidance**, with placement of localization device(s), when performed, and imaging of the biopsy specimen, when performed.
- +19086** Breast biopsy (percutaneous), each additional lesion, **using magnetic resonance guidance**, with placement of localization device(s), when performed, and imaging of the biopsy specimen, when performed.
- (Use **19086** in conjunction with **19085**).
- (Do not report **19081–19086** in conjunction with **19281–19288**, **76098**, **76942**, **77002**, **77021** for same lesion).
- 19100** Biopsy of breast; needle core (no imaging guidance)
- (For fine needle aspiration **biopsy**, see **10004**, **10005**, **10006**, **10007**, **10008**, **10009**, **10010**, **10011**, **10012**, **10021**)
- 19281** Placement of breast localization device(s) (percutaneous) first lesion, **using mammographic guidance**.
- +19282** Placement of breast localization device(s) (percutaneous) each additional lesion, **using mammographic guidance**.
- Use **19282** in conjunction with **19281**.
- 19283** Placement of breast localization device(s) (percutaneous) first lesion, using stereotactic guidance.
- +19284** Placement of breast localization device(s) (percutaneous) each additional lesion, **using stereotactic guidance**.
- Use **19284** in conjunction with **19283**.
- 19285** Placement of breast localization device(s) (percutaneous) first lesion, **using ultrasound guidance**.

- +19286** Placement of breast localization device(s) (percutaneous) each additional lesion, **using ultrasound guidance**.
Use **19286** in conjunction with **19285**.
- 19287** Placement of breast localization device(s) (percutaneous) first lesion, **using magnetic resonance guidance**.
- +19288** Placement of breast localization device(s) (percutaneous) each additional lesion, **using magnetic resonance guidance**.
Use **19288** in conjunction with **19287**.
Do not report **19281–19288** in conjunction with **19081–19086**, **76942**, **77002**, **77021** for same lesion.
(For surgical specimen radiography, use **76098**).
- 19296** Placement of radiotherapy after loading expandable catheter (single/multichannel) in breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy.
- +19297** Concurrently with partial mastectomy (List separately in addition to code for primary procedure).
- 19298** Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into breast (at the time of or subsequent to) partial mastectomy, includes imaging guidance.

MUSCULOSKELETAL SYSTEM (BIOPSY, ASPIRATION, INJECTION)

- 20216** Muscle biopsy, percutaneous needle.
Imaging guidance is separately reportable with code **20216**; use **77002**, **77012**, **77021** or **76942** to report appropriate modality-specific guidance.
- 20220** Bone biopsy, trocar/needle, superficial (e.g., ilium, sternum, ribs).
- 20225** Bone biopsy, trocar/needle, deep (e.g., vertebral body, femur).

Imaging guidance is separately reportable with code **20220** and **20225**; use **77002**, **77012** or **77021** to report appropriate modality-specific guidance.

Do not report **20225** in conjunction with vertebroplasty or vertebral augmentation procedures (**22510**, **22511**, **22512**, **22513**, **22514**, **22515**, **0200T**, **0201T**) when performed at the same level.

20500 Injection of sinus tract, therapeutic.

20501 Injection of sinus tract, diagnostic (sinogram) For RS&I/S&I, see **76080**.

For contrast injection and radiological evaluation of G-, J-, G-J, cecostomy or duodenostomy tube, see **49465**.

For reporting ultrasound guidance for arthrocentesis procedures (**20604**, **20606**, **20611**), please review the *CPT® 2021 Professional Edition Manual*.

20600 Arthrocentesis, aspiration and/or injection of small joint or bursa (e.g., fingers, toes); without ultrasound guidance. (If fluoroscopic, CT or MRI guidance is performed, see **77002**, **77012**, **77021**).

20604 Arthrocentesis, aspiration and/or injection of small joint or bursa with ultrasound guidance, with permanent recording and reporting.

(Do not report **20600** or **20604** in conjunction with **76942**).

20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance. (For fluoroscopic, CT or MR imaging guidance, see **77002**, **77012**, **77021**).

20606 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance.

(Do not report **20605** or **20606** in conjunction with **76942**).

20610 Major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa), without ultrasound guidance. (If fluoroscopic, CT or MRI guidance is performed, see **77002**, **77012**, **77021**).

- 20611** Major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa) with ultrasound guidance, with permanent recording and reporting.
(Do not report **20610** or **20611** in conjunction with **27369** or **76942**).

KNEE ARTHROGRAPHY

- 27369** Injection procedure for contrast knee arthrography or contrast-enhanced CT/MRI knee arthrography
(Use **27369** in conjunction with **73580**, **73701**, **73702**, **73722**, **73723**)
(Do not report **27369** with **20610**, **20611**, **29871**)
(For arthrocentesis of the knee or injection of any material other than contrast for subsequent arthrography, see **20610**, **20611**)
(When fluoroscopy-guided injection is performed for enhanced CT arthrography, use **27369**, **77002**, and **73701** or **73702**)

BONE ABLATION

Both codes **20982** and **20983** include any type of imaging guidance, regardless of type(s) of modality used (previously it had been limited to CT guidance). The descriptors also acknowledge that the work includes treatment of any direct tumor extension outside the bone if performed.

- 20982** Radiofrequency one or more bone tumors, including adjacent soft tissue, percutaneous, includes imaging guidance.
- 20983** Cryoablation, one or more bone tumors, including adjacent soft tissue, percutaneous, including imaging guidance.

VERTEBROPLASTY AND VERTEBRAL AUGMENTATION

Six CPT® codes (**22510–22515**) describe procedures for percutaneous vertebroplasty (injecting cement into the vertebral cavity) of the cervical, thoracic, lumbosacral spine and vertebral augmentation (creating a cavity followed by cement injection, e.g.,

kyphoplasty) of the thoracic and lumbar spine. The procedure codes are inclusive of bone biopsy when performed and imaging guidance necessary to perform the procedure. Assign one code per vertebral body, regardless of whether unilateral or bilateral injections are performed. Assign one primary procedure code and an add-on code for additional levels in the same setting, regardless of region. When treating the sacrum, sacral procedures are reported only once per encounter. These codes bundle the surgical and radiological portions of these procedures. Category III codes **0200T** and **0201T** are specifically for sacral augmentation with use of a cavity creation device (e.g., kyphoplasty). SIR and ACR recommend that, if a provider performs a vertebroplasty in the sacral region, the Category I lumbosacral code should be reported (i.e., **22511**).

22510 Percutaneous **vertebroplasty**, of an **initial cervicothoracic vertebral body**, includes imaging guidance and bone biopsy when performed.

22511 Percutaneous **vertebroplasty**, of an **initial lumbosacral, vertebral body**, includes imaging guidance and bone biopsy when performed.

+22512 Percutaneous **vertebroplasty** of **each additional cervicothoracic or lumbosacral vertebral body**, includes imaging guidance and bone biopsy when performed.

(Use **22512** in conjunction with **22510**, **22511**).

(Do not report **22510–22512** in conjunction with **20225**, **22310**, **22315**, **22325**, **22327** when performed at the same level as **22510–22512**).

22513 Percutaneous **vertebral augmentation**, of an **initial thoracic vertebral body**, includes imaging guidance and bone biopsy when performed.

22514 Percutaneous **vertebral augmentation**, of an **initial lumbar vertebral body**, includes imaging guidance and bone biopsy when performed.

+22515 Percutaneous **vertebral augmentation** of **each additional thoracic or lumbar vertebral body**, includes imaging guidance and bone biopsy when performed.

Use **22515** in conjunction with **22513**, **22514**.

(Do not report **22513–22515** in conjunction with **20225**, **22310**, **22315**, **22325**, **2232** when performed at the same level as **22513–22515**).

(For sacral augmentation, report **0200T**, **0201T**. For facet joint arthroplasty, use **0202T**. For reporting cervical augmentation, see code **22899**).

ARTHROGRAM

Fluoroscopic guidance code **77002** is included in the RS&I/S&I for planar arthrography procedures. Use **77002** only in cases of joint enhancement for CT or MRI-enhanced study when planar arthrography is not also performed/reported.

- 23350** Injection for shoulder arthrogram.
For RS&I/S&I, see **73040**.
- 24220** Injection for elbow arthrogram (for tennis elbow injection, see **20550**).
For RS&I/S&I, see **73085**.
- 27093** Injection for hip arthrogram without anesthesia.
For RS&I/S&I, see **73525**.
- 27095** Injection for hip arthrogram with anesthesia.
For RS&I/S&I, see **73525**.
- 27096** Sacroiliac joint injection (anesthetic or steroid), unilateral; includes image guidance (fluoroscopy or CT) and arthrogram when performed.
For bilateral SI joint injection, report **27096** with modifier **-50**.

LUNGS AND PLEURA

- **32408** Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed.

(Do not report **32408** in conjunction with **76942**, **77002**, **77012**, **77021**)

If a fine needle aspiration (FNA) and core needle biopsy of the lung are performed on the same lesion at the same session on the same day using the same type of imaging guidance, modifier **52** should be used with either the FNA biopsy code or the core lung biopsy code.

- 32550** Insertion of indwelling tunneled pleural catheter with cuff.
If imaging guidance is performed, use **75989**.
(Do not report **32550** in conjunction with **32554**, **32555**, **32556**, **32557** when performed on the same side of the chest).
- 32551** Tube thoracostomy has been revised to indicate that this code is used for reporting an open procedure.
(Do not report **32551** in conjunction with **33020**, **33025**, if pleural drain/ chest tube is placed on the ipsilateral side).
(For percutaneous chest tube placement, see **32556–32557**).

Codes **32554–32557** are not to be reported in conjunction with codes **32550**, **32551** when performed on the same side of the chest. Additionally, codes **32554–32557** cannot be reported in conjunction with imaging codes **75989**, **76942**, **77002**, **77012**, **77021**.

- 32554** Thoracentesis, via needle or catheter, without imaging guidance.
- 32555** Thoracentesis, via needle or catheter, with imaging guidance.
- 32556** Percutaneous insertion of indwelling pleural drainage catheter, without imaging guidance.
- 32557** Percutaneous insertion of indwelling pleural drainage catheter, with imaging guidance. To report insertion of indwelling **tunneled** pleural catheter with cuff, see code **32550**.

PLEURAL FIBRINOLYSIS

- 32561** Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day
- 32562** Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day

ABLATION THERAPY—PULMONARY

- 32994** Cryoablation of 1 or more tumors of the pleura or chest wall imaging guidance when performed, unilateral.
- 32998** Radiofrequency ablation of 1 or more tumors of the pleura or chest wall imaging guidance when performed, unilateral. If ablation is performed in a bilateral setting, report codes **32994** or **32998** with modifier **-50**.

Codes **32994** and **32998** are used to report either reduction/“debulking” or the eradication of pulmonary tumor(s).

ENDOVASCULAR REPAIR OF THE THORACIC AORTA

The following family of codes describes repair of the thoracic aorta. This code set is component coded; therefore, separate codes exist for the RS&I/S&I or imaging guidance component of the procedure. Nonselective and selective catheter placement codes are also separately reportable. Additional interventions outside of the treatment zone, such as angioplasty, stenting and embolization, are also separately reportable. The following codes can be used in the setting of a variety of morphologies (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption).

Codes **33880** and **33881** include the initial graft plus additional grafts placed into the descending thoracic aorta to the level of the celiac artery.

- 33880** Endovascular repair of the descending thoracic aorta, including coverage of the left subclavian artery, initial graft.

For RS&I/S&I, see **75956**.

- 33881** Endovascular repair of the descending thoracic aorta, not involving coverage of the left subclavian artery, initial graft.

For RS&I/S&I, see **75957**.

Codes **33883** and **33884** should be used when proximal extensions are placed in the same setting as the initial graft or in a delayed setting.

33883 Placement of an initial proximal extension for repair of the descending thoracic aorta.

For RS&I/S&I, see **75958**.

+33884 Placement of each additional proximal extension for repair of the descending thoracic aorta.

For RS&I/S&I, see **75958**.

Use **33884** in conjunction with **33883**.

Code **33886** should be used when a distal extension is placed in a delayed setting from the initial graft.

33886 Delayed placement of a distal extension after the initial repair of the descending thoracic aorta.

For RS&I/S&I, see **75959**

Do not report **33886** with **33880** or **33881**

ENDOVASCULAR REPAIR OF THE INFRARENAL AORTA

The following family of codes describes endovascular repair of infrarenal abdominal aortic pathology and procedures that support endograft services. This code set is bundle coded, so codes below are inclusive of all imaging guidance.

Overall, the hierarchy of codes from **34701–34708** is based on the vascular anatomy involved and type of endograft deployed. The new codes also distinguish between endovascular repair “with rupture” (**34702, 34704, 34706, 34708**) and for “other than rupture” (**34701, 34703, 34705, 34707**). Services that have been combined into **34701–34708** and may not be separately reported include:

- Angioplasty and stenting performed within the treatment zone
- Placement of endografts
- Placement of extensions in the aorta from the renal arteries to the iliac
- Bifurcation treatment zone
- Nonselective catheterization
- Selective catheterization within the treatment zone
- Radiological supervision and interpretation

Important notes include:

1. Interventional procedures performed outside the endograft treatment zone at the time of endovascular abdominal aortic aneurysm repair may be additionally reported (e.g., renal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty, or stenting of native artery[s] outside the endograft treatment zone, when done before or after deployment of endograft).
2. Selective catheterization of vessels outside the treatment zone may be reported for diagnostic or therapeutic purposes.
3. The treatment zone is defined by those vessels that contain an endograft(s) deployed during that operative session.

- 34701** EVAR of infrarenal aorta with aorto-aortic tube endograft, for other than rupture.
- 34702** EVAR of infrarenal aorta with aorto-aortic tube endograft, for rupture.
- 34703** EVAR of infrarenal aorta with aorto-uni-iliac endograft, for other than rupture.
- 34704** EVAR of infrarenal aorta with aorto-uni-iliac endograft, for rupture.
- 34705** EVAR of infrarenal aorta with aorto-bi-iliac endograft, for other than rupture.
- 34706** EVAR of infrarenal aorta with aorto-bi-iliac endograft, for rupture. For simultaneous bilateral iliac artery aneurysm repairs report **34705** or **34706** with aorto-bi-iliac endograft. For isolated bilateral iliac artery repair using iliac artery tube endografts, report **34707** or **34708** with modifier **-50**.
- 34707** EVAR of iliac artery with ilio-iliac tube endograft, for other than rupture.
- 34708** EVAR of iliac artery with ilio-iliac tube endograft, for rupture. For endovascular repair of iliac artery by deployment of an iliac branched endograft, see **34717**, **34718**.
- +34709** Placement of extension endograft distal to the common iliac or proximal to the renal artery(ies) when performed in the same setting as initial placement.

- +34717** Endovascular repair of iliac artery at the time of aorto-iliac artery endograft placement, when performed, for rupture or other than rupture, unilateral.
- Report **34717** only once per side. For bilateral procedure, report **34717** twice, do not report with **-50**.
- For placement of an iliac branched endograft at a separate setting than aorto-iliac endograft placement, use **34718**.
- 34718** Endovascular repair of iliac artery not associated with placement of an aorto-iliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing, device selections, all ipsilateral selective iliac artery catheterization(s), radiological supervision and interpretation, all endograft extensions(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (e.g., for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, unilateral).
- For bilateral placement of an iliac branched endograft, report modifier **-50**.
- Do not report **34X01X** in conjunction with **34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34709, 34717**
- Do not report **34718** with **34710, 34711** on the same side
- For placement of an iliac branched endograft in the same setting as aorto-iliac endograft placement, use **34717**
- For placement of an isolated iliac branched endograft for rupture, use **37799**
- 34710** Delayed placement of a distal or proximal extension after the initial repair of the infrarenal aorta or iliac artery, initial vessel treated.
- +34711** Delayed placement of a distal or proximal extension after the initial repair of the infrarenal aorta or iliac artery, each additional vessel treated.
- 34712** Placement of endoanchors.
- +34713** Percutaneous closure of femoral artery from large (12 French or greater) sheath.

ENDOVASCULAR REPAIR OF VISCERAL AND INFRARENAL AORTA USING FENESTRATED ENDOGRAFT

The following family of codes is used to report endovascular abdominal aortic repair (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) involving visceral branches using a fenestrated graft. These codes include all associated radiological supervision and interpretation, including target zone angioplasty and stenting, when performed.

- 34839** Physician planning for placement of a fenestrated visceral aortic endograft, patient-specific and requiring a minimum of 90 minutes of physician time.
- (Do not report **34839** in conjunction with **76376**, **76377**).
- (Do not report **34839** in conjunction with **34841**, **34842**, **34843**, **34844**, **34845**, **34846**, **34847**, **34848**, when performed on the day before or the day of the fenestrated endovascular repair procedure).
- 34841** Endovascular repair of visceral aorta using a fenestrated visceral aortic endograft, including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery). All associated imaging guidance is included.
- 34842** Endovascular repair of visceral aorta using a fenestrated visceral aortic endograft, including two visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[ies]). All associated imaging guidance is included.
- 34843** Endovascular repair of visceral aorta using a fenestrated visceral aortic endograft, including three visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[ies]). All associated imaging guidance is included.
- 34844** Endovascular repair of visceral aorta using a fenestrated visceral aortic endograft, including four or more visceral artery endoprosthesis (superior mesenteric, celiac and/or renal artery[ies]). All associated imaging guidance is included.
- (Do not report **34841–34844** in conjunction with **34701–34706** or **34845–34848**).

- 34845** Endovascular repair of visceral aorta and infrarenal abdominal aorta using a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft, including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery). All associated imaging guidance is included.
- 34846** Endovascular repair of visceral aorta and infrarenal abdominal aorta using a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft, including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[ies]). All associated imaging guidance is included.
- 34847** Endovascular repair of visceral aorta and infrarenal abdominal aorta using a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft, including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[ies]). All associated imaging guidance is included.
- 34848** Endovascular repair of visceral aorta and infrarenal abdominal aorta using a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft, including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[ies]). All associated imaging guidance is included.

Do not report **34845–34848** in conjunction with **34701–34706**, **34841–34844**, **35081**, **35102**.

Do not report **34841–34848** in conjunction with **37236–37237** for bare metal or covered stents placed into the visceral branches within the endoprosthesis target zone.

For placement of distal extension prosthesis[s] terminating in the internal iliac, external iliac or common femoral artery[ies], see **34709**, **34710**, **34711**, **34718**.

Use **34845–34848** in conjunction with **37220–37223** only when these procedures are performed outside the target treatment zone of the endoprosthesis.

INTRAVASCULAR INJECTION/CATHETER PLACEMENT

- 36000** Introduction of a needle/intracatheter vein
- 36002** Injection procedures for percutaneous treatment of extremity pseudoaneurysm. (e.g., thrombin injection)
- For imaging guidance, see **76942**, **77002**, **77012**, **77021**.
- For ultrasound-guided compression repair of pseudoaneurysms, use **76936**.
- Do not report **36002** for vascular sealant of an arteriotomy site.
- 36005** Injection procedure for extremity venography (including introduction of needle or intracatheter).
- For radiological supervision and interpretation, see **75820** or **75822**.
- 36010** Venous catheterization, vena cava (IVC or SVC)
- (For venous catheterization for selective organ blood sampling, see **36500**).
- 36011** Selective venous catheterization, first order vein.
- 36012** Selective venous catheterization, second or higher order vein.
- 36013** Catheterization, right heart or main pulmonary artery.
- 36014** Selective catheterization, left or right pulmonary artery.
- 36015** Selective catheterization, left or right segmental or subsegmental pulmonary artery, each vessel.
- 36100** Catheterization by direct puncture, carotid or vertebral.
- 36140** Catheterization by direct puncture, of an extremity artery (upper or lower extremity).
- 36160** Catheterization aorta, translumbar approach.
- 36200** Catheterization aorta, any approach but translumbar.
- 36215** Selective arterial catheter placement, each first order thoracic or brachiocephalic branch, within a vascular family.

- 36216** Selective arterial catheter placement, initial second order thoracic or brachiocephalic branch, within a vascular family.
- 36217** Selective arterial catheter placement, initial third order or greater thoracic or brachiocephalic branch, within a vascular family.
- +36218** Selective arterial catheter placement, each additional second order or third order or greater, thoracic or brachiocephalic branch, within a vascular family.
- Use **36218** in conjunction with **36216**, **36217**, **36225**, **36226**.
- 36245** Selective arterial catheterization placement, first order abdominal, pelvic or lower extremity branch, within a vascular family.
- 36246** Selective arterial catheterization placement, initial second order abdominal, pelvic or lower extremity branch, within a vascular family.
- 36247** Selective arterial catheterization placement, initial third order or greater selective abdominal, pelvic or lower extremity branch, within a vascular family.
- +36248** Selective arterial catheterization placement, each additional second order or third order or greater, abdominal, pelvic or lower extremity branch, within a vascular family.
- Use **36248** in conjunction with **36246**, **36247**.

CERVICOCEREBRAL ANGIOGRAPHY

The cervicocerebral angiography codes **36221–36228** report nonselective and selective arterial catheter placement and diagnostic imaging of the aortic arch, carotid and vertebral arteries. The code set is based upon a combination of location of the catheter during the angiography and which vessel(s) were studied. Please consult the accompanying introductory language describing the codes and reporting instructions in the *CPT® 2021 Professional Edition Manual*.

These codes describe arterial contrast injections with arterial, capillary and venous phase imaging, when performed. Accessing the vessel, placement of catheter(s), contrast injection(s), fluoroscopy, RS&I and the closure of the arteriotomy by pressure or by

application of an arterial closure device is inherent in codes **36221–36226** and not separately reportable. Add modifier **-50** to codes **36222–36226** if the same procedure is performed on both sides. Report add-on codes **36227**, **36228** twice; do not append modifier **-50** if the same procedure is performed on both sides. Modifier **-59** may be used to indicate when different carotid and/or vertebral arteries are being studied in the same session.

Codes **36221–36226** progress up a hierarchy in which the lesser intensive services are included in the higher intensity code—i.e., use the code of the most intensive service provided. For example, **36221** is reported for nonselective catheter placement, thoracic aorta, with angiography of the aortic arch and great vessel origins. Do not report **36221** in conjunction with **36222–36226** selective codes, as these include the work of **36221** when performed.

36221 Nonselective catheter placement in the thoracic aorta (which includes aortic arch or root), with angiography of the arch and extracranial arteries, if performed (e.g., carotid, vertebral, and/or intracranial vessels) unilateral or bilateral, includes associated supervision and interpretation.

Do not report **36221** with **36222–36226**.

36222 Selective catheter placement in the common carotid or innominate artery, unilateral, with angiography of the ipsilateral extracranial carotid circulation, includes associated supervision and interpretation and includes angiography of the cervicocerebral arch, when performed.

36223 Selective catheter placement in the common carotid or innominate artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation, includes associated supervision and interpretation and includes angiography of the extracranial carotid and cervicocerebral arch, when performed.

36224 Selective catheter placement in the internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation, includes associated supervision and interpretation and includes angiography of the extracranial carotid and cervicocerebral arch, when performed.

Do not report the common or internal carotid or innominate artery selective catheter placement codes **36223** or **36224** in conjunction with the stenting codes **37215**, **37216** or **37218** for the treated carotid artery.

Do not report **36222**, **36223** or **36224** together for ipsilateral angiography. Select the most comprehensive service following the hierarchy of complexity.

36225 Selective catheter placement in the subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation, includes associated supervision and interpretation and, includes angiography of the cervicocerebral arch, when performed.

36226 Selective catheter placement in the vertebral artery, unilateral, with angiography of the ipsilateral vertebral, includes associated supervision and interpretation and includes angiography of the cervicocerebral arch, when performed.

Do not report **36225** with **36226** for ipsilateral angiography. Select the most comprehensive service following the hierarchy of complexity.

+36227 Selective catheter placement in the external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation, includes associated supervision and interpretation.

Note that **36227** is an add-on code. This code must be reported in conjunction with **36222**, **36223** or **36224**.

+36228 Selective catheter placement, each additional intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation, includes associated supervision and interpretation.

Note that **36228** is an add-on code. This code must be reported in conjunction with **36223**, **36224**, **36225** or **36226**.

(Do not report **36228** more than twice per side).

Report **76376** or **76377** for 3D rendering when performed in conjunction with **36221–36228**.

CPT® code **76937** for ultrasound guidance for vascular access is reportable when performed (and documentation requirements are met) in conjunction with **36221–36228**.

RENAL ANGIOGRAPHY

The renal angiography codes, **36251–36254**, include arterial access and catheter placement, contrast injection(s), fluoroscopy, flush aortogram, image postprocessing, permanent images recording, and radiological supervision and interpretation (RS&I). Therefore, it is not appropriate to report these services separately.

36251 **Unilateral** selective catheter placement (first-order), **main renal artery** and any accessory renal artery(ies) for renal angiography, includes associated supervision and interpretation, includes pressure gradient measurements when performed, and flush aortogram when performed.

36252 **Bilateral** selective catheter placement (first-order), **main renal artery** and any accessory renal artery(ies) for renal angiography, includes associated supervision and interpretation, includes pressure gradient measurements when performed, and flush aortogram when performed.

36253 **Unilateral** superselective catheter placement (second order or higher) **renal artery branch(es)** and any accessory renal artery(ies) for renal angiography, includes associated supervision and interpretation, includes pressure gradient measurements when performed, and flush aortogram when performed.

Do not report **36253** with **36251** when performed for the same kidney.

36254 **Bilateral** superselective catheter placement (second order or higher) **renal artery branch(es)** and any accessory renal artery(ies) for renal angiography, includes associated supervision and interpretation, pressure gradient measurements when performed, and flush aortogram when performed.

(Do not report **36254** in conjunction with **36252**).

(Do not report **36251**, **36252**, **36253**, **36254** in conjunction with **0338T–0339T**).

VENOUS PROCEDURES

- 36400** Venipuncture, necessitating physician's skill, younger than 3 years old, femoral or jugular vein
- 36406** Venipuncture, necessitating physician's skill, younger than 3 years old, other vein
- 36410** Venipuncture, necessitating physician's skill, 3 years or older, for diagnostic or therapeutic purposes

Codes **36400**, **36406** and **36410** are not to be used to report routine venipuncture.

LOWER EXTREMITY VENOUS INSUFFICIENCY TREATMENT

In recent years, there have been many additional codes added and revisions to the existing codes in the venous insufficiency coding family. The family of codes cover the different modalities and methods available for treating the spectrum of lower extremity venous insufficiency.

Codes **36465**, **36466** describe injection(s) of a non-compounded foam sclerosant into an extremity truncal vein (e.g., great saphenous vein, accessory saphenous vein) using ultrasound-guided compression of the junction of the central vein (saphenofemoral junction or saphenopopliteal junction) to limit the dispersion of injectate. Imaging guidance is included in these codes and may not be reported separately.

Stab phlebectomy as a means to treat varicose veins is reported with **37765**, **37766**.

Other ablative therapeutic procedures include thermal, mechanochemical, and adhesive techniques. Thermal ablative techniques are divided by modality/energy used to achieve the thermal ablation (RF ablation [**36475–36476**], laser ablation [**36478–36479**]).

Mechanochemical ablation (**36473–36474**) combines the use of an injected sclerosant and disruption of the venous intima by a mechanical device. Chemical adhesive (**36482**, **36483**) ablation includes various glue injections to create a cast that obstructs the incompetent vein. All of these code sets consist of a primary code to report the initial vein treated and an add-on code to report the second and subsequent veins treated, within the same extremity. Regardless of how many veins are treated in addition to the initial vein, the add-on codes are only reportable once per extremity treated. If

the same treatment is performed bilaterally, use modifier **-50**. Imaging guidance and catheterization is included in these codes and may not be separately reported.

The CPT® code for venous embolization (**37241**) has been proposed by some individuals as an appropriate code for venous insufficiency. However, SIR has noted in its coding education that **37241** is to be used for venous embolization or occlusion, **excluding lower extremity venous insufficiency**. The October 2014 edition of the AMA guidance publication, *CPT® Assistant*, contains an excellent overview of how to code lower extremity venous insufficiency procedure.

Codes **93970**, **93971** describing extremity venous duplex imaging for the imaging services associated with the guidance and monitoring of endovenous ablation may not be reported. However, there may be occasions when a patient requires a diagnostic extremity Doppler ultrasound on the same day as the endovenous ablation. In this case, one should separately report the diagnostic study using codes **93970**, **93971**. CMS requires modifier use signifying the provision of a separate and distinct service.

SCLEROTHERAPY

36468 Injection therapy (sclerosing solution), spider veins.

36470 Injection therapy (sclerosing solution), single vein (other than spider).

36471 Injection therapy (sclerosing solution), multiple veins (other than spider) same leg.

Codes **36470** and **36471** are used to report treatment of veins larger than spider veins but smaller than varicosities in main veins such as the saphenous vein.

Only report **36468**, **36470** and **36471** once per extremity per session, regardless of the number of needle injections performed.

Ultrasound guidance (**76942**), when performed, is not included in **36468**, **36470**, **36471** and may be reported separately.

36465 Injection therapy (non-compounded foam sclerosant) single incompetent extremity truncal vein (e.g., great saphenous vein, accessory saphenous vein) includes ultrasound guidance and compression maneuvers to guide dispersion of injectate

- 36466** Injection therapy (non-compounded foam sclerosant) multiple incompetent truncal veins (e.g., great saphenous vein, accessory saphenous vein), same leg, includes ultrasound guidance and compression maneuvers to guide dispersion of injectate
- For injection of a sclerosant into an incompetent vein without compression maneuvers to guide dispersion of the injectate, see **36470**, **36471**.

ABLATION TECHNIQUES

- 36473** Mechanochemical, EVAT of incompetent vein extremity, percutaneous, first vein treated.
- +36474** Mechanochemical, EVAT of incompetent vein extremity, percutaneous, subsequent vein(s) treated in a single extremity, each through separate access sites.
- (Use **36474** in conjunction with **36473**).
- (Do not report **36474** more than once per extremity)
- Do not report **36473**, **36474** in conjunction with **29520**, **29530**, **29540**, **29550**, **29580**, **29581**, **29584**, for the same extremity.
- Do not report **36473**, **36474** in conjunction with **36000–36005**, **36410**, **36425**, **36475–36479**, **37241**, **75894**, **76000**, **76937**, **76942**, **76998**, **77022**, **93970**, **93971**, in the same surgical field.
- 36475** Radiofrequency, EVAT of incompetent vein, extremity, percutaneous, first vein treated.
- +36476** Radiofrequency, EVAT of incompetent vein extremity, percutaneous, subsequent vein(s) treated in a single extremity, each through separate access sites.
- (Use **36476** in conjunction with **36475**).
- (Do not report **36475**, **36476** in conjunction with **36000–36005**, **36410**, **36425**, **36478**, **36479**, **36482**, **36483**, **37241–37244**, **75894**, **76000**, **76937**, **76942**, **76998**, **77022**, **93970**, **93971** in the same surgical field)
- (Do not report **36475**, **36476** in conjunction with **29520**, **29530**, **29540**, **29550**, **29580**, **29581**, **29584**, for the same extremity)

- 36478** Laser, EVAT of incompetent vein, extremity; first vein treated.
- +36479** Laser, EVAT of incompetent vein extremity, percutaneous, subsequent vein(s) treated in a single extremity, each through separate access sites.
- (Use **36479** in conjunction with **36478**).
- (Do not report **36478, 36479** in conjunction with **29520, 29530, 29550, 29580, 29581, 29584** for the same extremity)
- (Do not report **36479, 36479 with 36000, 36002, 36005, 36410, 36425, 36475, 36476, 36482, 36483, 37241, 75894, 76000, 76937, 36942, 76998, 77022, 93970, 93971** in the same surgical field).
- 36482** Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated.
- +36483** Subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure).
- (Use **36483** in conjunction with **36482**)
- (Do not report **36483** more than once per extremity)
- (Do not report **36482, 36483** in conjunction with **36000, 36002, 36005, 36410, 36425, 36475, 36476, 36478, 36479, 37241, 75894, 76000, 76937, 76942, 76998, 77022, 93970, 93971** in the same surgical field)
- (Do not report **36482, 36483** with **29520, 29530, 29540, 29550, 29580, 29581, 29584** for the same extremity)

STAB PHLEBECTOMY

- 37765** Stab phlebectomy (10–20 incisions), one extremity.
- 37766** Stab phlebectomy (more than 20 incisions), one extremity. (Less than 10 incisions, use unlisted code **37799**).
- Imaging guidance is not included in codes **37765** and **37766**.

ADDITIONAL VENOUS CATHETERIZATIONS

- 36481** Portal venous catheterization, percutaneous.
- (This service only includes nonselective portal vein catheter placement. Code additionally any selective catheter placement and other necessary venous access).
- 36500** Selective venous catheterization for venous organ sampling (use once for each organ sampled) (for RS&I/S&I, use **75893**).
- Do not report venous catheterization codes (**36010–36012**) in combination with **36500** for site sampled.

CENTRAL VENOUS ACCESS PROCEDURES

Central venous access (CVA) devices' entry site is either peripheral (e.g., basilic, cephalic or saphenous vein entry site) or central (jugular, subclavian, inferior vena cava, femoral vein) with the catheter/device tip placed into the superior/inferior vena cava, right atrium, or subclavian, brachiocephalic innominate or iliac vein. Placement can be either "nontunneled," with a short tract created through which the catheter is advanced from the skin entry site to the point of venous cannulation, or "tunneled," which requires a counter incision with a segment of the device placed subcutaneously. To accurately code venous access device insertion, the site of entry, type of device, age of patient and tunneling status must be known.

Many of the CPT® codes in this section are dependent on the age of the patient (younger than 5 years or 5 years and greater). Refer to the *AMA CPT® 2021 Professional Edition Manual* for the differentiation related to age when noted.

With the exception of peripherally inserted central catheter placement, the codes in the central venous access family are component coded; therefore, radiologic guidance supervision and interpretation is separately reportable when performed.

CENTRAL VENOUS ACCESS PLACEMENT

When reportable, for RS&I/S&I provided in conjunction with central venous access device insertion, replacement, or removal, see code **77001** for fluoroscopic guidance and **76937** for ultrasound guidance.

- 36555, 36556** Centrally inserted, nontunneled CV catheter. (See AMA *CPT® 2021 Professional Edition Manual* for differentiation related to age).
- 36557, 36558** Centrally inserted, tunneled CV catheter, no port/no pump. (See AMA *CPT® 2021 Professional Edition Manual* for differentiation related to age).
- 36560, 36561** Centrally inserted, tunneled CV catheter with subcutaneous port. (See AMA *CPT® 2021 Professional Edition Manual* for differentiation related to age).
- 36563** Centrally inserted, tunneled CV catheter with subcutaneous pump.
- 36565** Centrally inserted, tunneled CV catheter, requiring two catheters via two separate access sites; no port/no pump. (e.g., Tesio type catheter).
- 36566** Centrally inserted, tunneled CV catheter; requiring two catheters via two separate access sites with subcutaneous, port.
- 36568** Peripherally inserted, CV catheter, no port/no pump (PICC) without imaging guidance, younger than 5 years of age
- 36569** Peripherally inserted, CV catheter, no port/no pump (PICC) without imaging guidance, older than 5 years of age
- Do not report **36568, 36569** with **76937, 77001**
- 36570** Peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age
- 36571** Peripherally inserted central venous access device, with subcutaneous port; age 5 years or older
- 36572** Peripherally inserted, CV catheter, no port/no pump (PICC) performed under imaging guidance, younger than 5 years of age.
- 36573** For placement of PICC, without subcutaneous port or pump, with imaging guidance, age 5 years or older

CENTRAL VENOUS ACCESS REPAIR

Repair codes are used when the device is “fixed” without replacement of either the catheter or port/pump component.

- 36575** Repair CV catheter, tunneled or nontunneled without subcutaneous port.
- 36576** Repair CV catheter, with subcutaneous port.

CENTRAL VENOUS ACCESS REPLACEMENT OR EXCHANGE

For RS&I/S&I provided in conjunction with central venous access device insertion, replacement or removal, see code **77001**.

A partial replacement code is used if only the catheter component of the device is replaced. If the entire device is replaced through the same access site, then the appropriate complete replacement code is reported.

- 36580** Complete replacement nontunneled CV catheter, without subcutaneous port.
- 36581** Complete replacement tunneled CV catheter, without subcutaneous port, through same access.
- 36582** Complete replacement tunneled CV catheter, with subcutaneous port, through same access.
- 36583** Complete replacement tunneled CV catheter, with subcutaneous pump, through same access.
- 36584** Complete replacement peripherally inserted CV catheter, without subcutaneous pump or port, through same access including RS&I. (Do not report **36584** in conjunction with **76937**, **77001**)

(For replacement of a peripherally inserted central venous catheter [PICC] without subcutaneous port or pump, through same venous access, without imaging guidance, use **37799**)
- 36585** Complete replacement peripherally inserted CV catheter, with subcutaneous port, through same access.
- 36578** Partial replacement (catheter only) of CV catheter, with subcutaneous port/pump.

CENTRAL VENOUS ACCESS REMOVAL

When the entire device is removed, the appropriate removal code is reported. There is not a code for the removal of non-tunneled devices as this work is considered inherent to an E/M service (see discussion of E/M coding beginning on page 4 of the *AMA CPT® 2021 Professional Edition Manual*). If a venous access device is removed and a new device placed through a separate site, both the appropriate removal and placement codes are reported.

Please see the central venous access device grid on the following page for a comprehensive summary of the codes for central venous access device placement.

36589 Removal of tunneled CV catheter, no port/no pump.

36590 Removal of tunneled CV catheter, with port.

(For RS&I/S&I provided in conjunction with central venous access device insertion, replacement or removal, see code **77001**).

CENTRAL VENOUS ACCESS SPECIMEN COLLECTION

As indicated in the code descriptor, **36598** specifically includes fluoroscopy; image documentation and report production are considered integral to this service.

Parenthetical text prohibits the reporting of **76000** (fluoroscopy, up to 1 hour physician time), **36595** and **36596** (codes used to report removal of CVA device obstructive material). Additionally, parenthetical text has been added cross-referencing the diagnostic venography codes **75820**, **75825** and **75827**, which would be applicable when a more extensive diagnostic study than that of **36598** is provided.

36591 Collection of blood specimen from a completely implantable venous access device.

36592 Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified.

36593 Dec clotting by thrombolytic agent of implanted vascular access device or catheter.

36595 Mechanical removal pericatheter obstructive material from CVA device (e.g., fibrin sheath stripping) via a separate venous access.

For RS&I/S&I, see **75901**.

36596 Mechanical removal intraluminal obstructive material from CVA device (e.g., catheter brushing) via the device lumen.

For RS&I/S&I, see **75902**.

36597 Repositioning of CVC using fluoroscopic guidance.

For RS&I/S&I see **76000**.

36598 Contrast injection(s) for radiologic evaluation of existing central venous access device, including fluoroscopy, image documentation and report.

(Do not report **36598** in conjunction with **76000**).

(Do not report **36598** in conjunction with **36595**, **36596**).

(For complete diagnostic studies, see **75820**, **75825**, **75827**).

CENTRAL VENOUS ACCESS DEVICE PROCEDURES

DEVICE SITE	DEVICE TYPE	AGE	INSERTION	REPAIR	PARTIAL REPLACEMENT (CATH ONLY)	COMPLETE REPLACEMENT	REMOVAL	
Centrally Inserted	Nontunneled	under 5	36555	36575		36580	99XXX **	
		5 and older	36556					
	Tunneled (no port, no pump)	under 5	36557	36575		36581	36589	
		5 and older	36558					
	Tunneled port	under 5	36560	36576		36578	36582	36590
		5 and older	36561					
	Tunneled pump	not specified	36563	36576		36578	36583	36590
	Two tunneled cath, two access sites (no port, no pump)	not specified	36565	36575 (X 2)*			36581 (X 2)*	36589 (X 2)*
Two tunneled cath, two access sites (port)	not specified	36566	36576 (X 2)*	36578 (X 2)*	36582 (X 2)*	36590 (X 2)*		
Peripherally Inserted	Nontunneled (PICC), without image guidance	under 5	36568	36575		37799	99XXX **	
		5 and older	36569					
	Nontunneled (PICC), with image guidance	under 5	36572	36575		36584	99XXX **	
		5 and older	36573					
	Tunneled port	under 5	36570	36576		36578	36585	36590
		5 and older	36571					

IMAGING GUIDANCE

77001 Fluoro guidance placement, partial/complete replacement or removal

76937 Ultrasound guidance vascular access

* For multicatheter devices use the appropriate repair, partial replacement, complete replacement or removal code describing the service with a frequency of two.

** Removal of a nontunneled device is considered inherent to E/M, report appropriate level of E/M provided.

PORTAL DECOMPRESSION PROCEDURES

Codes **37182** and **37183** describe all the work involved with shunt creation or revision including all imaging guidance, venous access, portal vein catheterization (shunt recanalization), hemodynamic evaluation, tract preparation, angioplasty and stent placement. However, if variceal embolization is performed in conjunction with TIPS or TIPS revision, this service is separately reportable. Catheterization of the varix (via the TIPS) is reported using selective venous catheterization codes (**36011–36012**) and transcatheter embolization is reported using code **37241** or **37244**, depending on the indication for the embolization.

Unlike many other surgical procedures, TIPS insertion and revision procedures as described by codes **37182/37183**, respectively, have 0-day global periods and, therefore, do not include pre- or postprocedural E/M work. E/M work performed outside of the 1-day global period is separately reported (see E/M section).

37182 Insert hepatic shunt (TIPS).

37183 Revision previously placed hepatic shunt (TIPS).

MECHANICAL THROMBECTOMY

Five codes (**37184**, **37185**, **37186** for arterial and **37187**, **37188** for venous) were established to report mechanical thrombectomy in peripheral vessels. **These codes are not to be used for coronary or arterial intracranial vessels.** (For coronary arterial mechanical thrombectomy, see code **92973** and for arterial intracranial, see code **61645**.) They can be used in both native vessels or bypass grafts. Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (e.g., transluminal balloon angioplasty, stent placement) provided are separately reportable. However, there are no separate RS&I codes to report imaging services provided in conjunction with mechanical thrombectomy.

Arteriography and/or venography related to guidance and monitoring of the mechanical thrombectomy and the same session completion study(ies) for this service are included in codes **37184–37188**. However, diagnostic arteriography or venography provided to diagnose a problem before therapy is begun is separately reportable. Also included, and not separately reported, are any intraoperative injection(s) of thrombolytic. However, subsequent or prior continuous infusion of thrombolysis is not an included service and is separately reportable using codes **37211–37214**.

PRIMARY VS. SECONDARY ARTERIAL MECHANICAL THROMBECTOMY

The arterial mechanical thrombectomy codes differentiate between primary and secondary mechanical thrombectomy. The differentiation between primary and secondary mechanical thrombectomy is not dependent on whether mechanical thrombectomy is the only percutaneous procedure provided.

Both primary and secondary mechanical thrombectomy can be provided in conjunction with other percutaneous interventions. Primary arterial mechanical thrombectomy is defined by the planned intent to provide the service.

Most commonly, primary mechanical thrombectomy will precede another percutaneous intervention, with the decision regarding the need for other services not made until after mechanical thrombectomy has been performed. PTA and/or stenting or thrombolytic infusion services may follow the performance of primary mechanical thrombectomy.

Mechanical thrombectomy is considered primary, as the need for these other services was not known prior to the mechanical thrombectomy. Occasionally, the performance of primary mechanical thrombectomy may follow another percutaneous intervention.

Performance of mechanical thrombectomy after a course of thrombolytic infusion therapy is the most common example of primary mechanical thrombectomy following another percutaneous intervention.

Secondary arterial mechanical thrombectomy, also commonly referred to as rescue mechanical thrombectomy, is always performed in conjunction with another percutaneous intervention (e.g., percutaneous transluminal balloon angioplasty, stent placement). These circumstances include those in which a small amount of clot is present in the lesion and needs to be removed prior to PTA/stent or thrombus/embolus has complicated a PTA/stent procedure, requiring removal of the thrombus/embolus to complete the procedure. For secondary mechanical thrombectomy, pretreatment planning, performance of the procedure and postprocedure evaluation are not focused on removal of the clot. Secondary arterial mechanical thrombectomy is reported using add-on code **37186** and is not reportable at the same session as the primary mechanical thrombectomy codes (**37184**, **37185**).

ARTERIAL MECHANICAL THROMBECTOMY

- 37184** Primary percutaneous transluminal arterial mechanical thrombectomy, initial vessel.
- +37185** Primary percutaneous transluminal arterial mechanical thrombectomy, second and all subsequent arteries within the same vascular family. Code **37185** should be used in conjunction with **37184**.
- Do not report **37184** or **37185** in conjunction with **61645**, **76000** or **96374**.
- +37186** Secondary percutaneous transluminal arterial thrombectomy provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy.
- Do not code **37186** with **37184** or **37185**.

VENOUS MECHANICAL THROMBECTOMY

As the use of venous mechanical thrombectomy was found to not be quite as variable as that of arterial mechanical thrombectomy, determination was made that two codes could effectively capture these services. Venous mechanical thrombectomy may be the only intervention in the treatment of venous thrombus or it may be provided in conjunction with thrombolytic infusion therapy; code **37187** may be used to report venous mechanical thrombectomy either by itself or in conjunction with other percutaneous interventions.

Occasionally, it is necessary to repeat venous mechanical thrombectomy during a course of thrombolytic therapy. For example, mechanical thrombectomy may initially be used to debulk venous thrombus, followed by pharmacological thrombolysis (separately reportable using code procedural **37212–37214**) and, if the thrombus is particularly resistant, it may be necessary to repeat venous mechanical thrombectomy. Code **37188** is used to report repeat venous mechanical thrombectomy on a subsequent day of treatment during a course of pharmacological thrombolysis.

- 37187** Percutaneous transluminal venous mechanical thrombectomy.
- 37188** Percutaneous transluminal venous mechanical thrombectomy, repeat treatment on subsequent day during course of thrombolytic therapy.
- Do not report **37187** or **37188** in conjunction with **76000**, **96375**.
- Code **37188** is also reportable in conjunction with other percutaneous interventions.

VENA CAVA FILTER

Three codes (**37191–37193**) were established to describe procedures for placement, repositioning and retrieval of vena cava filters. These codes include all imaging guidance (ultrasound and fluoroscopic) necessary to place the filter. This includes guidance for vessel access, vessel selection and all intraprocedural imaging, including intravascular ultrasound if performed; do not report codes **37252–37253** in conjunction with **37191–37193**.

37191 Insertion of intravascular vena cava filter, via an endovascular approach.

37192 Repositioning of intravascular vena cava filter, endovascular approach.

(Do not report **37192** in conjunction with **37191**).

37193 Retrieval (removal) of intravascular vena cava filter, endovascular approach.

(Do not report **37193** in conjunction with **37197**).

IV INFUSION FOR INTRACRANIAL THROMBOLYSIS

This code (**37195**) is to be used when a thrombolytic agent is infused through a (peripheral) intravenous catheter for the purposes of resolving cerebral clot. For intracranial thrombolysis via transcatheter approach, see codes **61645, 61650–61651**.

37195 Thrombolysis, cerebral, by intravenous infusion.

FOREIGN BODY RETRIEVAL

37197 Percutaneous transcatheter foreign body retrieval, includes all imaging guidance (ultrasound, intravascular ultrasound or fluoroscopy).

For removal of IVC filter, see code **37193**.

TRANSCATHETER BIOPSY

Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (e.g., transluminal balloon angioplasty, stent placement) provided are separately reportable in addition to transcatheter biopsy.

- 37200** Transcatheter biopsy.
For RS&I/S&I, see **75970**.

TRANSCATHETER THROMBOLYTIC INFUSION THERAPY

Four codes were established to report arterial and venous transcatheter thrombolytic infusion therapy. These codes cover the entire therapeutic period of time. Critical guidance on these codes can be found on page 283 in the *CPT® 2021 Professional Edition Manual*.

Codes **61645–61651** have been established to represent intracranial arterial thrombectomy and/or transcatheter infusion therapies. Do not use **37211–37214** to report thrombolytic therapy of the arterial intracranial or coronary vasculature.

Codes **37211** and **37212** are used to report the entire initial (calendar) day of transcatheter thrombolytic infusion. This includes follow-up arteriography/venography and catheter position change or exchange, when performed. Consequently, if initiation and completion therapy occur on the same calendar day, only the initial code (**37211** or **37212**) is reportable.

Code(s) for catheter placement(s), diagnostic studies and other percutaneous interventions (e.g., transluminal balloon angioplasty, stent placement) provided are separately reportable in addition to thrombolytic therapy.

Codes **37211–37214** include fluoroscopic guidance and associated RS&I. Ultrasound guidance for vascular access (see code **76937**) may be reported separately when all required elements are performed. Do not report **75898** in conjunction with **37211–37214**.

Establishment of bilateral thrombolytic infusion through separate access site(s) may be reported with modifier **-50** in conjunction with codes **37211**, **37212**.

- 37211** Transcatheter thrombolytic infusion therapy, arterial, initial treatment day.
37212 Transcatheter thrombolytic infusion therapy, venous; initial treatment day.

37213 Transcatheter thrombolytic infusion therapy, arterial or venous infusion, continued treatment on subsequent day.

Includes all follow-up catheter contrast injections, catheter position change or exchange, when performed.

37214 Final day transcatheter thrombolytic infusion therapy. Code **37214** includes all final contrast injections, removal of catheter and vessel closure by any method.

CAROTID STENT PLACEMENT

Carotid stent placement is coded with one of four CPT® codes. The codes are based on whether the stent is placed in the cervical carotid artery (**37215–37216**) or the intrathoracic carotid artery (**37217–37218**).

Carotid stent placement codes include the following services for the vessel being treated:

- Ipsilateral selective carotid catheterization
- All diagnostic and roadmapping angiography (including arch angiogram, if necessary to repeat, and intracranial views)
- All angioplasties within the stent target zone
- Preparation and deployment of the stent

A physician may elect to perform and may separately report diagnostic cerebral angiography for the contralateral vessel not being stented at the same session as carotid stent placement if these services have not been previously provided. Therefore, even if the physician performs bilateral cerebral and cervical diagnostic studies at the time of carotid stent placement, he or she may only report **36222–59** or **36223–59** for the contralateral study.

Vascular coding conventions dictate that nonselective catheter placement is always included in the service of selective catheter placement when performed from the same access site. Since the carotid stent codes include the work of selective catheter placement into the vessel being stented, providers may not additionally report nonselective catheter placement, unless two separate catheters are introduced into

two separate arteries and/or the provider performs the nonselective and selective catheterizations at two separate patient encounters on the same date of service.

If diagnostic cerebral angiography was completed at a prior setting and the subsequent stent deployment is undertaken within an adequately short time (with no change in the patient's clinical status occurring in the interim that would mandate a repeat diagnostic study), these repeat diagnostic services are not reportable.

If distal protection with carotid stenting is attempted but placement of the distal protection device is found not to be possible and carotid stenting is subsequently performed without distal protection, then code **37216** is reported.

- 37215** Transcatheter placement of cervical carotid artery stent with distal embolic protection, via an open or percutaneous approach.
- 37216** Transcatheter placement of cervical carotid artery stent without distal embolic protection, via an open or percutaneous approach. **37215** and **37216** include all ipsilateral selective catheterization, all diagnostic imaging for ipsilateral, cervical and cerebral carotid angiography, and angioplasty of the target lesion. Following diagnostic angiography, if carotid stenting is not indicated, then the appropriate codes for cervicocerebral angiography codes (**36221–36224**) should be reported in lieu of **37215** and **37216**.
- 37217** Transcatheter placement of an intrathoracic common carotid artery or innominate artery stent by retrograde treatment, via open ipsilateral cervical carotid artery exposure.
- 37217** includes open vessel exposure, as well as standard closure of the vessel. All access, ipsilateral selective catheterization, diagnostic imaging for ipsilateral, cervical and cerebral carotid angiography, and angioplasty of the target lesion.
- 37218** Transcatheter placement of an intrathoracic common carotid artery or innominate artery stent by antegrade treatment, via percutaneous approach or open exposure.
- Code **37218** includes all ipsilateral selective innominate and carotid catheterization, all diagnostic imaging for ipsilateral extracranial intrathoracic innominate and/or carotid artery stenting, and angioplasty

of the target lesion. Following diagnostic angiography, if carotid stenting is not indicated, then the appropriate codes for cervicocerebral angiography codes (**36221–36224**) should be reported in lieu of **37218**.

(For open or percutaneous transcatheter placement of extracranial vertebral artery stent[s], see **0075T, 0076T**).

(For transcatheter placement of intracranial stent[s], use **61635**).

LOWER EXTREMITY ENDOVASCULAR ARTERIAL REVASCULARIZATION

There are 16 codes that describe transcatheter therapies (via an open or percutaneous approach) for lower extremity revascularization performed for treatment of occlusive disease. The *AMA CPT® 2021 Professional Edition Manual* guidelines for these services are extensive, and SIR recommends reading this language carefully.

These codes take into account the fact that multiple techniques may be needed to open areas of disease in some vessels and that these interventions may take place in different vascular territories. In general, the codes for interventions progress up a hierarchy of intensity with the work of the less-intense intervention included in the higher intensity code. For example, angioplasty prior to a stent placement would be a progression up this hierarchy and only the stent code would be reported. Each of these codes includes the work of accessing the artery, selecting the vessel, crossing the lesion, interpreting the images, performing therapeutic intervention(s) in the entire vessel segment, using any embolic protection device, performing final image interpretation and closing the arteriotomy by any method. If angioplasty is performed in addition to facilitate a more advanced procedure, such as atherectomy, or stenting, it is included in the code for the more advanced procedure. Mechanical thrombectomy and thrombolysis are not included in the work of codes **37220–37235** and can be reported additionally with the appropriate component codes when these techniques are used in combination with PTA/stenting/atherectomy to restore flow to areas of occlusive disease. The codes apply to the procedure if performed percutaneously or openly.

Revascularization procedures are grouped into three vascular territories based on the anatomy and are specific to the procedures of angioplasty, stenting or atherectomy. PTA is considered an inherent part of stenting or atherectomy procedures and is not separately reportable. Each code applies to a single extremity.

1. **Iliac territory: subdivided into common, internal and external iliac artery**
 - a. **37220–37223.**
 - b. Single code used for a single vessel.
 - c. Add-on codes used for additional iliac vessels that are treated (common, internal or external).
2. **Femoral/popliteal territory: this entire territory is considered a single vessel**
 - a. **37224–37227.**
 - b. Includes the common, deep and superficial femoral as well as popliteal.
 - c. Since it is a single vessel, only a single code may be reported, even if multiple lesions are treated.
 - d. If two procedures are performed in different areas of the vessel territory, report the code that includes all therapies provided in that region.
3. **Tibial/peroneal territory: subdivided into anterior tibial, posterior tibial and peroneal**
 - a. **37228–37235.**
 - b. Report the initial vessel treated as the primary code for the highest level of service provided within the tibial-peroneal territory with add-on codes for additional vessels treated (not additional lesions or procedures in the same vessel).
 - c. The tibioperoneal trunk is not considered a separate vessel.

If a lesion extends across the margin of a territory, but is opened with a single therapy, report with only a single code. For example, if a distal popliteal artery stenosis extends into the tibioperoneal trunk and the lesion is treated with a single angioplasty spanning both lesions, only code a single vessel treatment.

If both legs are treated at the same time with different interventions, use modifier **-59** to indicate separate and distinct services performed on the same day. If the same treatment/intervention is performed bilaterally in the same territory, use modifier **-50**.

When treating multiple vessels within a territory, report each additional vessel using an add-on code, as applicable. Select the base code that represents the most complex service using the following hierarchy of complexity (in descending order of complexity): atherectomy and stent > atherectomy > stent > angioplasty. When treating multiple lesions within the same vessel, report one service that reflects the combined procedures, whether done on one lesion or different lesions, using the same hierarchy.

A “+” sign indicates an add-on code that must be used after the appropriate code for the initial vessel treated.

An editorial change was made to the lower extremity revascularization codes and to the arterial stent codes as they pertain to lower extremity procedures. The lower extremity revascularization code set (**37220–37235**) is now specifically to be used for treatment of occlusive disease. For stenting of nonocclusive disease (e.g., aneurysm, pseudoaneurysm, rupture/extravasation, vascular malformation or fistula) in the infra-inguinal arteries, **37236–37237** should be used.

An additional editorial change was made to clarify that codes **37220–37223** should be reported in conjunction with codes **34701–34711**, **34718**, **34845–34848**, only when iliac angioplasty or stenting is performed outside the target treatment zone of the endoprosthesis, for the indication of occlusive disease. Category III code **0254T** has been converted to Category 1 codes **34717** and **34718**, and has been deleted. Please review the AMA CPT® 2021 Professional Edition Manual guidelines.

ILIAC ARTERY REVASCULARIZATION

- 37220** Initial iliac artery revascularization, transluminal angioplasty.
- 37221** Initial iliac artery revascularization, transluminal stent(s) placement with or without angioplasty. (Report **37220**, **37221** with **34701–34711**, **34718**, **34845–34848** only when **37220** or **37221** are performed outside the treatment zone of the endograft)
- +37222** Each additional ipsilateral iliac artery revascularization, transluminal angioplasty.
- (**37222** is used in conjunction with **37220**, **37221** for additional ipsilateral iliac segment PTA).

+37223 Each additional ipsilateral iliac artery revascularization, transluminal stent placement(s), with or without angioplasty.

(**37223** is used in conjunction with **37221** for additional iliac segment stent placement).

(Report **37222**, **37223** with **34701-34711**, **34718**, **34845-34848** only when **37222** or **37223** are performed outside the treatment zone of the endograft)

For atherectomy of iliac artery, see codes **0238T**.

FEMORAL/POPLITEAL ARTERY REVASCULARIZATION

37224 Femoral, popliteal artery(ies) revascularization, transluminal angioplasty.

37225 Femoral, popliteal artery(ies) revascularization, atherectomy, with or without angioplasty.

37226 Femoral and/or popliteal artery(ies) revascularization, transluminal stent placement(s), with or without angioplasty.

37227 Femoral, popliteal artery(ies) revascularization, transluminal stent placement(s) and atherectomy, with or without angioplasty

TIBIAL/PERONEAL ARTERY REVASCULARIZATION

37228 Initial tibial/peroneal artery revascularization, transluminal angioplasty.

37229 Initial tibial/peroneal artery revascularization, atherectomy, with or without angioplasty.

37230 Initial tibial/peroneal artery revascularization, transluminal stent placement(s), with or without angioplasty.

37231 Initial tibial/peroneal artery revascularization, transluminal stent placement(s) and atherectomy, with or without angioplasty.

+37232 Each additional ipsilateral tibial/peroneal artery revascularization, transluminal angioplasty.

(**37232** is used in conjunction with **37228-37231**).

- +37233** Each additional ipsilateral tibial/peroneal artery revascularization, atherectomy, with or without angioplasty.
(**37233** is used in conjunction with **37229**, **37231**).
- +37234** Each additional ipsilateral tibial/peroneal artery revascularization, transluminal stent placement(s), with or without angioplasty.
(**37243** is used in conjunction with **37229–37231**).
- +37235** Each additional ipsilateral tibial/peroneal artery revascularization, transluminal stent placement(s) and atherectomy, with or without angioplasty.
(**37235** is used in conjunction with **37231**).

TRANSCATHETER STENT PROCEDURES

CPT® codes **37236–37239** are used to report transcatheter placement of an intravascular stent(s), via percutaneous approach or open exposure, which include the RS&I and angioplasty within the same vessel when performed. Multiple stents placed in a single vessel may only be reported once. If a code exists for stent placement in a more specific vessel, use that code (e.g., lower extremity for revascularization, carotid artery, extracranial vertebral, intracranial).

Codes **37236**, **37237** are used to report stent insertion in an artery. These codes exclude lower extremity artery(ies) for occlusive disease. These codes also exclude cervical or intrathoracic carotid artery, extracranial vertebral or intracranial arteries, and coronary arteries. There are dedicated CPT® codes for these vascular beds and the most specific CPT® code should be used.

Codes **37236–37237** be used for stent treatment of infrainguinal arterial nonocclusive disease. If both occlusive and nonocclusive disease are treated in the same vessel, report the code for the dominant pathology being treated.

Codes **37238**, **37239** are used to report stent insertion in a vein.

Balloon angioplasty(ies), including failed angioplasty, pre-/post dilation following stent placement, treatment of a lesion outside the stented segment in the same vessel,

arteriotomy closure by any means and imaging on completion of the treatment are included in this family of codes. Angioplasty performed in a separate vessel may be reported separately.

A stent code is reported when placed for the management of an aneurysm, pseudoaneurysm or vascular extravasation.

Stents placed with the purpose of providing a latticework to assist in the embolization of an aneurysm are included in the embolization code and are not separately reportable.

Nonselective and/or selective catheterization is not included in these codes and may be separately reported.

Intravascular ultrasound may be reported separately (see codes **37252**, **37253**).

37236 Initial artery, transcatheter placement of an intravascular stent(s) with or without angioplasty within the same vessel.

+37237 Each additional artery transcatheter placement of an intravascular stent(s) with or without angioplasty within the same vessel. For placement of cervical carotid artery stent(s), see **37215**, **37216**.

For placement of extracranial vertebral artery stent see Category III codes **0075T**, **0076T**.

For placement of intrathoracic common carotid/innominate artery stent(s), see **37217**, **37218**.

For placement(s) in iliac, femoral, popliteal or tibial/peroneal artery(ies) stents(s) for occlusive disease, see **37221**, **37223**, **37226**, **37227**, **37230**, **37231**, **37234**, **37235**.

For placement of intracranial stent(s), see **61635**.

For visceral arteries stent(s) in conjunction with fenestrated endovascular repair, see **34841–34848**.

37238 Initial vein, transcatheter placement of an intravascular stent(s) with or without angioplasty within the same vessel.

+37239 Each additional vein transcatheter placement of an intravascular stent(s) with or without angioplasty within the same vessel. **For stent placement within a dialysis circuit see codes 36903, 36906.** Use **36908** for transcatheter placement of intravascular stent(s), central dialysis segment.

VASCULAR EMBOLIZATION AND OCCLUSION PROCEDURES

Codes **37241–37244** were established to describe non-central nervous system, non-head and neck vascular and non-dialysis circuit embolization and occlusion procedures.

This family of CPT® codes bundles together the surgical and radiological portions of the procedures. The vascular embolization and occlusion CPT® codes bundle together the previous transcatheter embolization surgical code (**37204**) with the RS&I codes for embolization (**75894**) and postembolization follow-up angiography (**75898**). As a result, CPT® code **37204** was deleted. In 2014, code **37210** (previously used to report non-emergent uterine artery embolization) was also deleted; this service is now being reported with **37243**.

The embolization codes, **37241–37244**, include all RS&I, intraprocedural guidance and roadmapping, and imaging necessary to document procedure completion. However, selective catheterizations, and any medically necessary diagnostic imaging, needed to perform an embolization should be reported separately.

Please note that the embolization code may only be reported once per surgical field, regardless of the number of vessels embolized on that surgical field. A surgical field is the area immediately surrounding and directly involved in a treatment/procedure. In embolization, different organs typically represent different surgical fields. In some cases, the same organ may consist of more than one surgical field, such as the lungs, where the right and left lung are separate surgical fields.

Embolization procedures involving the central nervous system or the head or neck are reported using codes **61624**, **61626** or **61710** with any associated RS&I still reported using code **75894** (RS&I for embolization) and **75898** (RS&I for completion angiography).

Embolization or occlusion for branch vessels of a dialysis circuit should be used with code **36909**.

Embolization or occlusion of the ureter is reportable with code **50705**.

- 37241** Vascular embolization or occlusion, venous, other than hemorrhage (e.g., congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles).
- 37242** Vascular embolization or occlusion, arterial, other than hemorrhage or tumor (e.g., congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms).
- 37243** Vascular embolization or occlusion, for tumors, organ ischemia or infarction.
- 37244** Vascular embolization or occlusion, for arterial or venous hemorrhage or lymphatic extravasation.

TRANSLUMINAL ANGIOPLASTY

CPT® codes **37246–37249** are used to report transluminal balloon angioplasty, via percutaneous approach or open exposure, which include the RS&I. Codes **37246** and **37247** are used to report angioplasty within an artery, when performed outside of the central nervous system, coronary, pulmonary and lower extremities for occlusive disease. There are dedicated CPT® codes for these vascular beds and the most specific CPT® code should be used. Codes **37248** and **37249** are used to report angioplasty within a vein, when performed outside of a dialysis circuit.

Multiple angioplasties performed in the same vessel or within the same lesion should only be reported once.

When a separate and distinct lesion in a separate vessel is treated, the add-on codes **37247** or **37249** (respective of vascular bed) should be used. Do not report **37246–37249** in combination with **37236–37239** when angioplasty and stenting are performed in the same vessel and lesion in the same setting.

Nonselective and/or selective catheterization is not included in these codes and may be separately reported.

Intravascular ultrasound may be reported separately (see codes **37252, 37253**).

- 37246** Initial artery, transluminal balloon angioplasty, open or percutaneous, within the same artery.

- +37247** Each additional artery, transluminal balloon angioplasty. (List separately in addition to code for primary procedure).
- 37248** Initial vein, transluminal balloon angioplasty, open or percutaneous, within the same vein.
- +37249** Each additional vein, transluminal balloon angioplasty. (List separately in addition to code for primary procedure). To report percutaneous transluminal angioplasty in an artery, report codes **37246**, **37247** except in the central nervous system (**61630**, **61635**), coronary (**92920-92944**), pulmonary (**92997**, **92998**) and lower extremities for occlusive disease (**37220-37235**).

To report percutaneous transluminal angioplasty in a vein, report codes **37248**, **37249** except in the dialysis circuit (**36902**, **36905**, **36907**) when approached through the ipsilateral dialysis access.

INTRAVASCULAR ULTRASOUND

37252 and **37253** should be reported in addition to the therapeutic intervention (e.g., stent or stent graft placement, angioplasty, atherectomy, embolization, thrombolysis, transcatheter biopsy), during which the intravascular ultrasound is performed.

Continuous lesions count as one vessel and should be reported with one code, even if imaging of more than one vessel is performed. For example, if a lesion bridges into two or more vessels, it would still be counted as one vessel, and therefore, it would be reported with code **37252**. If there are two separate vessels and each has a lesion that is not continuous, then the add-on code **37253** should be used.

These IVUS codes are to be used for noncoronary vasculature.

- +37252** Initial vessel, intravascular ultrasound.
- +37253** Each additional vessel, intravascular ultrasound.
- Use **37253** in conjunction with **37252**.

HEMIC AND LYMPHATIC SYSTEMS

- 38200** Injection for splenoportogram.
For RS&I/S&I, see **75810**.
- 38220** Bone marrow collection by aspiration(s) only, for diagnostic purposes.
- 38221** Bone marrow biopsy(ies), by needle or trocar, for diagnostic purposes.
- 38222** Bone marrow biopsy(ies) and aspiration(s), for diagnostic purposes. Do not report **38220** with **38221** in the same setting.

Imaging guidance is not included in bone marrow aspiration and biopsy codes. Report the appropriate imaging guidance modality code if performed.

- 38505** Needle biopsy of superficial lymph node(s).
(See code **49180** for percutaneous biopsy of retroperitoneal lymph nodes).
(See codes **10004–10012**, **10021** for fine needle aspiration).
- 38790** Injection for lymphangiography (single extremity).
For RS&I/S&I, see **75801–75807**.
- 38792** Injection for identification of sentinel node.
- 38794** Thoracic duct cannulation.

LIVER/BILIARY PROCEDURES

LIVER BIOPSY

- 47000** Percutaneous needle biopsy of liver.
- +47001** Percutaneous needle liver biopsy, done at time of other procedure.
For RS&I, see **77002**, **77012**, **76942**, **77021**.

LIVER ABLATION

The following ablation codes do not include radiologic supervision and interpretation. Therefore, imaging guidance is separately reportable with the following codes. Ablation can be performed via an open approach with using intra-operative ultrasound guidance or via a percutaneous approach using CT, MRI, fluoro or ultrasound guidance.

- 47380** Open radiofrequency ablation, liver tumor(s).
(For imaging guidance, use **76940**, US guidance for tissue ablation).
- 47381** Open cryosurgical ablation, liver tumor(s).
(For imaging guidance, use **76940**, US guidance for tissue ablation).
- 47382** Percutaneous radiofrequency ablation, liver tumor(s).
(For imaging guidance, see **77013**, **77022**, **76940**).
- 47383** Percutaneous cryoablation, liver tumor(s).
(For imaging guidance, see **77013**, **77022**, **76940**).

PERCUTANEOUS BILIARY PROCEDURES

A comprehensive code set (**47531-47544**) exists to describe all image-guided percutaneous biliary procedures. This code set differentiates image-guided procedures from endoscopic procedures. These codes are intended to provide greater clarity and granularity for coding percutaneous, image-guided biliary diagnostic and therapeutic interventions. Please consult the accompanying introductory language describing the codes and reporting instructions in the *CPT® 2021 Professional Edition Manual*. These codes include diagnostic cholangiography, if performed, as well as all associated imaging guidance (ultrasonography and/or fluoroscopic) and RS&I. Therefore, do not report **47531** or **47532** with codes **47490**, **47533-47541**. Additionally, when a new biliary drain catheter is placed, the codes include all elements of access into the biliary tree.

These codes describe the placement, replacement and removal of external biliary catheters (externally accessible drainage catheter placed in bile duct, that does not terminate in the bowel) and internal-external catheters (externally accessible drainage catheter that terminates in the bowel). The term “stent,” as used in this code set

describes a percutaneously placed device (e.g., metallic stent or plastic tube) that is positioned completely internally within the biliary tree.

See the *CPT® 2021 Professional Edition Manual* for introductory guidelines.

47490 Image-guided percutaneous cholecystostomy catheter placement.

47531 Injection cholangiography, through an existing access (e.g., via biliary drainage catheter or cholecystostomy tube).

47532 Injection cholangiography, through a new access (e.g., percutaneous transhepatic cholangiogram), includes all associated imaging.

Do not report **47531**, **47532** in conjunction with **47490**, **47533–47541** for procedures performed through the same percutaneous access.

For intraoperative cholangiography, see **74300**, **74301**.

47533 Placement of external biliary drainage catheter, includes cholangiography and all associated imaging.

47534 Placement of internal-external biliary drainage catheter, includes cholangiography and all associated imaging.

47535 Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, includes cholangiography and all associated imaging.

47536 Exchange of biliary drainage catheter (e.g., external, internal-external or conversion of internal-external to external only), includes cholangiography and all associated imaging.

Code **47536** may be reported for exchange of each biliary drainage catheter, if more than one is present. Use modifier **-59** for each additional exchange.

47537 Removal of biliary drainage catheter, requiring fluoroscopic guidance (e.g., with concurrent indwelling biliary stents); includes cholangiography.

Do not report **47537** in conjunction with **47538** for the same access.

For removal of biliary drainage catheter not requiring fluoroscopic guidance, see E/M services.

47538 Placement of stent(s) into a bile duct, via an existing access, each stent; includes diagnostic cholangiography, all associated imaging guidance, balloon dilation, catheter exchange(s) and catheter removal(s) when performed.

Do not report **47538** in conjunction with **47536**, **47537** for the same percutaneous access.

47539 Placement of stent(s) into a bile duct, via a new access, each stent; without placement of separate biliary drainage catheter. Includes diagnostic cholangiography, all associated imaging guidance and balloon dilation.

47540 Placement of stent(s) into a bile duct, via a new access, each stent; with placement of separate biliary drainage catheter. Includes diagnostic cholangiography, all associated imaging guidance and balloon dilation.

Do not report **47538**, **47539**, **47540** in conjunction with **43277**, **47542**, **47555**, **47556** for the same lesion in the same session.

Codes **47538–47540** should be reported once per session for stent(s) placed in a single bile duct. Report these codes (**47538–47540**) more than once per session for the following circumstances: 1) side-by-side stents within a single duct, 2) placement of stents in separate bile ducts, or 3) placement of stents through two or more access sites. Do not report **47540** in conjunction with **47533**, **47534** for the same percutaneous access.

47541 Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (e.g., rendezvous procedure) via a new access; includes cholangiography and all associate imaging.

Do not report **47541** in conjunction with **47531**, **47532**, **47533**, **47534**, **47535**, **47536**, **47537**, **47538**, **47539**, **47540**.

Do not report **47541** when there is existing catheter access.

For use of existing access through the biliary tree into small bowel to assist with an endoscopic biliary procedure, see **47535**, **47536**, **47537**. **+47542** Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, includes all associate imaging.

Use **47542** in conjunction with **47531, 47532, 47533, 47534, 47535, 47536, 47537, 47541**.

Do not report **47542** in conjunction with **43262, 43277, 47538, 47539, 47540, 47555, 47556**.

Do not report **47542** in conjunction with **47544**, if a balloon is used for removal of calculi, debris and/or sludge rather than for dilation.

For percutaneous balloon dilation of multiple ducts during the same session, report an additional dilation once with **47542** and modifier **-59**, regardless of the number of additional ducts dilated.

+47543

Endoluminal biopsy(ies) of biliary tree, by any method(s) (e.g., brush, forceps and/or needle), includes all associate imaging.

Use **47543** in conjunction with **47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540**.

Report **47543** once per session.

For endoscopic brushings, see **43260, 47552**. For endoscopic biopsy, see **43261, 47553**.

+47544

Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (e.g., mechanical, electrohydraulic, lithotripsy), includes all associate imaging.

Use **47544** in conjunction with **47531, 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540**.

Do not report **47544** if no calculi or debris are found, even if removal device is deployed.

Do not report **47544** in conjunction with **43264, 47554**.

Do not report **47544** in conjunction with **47531–47543** for removal of incidental sludge and/or debris.

For endoscopic removal of calculi, see **43264, 47554**. For endoscopic destruction of calculi, use **43265**.

- 47553** Biliary endoscopy, with biopsy, single or multiple.
- 47554** Biliary endoscopy, through skin with stone removal.
- 47555** Biliary endoscopy, with dilation, no stent (Dilation without stent, percutaneous).
For RS&I, see **74363**.
- 47556** Biliary endoscopy, with dilation and stent (Dilation with stent, percutaneous; see also **47801**).
For RS&I, see **74363**.
- 47801** Placement of bile duct stent (e.g., endoprosthesis) (see also code **47556**).

SCLEROTHERAPY OF FLUID COLLECTION

CPT® code **49185** was developed to describe sclerotherapy of fluid collections, such as lymphoceles, cysts or seromas. This code includes contrast injections, if performed. Code **49185** should be reported once per day for each collection treated through a separate catheter. Codes for access to and placement of drainage catheters into the collection may be separately reportable. (See codes **10030**, **10160**, **49405–49407**, **50390** for catheter placement). This code is intended for nonvascular collections and should not be used for sclerosing of incompetent extremity veins, vascular or lymphatic malformations.

- 49185** Sclerotherapy of a percutaneous fluid collection.
Do not report **49424** or **76080** in combination with **49185**.

DRAINAGE OF ABSCESS

To report image-guided catheter drainage of fluid collections/abscess, four bundled codes are used—**10030**, **49405**, **49406** and **49407**. These codes bundle the surgical and radiological portions of the procedure into single codes. These codes include the work of placement of a drainage catheter within the collection, including all imaging guidance (e.g., ultrasonography, fluoroscopic and/or CT). Therefore, do not report **10030**, **49405–49407** with S&I codes **75989**, **76942**, **77002**, **77003**, **77012** or **77021**.

It is not appropriate to report these codes for drainage procedures such as a catheter aspiration of a fluid collection if a catheter is temporarily placed to drain the fluid but then immediately removed.

The code structure for reporting the treatment and management of percutaneous image-guided fluid collection drainage procedures follows anatomical location and approach. A critical point is that one catheter placement into a single collection is reported with a single code (i.e., considered one drainage). If multiple catheters are placed into a collection, the appropriate code should be reported once for each collection drained regardless of the number of catheters required to drain that collection. If a single catheter is placed that drains multiple collections, a single drainage code is reported. If separate catheters are placed in separate and distinct collections in the same setting, then the appropriate code may be used for each drain placed in each individual collection. The appropriate modifier (e.g., **-59**) should be included to indicate that separate and distinct procedures have been performed.

- 10030** Soft tissue, percutaneous fluid collection drainage by catheter (e.g., abscess, hematoma, seroma, lymphocele, cyst), soft tissue (e.g., extremity, abdominal wall, neck), includes all associated imaging.
- 49405** Visceral, percutaneous, fluid collection drainage by catheter (e.g., abscess, hematoma, seroma, lymphocele, cyst), visceral (e.g., kidney, liver, spleen, lung/mediastinum), includes all associated imaging.
- 49406** Peritoneal or retroperitoneal, percutaneous fluid collection drainage by catheter, includes all associated imaging.
- (For percutaneous insertion of a tunneled intraperitoneal catheter without subcutaneous port, use **49418**).
- 49407** Peritoneal or retroperitoneal, transvaginal or transrectal, fluid collection drainage by catheter, includes all associated imaging.
- (For thoracentesis, see **32554, 32555**).
- (For percutaneous pleural drainage by catheter, see **32556, 32557**).
- (For abdominal paracentesis [diagnostic or therapeutic], see **49082, 49083**).
- (For percutaneous cholecystostomy, use **47490**).

- 49418** Insert tunneled intraperitoneal catheter (e.g., dialysis catheter, ascites management), includes all associated imaging, including contrast injections if performed.
- 49419** Insert intraperitoneal cannula or catheter, with subcutaneous reservoir (permanent).
- 49422** Removal of tunneled intraperitoneal catheter.
- 49423** Exchange of abscess drainage catheter.
- 49424** For RS&I/S&I, see **75984**.
Injection for evaluation of abscess drainage catheter.
- 49425** For RS&I/S&I, see **76080**.
Placement of peritoneal-venous shunt.
- 49426** For RS&I/S&I, see **75989**.
Revision of peritoneal-venous shunt.
- 49427** For shunt patency test, use **78291**.
Injection peritoneal-venous shunt.
For RS&I/S&I, see **75809**, **78291**.

PERCUTANEOUS GASTROENTERIC TUBE PROCEDURES

All initial placements, conversion or replacements of gastroenteric tubes include all fluoroscopic guidance and contrast injections to complete the procedure, as well as the placement of a nasogastric or orogastric tube to insufflate the stomach prior to percutaneous gastric tube placement, when performed. Do not report **43752** in combination with the codes below.

- 49440** Place gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).

(For conversion to a gastrojejunostomy tube at the time of initial gastrostomy tube placement, report code **49446** in addition to **49440**).

49441 Place duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).

(For conversion of gastrostomy tube to gastrojejunostomy tube, use **49446**).

49442 Place cecostomy or other colonic tube, percutaneous, under fluoroscopic guidance including contrast injection(s).

49446 Change gastrostomy tube to gastrojejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).

43762 Replacement of gastrostomy tube, percutaneous, includes removal, when performed, **without imaging** or endoscopic guidance; not requiring revision of gastrostomy tract.

43763 Replacement of gastrostomy tube, percutaneous, includes removal, when performed, **without imaging** or endoscopic guidance; requiring revision of gastrostomy tract.

To report percutaneous gastrostomy tube replacement using fluoroscopic guidance, use **49450**.

49450 Replace gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s).

49451 Replace duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).

49452 Replace gastrojejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).

49460 Mechanical removal of obstructive material from gastric tube, any type, any method, under fluoroscopic guidance including contrast injection(s).

(Do not report code **49460** in conjunction with codes **49450–49452**, **49465**).

49465 Contrast injection(s) for radiological evaluation of existing gastric tube, any type, from percutaneous approach.

(Do not report code **49465** in conjunction with codes **49450–49460**).

PERCUTANEOUS GENITOURINARY INTERVENTIONS

RENAL BIOPSY

50200 Biopsy of kidney, by needle or trocar.

For RS&I, see **77002**, **77012**, **77021**, **76942**.

For FNA biopsy see **10005–10012**.

URINARY DRAINAGE PROCEDURES (NEPHROSTOMY, URETERAL, NEPHROURETERAL)

Several revisions and bundled codes have been established to describe image-guided procedures performed in the genitourinary system. The codes below maybe out of numeric sequence but are categorized by procedure type. Guidelines have been added to provide special instructions regarding the intent and use of genitourinary procedure coding. Most notably, image guidance is no longer separately reportable. Diagnostic or routine nephrography or ureterography, if performed, is considered inherent in all of these procedures and not separately reportable unless performed independently.

Throughout these genitourinary code descriptions, the word “catheter” is used to describe something that is externally accessible (e.g., nephroureteral catheter), while the word “stent” is used to describe a device that is not externally accessible and is completely indwelling (e.g., double-J ureteral stent). When the identical procedure is performed bilateral, use modifier **-50** to report the service bilaterally.

Please consult the accompanying introductory language describing the codes and reporting instructions in the *CPT® 2021 Professional Edition Manual*.

NEPHROSTOGRAMS AND NEPHROSTOMY CATHETERS

50430 Injection antegrade nephrostogram and/or ureterogram; via a new access; includes all associated imaging.

- 50431** Injection antegrade nephrostogram and/or ureterogram; via an existing access; includes all associated imaging.
- 50432** Placement of percutaneous nephrostomy catheter, percutaneous; includes all associated imaging.
- Do not report **50432** in conjunction with **50430**, **50431**, **50433**, **50436**, **50437**, **50694**, **50695**, **74425** for the same renal collecting system and/or associated ureter.
- (Do not report code **50432** in conjunction with **50436**, **50437**, for dilation of the nephrostomy tube tract)
- 50435** Exchange percutaneous nephrostomy catheter, percutaneous; includes all associated imaging.
- 50389** Removal of nephrostomy tube, requiring fluoroscopic guidance (e.g., with concurrent indwelling ureteral stent).
- (Removal of nephrostomy tube not requiring fluoroscopic guidance is considered inherent to E/M services; report appropriate level E/M provided).

NEPHROURETERAL CATHETERS

- 50433** Placement of percutaneous nephroureteral catheter via a new access, percutaneous; includes all associated imaging.
- 50434** Convert pre-existing percutaneous nephrostomy catheter to nephroureteral catheter; includes all associated imaging.
- (Code **50387** should be used when exchange of nephroureteral catheter is performed).
- 50387** Removal and replacement of nephroureteral catheter (e.g., external/internal stent) requiring fluoroscopic guidance, including RS&I.
- (For exchange of externally accessible ureteral stent via ureterostomy or ileal conduit, use **50688**).

URETERAL STENTS

- 50693** Placement of percutaneous ureteral stent via pre-existing nephrostomy tract; includes all associated imaging.
- (Includes replacement of existing nephrostomy tube; if performed, do not report with **50434**).
- 50694** Placement of percutaneous ureteral stent via new access, without separate nephrostomy catheter; includes all associated imaging.
- 50695** Placement of percutaneous ureteral stent via new access, with separate nephrostomy catheter; includes all associated imaging.
- 50382** Exchange (via snare/capture) of ureteral stent via percutaneous approach, includes all associated imaging.
- 50384** Removal (via snare/capture) of ureteral stent via percutaneous approach, includes all associated imaging.
- (Do not report **50382**, **50384** in conjunction with **50436**, **50437**).
- (For removal of an internally dwelling ureteral stent via a transurethral approach, use **50386**).
- 50684** Injection for ureter x-ray via indwelling ureteral catheter.
- For RS&I/S&I, see **74425**.

INDWELLING URETERAL STENT, VIA TRANSURETHRAL APPROACH

Codes **50385** and **50386** should be used when a transurethral approach is used without the use of cystoscopy.

- 50385** Exchange (via snare/capture) of ureteral stent via transurethral approach, includes all associated imaging.
- 50386** Removal (via snare/capture) of internally dwelling ureteral stent via transurethral approach, includes all associated imaging.

URETERAL STENT, VIA ILIEAL CONDUIT

50688 Change of ureterostomy tube or externally accessible ureteral stent via ileal conduit.

For RS&I/S&I, see **75984**.

50690 Injection for ileal conduit and/or ureterography.

For RS&I/S&I, see **74425**.

OTHER GENITOURINARY SERVICES

50390 Needle puncture for aspiration or injection, renal cyst or renal pelvis, for injection.

For RS&I/S&I, see **74425, 74470, 77002, 77012, 76942, 77021**.

For antegrade nephrostogram and/or antegrade pyelogram, see **50430, 50431**.

#50436 Percutaneous dilation of existing tract for an endourologic procedure including imaging guidance (e.g., ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed

#50437 including new access into the renal collecting system

(Do not report **50436, 50437** with **50080, 50081, 50382, 50384, 50430-50433, 52334, 74485**)

50396 Manometric studies (e.g., measure kidney pressure [Whitaker]) through nephrostomy catheter

For RS&I/S&I, see **74425**.

50686 Manometric studies (e.g., measure ureteral pressure [Whitaker]) through ureteral catheter.

50391 Instillation of therapeutic agent into an established nephrostomy or ureterostomy tube (e.g., anticarcinogenic, antifungal).

(For injection of sclerosing agent into renal cyst, see code **49185**).

- +50606** Endoluminal biopsy of ureter and/or renal pelvis, any method, non-endoscopic; includes all associated imaging.

(List separately in addition to code for primary procedure).
- +50705** Ureteral embolization or occlusion; includes all associated imaging. (List separately in addition to code for primary procedure).
- +50706** Balloon dilation, ureteral stricture; includes all associated imaging. (List separately in addition to code for primary procedure).

PERCUTANEOUS GENITOURINARY INTERVENTIONS

	NEPHROSTOMY CATHETER	NEPHROURETERAL CATHETER	URETERAL STENT <i>WITHOUT</i> SEPARATE NEPHROSTOMY CATHETER	URETERAL STENT <i>WITH</i> SEPARATE NEPHROSTOMY CATHETER
Placement/ Introduction (via new access)	50432	50433	50694	50695
Placement/ Introduction (via existing access)		50434	50693	
Exchange (remove & replace)	50435	50387	50382	
Removal	50389	50389	50384	

PERCUTANEOUS RENAL TUMOR ABLATION

As different modes of imaging may be used depending on the patient’s specific clinical circumstances, imaging for the guidance and monitoring of the percutaneous renal tumor ablation procedure is separately coded. The modality-specific imaging codes for the guidance and monitoring of parenchymal tissue ablation are **76940**, **77013** and **77022** (ultrasound, computed tomography and magnetic resonance, respectively).

- 50592** Percutaneous, radiofrequency ablation, renal tumor(s), unilateral.

(For imaging guidance and monitoring, see codes **76940**, **77013**, **77022**).

- 50593** Percutaneous, cryoablation, renal tumor(s), unilateral.
(For imaging guidance and monitoring, see codes **76940**, **77013**, **77022**).

BLADDER PROCEDURES

- 51100** Aspiration of bladder, via needle.
(For imaging guidance, see **76942**, **77002**, **77012**).
- 51101** Aspiration of bladder (via trocar or intracatheter).
(For imaging guidance, see **76942**, **77002**, **77012**).
- 51102** Aspiration of bladder with insertion of suprapubic catheter.
(For imaging guidance, see **76942**, **77002**, **77012**).
- 51600** Injection for bladder x-ray or voiding urethrocytography.
For RS&I/S&I, see **74430**, **74455**.
- 51610** Injection for retrograde urethrocytography.
For RS&I/S&I, see **74450**.
- 51700** Irrigation of bladder simple.
- 51701** Insert non-indwelling bladder catheter (e.g., straight cath).
- 51702** Insert temporary bladder catheter (e.g., Foley).
- 51703** Insert bladder catheter, complicated (fractured catheter, balloon).
- 51705** Change of bladder catheter, simple.
For RS&I/S&I, see **75984**.
- 51710** Change of bladder catheter, complicated.
For RS&I/S&I, see **75984**.

INTRACRANIAL AND EXTRACRANIAL ENDOVASCULAR INTERVENTIONS

BALLON OCCULSION TESTING (BOT)

61623 Endovascular temporary vessel occlusion (BOT), head or neck.

Code **61623**, endovascular temporary balloon arterial occlusion (BOT), head or neck (extracranial/intracranial), includes:

1. Selective catheterization of vessel to be occluded
2. Positioning and inflation of occlusion balloon
3. Concomitant neurological monitoring
4. RS&I/S&I of all angiography for balloon occlusion and post occlusion

Selective catheterization for vessel occluded, RS&I/S&I, neurologic monitoring and post occlusion angiography are not separately reportable when performed in conjunction with BOT (code **61623**). However, if selective catheterization and angiography of arteries other than the artery to be occluded is performed, appropriate catheterization and RS&I/S&I codes are reported. Additionally, RS&I/S&I for full and complete pre-procedural diagnostic angiography of vessel occluded is reportable, as is catheterization and diagnostic RS&I/S&I of all other vessels studied. Catheterization coding for these scenarios follows established coding guidelines (see *CPT® 2021 Professional Edition Manual*). Because codes **61623** and **61624** vary significantly in what is included in the work described by each code, special attention must be paid to use each of these codes correctly.

EMBOLIZATION AND OCCLUSION PROCEDURES

Component coding conventions are retained with codes **61624** and **61626**. For RS&I/S&I services, code **75894** for embolization and code **75898** for postembolization arteriography. Associated diagnostic angiography with selective catheterization codes are also reportable, see codes **36222–36228**.

Embolization is performed in one operative field. Even if the embolization is accomplished through multiple vessels, **61624** and **61626** are reported only once. Multiple operative fields (e.g., bilateral AVMs, multiple tumors) should be coded as many

times as there are separate operative fields treated. Documentation should be clear and support the separate operative fields.

61624 Transcatheter permanent occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, central nervous system.

For radiological supervision and interpretation, use **75894**. For postembolization angiography, use **75898**.

For non-central nervous system and non-head or neck embolization, see **37241-37244**.

61626 Transcatheter permanent occlusion or embolization, percutaneous, non-central nervous system, head or neck (extracranial, brachiocephalic branch)

For radiological supervision and interpretation, use **75894**. For postembolization angiography, use **75898**.

For non-central nervous system and non-head or neck embolization, see **37241-37244**.

INTRACRANIAL DILATION, ANGIOPLASTY AND STENT

Codes **61630-61642** were established to report intracranial angioplasty, stent placement and balloon dilation. These codes include all ipsilateral selective vascular catheterization and diagnostic angiography of the target vascular family, and all associated imaging.

When diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, diagnostic angiography of the target vascular family is not reported in addition to **61630** and **61635**. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging (**36222-36228**) should be reported in lieu of **61630** and **61635**.

Code **61630** is used to report intracranial percutaneous endovascular balloon angioplasty. Code **61635** is used to report intracranial percutaneous endovascular stent placement and includes concurrent angioplasty when performed.

61630 Balloon angioplasty, intracranial (e.g., atherosclerotic stenosis), percutaneous.

61635 Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty, if performed.

Do not report **61630** or **61635** in conjunction with **61645** for the same vascular territory.

Codes **61640–61642** are used to report intracranial endovascular balloon dilation. This code set includes a primary code for the dilation of the initial vessel (**61640**) and two add-on codes for dilation of each additional vessel in the same vascular family (**61641**) and each additional vessel in a different vascular family from the initial dilation (**61642**).

61640 Balloon dilation of intracranial vasospasm, percutaneous; initial vessel.

+61641 Balloon dilation of intracranial vasospasm, percutaneous; each additional vessel in same vascular territory (List separately in addition to code for primary procedure).

+61642 Balloon dilation of intracranial vasospasm, percutaneous; each additional vessel in different vascular territory (List separately in addition to code for primary procedure).

(Use **61641** and **61642** in conjunction with **61640**).

Do not report **61640**, **61642** in conjunction with **61650** or **61651** for the same vascular territory.

Codes have been established to describe endovascular intracranial interventions. Code **61645** has been established to describe percutaneous endovascular revascularization of cerebral vessels occluded by thrombus or embolus. Codes **61650** and **61651** have been established to describe prolonged intracranial arterial continuous infusion of pharmacologic agents. Please consult the accompanying introductory language describing these codes and reporting instructions in the *CPT® 2021 Professional Edition Manual*.

These codes are described and reported by vascular territory. For the purposes of these codes, the intracranial arteries are divided into three vascular territories: right carotid circulation, left carotid circulation and the vertebrobasilar circulation. They include all selective catheterization and diagnostic and completion angiography for the treated territory. However, diagnostic angiography of a nontreated vascular territory may be reported separately.

Code **61645** describes endovascular revascularization of thrombotic/embolic occlusion of intracranial arteries; this code describes any method of revascularization (e.g., mechanical retrieval device, aspiration catheter or the administration of any thrombolytic agents). Code **61645** is reported once for vascular territory treated.

61645 Intracranial arterial mechanical thrombectomy and/ or infusion for thrombolysis, intracranial, any method, including pharmacological thrombolytic injection(s); includes all associated imaging.

To report venous mechanical thrombectomy and/or thrombolysis, see **37187, 37188, 37212, 37214**.

Do not report **61645, 61650** or **61651** in conjunction with **36221–36226, 37184** or **37186** for the treated vascular territory.

Do not report **61645** in conjunction with **61650** or **61651** for the same vascular distribution.

Codes **61650, 61651** describe the cerebral endovascular continuous or intermittent therapeutic prolonged administration of any non-thrombolytic agent(s) (e.g., spasmolytics or chemotherapy) into an artery to treat non-iatrogenic central nervous system diseases or sequelae thereof. These codes should not be used to report administration of agents (e.g., heparin, nitroglycerin, saline) usually administered during endovascular interventions. These codes are used for prolonged administrations (i.e., of at least 10 minutes continuous or intermittent duration).

61650 Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, initial vascular territory; includes all associated fluoroscopy and angiography.

+61651 Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, each additional vascular territory; includes all associated fluoroscopy and angiography.

Use **61651** in conjunction with **61650**.

Do not report **61650** or **61651** in conjunction with **36221–36226, 61640, 61641, 61642, 61645** for the same vascular territory.

Do not report **61650** or **61651** in conjunction with **96420, 96422, 96423, 96425** for the same vascular territory.

LUMBAR PUNCTURE

- 62270** Lumbar puncture, diagnostic;
- 62328** Lumbar puncture, diagnostic; with fluoroscopic or CT guidance
- Do not report **62270**, **62328** with **77003**, **77012**
- For ultrasound or MRI guidance see codes **76942**, **77021**
- 62272** Lumbar puncture, therapeutic (by needle or catheter to drain CSF);
- 62329** Lumbar puncture, therapeutic (by needle or catheter to drain CSF); with fluoroscopic or CT guidance
- Do not report **62272**, **62329** with **77003**, **77012**
- For ultrasound or MRI guidance see codes **76942**, **77021**

MYELOGRAPHY

There are four codes (**62302–62305**) that bundle the injection and image guidance for myelography procedures. The current injection and radiologic supervision and interpretation codes (**72240–72270**) for myelography are retained to allow correct reporting when only one component of the service is provided (e.g., injection only is performed for MR myelography and radiographic myelography is not performed). The components may also be reported when two separate providers perform the surgical and radiological components. However, even though the existing component codes were retained, they should not be reported together. When the same provider performs both components, the bundled codes should be reported.

- 62284** Injection procedure for myelography and/or computed tomography, lumbar.
- (Do not report **62284** in conjunction with **62302**, **62303**, **62304**, **62305**, **72240**, **72255**, **72265**, **72270**).
- (When both **62284** and **72240**, **72255**, **72265**, **72270** are performed by the same physician or other qualified health care professional for myelography, see **62302**, **62303**, **62304**, **62505**).
- (For injection procedure at C1–C2, use **61055**).

- 62302** Myelography via lumbar injection, including RS&I; cervical.
(Do not report **62302** in conjunction with **62284**, **62203**, **62304**, **62305**, **72240**, **72255**, **72265**, **72270**).
- 62303** Myelography via lumbar injection, including RS&I; thoracic.
(Do not report **62303** in conjunction with **62284**, **62302**, **62304**, **62305**, **72240**, **72255**, **72265**, **72270**).
- 62304** Myelography via lumbar injection, including RS&I; lumbosacral.
- 62305** Myelography via lumbar injection, including RS&I; two or more regions (e.g., lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical).
Do not report **62305** in conjunction with **62284**, **62302**, **62303**, **62304**, **72240**, **72255**, **72265**, **72270**.
(For myelography lumbar injection and imaging performed by different physicians or other qualified health care professionals, see **62284** or **72240**, **72255**, **72265**, **72270**).
(For injection procedure at C1–C2, use **61055**).
Injection(s) of diagnostic or therapeutic substance(s) codes **62310**, **62311**, **62318**, **62319** have been deleted.
- 62320** Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging.
- 62321** With imaging guidance (i.e., fluoroscopy or CT). Do not report **62321** with **77003**, **77012**, **76942**.
- 62322** Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging.

- 62323** With imaging (i.e., fluoroscopy or CT).
Do not report **62323** with **77003**, **77012**, **76942**.
- 62324** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging.
- 62325** With imaging (i.e., fluoroscopy or CT).
Do not report **62325** with **77003**, **77012**, **76942**.
- 62326** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging.
- 62327** With imaging (i.e., fluoroscopy or CT).
Do not report **62327** in conjunction with **77003**, **77012**, **76942**.
Report **01996** for daily hospital management of continuous epidural or subarachnoid drug administration performed with **62324**, **62325**, **62326**, **62327**.

DESTRUCTION BY NEUROLYTIC AGENT (E.G., CHEMICAL, THERMAL, ELECTRICAL OR RADIOFREQUENCY), CHEMODENERVATION-SOMATIC NERVES

Several changes have been made recently in the neurolysis/chemodenerivation codes to provide greater granularity. Readers should refer to the *AMA CPT® 2021 Professional Edition Manual* for the guidelines, language and instructional parenthetical notes that inform users about appropriate code selection when reporting these services.

Some existing codes have been revised to provide clarity on reporting these procedures and codes **64613** and **64614** have been deleted. Six codes, **64642-64647**, specify reporting chemodenerivation of extremity and trunk muscles.

Codes **64642-64644** are reported for chemodenervation of extremity, one to four muscles and five or more muscles. Codes **64645-64647** are to report chemodenervation of trunk, one to five muscles and six or more muscles.

64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (e.g., for blepharospasm, hemifacial spasm).

64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (e.g., for blepharospasm, hemifacial spasm).

64615 Chemodenervation of muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (e.g., for chronic migraine).

Report **64615** only once per session.

Do not report **64615** in conjunction with **64612, 64616, 64617, 64642-64647**.

For guidance, see **95873, 95874**. Do not report more than one guidance code for **64615**.

64616 Chemodenervation of neck muscle(s), excluding muscles of the larynx, unilateral (e.g., for cervical dystonia, spasmodic torticollis).

(For chemodenervation guided by needle electromyography or muscle electrical stimulation, see **95873, 95874**).

Do not report more than one guidance code for any unit of **64616** (**64614** has been deleted; to report, see **64642, 64643, 64644, 64645, 64646, 64647**).

64617 Chemodenervation of larynx, unilateral, percutaneous (e.g., for spasmodic dysphonia), includes guidance by needle electromyography, when performed.

For diagnostic needle electromyography of the larynx, use **95865**.

For chemodenervation of the larynx performed with direct laryngoscopy, see **31570, 31571**.

Do not report **64617** in conjunction with **95873, 95874**.

- 64620** Destruction by neurolytic agent, intercostal nerve.
- 64624** Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed.
- 64625** Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
- 64630** Destruction by neurolytic agent, pudendal nerve, includes imaging guidance.
- 64632** Destruction by neurolytic agent, digital nerve, includes imaging guidance.
- 64633** Destruction by neurolytic agent, paravertebral facet joint, cervical or thoracic, single facet joint, includes imaging guidance.
- (For bilateral procedure, report **64633** with modifier **-50**)
- +64634** Each additional cervical or thoracic facet joint, includes imaging guidance.
- (Use **64634** in conjunction with **64633**)
- For bilateral procedure, report **64634** twice. Do not report modifier **-50** in conjunction with **64634**)
- 64635** Destruction by neurolytic agent, paravertebral facet joint, lumbar or sacral, single facet joint, includes imaging guidance.
- +64636** Each additional lumbar or sacral facet joint, includes imaging guidance.
- Report **64642**, **64643**, **64644**, **64645** once per extremity. Codes **64642-64645** can be reported together up to a combined total of four units of service per patient when all four extremities are injected. Report only one base code **64642** (or **64643**) per session. Report one or more units of additional extremity code(s) **64643** or **64645** for each additional extremity injected.
- Report **64646** or **64647** for chemodenervation of muscles of the trunk.
- Trunk muscles include the erector spinae and paraspinal muscles, rectus abdominus, and obliques. All other somatic muscles are extremity muscles, head muscles, or neck muscles.

For chemodenervation guided by needle electromyography or muscle electrical stimulation, see **95873**, **95874**. Do not report more than one guidance code for each corresponding chemodenervation of extremity or trunk code.

Do not report modifier **-50** in conjunction with **64642-64647**.

64640 Destruction by neurolytic agent; other peripheral nerve or branch.

64642 Chemodenervation of one extremity; one to four muscle(s).

+64643 Each additional extremity, one to four muscle(s). (List separately in addition to code for primary procedure).

Use **64643** in conjunction with **64642**, **64644**.

64644 Chemodenervation of one extremity; five or more muscle(s).

+64645 Each additional extremity, five or more muscle(s). (List separately in addition to code for primary procedure).

Use **64645** in conjunction with **64644**.

64646 Chemodenervation of trunk muscle(s); one to five muscle(s).

64647 Six or more muscle(s).

Report either **64646** or **64647** only once per session.

64680 Destruction by neurolytic agent of celiac plexus, with or without radiologic monitoring.

64681 Destruction by neurolytic agent of superior hypogastric plexus, with or without radiologic monitoring.

(For destruction by neurolytic agent of sympathetic chain, use unlisted code.)

Radiological supervision and interpretation codes

SPINE AND PELVIS

72240 Myelography (cervical).

72255 Myelography (thoracic).

72265 Myelography (lumbosacral).

72270 Myelography (two or more regions).

(Use **72240–72270** when RS&I is performed by separate physician from injection procedure).

(Do not report **72240**, **72255**, **72265** and/or **72270** in conjunction with **62284**, **62302**, **62303**, **62304** or **62305**).

See *CPT® 2021 Professional Edition Manual* for revisions of exclusionary parenthetical notes.

72275 Epidurography, RS&I.

72285 Cervical or thoracic discography, RS&I (for injection procedure, see **62291**).

72295 Lumbar discography, RS&I (for injection procedure, see **62290**).

UPPER EXTREMITIES

73040 Shoulder arthrography, RS&I (includes S&I for needle placement unless CT/MR arthrography is only procedure; **77002** excluded by the NCCI).

73085 Elbow arthrography, RS&I (includes S&I for needle placement unless CT/MR arthrography is only procedure; **77002** excluded by the NCCI).

73115 Wrist arthrography, RS&I (includes S&I for needle placement unless CT/MR arthrography is only procedure; **77002** excluded by the NCCI).

LOWER EXTREMITIES

- 73525** Hip arthrography, RS&I (includes S&I for needle placement unless CT/MR arthrography is only procedure; **77002** excluded by the NCCI).
- 73580** Knee arthrography, RS&I (includes S&I for needle placement unless CT/MR arthrography is only procedure; **77002** excluded by the NCCI).
- 73615** Ankle arthrography, RS&I (includes S&I for needle placement unless CT/MR arthrography is only procedure; **77002** excluded by the NCCI).

GASTROINTESTINAL TRACT

(For percutaneous placement of gastrostomy tube, see **49440**).

- 74300** Cholangiography, or pancreatography, intraoperative, RS&I.
- 74363** Percutaneous transhepatic biliary duct dilation, with or without placement of stent, RS&I. (For procedure, see **47555**, **47556**).

URINARY TRACT

- 74420** Retrograde urography.
- 74425** Urography, antegrade (e.g., pyelogram, nephrostogram, loopogram), RS&I.
- 74430** Cystography, three views minimum, RS&I.
- 74485** Dilatation of ureter(s) or urethra, RS&I
- (Do not report **74485** with **50436**, **50437**)
- (For dilation of a nephrostomy tract for endourologic procedure, see **50436**, **50437**)

VASCULAR SYSTEM

- 75600** Aortography, thoracic, single shot, RS&I.
- 75605** Aortography, thoracic, serialographic, RS&I.

- 75625** Aortography, abdominal, serialographic, RS&I.
- 75630** Aortography, abdominal plus bilateral iliofemoral lower extremity angiography, RS&I.
- If the abdomen and lower extremity vessels are examined as a continuous examination (e.g., stepping table top or long leg changer), then **75630** describes the total examination. If a full and complete examination of the abdominal aorta (in one or several views) is obtained and then the catheter is repositioned and a full and complete examination of the iliofemoral and lower extremity arteries is performed, then **75625** should be coded in conjunction with **75716** for bilateral lower extremity.
- 75635** CT angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing.
- 75658** Deleted
- 75705** Angiography, spinal selective, RS&I.
- 75710** Angiography, extremity, upper or lower, unilateral RS&I.
- 75716** Angiography, extremity, upper or lower, bilateral.
- 75726** Visceral angiography, selective, including flush aortogram if performed, RS&I. For example, the superior mesenteric artery constitutes a basic examination. The inferior mesenteric artery constitutes a basic examination. The hepatic artery constitutes a basic examination. For further selective catheterizations within an evaluated vessel, please see **75774**. For example, if the common hepatic artery were studied, it would be described by the RS&I code **75726**. If selective studies of the right and left hepatic artery were subsequently performed, each of these radiology tests would be described by the RS&I code **75774** in addition to appropriate procedural codes. The celiac axis would have a similar relationship to the hepatic artery and the splenic artery if all three vessels were injected and studied.
- 75731** Angiography, adrenal, unilateral RS&I.
- 75733** Angiography, adrenal, bilateral RS&I.

- 75736** Angiography, pelvis, selective or supraseductive, RS&I.
- This code should be used for each selective pelvic (e.g., internal iliac or median sacral artery) artery completely studied. Therefore, if bilateral internal iliac vessels are catheterized and studied, then **75736** would be used twice. If, following an internal iliac catheterization, there was separate catheterization of several branches of that vessel, then **75774** would be used to describe the RS&I/S&I work of each of these further selective branch catheterizations.
- 75741** Angiography, pulmonary, unilateral, selective, RS&I.
- 75743** Angiography, pulmonary, bilateral, selective, RS&I.
- 75746** Angiography, pulmonary, nonselective, RS&I.
- 75756** Angiography, internal mammary, RS&I.
- +75774** Artery x-ray, each vessel (each additional selective after basic exam). Code **75774** is used to report each additional selective or subselective vessel studied after the basic examination. Use of this code requires selective catheterization of the additional vessel studied (with selective catheterization separately reportable according to the selective catheterization coding conventions; see *AMA CPT® 2021 Professional Edition Manual* for discussion of these coding conventions).

VEINS AND LYMPHATICS

(For injection procedure for lymphatic system, see **38790**).

- 75801** Lymphangiography, extremity, unilateral, RS&I.
- 75803** Lymphangiography, extremity, bilateral, RS&I.
- 75805** Lymphangiogram, pelvic/trunk, unilateral, RS&I.
- 75807** Lymphangiogram, pelvic/trunk, bilateral, RS&I.
- 75809** Nonvascular shunt x-ray (e.g., LeVein), RS&I.
- 75810** Splenoportography, RS&I.

- 75820** Venography, extremity, unilateral, RS&I.
- 75822** Venography, extremity, bilateral, RS&I.
- 75825** Inferior vena cavography, RS&I.
- 75827** Superior vena cavography, RS&I.
- 75831** Venography, renal unilateral, selective, RS&I.
- 75833** Venography, renal bilateral, selective, RS&I.
- 75840** Venography, adrenal unilateral, selective, RS&I.
- 75842** Venography, adrenal bilateral, selective, RS&I.
- 75860** Venography, venous sinus or jugular, RS&I.
- 75870** Venography, superior sagittal, RS&I.
- 75872** Venography, epidural, RS&I.
- 75880** Venography, orbital, RS&I.
- 75885** Venography, portal (perc transhepatic with pressures), RS&I.
- 75887** Venography, portal (perc transhepatic without pressures), RS&I.
- 75889** Venography, hepatic (with pressures), RS&I.
- 75891** Venography, hepatic (without pressures).

TRANSCATHETER PROCEDURES

- 75893** Venous sampling by catheter, with or without angiography, per organ sampled, RS&I. (For procedure, see **36500**).
- 75894** Transcatheter therapy (embolization), RS&I. (For procedure, see **61624** or **61626**).
- Do not use **75894** in combination with **36909**, **37241-37244**, **50705**.
- 75898** Follow-up angiogram through existing catheter, during embolization or thrombolysis, RS&I.

Do not report **75898** in conjunction with **37211–37214**, **37241–37244**, **61645**, **61650** or **61651**.

- 75901** Removal CVA device obstruction, RS&I. (For procedure, see **36595**).
- 75902** Remove CVA intraluminal obstruction, RS&I. (For procedure, see **36596**). **75952**, **75953**, **75954** have been deleted. To report, see **34701–34711**, **34718**).

ENDOVASCULAR ABDOMINAL AND THORACIC AORTA REPAIR

- 75956** Endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption); involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, RS&I.
- (For placement of endovascular graft, use **33880**).
- 75957** Not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, RS&I.
- (For placement of endovascular graft, use **33881**).
- 75958** Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma or traumatic disruption), RS&I (Report **75958** for each proximal extension).
- (For placement of proximal endovascular extension, see **33883**, **33884**).
- 75959** Placement of distal extension prosthesis(es) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, RS&I.
- (Do not report **75959** in conjunction with **75956**, **75957**).
- (Report **75959** once, regardless of number of modules deployed).
- (For implantation of distal endovascular extension, use **33886**).

BIOPSY AND DRAINAGE CATHETER

X-ray, CT and ultrasound codes for biopsy and drainage and aspiration do not include a full examination of the organ or area. The RS&I code only describes the work inherent in the actual guidance and interpretation of images obtained during the intervention. If a diagnostic study is performed in addition, this should be separately coded.

75970 Transcatheter biopsy, RS&I.

75984 Change of percutaneous tube or drainage catheter with contrast monitoring (e.g., GI, GU or abscess), RS&I.

(For percutaneous placement of G-, J-, G-J, cecostomy, or other colonic tube, see **49450-49452**).

75989 Radiologic guidance, abscess drainage, CT, fluoroscopy, or ultrasound, RS&I.

(Do not report **75989** in conjunction with **10030**, **32554**, **32555**, **32556**, **32557**, **47490**, **49405**, **49406**, **49407**).

IMAGING GUIDANCE

76000 Fluoroscopy (separate procedure), up to one hour physician time, other than cardiac fluoroscopy.

(Do not report **76000** in conjunction with **33274**, **33275**, **33957-33959**, **33962-33964**, **0515T-0520T**).

76001 Deleted

76080 Fistulogram, abscessogram, sinogram, RS&I. (See codes **20501** and **49424**).

76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; with image postprocessing under concurrent supervision not requiring an independent workstation.

(Use **76376** in conjunction with code[s] for base imaging procedure[s]).

(Do not report **76376** in conjunction with **31627, 34839, 70496, 70498, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261-74263, 75557, 75559, 75561, 75563, 75565, 75571-75574, 75635, 76377, 77046-77049, 77061, 77062, 77063, 78012-78999, 93355, 0523T, 0559T-0562T**).

76377 Requiring image postprocessing on an independent workstation.

(Use **76377** in conjunction with code[s] for base imaging procedure[s]).

(Do not report **76377** in conjunction with **34839, 70496, 70498, 70544, 70544-70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261-74263, 75557, 75559, 75561, 75563, 75565, 75571-75574, 75635, 76376, 77046-77049, 77061, 77062, 77063, 78012-78999, 93355, 0523T, 0559T-0562T**, for which 3D reconstruction postprocessing is considered inherent).

Code **76376** is used to report 3D imaging, ultrasound or other tomographic modality not requiring image postprocessing on an independent workstation. Code **76377** is used to report 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality requiring image postprocessing on an independent workstation. (**76376, 76377** require concurrent supervision of image postprocessing 3D manipulation of volumetric data set and image rendering).

The 2D reformatting/3D rendering code **76375** was deleted in 2006, as it no longer described current technology. Codes **76376** and **76377** cannot be reported in conjunction with those MRA, CTA and PET codes.

ULTRASOUND GUIDANCE

76936 Ultrasound-guided compression repair arterial pseudoaneurysm (includes DX evaluation, compression of lesion, imaging).

+76937 Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting. (List separately in addition to code for primary procedure).

(Do not use **76937** in conjunction with **76942**).

(If extremity venous noninvasive vascular diagnostic study is performed separate from venous access guidance, use **93970** or **93971**).

It may be necessary to utilize ultrasound guidance to achieve vascular access in performing interventional radiology procedures. This service represents additional physician work, utilizing a different imaging modality, and is separately reportable. Code **76937** was created to report this service when performed in conjunction with any other surgical or imaging service where the modality of ultrasound imaging is not inherent. The use of a handheld device to ease vascular access without evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, and permanent recording/reporting is not reportable using code **76937**.

76940 US guidance and monitoring, parenchymal tissue ablation.

(For ablation, see **32998**, **47370–47382**, **47383**, **50592**, **50593**).

Liver, kidney and lung tissue are considered “parenchymal” tissue. Imaging services provided for the guidance and monitoring of tissue ablation of these organs is accurately reported using the modality specific imaging codes. If more than one imaging modality is utilized for ablation guidance and monitoring only the predominant modality is reported. This coding convention is inconsistent with and not applicable to most other interventional radiology imaging codes.

76942 Ultrasound guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) imaging S&I x-ray, CT, ultrasound and MR guidance codes for biopsy, drainage and aspiration procedures do not include a full examination of the organ or area. The imaging code only describes the work inherent in the actual guidance and interpretation of images obtained during the intervention. If a diagnostic evaluation is performed in addition, this should be separately coded.

(Note: Code **76942** should not be used to report ultrasound guidance for vascular access; see code **76937**).

(Do not report **76942** in conjunction with **10004, 10005, 10006, 10021, 10030, 19083, 19285, 20604, 20606, 20611, 27096, 32554-32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 46948, 55874, 64479, 64480, 64483, 64484, 64490, 64491, 64493, 64494, 64495, 76975, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0228T, 0229T, 0230T, 0231T, 0232T, 0481T, 0582T**)

FLUOROSCOPIC GUIDANCE

+77001 Fluoroscopic guidance for CVA device placement, replacement or removal.

Includes fluoroscopic guidance for vascular access, fluoroscopic guidance for catheter manipulation, any necessary contrast injections through access site or catheter with related venography RS&I/S&I, and radiographic documentation of final catheter position.

(Do not report **77001** in conjunction with **33957-33959, 33962-33964, 77002**).

(If formal extremity venography is performed from a separate venous access and separately interpreted, use **36005** and **75820, 75822, 75825** or **75827**).

(For ultrasound guidance for vascular access, see code **76937**; please note the documentation requirements associated with code **76937**).

Not all venous access procedures necessitate the use of imaging guidance. Therefore, when imaging services are provided in conjunction with the placement, partial/complete replacement, or removal of CVA these services are separately reportable.

In 2017, fluoroscopic guidance codes **77002** and **77003** were changed from stand-alone procedures to add-on codes. See the *CPT® 2021 Professional Edition Manual* for a listing of appropriate primary procedure codes with which **77002** may be reported.

+77002 Fluoroscopic localization for needle placement (e.g., biopsy, aspiration, injection or fine needle aspiration) X-ray, CT, ultrasound and MR codes for biopsy and drainage and aspiration do not include a full examination of the organ or area. The guidance code only describes the work inherent in the actual guidance and interpretation of images obtained during the

intervention. If an evaluation or localization is performed in addition, this should be separately coded.

(Do not report **77002** in conjunction with **10030**, **19081-19086**, **19281-19288**, **20982**, **20983**, **32554**, **32555**, **32556**, **32557**, **70332**, **73040**, **73085**, **73115**, **73525**, **73580**, **73615**, **0232T**).

+77003 Fluoroscopic guidance and needle localization for spine injection procedures. Contrast injection is included in codes **62270-62273**, **62280-62282**.

Use **77003** with these codes when fluoroscopy guidance is required. For facet joint injections, see codes **64470-64476**.

Use for epidurography injections, see codes **64479-64484**. Use for neurolytic destruction, see codes **64600-64680**.

For SI joint arthrography, see codes **27096**.

If formal arthrography is not performed, recorded, and a formal radiographic report is not issued, use **77003** for fluoroscopy guidance for SI joint injections.

For myelography codes **72240-72270** fluoroscopy guidance included; **77003** is not coded additionally.

Use **77003** with these codes when fluoroscopy guidance is required. For facet joint injections, see codes **64470-64476**.

CT GUIDANCE

77012 CT guidance for needle placement (e.g., biopsy, aspiration, injection or localization device) RS&I

77013 CT guidance for, and monitoring of, parenchymal tissue ablation. Liver, kidney and lung tissue are considered “parenchymal” tissue and imaging services provided for the guidance and monitoring of ablation of tissue of these organs is accurately reported using these modality-specific imaging codes. If more than one imaging modality is utilized for ablation guidance and monitoring, only the predominant modality is reported.

This coding convention is inconsistent with and not applicable to most other interventional radiology imaging codes.

MR GUIDANCE

77021 MR imaging guidance for needle placement (e.g., injection, localization, Bx, aspiration), RS&I/S&I.

(Do not report **77021** in conjunction with **10011, 10012, 10030, 19085, 19287, 32554, 32555, 32556, 32557, 0232T, 0481T**).

X-ray, CT, ultrasound and MR for biopsy and drainage and aspiration do not include a full examination of the organ or area. The RS&I/S&I code only describes the work inherent in the actual guidance and interpretation of images obtained during the intervention. If an evaluation or localization is performed in addition, this should be separately coded.

77022 MR imaging guidance for, and monitoring of, parenchymal tissue ablation.

(Do not report **77022** in conjunction with **0071T, 0072T, 20982, 20983, 32994, 32998**).

Liver, kidney and lung tissue are considered “parenchymal” tissue. Imaging services provided for guidance and monitoring of tissue ablation of these organs is accurately reported using the modality specific imaging codes. If more than one imaging modality is utilized for ablation guidance and monitoring, only the predominant modality is reported.

This coding convention is inconsistent with and not applicable to most other interventional radiology imaging codes.

(For percutaneous ablation, see, **47382, 47383, 50592, 50593**).

(For focused ultrasound ablation treatment of uterine leiomyomata, see Category III codes **0071T, 0072T**).

(To report stereotactic localization guidance for breast biopsy or for placement of breast localization device[s], see **19081, 19283**).

(To report mammographic guidance for placement of breast localization device[s], use **19281**).

RADIOPHARMACEUTICAL ADMINISTRATION

79445 Intra-arterial administration of particulate for radiopharmaceutical therapy.

Code **79445** was created to capture the work of prescribing, handling, and administering the radioactive agent added to the embolization agent. Procedural and RS&I/S&I services performed prior to radiopharmaceutical therapy are reported separately.

CEREBROVASCULAR ARTERIAL STUDIES, ULTRASOUND

93880 Extracranial study (imaging, complete bilateral).

93882 Extracranial study (unilateral or limited study).

93886 Intracranial study (transcranial, complete).

93888 Intracranial study (limited study).

EXTREMITY ARTERIAL STUDIES, ULTRASOUND

93922- Extremity study (for nonimaging, noninvasive physiologic studies of **93924** upper or lower extremity arteries). These codes describe increasing levels of service. If ultrasound imaging of extremity arteries is performed, use **93925-93931**.

93925 Lower extremity study (duplex imaging arterial, complete bilateral arteries or grafts).

93926 Lower extremity study (duplex, unilateral or limited study).

93930 Upper extremity study (duplex imaging arterial, complete bilateral arteries or grafts).

93931 Upper extremity study (duplex, unilateral or limited study).

93970 Extremity study (duplex imaging, venous bilateral, complete).

93971 Extremity study (duplex, unilateral or limited study).

93975 Visceral vascular study (duplex imaging arterial/venous abdomen, pelvic and/or retroperitoneum, complete).

- 93976** Visceral vascular study (duplex, limited study).
- 93978** Visceral vascular study (duplex imaging aorta, IVC, iliacs, grafts, complete).
- 93979** Visceral vascular study (duplex, unilateral or limited study).
- 93980–93981** Penile vascular study (duplex, complete or limited study).

EXTREMITY ARTERIAL-VEIN STUDIES

- 93990** Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)
- 93985** Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study
- 93986** Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study

CHEMOTHERAPY ADMINISTRATION

- 96420** Chemotherapy administration, intra-arterial (see *CPT® 2021 Professional Edition Manual* for **96425** differentiation).

There is greater caution and additional physician work in the handling and administration of a chemotherapy agent as compared to that of an embolic agent. Due to the increased physician work and intensity, this service is separately reportable using code **96420** (chemotherapy administration, intra-arterial, push technique) in those cases where the interventional radiologist determines the dose, prescribes and personally administers the chemotherapeutic agent in conjunction with the embolic agent.

Code **96420** is an “Incident To” code and will not be paid by the Medicare program when performed in the hospital setting. The *CPT® 2021 Professional Edition Manual* states: “Codes **96360–96379**, **96401**, **96402**, **96409–96425**, **96521–96523** are not intended to be reported by the physician in the facility setting.”

Time-based moderate sedation

See AMA CPT® 2021 Professional Edition Manual for specific criteria, which must be met to report this service.

- 99151** Moderate sedation services provided by the same physician performing the diagnostic or therapeutic service under 5 years of age; first 15 minutes intra-service time.
- 99152** Moderate sedation services provided by the same physician performing the diagnostic or therapeutic service over 5 years of age; first 15 minutes intra-service time.
- +99153** Each additional 15 minutes intra-service time. (Use **99153** in conjunction with **99151, 99152**).
- 99155** Moderate sedation services provided by a physician or other qualified health care professional other than the physician performing the diagnostic or therapeutic service that the sedation supports, under 5 years of age; first 30 minutes intraservice time.
- 99156** Initial 15 minutes of intraservice time, 5 years or older.
- +99157** Each additional 15 minutes intra-service time. (List separately in addition to code for primary service).
- (Use **99157** in conjunction with **99155, 99156**).

Category III codes

Use of Category III codes to report services for which FDA approval has not been granted require the prior arrangement of an institutional investigational device exemption (IDE) number to recognize the site as one approved for research into applicability of new procedures and techniques.

Category III codes do not go through the RUC valuation process and CMS does not establish RVUs for these procedures. Providers are urged to contact their local carrier in advance of providing any Category III code services to ascertain the coverage, reporting and reimbursement policies for these procedures.

Like unlisted codes, Category III codes do not have a set relative value and thus payment for procedures is considered on an individual basis. In fact, considerable latitude is given to carrier medical directors (CMDs) to pay for these procedures on a case-by-case basis. For this reason, it is crucial that the CMDs have access to information about the procedure(s) being reported using a Category III code. Supporting documentation including literature, an estimate of physician work, appropriate indications and, if appropriate, cost savings associated with the procedure should be submitted to the CMD for consideration. It would also behoove providers and their institutions to develop a list of standard supplies, equipment costs and nonphysician clinical staff requirements to facilitate consideration of technical component reimbursement.

Your local radiology societies and Carrier Advisory Committee members can be excellent resources for approaching CMDs due to their frequent access. For additional information regarding the Carrier Advisory Committee and guidance in contacting your representatives, please see the SIR website at sirweb.org and the ACR website at acr.org.

MR-GUIDED FOCUSED ULTRASOUND ABLATION

Currently, there are three Category III codes to describe two of the FDA-approved applications for MR-guided focused ultrasound (MRgFUS); uterine fibroid and intracranial movement disorder.

- 0071T** Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume **less than 200 cc** of tissue.
- 0072T** Focused ultrasound ablation of uterine leiomyomata, including MR guidance; total leiomyomata volume **greater than or equal to 200 cc** of tissue.
- 0398T** MRgFUS, stereotactic ablation of an intracranial lesion for movement disorder.

Other applications for MRgFUS, such as pain palliation in the setting of bone metastasis, have been FDA approved; however, they do not have a corresponding listed CPT® code. Therefore, SIR recommends the use of the appropriate unlisted code for the body part that this treated. See codes **22899** (spine), **22999** (abdomen, MSK), **23999** (shoulder), **24999** (humerus/elbow), **25999** (forearm/wrist), **27299** (pelvis/hip joint) and **27899** (leg/ankle).

SACRAL AUGMENTATION WITH CAVITY CREATION

Category III codes **0200T** and **0201T** for percutaneous sacral augmentation include imaging guidance and bone biopsy to align with the services included in the comprehensive percutaneous vertebral augmentation codes. An exclusionary parenthetical has been added restricting the use of codes **0200T** and **0201T** in addition to bone biopsy code **20225**, when performed at the same level, as this procedure is now inclusive of these services.

0200T Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of balloon or mechanical device, one or more needles, includes imaging guidance and bone biopsy, when performed.

0201T Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of balloon or mechanical device, two or more needles, includes imaging guidance and bone biopsy, when performed.

ATHERECTOMY PROCEDURES ABOVE THE INGUINAL LIGAMENT

0234T Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery.

0235T Visceral artery (except renal), each vessel.

0236T Abdominal aorta.

0237T Brachiocephalic artery trunk and branches, each vessel.

0238T Iliac artery, each vessel.

Category III codes **0234T-0238T** were implemented on Jan. 1, 2011, to describe arterial atherectomy above the inguinal ligaments performed percutaneously and/or through open surgical exposure. These codes include the work of performing the atherectomy and the RS&I of the atherectomy procedure.

Unlike the atherectomy codes below the inguinal ligaments (**37225**, **37227**, **37229**, **37231**, **37233**, **37235**), codes **0234T-0238T** do not include the work of accessing and selectively catheterizing the vessel, traversing the lesion, embolic protection if used, other intervention used to treat the same or other vessels, or closure of the arteriotomy (by any method).

Therefore, it is appropriate to report separately the catheterization codes, any diagnostic studies and any other interventions performed during the same session. There are no atherectomy codes for use in veins including AV dialysis accesses.

RENAL DENERVATION

0338T Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral.

0339T Bilateral.

(Do not report **0338T**, **0339T** in conjunction with **36251**, **36252**, **36253**, **36254**).

UTERINE FIBROID RADIOFREQUENCY ABLATION

0404T Transcervical uterine fibroid(s) ablation with ultrasound guidance, radiofrequency.

CRYOABLATION OF NERVE PAIN

0440T Percutaneous cryoablation, including imaging guidance, upper extremity distal/peripheral nerve.

0441T Lower extremity distal/peripheral nerve.

0442T Nerve plexus or other truncal nerve (brachial plexus, pudendal nerve)

ENDOVENOUS REVASCULARIZATION

0505T Endovenous femoral-popliteal arterial revascularization, with transcatheter placement of intravascular stent graft(s) and closure by any method, including percutaneous or open vascular access, ultrasound guidance for vascular access when performed, all catheterization(s) and intraprocedural roadmapping and imaging guidance necessary to

complete the intervention, all associated radiological supervision and interpretation, when performed, with crossing of the occlusive lesion in an extraluminal fashion.

0505T includes all ipsilateral selective arterial and venous catheterization, all diagnostic imaging for ipsilateral, lower extremity arteriography, and all related radiological supervision and interpretation).

Do not report **0505T** in conjunction with **37224**, **37225**, **37226**, **37227**, **37238**, **37239**, **37248**, **37249** within the femoral-popliteal segment).

(Do not report **76937** in conjunction with **0505T** for ultrasound guidance for vascular access).

ANATOMIC MODEL 3D PRINTING

0559T Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure

+0560T each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure).

(Use **0560T** in conjunction with **0559T**).

(Do not report **0559T**, **0560T** in conjunction with **76376**, **76377**)

0561T Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide

+0562T each additional anatomic guide (List separately in addition to code for primary procedure)

(Use **0562T** in conjunction with **0561T**)

(Do not report **0561T**, **0562T** in conjunction with **76376**, **76377**)

BREAST CRYOABLATION

0581T Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral.

Frequently asked questions

EVALUATION AND MANAGEMENT (E/M)

Q: What are the defining factors that would allow for use of these interprofessional telephone/internet/electronic health record consultation codes 99446–99449, 99451?

A: When the patient's treating or primary physician requests a consultation from a specialty physician, who has not yet had face-to-face contact with the patient, the consultant should use codes 99446–99449 or 99451 to report interprofessional telephone/internet/electronic health record consultation. The majority of the service time should be devoted to the medical consultative verbal or internet discussion. These codes should not be reported when greater than 50% of the time for the interprofessional consultation is spent in performing data review and/or analysis of the patient's record. However, the service time for 99451 is based on total review and interprofessional communication time.

The patient must be a new patient to the consultant or an established patient with a new problem or exacerbation of an existing problem. The consultant should not have seen the patient in a face-to-face encounter within the last 14 days. If the telephone/internet/electronic health record consultation leads to transfer of care or face-to-face service, surgery, hospital visit or scheduled office evaluation for the patient within the next 14 days **or** next available appointment date of the consultant, 99446–99449, 99451 are not reported.

Do not report codes 99446–99449, 99451 more than once in a 7-day interval for the same patient.

Communications and time with the patient and/or family related to these services is not reported with codes 99446–99449. To report these services, see telephone services codes 98966–98969 and Evaluation and Management services 99441–99443. Code 99444 has been deleted. See codes 99421–99423.

Q: What are the requirements for reporting Interprofessional telephone/internet/electronic health record consultations (99446–99449, 99451)?

A: The written or verbal request, including the reason for the telephone/internet/electronic health record consultation from the treating, requesting physician must be documented in the patient’s medical record.

Codes **99446–99449** must conclude with a verbal opinion report and written report from the consultant to the treating/requesting physician. Code **99451** concludes with a written report only.

The time spent reviewing laboratory studies, pertinent medical records, imaging studies, medications, pathology specimens is included in the telephone/internet/electronic health record consultation and not separately reported with **99446–99449, 99451**.

Telephone/internet/electronic health record consultations of less than 5 minutes are not reportable. However, cumulative time may be counted toward a single code if the consultation requires more than one date of service during the seven-day period.

Verbal patient consent must be documented in the patient’s medical record for each consultation and include assurance that the patient is aware of applicable cost-sharing.

Q: What are the requirements for the treating, requesting physician for reporting time spent requesting and/or communicating with the specialist consultant (99452)?

99452 Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

A: The treating, requesting physician must spend 16–30 minutes in a service day preparing the referral and/or communicating with the consultant to report code **99452** for the interprofessional telephone/internet/electronic health record referral service.

Code **99452** is allowed to be reported once in a 14-day period.

If the time exceeds 30 minutes, and the patient is present and accessible to the treating, requesting physician, prolonged service codes **99354–99357** may be reported for time spent on interprofessional telephone/internet/electronic health record discussion with the specialist.

If the patient is not present in front of the treating, requesting physician and the interprofessional telephone/internet/electronic health record assessment and management service exceeds 30 minutes in a day, non-face-to-face prolonged service codes **99358**, **99359** may be reported by the treating, requesting physician.

Please consult the *CPT® 2021 Professional Edition Manual* for complete instructions on reporting all evaluation and management/non-face-to-face services.

Virtual check-ins

CMS has also introduced a HCPCS code, (procedures and professional services principally used to be reimbursed for new technology) for “virtual check-ins” with patients who are unsure if their symptoms warrant an in-office visit. HCPCS code **G2012**, allows physicians to be reimbursed for “virtual check-ins that may be “audio-only” (e.g., a telephone call between the patient and the physician or qualified health care provider) or live two-way audio with video. If the virtual check-in does not lead to an in-office visit and does not occur within 7 days of a prior E/M service by the practitioner, it may be reported as a standalone service.

G2012 Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

CENTRAL VENOUS ACCESS PROCEDURES

Q: What is the code for removal of a PICC line?

A: There is no code for removal code of non-tunneled catheters as this work is considered inherent to an E/M service. Report appropriate level of E/M as supported by documentation. A tunneled PICC line removal is coded as **36589**.

Q: How do you code for placement of a tunneled PICC line?

A: The term “tunneled PICC” is commonly being used to describe the placement of a small-bore catheter, tunneled into the internal jugular vein. Correct coding for insertion of a central venous access device is dependent on the device site, device type and

patient age. The placement of a small-bore central venous access catheter tunneled into the internal jugular vein would be considered centrally placed and would be reported using code **36557** for patients under 5 years of age or **36558** for patients 5 years of age and older. If ultrasound guidance is necessary to garner vascular access (and the documentation requirements met as detailed in the code descriptor), code **76937** is also reported. The use of fluoroscopic guidance for the placement of the central venous access device is reported using code **77001**.

Q: Can the venous angioplasty codes be used to report fibrin sheath disruption during a central venous catheter procedure?

A: No. Dilating a clot or macerating fibrin sheath with a balloon is not considered to be dilating a vessel stricture and is not considered to be an angioplasty service. If balloon fibrin sheath maceration is performed from a separate access, the accurate code to describe the service is **36595** (mechanical removal of pericatheter obstructive material [e.g., fibrin sheath] from the central venous device via separate access). See CPT® code **75901** for corresponding RS&I.

Q: Is injection of a thrombolytic agent into a central venous catheter for the purposes of declotting an occluded catheter reportable? And if so, does it matter what type of catheter is being injected?

A: Yes, CPT® code **36593** (*Declotting by thrombolytic agent of implanted vascular access device or catheter*) could be reported in this scenario. This code should be reported once per catheter or device; and is not intended to be reported by lumen for multi-lumen catheters. Report **36593** once per treatment session, and report the same code for the subsequent treatments. CPT® code **36593** is used for injection, subsequent dwelling, or the short infusion of a thrombolytic agent. Note that if injection is performed in combination with a chemotherapy procedure, CPT® code **36593** should not be reported as it is considered inclusive with the chemotherapy service.

ARTERIAL ACCESS

Q: If the catheter is positioned in the contralateral external iliac for contralateral leg arteriogram, and then pulled back into the ipsilateral iliac for ipsilateral leg arteriogram, should it be coded 75710-50 or 75716?

A: 75716 would be the appropriate code for the RS&I, if there is medical necessity and documentation of that medical necessity to perform a bilateral lower extremity exam. Selective catheter placement would be coded with the single code 36246, as only one vascular family was selected.

Q: Do I need to see all the way to the toes to code 75716 when performing a leg angiogram?

A: The entire leg does not need to be imaged for the bilateral extremity angiography code (75716) to apply as long as intent is to image beyond the common femorals. One does not need to use reduced services modifier -52 if imaging is only done to the knees.

Q: How do I code for an arch aortogram, when performed with a thoracic aortogram?

A: One would use codes 36221 and 75605 to report the services described above. Since CPT® code 36221 includes catheter placement of the catheter in the aorta, 36200 would not be reported.

Q: How do I report imaging and catheterization of a horseshoe kidney?

A: The horseshoe kidney is two kidneys that have fused. There may be five or more renal arteries in this situation. For coding purposes, if both the right and left halves are studied, a horseshoe kidney is coded using the bilateral code 36252. The unilateral code 36251 would be reported if only the right or the left half is studied.

Q: How do I code for selective catheterizations (e.g., internal maxillary and facial arteries) off of the external carotid artery, as in during an embolization for epistaxis?

A: All selective catheterizations, as well as imaging, performed within the external carotid vascular family are included in the work and value of code 36227. There are no additional codes to report in this scenario. If bilateral external carotid arteries were selectively catheterized, one should report 36227-50 (depending on payer preference).

Q: CPT® code 36225 is used when the subclavian or innominate is selected and imaging of the vertebral circulation is performed. How would one code for selective catheterization of the subclavian or innominate artery for the purpose of visualizing the proximal vessel of the extremity only?

A: If selective catheterization is performed of the subclavian or innominate artery, but imaging is performed of the proximal vessel, then CPT® code 75710 with appropriate selective catheterization code 36215 or 36216 should be used. Code 36225 is specific for imaging the vertebral circulation and should only be used when vertebral circulation is imaged.

Q: Can you help me understand the introductory language for the cervicocerebral codes?

A: Clarification was made beginning in 2015 that highlights two points for the cervicocerebral codes: It is acceptable to use CPT® codes 36223 and 36225, in addition to 36224 and 36226, as the base or initial codes for the add-on code 36228 in instances when superselective microcatheter angiograms are performed following the lesser selective, base catheter angiogram.

It is acceptable to use the CPT® codes 75774 and 36218 in the scenario when additional arteries of the upper extremities and other vascular beds of the neck are performed in the same session as vertebral angiography. For example, if the costocervical artery is selected in addition to the vertebral artery, it would be appropriate to use the bundled code 36226 (for the vertebral) and component codes 36218 and 75774 (for the costocervical artery).

Q: Is abdominal aortogram, CPT® 75625, included in the visceral angiography codes for the celiac and superior mesenteric arteries?

A: Yes, an abdominal aortogram (75625) is included in visceral angiography (75726 *angiography, visceral, selective or supraseductive [with or without flush aortogram], radiological supervision and interpretation*) when it is performed, and is not separately reportable.

Q: When I select and perform angiograms of the following arteries in order, how is it coded: celiac artery (first order), common hepatic artery (second order), right hepatic or left hepatic artery (third order) and subselective arteriography (beyond)? I know that the CPT® codes for visceral angiography are 36245–36248. If I select and

document arteriography for each successive artery, do I code for each or just the highest level?

A: Selective and supraseductive catheterization codes include catheterization of lesser order branches in the same vascular family. The hepatic arterial system is considered a “vascular family” with the parent being the celiac artery. Assuming all vessels were selectively catheterized, and injections were made in each vessel (celiac, common hepatic, right or left hepatic, and supraseductive branches) in the same session, one third-order code (**36247**) plus one visceral angiography S&I code (**75726**) are reported for this service. The add-on CPT® code **75774** would be reportable for the additional selective angiograms if they are diagnostic in nature and supported in your documentation. The add-on CPT® code **36248** is used when additional second- or third- order branches are selected within the same vascular family. For example, if you selected the right **and** left hepatic branches, then **36247** and **36248** would be reportable. The number of times **36248** and **75774** can be reported together depends on actual number of vessels selectively catheterized, injected and documented both in the medical record and in the image archive. Note that documentation of the catheterization includes description of the catheter location in the operative note and the S&I includes imaging archival and an interpretation of the angiographic images (description of what the angiographic images demonstrated) in the medical record. If either documentation requirement is absent, then the respective code may not be reported.

Q: If multiple obliquities of the target vessel being studied are obtained during angiography, how are these extra views coded?

A: Multiple views are not separately coded when multiple obliquities of the target vessel being studied are obtained during angiography. The code for a full and complete examination includes all necessary views unless otherwise stated. If multiple areas are examined, however, then these are separately coded. For example, if the abdominal aorta is studied in an additional lateral projection, only **75625** is coded.

Q: How should one report vascular catheterization services when these are performed through a sheath already placed by another physician?

A: One may still use the coding conventions described in this *Update* but should use the modifier **-52** to delineate a decreased level of service for the primary access or selection code. All codes should not be at a decreased level of service since access is only

achieved once during the typical case, whether performed by the operating physician or already in place.

VENOUS

Q: Are selective catheter placements and venography reportable when performing bilateral main renal vein renin samples with venography and peripheral sampling?

A: No, selective catheter placements and venography are not reportable when performing bilateral main renal vein samples with venography and peripheral sampling. The NCCI edits exclude reporting a selective venous catheterization access code when using **36500**. Therefore, **36011** should not be reported. Likewise, RS&I codes associated with diagnostic venogram (**75831** or **75833** for renal venography) should not be reported. The procedural code for renal vein renin sampling (**36500**) should be used for each organ selected but is not used for nonselective sampling from the IVC. The RS&I code for venous sampling (**75893**) is likewise used for each selective organ sampled and includes venography. Code **36500** is not coded multiple times when multiple samples are obtained from the same organ through the same access site. When separate and distinct samples from separate organs are obtained, code **36500** should be used for each organ sampled.

DIALYSIS CIRCUIT

Q: What if I am asked to perform a dialysis circuit evaluation on a patient who is coming to me directly from the dialysis unit with needles already in place within the graft?

A: Report code **36901** with modifier **-52** when a dialysis A-V circuit evaluation is performed through existing access that has been placed outside of the angiography suite (e.g., if the patient presents from dialysis with needles placed within the graft or fistula, and contrast is injected through the needle to image the graft and its outflow).

Q: How do I code for a dialysis circuit evaluation (shuntogram, graftogram) when performed in conjunction with an intervention to treat a thrombosed or jeopardized hemodialysis access graft?

A: CPT® code **36904** includes the work of all punctures into the thrombosed graft or fistula, as well as the imaging to the central outflow vein performed during the

procedure. This code also includes all methods of percutaneous removal of a clot from the dialysis access to restore patency: any type of mechanical thrombectomy, Fogarty maneuver and use of thrombolytic agents within the circuit, regardless of the technique for infusion such as “lyse and wait,” pulse spray, bolus injections and prolonged infusions.

It also includes all means of removing the arterial plug by any method. The thrombolysis codes (**37211–37214**) would only be used if the patient left the department with lysis catheter in place.

Q: Through two separate arteriovenous fistula or graft accesses, a physician diagnosed and treated two different obstructions—one at the arterial anastomosis and one in the subclavian vein. Is this reported with two percutaneous transluminal angioplasties (PTAs)—one arterial and one venous—or only a venous PTA? For coding purposes, where is the transition between artery and vein in an arteriovenous dialysis access?

A: Extensive guidance is provided in the *CPT® 2021 Professional Edition Manual* that addresses coding of the dialysis circuit. For the purposes of AV access interventions, the AV access is divided into two vessel segments; the peripheral dialysis segment and the central dialysis segment. The peripheral dialysis segment is the portion of the circuit that begins at the arterial anastomosis and extends through the axillary or cephalic veins.

Furthermore, the perianastomotic region (the short segment of the circuit immediately adjacent and encompassing a short segment of the parent artery) is also included within the peripheral segment of the circuit. The central dialysis segment includes the subclavian and innominate veins through the SVC. Therefore, in the scenario above, CPT® code **36902** would be reported to account for the PTA at the arterial anastomosis (which includes all PTA performed in the peripheral segment). In addition, the add-on code **36907** would be reported for the PTA for the subclavian vein. The current coding conventions would not allow for separate reporting of arterial PTA code (**37247**) in this scenario. Only when a stenosis within the native arterial system is identified and treated would reporting of **37247** be appropriate.

Q: A patient presents with poor right upper arm dialysis graft function. Access towards the arterial and venous anastomoses is obtained and an arteriovenous circuit evaluation is performed. To further examine arterial inflow, a catheter is advanced beyond the arterial anastomosis into the axillobrachial artery and angiography is

performed. Is the catheterization of the native artery considered a part of the initial access code 36901?

A: In this scenario, because the catheter is advanced beyond the arterial anastomosis/perianastomotic region, the selective catheterization of the native artery is reported separately. It is appropriate to report code **36215** for selective catheterization of the upper extremity or **36245** for selective catheterization of the lower extremity in addition to CPT® code **36901**.

Q: A patient presents with increased pulsatility of a right upper arm arteriovenous fistula. Direct fistula access towards the venous outflow is obtained and diagnostic fistulogram is performed revealing superior vena cava (SVC) stenosis. The size of the balloon needed to treat this lesion requires a sheath too large to safely place into the current fistula access. Subsequently, access into the right internal jugular vein is achieved and SVC angioplasty is performed. How should this be coded?

A: CPT® code **36901** would be reported to account for the direct access and diagnostic fistulogram performed. It is also appropriate to report CPT® code **36010** to account for catheter or device placement into the SVC since it is via a separate access site, as well as the CPT® code for venous angioplasty, **37248**. A modifier may be necessary to indicate to the payer that a distinct procedure was performed. The use of the add-on code **36907** would not be appropriate in the scenario because the angioplasty was not performed through the dialysis circuit.

Q: The CPT® 2021 Professional Edition Manual states that the work of all catheterizations during dialysis AV shunt are included in CPT® code 36901 but also goes on to explain some exceptions. Are the selective catheterizations of multiple side branches performed during an embolization reportable?

A: No. CPT® code **36901** includes catheterization of additional venous side branches or accessory veins. If embolization is performed, then the add-on code **36909** would be reported in conjunction with **36901**. **36909** is reported once per session, regardless of the number of branches embolized.

VASCULAR INTERVENTIONS

Q: How would the following be coded? A diagnostic aortogram and runoff angiogram of the left lower extremity is performed via retrograde puncture of the right common femoral artery. Based on diagnostic angiographic findings, an antegrade left femoral puncture for SFA recanalization followed by SFA angioplasty and stenting is then performed.

A: In this scenario, the first (retrograde) access that was obtained was for diagnostic purposes and is separately reportable with the appropriate modifier: **36246-59** for this case. Additionally, if full and complete diagnostic angiograms are performed and appropriately documented, the RS&I codes **75625-59** and **75710-59** would be reported as well as the appropriate lower extremity revascularization code (**37226** in this case). Code **37226** includes catheter placement; therefore, the antegrade left femoral access would not be reported.

Q: How would I code for the following? Diagnostic arch aortogram and bilateral selective common carotid angiograms are performed, supporting indication for, and performance of, right cervical carotid stent placement using an embolic protection device.

A: Code **37215** would be used for the cervical carotid stent placement code, which includes the following services for the vessel being treated:

- Selective carotid catheterization
- All road-mapping angiograms (including arch angiogram, if necessary to repeat, and intracranial views) and all radiologic supervision and interpretation related to the ipsilateral carotid angiogram and stent placement
- All angioplasties within the stent target zone
- Preparation and deployment of the stent
- Placement, deployment and retrieval of embolic protection device

The diagnostic study and catheterization of the vessel not being stented is separately reportable when clinically necessary and when no recent previous angiogram is available. Even though bilateral cervical diagnostic studies were provided, only the appropriate bundled code for the vessel not being stented is reportable. In this case,

36222-59 would be coded for the left, which also includes imaging of the aortic arch when performed. RS&I modifier **-59** must be appended to the diagnostic angiography codes to signify that a separate site other than that of the cervical carotid stent placement is being examined.

Q: If a diagnostic arch aortogram is performed prior to placing a carotid stent, can I code 36221?

A: While the carotid stenting codes (**37215-37218**) include all ipsilateral imaging and selective catheter placement, it would be appropriate to code for **36221** if a full and complete diagnostic arch study is performed and reported. It is recommended that one should append a **-52** (reduced service) modifier to CPT® code **36221** since it is a bundled code that includes the work of catheterizing the aorta.

Q: When diagnostic and therapeutic interventional radiology services are provided at the same session, how is this reported?

A: Clear delineation between diagnostic RS&I services and RS&I services provided during the therapeutic intervention must be provided.

The guidelines in *2021 CPT® Professional Edition* describes in detail the scenarios in which diagnostic angiograms may be reported with transcatheter therapies. In general, it would be considered appropriate to report diagnostic angiography in the following scenarios:

1. no prior or recent study is available to guide therapy
2. the patient's condition has changed
3. the treatment plan may be affected
4. other vessels may be identified for treatment
5. further establishment of a diagnosis from a noninvasive study is necessary. In these scenarios, a **-59** modifier should be added to the diagnostic services to identify them as a distinct service.

All services should be documented in the patient's written record. Therefore, the exact nature of the procedural (surgical) services should be clearly delineated. If services are combined into one report, the individual types of services (surgical, radiological,

management) should be clearly separated and identified in the body and impression of the report. Alternatively, separate reports may be generated for each of the services.

Q: What are the proper codes for a stent-assisted coiling of a right supraclinoid ICA aneurysm? Are multiple follow-up angiograms reported if performed?

A: If a complete, diagnostic angiogram was performed prior to the embolization, then assign the appropriate cervicocerebral code; in this case, **36223** or **36224**. If prior imaging was available and diagnostic angiograms are not performed, then report the catheterization of the right carotid intracranial system with code **36217** for third order selective catheterization. Coding for the coil embolization of an intracranial aneurysm is best described as **61624**, transcatheter occlusion (tumor destruction, hemostasis, etc.) CNS; **75894**, the RS&I code for embolization, and **75898**, the RS&I code for completion angiography, should also be reported. If appropriately indicated and documented, multiple follow-up angiograms performed intermittently during embolization of the CNS are reportable.

Q: If mechanical thrombectomy is performed on a totally occluded synthetic femoral-popliteal graft, as well as within the native popliteal artery, is this coded once with 37184?

A: In this scenario, CPT® codes **37184** (primary thrombectomy, initial vessel) and **37185** (primary thrombectomy, subsequent vessel) would be reported because the native vessel is considered an additional, separate vessel than graft.

Q: Is catheterization additionally reportable in conjunction with the endovenous ablation therapy codes, 36475–36476 and 36478–36479?

A: No. Endovenous ablation therapy is performed using specialized catheters and placement of these catheters is considered inherent. Additionally, ultrasound used to guide and monitor EVAT is considered an inclusive service and intraoperative ultrasound (**76998**) and ultrasound guidance for vascular access (**76937**) are not separately reportable. Additionally, one may not report codes **93970–93971** describing extremity venous duplex imaging for the imaging services associated with the guidance and monitoring of endovenous ablation.

However, there may be occasions when a patient requires a diagnostic extremity Doppler ultrasound on the same day as the endovenous ablation. In this case, one should

separately report the diagnostic study using code **93970/93971**. CMS requires modifier use for such claims signifying the provision of a separate and distinct diagnostic service.

Q: Are multiple lesions within the same vessel or a long lesion within the same vessel treated with angioplasty coded with multiple angioplasty codes?

A: No, any necessary angioplasty within a single vessel is coded with only one procedural angioplasty and one RS&I angioplasty code. Multiple vessels treated at the same operative setting are coded separately. In the new lower extremity revascularization (LER) codes, the femoral and popliteal vessels are one vessel. Similarly, the tibioperoneal trunk is not considered a separate distinct vessel from the peroneal and PT.

Q: When there are multiple indications for embolization—e.g., a bleeding gastrointestinal tumor—which code is reported?

A: The code for the most acute indication should be reported. In the example above, code **37244** would be reported because the most acute indication is hemorrhage.

Q: When a stent is used for embolization or occlusion, is the embolization code or the stent code reported?

A: Depending on the circumstance, either the embolization code or the stent code is reported. If stent-assisted coil embolization is performed (the stent is placed to provide a latticework for subsequent deployment of coils), only the embolization code is reported.

If a covered stent is deployed to exclude a site of extravasation, only the stent code is reported. For example, treating an aneurysm with stent-assisted coil embolization would be reported using code **37242**, while treating an aneurysm by deploying a covered stent to prevent flow into the aneurysm would be reported using the appropriate stent code.

Please note that, like the embolization codes, the intravascular stent placement codes (**37236, 37239**) include RS&I.

VASCULAR EMBOLIZATION

Q: When several accessory veins of an upper-extremity arteriovenous fistula are embolized in a single session, are the embolizations considered to be in one or multiple surgical fields?

A: One upper extremity is considered one surgical field, so whether one or four accessory veins are embolized, only one embolization code (**37241**) is reported for this encounter.

When transcatheter embolizations of the accessory veins are performed, then the selective catheterizations are reported separately.

Q: Is code **37241 used to report sclerosis of telangiectasia or extremity veins, or to report endovenous ablation of incompetent extremity veins?**

A: No. The embolization codes are not used to report these services. Venous sclerosis of telangiectasia or extremity veins and endovenous ablation of incompetent extremity veins are reported using codes **36468**, **36470**, **36471**, **36475–36479**.

Q: Is it acceptable to use CPT® **37241 for embolization or occlusion of a lymphatic malformation or other lymphatic (non-extravasating) lesions?**

A: Yes, **37241** is acceptable to use for lymphatic malformation embolization. The introductory language to the embolization codes implies this and it was in the intention of CPT® code **37241**. The October 2014 issue of the AMA's coding reference newsletter, *CPT® Assistant*, also affirmed coding **37241** for lymphatic malformations.

Q: Is embolization for pelvic congestion considered one or two surgical fields? Also, how do I code for the diagnostic venograms that are performed during pelvic/gonadal venography?

A: The answer depends on what veins are embolized to achieve retrograde occlusion of the pelvic venous system. If bilateral gonadal veins are embolized in the distal pelvis, closer to where the left and right systems meet, this may be considered one surgical field (analogous to an embolization for uterine fibroids) and **37241** would be reported once. However, if the central outflow portion of the bilateral gonadal veins are embolized, this would be considered two separate surgical fields (analogous to a bilateral renal artery embolization) and **37241** should be reported twice.

When performing venography assessing female pelvic congestion syndrome, there is often selective catheterization and study of the iliac, hypogastric and sometimes femoral veins because these patients often have vulvar, labial, thigh and/or gluteal varices as well as pelvic symptoms. This procedure is most correctly coded as extremity venography (**75820–75822**) with the appropriate catheterization codes.

Selective left gonadal venography should be coded as **36012** and **75831**, since the left gonadal vein in males and females is typically a branch of the left renal vein. Selective right gonadal venography is more difficult to code, since the right gonadal vein typically arises directly from the inferior vena cava (therefore a first-order selective code **36011**) and does not typically include a renal venogram; therefore, it does not have a corresponding RS&I code.

Q: Is code 37242 used to report injection procedures for percutaneous treatment of extremity pseudoaneurysms (e.g., thrombin injection into an iatrogenic femoral artery pseudoaneurysm)?

A: No. This service is excluded from code **37242** and is reported using code **36002** (Injection procedures [e.g., thrombin] for percutaneous treatment of extremity pseudoaneurysm) plus the corresponding imaging guidance (i.e., **76942**).

Q: Given that code 37210, previously used to report uterine artery embolization, has been deleted, which of the embolization codes is used to report this service?

A: Code **37243** is now reported for uterine artery embolization. Selective catheterizations needed to perform the embolization should be reported separately. Emergent uterine artery embolization, such as in the setting of postpartum hemorrhage, would be reported with code **37244**.

Q: When an osseous metastasis is embolized preoperatively, typically multiple branches originating from different arteries are embolized on a single session. Are the embolizations considered to be in one or multiple surgical fields?

A: If one metastasis is located in one surgical field, only one embolization code (**37243**) is reported for this encounter regardless of how many branches are embolized. The selective catheterizations are reported separately.

Q: When chemoembolization is performed (e.g., conventional transarterial chemoembolization or chemoembolization with drug-eluting beads), what codes are reported to capture the work of the embolization and of administering chemotherapy?

A: In addition to the embolization code **37243**, code **96420** is reported to capture the work of intra-arterial chemotherapy administration.

Q: Sometimes the diagnostic arteriograms performed prior to hepatic chemoembolization reveal a vessel at risk for nontarget embolization (e.g., cystic artery, GDA). This vessel may be coil embolized prior to proceeding with chemoembolization. Are two embolization codes (37242 and 37243) reported in this setting when performed in the same session?

A: No. The code for the most acute indication (tumor chemoembolization) should be reported (**37243**). Coil embolizing of the vessel at risk is not separately reported because it involves an embolization on the same surgical field as the tumor (the area immediately surrounding and directly involved in a treatment/procedure). However, selective catheterizations needed to perform the embolizations should be reported separately.

Q: When radioembolization is performed (e.g., with yttrium-90 [Y-90] resin particles, Y-90 glass particles), what codes are reported to capture the work of the embolization and of administering a radioactive source? What about treatment situations where the IR is not the Authorized User (AU)?

A: Radioembolization, typically performed using the Yttrium-90 isotope, includes a planning and treatment procedure. The planning procedure includes a diagnostic arteriogram to determine vascular supply to the tumor, the risk of non-target embolization, and the fraction of administered radioactivity that is shunted to the lung. Non-target vessels that arise in the treatment field or close to the treated arterial branch are embolized in anticipation of Y-90 microsphere administration. Tc-99m MAA is then injected into the artery at the treatment position (which completes the planning procedure) after which the patient undergoes assessment of the distribution of the tracer in the nuclear medicine department. The information available from the planning procedure is used for treatment planning, simulation, and dose calculations. Next, an endovascular procedure is then performed to deliver the Y-90 resin or glass microspheres (treatment procedure).

CODING FOR THE PLANNING PROCEDURE:

- a. **Diagnostic arteriography:** All selective catheter placements and diagnostic imaging for this first session are separately reportable with the appropriate selective catheterization codes (**36245-36248**) and associated RS&I codes (**75726** and **75774**, if appropriate).
- b. **Embolization:** Embolization of non-target vessels to prevent administration of radioactivity to non-target vascular beds is reportable using code **37242**. Note that embolization in this setting is considered to take place in one “operative field” so even when more than one vessel is embolized, only a single embolization code is reported. Also note that angiography performed during and following the embolization is an included service within the embolization code and is not separately reportable.
- c. **Injection of Tc99m-MAA and NM reporting:** The intra-arterial injection of Tc99m-MAA during the planning procedure and subsequent nuclear medicine imaging is reportable using code **78803**. Note that **78803** (tomographic SPECT) is reported by the individual responsible for supervision and interpretation of the MAA exam which, depending on practice arrangements, may be a separate individual than the IR physician.

CODING FOR RADIATION PLANNING AND DOSIMETRY:

- a. **Dosimetric Treatment Planning:** The clinical treatment planning process includes interpretation of special testing, tumor localization, treatment volume determination, treatment time/dosage determination, choice of treatment modality, and selection of appropriate treatment devices. Institutions licensed to administer Y-90 must have an authorized user (AU) who is responsible for the pre-procedure dosimetry and treatment planning and may be reported using codes **77261-77263** depending on the complexity of the planning and appropriate documentation. Note that the complex therapeutic treatment planning code **77263** is reported when the AU utilizes the following data in planning for dose and timing of treatment; angiographic studies, cross sectional imaging, previous treatment, the Tc-99m MAA scan, as well as 3D reconstruction imaging to plan the treatment of Y-90 delivery. Documentation to support the use of **77263** must include indications and goals of the proposed treatment as well as description of dose prescription parameters such as the specific dose constraints for the target(s) and nearby critical structures.

CODING FOR THE TREATMENT PROCEDURE:

- a. **Single-Doctor (Interventional Radiologist is the Authorized User):** Any selective catheter placements are reportable using the appropriate codes (**36245-36248**). The associated R S&I codes should not be routinely reported since angiography is confirmatory and considered to be part of the therapeutic procedure. However, these RS&I codes (**75726** and **75774**), if appropriate, may be reportable if pre-procedural documentation indicates suspicion of new vascular flow patterns or the detrimental effect of chemotherapy on vessels. Once the appropriate artery is selected for therapeutic treatment, the Y-90 dose is delivered, and reported with **37243** and **79445** (for the supervision of radiopharmaceutical therapeutic injection). **37243** includes RS&I, as well as any additional embolizations (such as flow re-direction to preserve adjacent organs) performed in the same session as radioembolization. The AU is responsible for safe handling, receipt, and storage of the Y-90 dose and needs to ensure documentation supports the work of handling and loading the source in alignment with NRC regulations.
- b. **Two-Doctors (Interventional Radiologist is not the Authorized User):** In this situation, the IR reports only the catheter placement codes (**36245-36248**) and any associated angiographic S&I codes (**75726** and/or **75774**), if necessary and appropriately documented, as described above. A second, licensed physician (acting as the AU) may be involved in the planning and delivery of the Y-90 dose. In this two-doctor model, the AU has material involvement in the planning, dosimetry and administration (actually injects the Y-90), so the AU reports **77778** describing the work of application of an interstitial radiation source, (complex) in this setting. If the IR injects the radiopharmaceutical under the supervision of the AU (who plans the dosimetry calculations), the IR reports **37243** for the embolization procedure and the AU reports **79445** for the supervision of radiopharmaceutical therapeutic injection.

CODING FOR SAME-DAY PLANNING AND TREATMENT PROCEDURES:

Current practice of Y-90 radioembolization is evolving and some centers may perform all three of the above stages in a same day delivery model, however it should be noted that none of these stages are delivered in the same session. Each of these sessions require distinct procedural reports, outlining all of the services

performed in that session. In this situation reporting of services by the IR who also is the AU is identical to the above recommendations EXCEPT that catheter placement and RS&I codes for angiography should be reported with a **-59** modifier.

Q: When a patient is brought for the preparatory radioembolization procedure (e.g., phase I, angio-prep), multiple vessels are typically embolized (e.g., gastroduodenal artery, right gastric artery) to avoid nontarget embolization. Are multiple embolizations reported in this setting?

A: No. The embolization code (**37242**) should be reported only once, since all the vessels embolized are in the same surgical field (i.e., the area immediately surrounding and directly involved in a treatment/procedure). However, selective catheterizations needed to perform the embolizations should be reported separately.

Q: If a multitrauma patient presents with bleeding from the pelvis and the spleen, and both sites are embolized in the same session, are multiple embolizations reported?

A: Yes. In this setting, two embolization codes (**37244**) are reported with the appropriate modifier (e.g., modifier **-59**) because the pelvis and the spleen are two different surgical fields. The codes for catheter placement are reported separately as well as any imaging used for diagnostic evaluation.

Q: A patient presents with a lower GI bleed localized by colonoscopy to the region of the splenic flexure. Superior mesenteric and inferior mesenteric arteriograms are performed, and the bleeding site is not identified. The operator proceeds to super select branches of the left colic artery in an attempt to identify the bleed. One of the superselective arteriograms identifies the bleed, and the branch is coil embolized. Are the inferior mesenteric arteriogram and all superselective left colic arteriograms reported separately, or are they bundled into the embolization code?

A: In this scenario, the superior mesenteric arteriogram, inferior mesenteric arteriogram and superselective arteriograms of left colic branches performed for diagnostic purposes are reported separately using the corresponding codes with any appropriate modifier (e.g., modifier **-59**). Once a decision has been made to treat with embolization, all subsequent imaging is included in the embolization codes and is considered guidance for the embolization procedure.

Q: Can I use one the new embolization codes (37241–37244) to report gelfoam injection for biopsy tract closure?

A: No. Any maneuvers to close a biopsy tract is considered incidental to the biopsy procedure and should not be separately coded.

MISCELLANEOUS VASCULAR INTERVENTIONS

Q: How would the following be coded? Diagnostic arteriogram of the abdominal aorta and bilateral lower extremities are performed. Angioplasty of the contralateral popliteal artery stenosis and recanalization of an occluded tibioperoneal trunk and posterior tibial artery are performed with atherectomy followed by stent placement in the tibioperoneal trunk.

A: Use codes 75625–59, 75716–59, 37231, 37224. Diagnostic imaging is not included in the lower extremity revascularization codes and may be separately reported as long as the requirements set out by CPT® are met. Those requirements are described in detail under the above codes in this coding update.

In this case, an aortogram (75625) and the bilateral lower extremity arteriogram (75716) are performed and interpreted. The decision to perform an intervention is then based on these findings so that the diagnostic procedure is separate and distinct from the intervention and, therefore, the -59 modifier is necessary. The interpretation of the arteriogram and the justification for the intervention should be clearly defined in the report. If the same access was used for the intervention and the diagnostic arteriogram, no additional catheter code is used. However, if the intervention is performed from an access separate from the diagnostic arteriogram access, the appropriate catheterization code for the diagnostic study would also be reported with a -59 modifier. Code 37224 is used for the angioplasty of the popliteal artery lesion. If stent placement was performed at the popliteal segment, then the angioplasty would not be coded separately, but only the stent placement (37226) would be coded.

Code 37231 includes all the interventions performed to recanalize the tibioperoneal trunk and posterior tibial artery, including the atherectomy and stent (and angioplasty if performed). No additional codes if distal embolic protection is employed.

Q: When using the Category III codes for atherectomy of the iliac artery (0238T), the catheter placement is separately reportable. If we perform a common iliac artery angioplasty (CPT® code 37220) in combination with atherectomy in the same iliac vessel, are we allowed to charge for the catheter placement?

A: If performed in the same vessel and through the same access site, the answer would be no, the catheter placement is not separately reportable. However, if the interventions are performed in opposite iliac arteries, via separate access sites or if a more selective catheter placement was obtained to perform the atherectomy, then the appropriate catheter placement code would be reportable. Keep in mind that the use of a modifier may be necessary to avoid denials.

Q: How are selective catheterizations of the renal veins to delineate anatomy during IVC filter placement coded?

A: Selective catheterizations of the renal veins to delineate anatomy during intravascular vena cava filter placement are not separately reportable and this service would be reported using CPT® code 37191. Vascular access and vessel selection are included in code 37191.

Q: What code should be reported to describe the placement of IVC filters when placed in a duplicated IVC?

A: Report code 37191 twice to describe the placement of two vena cava filters in a duplicate IVC system. Use modifier -59 with the second code to denote to the payer that this is a separate and distinct study and to ensure appropriate reimbursement.

Q: Can you define “initial treatment day” for the thrombolytic therapy codes (CPT® codes 37211 and 37212)?

A: The definition of “initial day” is a calendar day; therefore, if a patient is brought back to the suite within the same calendar day, the second setting is not reportable.

Q: I know that TIPS is a bundled procedure, but is embolization separately reportable if performed during a TIPS procedure?

A: Yes, one would code the appropriate embolization code. See codes 37241 or 37244, depending on the indication for the embolization.

Q. How do I code for a BRTO (Balloon-Occluded Retrograde Transvenous Obliteration)?

A: There is no specific single CPT® code for the performance of BRTO so each individual component of the procedure should be reported with the appropriate procedure code(s). Selective venous catheterization(s) should be reported with the **36011** or **36012** (1st & 2nd order venous cath, respectively) or **36481** (portal vein cath). Diagnostic studies that meet the criteria to be separately reported should be assigned the appropriate venography code(s). However, there is no specific CPT® code that describes mesenteric venography. Unless payer guidelines instruct otherwise, appropriately documented mesenteric venography could be reported with the unlisted fluoroscopic procedure code **76496**. The occlusion component of the procedure should be reported with the appropriate embolization code (**37241** or **37244**) depending on the clinical situation.

Q: Must one be successful in order to code for a service?

A: No, success is desirable but is not a required element of coding. If one attempts a service and is unsuccessful but has performed some lesser, otherwise reportable elements of the service, then the lesser service(s) should be coded. As an example, consider an unsuccessful attempted aortic access from a right femoral approach (failed because of an iliac occlusion); the service should be coded as **36140** rather than **36200**. If an angioplasty of an occlusion is unsuccessful because the lesion cannot be crossed, then the appropriate access and/or selection only should be coded. On the other hand, if the lesion is crossed and the angioplasty is performed but with an unacceptable outcome, then the angioplasty is coded since all the work of the angioplasty was done. If significant portions of a procedure are performed, but the procedure must be terminated prematurely due to extenuating circumstances or those that threaten the wellbeing of the patient, a **-53** modifier (discontinued service) may be used.

Q: How do you code for hybrid angiography-CT systems (CT fluoroscopy)?

A: The CT capabilities of the new hybrid imaging systems are commonly being employed to garner diagnostic CT imaging studies, as well as to provide imaging guidance for interventions. Coding will depend on the procedure/service being provided and most often for diagnostic studies performed, the existing CT CPT® codes will be applicable.

When images are obtained for diagnostic purposes, one would report the applicable anatomic-specific diagnostic CT code. These are differentiated by the use of contrast

with specific codes for studies performed with, without or both “with and without” contrast. Any diagnostic CT exam provided using these hybrid systems will be expected to be performed and documented within established clinical standards and guidelines.

The ACR has issued various documents detailing the clinical standards for the performance of diagnostic CT studies of the brain, head, chest, abdomen and pelvis, which can be obtained via the ACR website.

For limited or focused diagnostic CT studies, often code **76380** (computed tomography, limited or localized follow-up study) will be applicable. Code **76380** would typically only be reported once regardless of the number of localized diagnostic CT studies obtained during a single therapeutic intervention.

There are also several existing CT guidance codes applicable for describing imaging guidance and monitoring of an intervention performed using a hybrid fluoroscopy-CT system when the CT imaging guidance capabilities are evoked, such as the following:

- 11476** Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation.
- 11477** Computerized tomography guidance for, and monitoring of, tissue ablation.
- 75989** Radiological guidance (e.g., fluoroscopy, ultrasound or computed tomography) for percutaneous drainage (e.g., abscess, specimen collection), with placement of catheter, radiological supervision and interpretation.

For interventions, if fluoroscopy and CT guidance capabilities are used intermittently, only the most intensive intraprocedural guidance code is reported, which is typically the CT guidance code. For example, one would not code **75989** two times when both fluoroscopy and CT imaging guidance are provided in conjunction with placement of an individual catheter to drain a single abscess. Despite the intermittent use of both modalities of imaging, **75989** would only be reported once in this scenario.

If both fluoroscopy and CT guidance were used for the placement of a needle, one would not report **77002** (fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]) in addition to **77012**; rather, only **77012** is reported.

Additionally, when 3D rendering is indicated and performed that is not considered inherent to the primary procedure* being reported, use of one of the 3D codes may be applicable.

10840 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post-processing on an independent workstation.

(Use **76376** in conjunction with code[s] for base imaging procedure[s]).

10841 Requiring image postprocessing on an independent workstation.

(Use **76377** in conjunction with code[s] for base imaging procedure[s]).

***Note:** 3D rendering is considered inherent to the following codes and **76376/76377** cannot be additionally reported.

(Do not report **76376** or **76377** in conjunction with **31627, 34839, 70496, 70498, 70544–70549, 71275, 71555, 72159, 72191, 72198, 73206, 73225, 73706, 73725, 74174, 74175, 74185, 74261–74263, 75557, 75559, 75561, 75563, 75565, 75571–75574, 75635, 77046–77049, 77061–77063, 78012–78999, 93355, 0523T, 0559T–0562T**).

For CT services provided for which there is not an existing code that accurately describes the service/procedure, the use of an unlisted CPT® code may be warranted (**76497**—unlisted computed tomography procedure [e.g., diagnostic, interventional]).

Q: Can you charge for 3D rendering with image postprocessing on an independent workstation (76377) when performing carotid or cerebral angiography?

A: The short answer is yes, you can charge for 3D rendering with image postprocessing if performed on a separate workstation (**76377**) when performing carotid or cerebral angiography. Code **76377** is used to report 3D rendering with interpretation and reporting of ultrasound, CT or MRI. It is important to note that the images have to be saved, and all of the criteria for concurrent supervision must be met. This code is not meant to describe the work done by a technologist without a separate workstation or the need to take a scanner offline for image processing.

76377 can only be reported once per procedure and medical necessity should be documented. This code cannot be reported in conjunction with CTA and MRA

procedures since 3D rendering is considered an inherent component of these studies. It should also not be reported with CT colonography, PET imaging or any nuclear medicine study. See the parentheticals following codes **76376** and **76377** in the *CPT® 2021 Professional Edition Manual* for a complete listing of procedures that do not permit the separate reporting of 3D renderings.

ENDOVASCULAR ANEURYSM REPAIR

Q: Can I code for stenting an external iliac outflow stenosis during an endovascular abdominal aneurysm repair?

A: Yes, with the proper documentation, CPT® code **37221** (iliac stent, including angioplasty) could be used in this scenario because the stenosis is outside of the treatment zone and unrelated to the repair of the aneurysm.

Q: How do I code for internal iliac artery embolizations at the time of EVAR?

A: Embolization performed at the time of an endovascular repair of an aneurysm (thoracic endovascular aortic repair [TEVAR] and endovascular aneurysm repair [EVAR]), including embolization of a hypogastric artery, is separately reportable.

Code **37242** and typically **36245** are both appropriate to report this procedure. Use of a selective catheter placement code for embolization obviates the use of **36200** for placing a catheter in the aorta under coding convention rules. Typically, a second aortic catheter placement is performed via a separate access site, which is reportable.

Q: If I place two extension cuffs in the same vessel to treat endoleak of an AAA endoprosthesis, after initial endograft placement, how many times can I report 34709?

A: Cuff placement services are reported per vessel treated, not per cuff or device placement, therefore **34709** would be reported once. However, if extensions are placed in separate vessels (for example, the right and left iliac arteries), then would be reported also. See codes **34710** and **34711** for extensions placed in a delayed setting.

NONVASCULAR INTERVENTION

Q: How do I code for the dilatation of distal ureter?

A: Dilation of ureter is reported using the add-on code **50706**. This code should be used in conjunction with **50382, 50384, 50385, 50386, 50387, 50389, 50430, 50431, 50432, 50433, 50434, 50435, 50684, 50688, 50690, 50693, 50694, 50695, 51610**.

Q: How does one code for a percutaneous transhepatic cholangiogram with external biliary drain placement?

A: Code **47533** describes the work of external biliary drain placement and includes diagnostic cholangiography and imaging guidance.

Q: When a patient returns at a later date for conversion of their external biliary drain to an internal-external drain, is this coded as an exchange?

A: Code **47535** describes the conversion of an external biliary drain to an internal-external biliary drain. This code includes diagnostic cholangiography and imaging guidance.

Q: How do I code for tunneled pleural or peritoneal catheter placement?

A: These tunneled, cuffed catheters are used for vacuum bottle assisted removal of fluid from either the pleural or peritoneal spaces. After placement, this subsequent removal can be performed by the physician, nurse or even properly instructed patient.

Placement of a tunneled cuffed catheter is typically coded as follows:

Tunneled peritoneal catheter placement: Code **49418** is used to report the initial placement of a tunneled peritoneal catheter and it includes all imaging guidance. Code **49422**, removal of permanent peritoneal catheter, should be used to report the subsequent removal of a tunneled peritoneal catheter.

Tunneled pleural catheter placement: Code **32550**, insertion of indwelling tunneled pleural catheter with cuff, along with **75989** when imaging is performed, should be used to report the initial placement of a tunneled pleural catheter. Code **32552**, removal of indwelling tunneled pleural catheter with cuff, should be used to

report the incisions and subcutaneous dissection of the indwelling cuff to remove a tunneled pleural catheter. Subsequent encounters in which fluid is removed by the physician should be reported with the appropriate E/M codes.

Q: How do I code for paravertebral facet joint injections at L2-L3 and L3-L4 performed under fluoroscopic guidance?

A: Code **64493** accounts for the first level performed and includes the imaging guidance used for the procedure. Code **64494** accounts for the second level performed and also includes the imaging guidance. Code **64494** is an add-on code and can only be used when **64493** is used as well. Moderate sedation is reported separately when performed.

Q: What are the appropriate codes to report for sclerotherapy of nonvascular structures, such as seromas, cysts, lymphoceles or abscesses?

A: Code **49185** was introduced in 2016 for sclerotherapy of fluid collections, such as those mentioned above. This code does not include placement of the catheter within the collection, which should be separately reported. Note that there is a difference between lymphocele and lymphatic malformations, this code is not intended for use highly complex lymphatic malformations.

Q: What are the appropriate codes to use when microwave ablation is the energy source used for liver, lung or renal lesions?

A: The existing CPT® codes for tumor ablation are defined for radiofrequency ablation. This definition has led to some confusion, occasionally resulting in the use of unlisted procedure codes for microwave ablation. SIR does not recommend the use of unlisted procedure codes for microwave ablation of kidney, lung or liver tumors. Microwave is part of the radiofrequency spectrum and uses a different part of the radiofrequency spectrum to generate heat energy to destroy abnormal soft tissue. Microwave ablation equipment is substantially comparable to operate in practice, which is also reflected in the FDA approval of microwave devices under the 510(K) clearance process as equivalent to radiofrequency. As such, SIR recommends that CPT® codes **32998**, **47382**, and **50592** be used for both microwave and radiofrequency ablation in their respective anatomic locations, in conjunction with the appropriate imaging guidance code, if imaging is separately reportable.

47382 Ablation, one or more liver tumor(s) percutaneous, radiofrequency; with appropriate image guidance code: **77013** (CT), **77022** (MRI), **76940** (US).

32998 Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency including imaging guidance when performed, unilateral; radiofrequency.

(Do not report **76940**, **77013**, **77022** in conjunction with **20982**, **20983**, **32994**, **32998**).

50592 Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency; with appropriate image guidance code: **77013** (CT), **77022** (MRI), **76940** (US).

Q: How many times should a biopsy code be used when multiple passes are made to obtain tissue from a lesion?

A: If multiple passes are made in a single lesion then only one biopsy code is assigned. See the introductory language that proceeds codes 10004 and 32408, that address correct coding guidelines for multiple lesions, multiple locations and the potential modalities used during the performance of Fine Needle Aspiration (FNA) biopsies and core biopsies. These guidelines should be consulted to determine the appropriate coding based on the individual clinical situation. NCCI edits may also impact code assignment and should also be consulted.

Q: Do you have to leave a catheter in place with the abscess drainage codes (10030, 49405-49407)?

A: Yes, the intention of the codes **10030**, **49405-49407** was that a catheter would be secured and remain in place when the patient left the imaging suite. These codes should not be used when a catheter (e.g., Yueh or Skater) is placed and removed in the same setting. These codes include all imaging guidance that is used in the placement of the drainage catheter.

Q: There were new myelogram codes introduced for 2015, but the old codes weren't deleted. Why?

A: It is believed there is still a need for the ability to report injection and the imaging supervision when these are separately performed by two different physicians. Therefore, the component coding remained. If both the injection and the imaging guidance are performed by the same provider, then that provider must report the bundled codes (**62302–62305**).

Q: Does code 50693 include the replacement of the existing nephrostomy tube following the placement of the ureteral stent?

A: Yes. CPT® code **50693** includes all drainage catheter manipulations and exchanges (when performed), as well as diagnostic nephrostograms and/or ureterograms (when performed), imaging guidance (e.g., ultrasonography and/or fluoroscopy) and all associated radiological supervision and interpretation. Do not report code **50435** in conjunction with **50693**.

Q: Can I report 50706 for ureteral dilation for each lesion dilated in the ureter?

A: No, this code should only be reported once per ureter, regardless of the number of treated lesions within the ureter.

Q: How does one code for the initial placement of a ureteral stent via an ileal conduit?

A: Retrograde ureteral stent placement via an ileal conduit access is atypical to be performed without cystoscopic guidance. Therefore, when this procedure is performed using fluoroscopic guidance, the unlisted procedure code **53899** should be used to report this service.

Q: We do contrast injection for each epidural steroid injection we perform just to confirm we are in the epidural space. Is this formal epidurography and should we be coding 72275 for all of these injections?

A: When performing contrast injection only to confirm location of the needle, one should not code for formal epidurography. In these instances, it is appropriate to code **62321**, **62323**, with imaging guidance (i.e., fluoroscopy or CT). Do not report **62323**

in conjunction with fluoro guidance (77003), CT guidance (77012) or US guidance (76942). 62310 and 62311 have been deleted.

Formal epidurography, rather, is coded with 72275, which includes 77003. Therefore, 77003 should not be additionally coded when performing formal epidurography. 72275 should only be used when an epidurogram is performed for diagnostic purposes (e.g., assessing flow of contrast to assess area[s] of scarring, nerve constriction or possible nerve inflammation, images are documented, and a radiologic report is issued describing the findings of the epidurogram).

Q . Could you provide me with the appropriate CPT® code for injection of thrombolytics into a chest tube (performed on the inpatient floor after initial chest tube placement)?

A. For therapeutic lysis of loculated pleural effusions, CPT® has two applicable codes that could be reported. Code 32561 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); initial day* is reported for the first day of service and includes any subsequent injections on the same calendar day. Code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* is to be reported when additional treatment is needed, once per each additional calendar day, within that same hospital visit as the reporting of 32561. These codes can be used for direct-stick chest tubes or tunneled pleural catheters.

Q . Can I use 32561 and 32562 for injection of thrombolytics into an abscess drainage catheter also?

A. No, CPT® codes 32561 and 32562 are only used for pleural catheters. There is currently no CPT® code to describe the therapeutic injection of lytic agents into non-pleural abscess cavities to break up loculated or thickened material. To report these services, an unlisted code should be reported that corresponds to the cavity or organ in which the catheter is placed.

Individual coverage request sample letters

The following are examples of a few common coverage request letters. The examples include letters for coverage for radiofrequency ablation of pulmonary tumor(s), ovarian vein embolization for pelvic congestion syndrome and MRI imaging of the uterus prior to uterine fibroid embolization. These templates include data, arguments for need and benefits and can save you considerable work. Please contact SIR staff to provide you with easily editable versions of these letters.

Ovarian vein embolization to treat pelvic congestion syndrome

https://www.sirweb.org/globalassets/documents/ove_for_pcs_template.docx

MRI of pelvis for UFE

https://www.sirweb.org/globalassets/documents/mri_pelvis_ufe.docx

Percutaneous cryoablation for pulmonary tumor(s)

https://www.sirweb.org/globalassets/documents/percutaneous_cryo_pulmonary_tumors.docx

Mechanochemical venous ablation

https://www.sirweb.org/globalassets/documents/mechano_venous.docx

Reporting unlisted codes

Letter for coverage when unlisted codes are reported

SAMPLE LETTERS START ON NEXT PAGE

LETTER FOR OVARIAN VEIN EMBOLIZATION TO TREAT PELVIC VENOUS CONGESTION SYNDROME

[CARRIER MEDICAL DIRECTOR]:

On [INSERT DATE OF PRECERTIFICATION/COVERAGE REQUEST DENIAL], notice was received from your company that ovarian vein embolization (OVE) is considered experimental and investigational and, therefore, a noncovered service. This is a formal request for individual consideration to extend coverage for OVE for [PATIENT NAME], who is suffering from pelvic congestion syndrome (PCS).

[PATIENT NAME] has presented with symptoms consistent with PCS, which is a well-defined condition. Namely, she has experienced longstanding [LIST RELEVANT SYMPTOMS: cyclical pelvic pain and pressure that correlates with her menses, pain during/after sexual intercourse, pelvic pain worse upon standing/sitting/walking]. She has been seen by [PHYSICIAN, MD] and has undergone a rigorous clinical evaluation to determine the cause of her symptoms. Both Dr. [REFERRING MEDICINE PHYSICIAN NAME]'s and my findings are consistent, confirming that [PATIENT NAME] has physical findings that are commonly found with PCS, including recurrent varicose veins in the lower extremity(ies) [ADD OTHER RELEVANT SIGNS: vulvar varices, hemorrhoids].

Additionally, [LIST RELEVANT DIAGNOSTIC STUDY(IES)-FOR EXAMPLE-an MR venogram of the pelvis shows large ovarian and pelvic veins/an ultrasound of the pelvis has been performed, which demonstrated enlarged pelvic varicosities, more prominent on the left than the right], supporting a diagnosis of PCS for this patient. OVE has been found to be an effective minimally invasive procedure to treat the symptoms of PCS and is recommended for this patient.

PCS symptoms

[PATIENT NAME] is not alone in suffering from the symptoms of PCS. It has been estimated that almost 40 percent of all women will experience chronic pelvic pain during their lifetime and that 15 percent of all women between the ages of 18–50 experience chronic pelvic pain. Of note, 15 percent of all hysterectomies and 35 percent of all diagnostic laparoscopies are performed due to chronic pelvic pain. Ovarian vein incompetence has been shown to occur in approximately 10 percent of women. This phenomenon can lead to PCS and its associated symptoms in 60 percent of these patients. Despite this incidence, PCS is significantly underdiagnosed. It typically results

in pelvic pain that is often described as dull and aching. The pain is typically worse in an upright position and becomes more severe with walking and postural changes. It may be associated with dyspareunia or a postcoital ache.

These symptoms of PCS are typically caused by the development of varicosities in the infundibulopelvic and broad ligaments within the pelvis. The exact reason for the development of these varicosities is unknown, but one important factor is the absence or incompetence of valves in the ovarian veins. Anatomy may also play a role: the left ovarian vein is more frequently incompetent than the right. Since the left ovarian vein drains vertically into the high-pressured left renal vein, it may be more prone to reflux than the right ovarian vein, which enters directly into the side of the inferior vena cava. Accordingly, symptoms can be more common or more severe on the left, as seen with [PATIENT NAME]. Hormones may also contribute since PCS mainly affects premenopausal women. Rarely, left-sided ovarian vein reflux can be caused by “nutcracker syndrome,” in which the left renal vein is compressed between the superior mesenteric artery and the aorta. The back pressure in the renal vein is transmitted to the renal venules and ovarian vein, resulting in hematuria and pelvic congestion respectively. The pain associated with pelvic congestion syndrome has been directly attributed to the presence of these dilated veins within the pelvis.

OVE treatment plan for PCS

Once a patient such as [PATIENT NAME] has been diagnosed with PCS, it is important to direct treatment towards eliminating retrograde flow in the abnormal ovarian vein(s). Doing so reduces pressure in the pelvic veins, which in turn alleviates or improves symptoms.

OVE, a percutaneous, catheter-based procedure that results in occlusion of the abnormal ovarian vein(s), effectively eliminates retrograde flow in the ovarian vein. For the past 15 years, this treatment has been associated with good clinical outcomes in most women suffering from the symptoms of PCS. The procedure is technically successful in almost 100 percent of patients. Symptomatic improvement tends to be seen in >80 percent of patients undergoing OVE.

The largest study with the longest follow-up was just completed in Europe; Laborda et al. (2013) prospectively followed 202 patients over 5 years and showed an astounding 93.9 percent clinical success rate and a significant reduction in the visual analog pain scale from 7.3 (out of 10) to 0.8. Gandini et al. (2008) demonstrated statistically

significant improvement in pelvic pain, dyspareunia, urinary urgency and menstrual pain in 38 women treated with OVE. Kim et al. (2006) demonstrated an 83 percent success rate in 127 patients treated with OVE, with an impressive 4-year follow-up. Kwon et al. (2007) reported symptomatic improvement in 82 percent of 67 patients treated with OVE. Venbrux et al. (2002) reported symptomatic improvement in 96 percent of the 56 patients 12 months after being treated with OVE. Other reports by Mowatt et al, Capasso et al, Sichlar et al, Tarazov et al, Maleux et al, and Cordts et al. have reported similar data to the studies outlined above. In select patients with the “nutcracker” syndrome described above, a less than 50 percent stenosis of the renal vein may be safely treated with OVE to relieve the pelvic pain caused by reflux into the ovarian vein. In summary, patients who present with clinical signs and symptoms as well as imaging findings consistent with PCS are excellent candidates for OVE.

OVE is performed on an outpatient basis. The OVE procedure begins with an ovarian venogram to confirm that retrograde flow is present. If reflux and retrograde flow is identified within the left and/or right ovarian vein, the vein is embolized to eliminate this reflux and reduce the pressure within pelvic varicosities.

Body of scientific literature supporting OVE as an effective treatment for PCS

Enclosed is a comprehensive listing of the scientific literature available that supports OVE as an effective treatment for PCS (see Attachment A). Also enclosed is a table (see Attachment B) summarizing the scientific articles available supporting ovarian vein embolization as an effective treatment for pelvic congestion syndrome. Of note, many of these articles support embolization of additional pelvic veins to maximize therapeutic benefit.

OVE emerged because of its safety, efficacy and noninvasiveness compared with surgery; in a Korean study, in which patients with documented PCS were randomized to hysterectomy (with either oophorectomy of ovary on the side of an incomplete gonadal vein or bilateral oophorectomy) or OVE, OVE demonstrated significantly better results than surgery.

Equitable coverage sought for equivalent treatments for comparable syndromes found in men and women

Painful dilated veins in the scrotum of men, caused by a refluxing testicular vein, result in varicoceles that are successfully treated with gonadal vein embolization.

Painful dilated veins of the uterus and pelvis in women results in PCS. These are comparable syndromes with a common etiology. Given that the safety and efficacy of embolotherapy for both conditions are well supported by the literature and that male varicocele is routinely covered, it would not be fair to deny women coverage for the same condition. As such, we respectfully request that you reconsider and reverse this inappropriate determination. Please extend coverage to [PATIENT NAME] for ovarian vein embolization to treat pelvic congestion syndrome.

I hope that you will find this information helpful in reversing the previous denial [FOR PREAUTHORIZATION/OF COVERAGE]. Please feel free to contact me if you require any further information.

Sincerely,

[SIR MEMBER NAME], MD CC: [PATIENT NAME]

[STATE INSURANCE COMMISSIONER]

LETTER FOR MRI OF THE PELVIS FOR UFE

To Whom It May Concern:

I am writing this letter to appeal your decision to deny coverage for an MRI of the pelvis for [PATIENT NAME], (DOB: [INSERT DATE OF BIRTH]; [PATIENT ID]) prior to a uterine artery embolization (UAE) procedure to treat symptomatic uterine fibroids.

As you know, UAE is a uterine-sparing procedure that effectively treats the symptoms associated with uterine fibroids and reduces both uterine and fibroid volume due to fibroid infarction. Prior to UAE, the interventional radiologist performing the procedure needs to be certain that the procedure is being performed for an appropriate indication. When fibroids were treated exclusively with hysterectomy, pre-procedure imaging was not critical to gynecologists because the uterus, in its entirety, was being removed.

As a result, a pathologic evaluation performed on the uterus after surgery was the primary means of determining the etiology of the presenting symptoms. Uterine artery embolization is different. Since the uterus is remaining in its anatomic position and the fibroids are not being removed, it becomes incumbent upon the physician responsible for performing this procedure to obtain definitive imaging of the pelvis prior to the procedure.

The standard imaging modality used to evaluate patients with suspected uterine fibroids is ultrasound. In fact, almost all patients presenting in consultation for UAE have been evaluated previously with a pelvic ultrasound that has demonstrated fibroids.

While ultrasound is certainly a good test to evaluate patients for fibroids, it is an operator-dependent imaging modality that has recognized limitations when it comes to evaluating patients specifically for UAE. Omary et al. (*J Vasc Interv Radiol* 2002; 13:1149–1153) evaluated the importance of imaging prior to UAE and recommended that MRI be considered in all patients prior to this procedure. They did this by evaluating the diagnostic confidence and anticipated treatment plan both before and after performance of a pelvic MRI. They found that MRI significantly increased diagnostic confidence. In addition, they found that MRI changed the initial diagnosis in 18 percent of patients and the immediate clinical management in 22 percent of patients. Overall, 19 percent of women who were anticipated to undergo UAE prior to MRI did not undergo that procedure as a result of the findings on MRI, which most often included abnormalities other than fibroids. MRI has also been shown to potentially predict the response to UAE and can therefore be helpful with patient selection for this procedure.

An MRI can accurately determine the location and size of fibroids within the uterus. As described by

Cura et al. (*Acta Radiol* 2006; 47:1105–1114), UAE may not be the appropriate therapy if a patient's symptoms do not correlate with the size and location of their fibroids. For example, a small subserosal fibroid is not likely to be responsible for abnormal bleeding so UAE may not be indicated in this particular type of patient. In addition, MRI is helpful in differentiating degenerated fibroids from cellular fibroids, which is important since cellular fibroids typically have the best response to UAE.

Cellular fibroids have characteristic MRI findings with high signal intensity on T2 weighted images and enhancement after contrast administration (Yamashita et al, *Radiology* 1993; 189:721–725) so fibroids with these characteristics may be expected to respond best to UAE. This has been supported by Burn et al. (*Radiology* 2000; 214:729–734), who reported on the good response of fibroids with high signal intensity on T2-weighted images, and by Jha et al. (*Radiology* 2000; 217:228–235), who reported that hypervascular fibroids which enhanced after contrast administration had a greater response to UAE. Therefore, an MRI can help determine which patients are appropriate candidates for UAE on the basis of size, location, signal characteristics and degree of enhancement after contrast administration. The findings on MRI can also help determine if vessels other than the uterine arteries provide arterial supply to the fibroids. Kroencke et al. (*Radiology* 2006; 241:181–189) determined that contrast-enhanced MRI can help predict the presence of ovarian arterial supply to uterine fibroids. This information is important to have prior to UAE because if these vessels are not recognized, the ability of this procedure to induce infarction within the treated fibroids becomes significantly limited. In addition, knowing that ovarian arteries may need to be treated during a UAE procedure is something that is important to discuss with a patient prior to UAE since treating these vessels could increase the possibility of postprocedure amenorrhea.

Finally, MRI is very helpful in determining if patients are potentially at risk for complications after UAE. For example, pedunculated submucosal fibroids are potentially at risk for transcervical expulsion or infection and pedunculated subserosal fibroids can potentially separate from the uterus and result in intraperitoneal complications. Pelvic MRI is able to define the morphology of pedunculated fibroids far better than ultrasound and therefore help determine which patients are potentially at risk for these complications. This was well described by Verma et al. (*AJR* 2008; 190:1220–1226), who reported on the utility of MRI in defining the interface between pedunculated submucosal fibroids and the endometrium. They found that this helps define the risk of

fibroid migration into the endometrial cavity with subsequent transcervical expulsion after UAE.

In summary, an MRI of the pelvis provides the information that is necessary for an interventional radiologist to determine if a patient with symptomatic uterine fibroids is a suitable candidate for uterine artery embolization. It can potentially provide information regarding the cellular morphology of fibroids, the presence or absence of other pathology that could explain a patient's symptoms, the contribution of other blood vessels responsible for the arterial supply of fibroids, and the potential risk of complications associated with pedunculated fibroids.

As a result, MRI has been shown to potentially change the treatment plan in a significant number of patients, underscoring its importance as a pre-procedure imaging test. It is my hope that this information will help support a reversal of your decision to deny coverage to [PATIENT NAME] for an MRI of the pelvis prior to her planned uterine artery embolization procedure.

Sincerely,

[SIR MEMBER NAME], MD CC: [PATIENT NAME]

[STATE INSURANCE COMMISSIONER]

LETTER FOR PERCUTANEOUS CRYOABLATION OF PULMONARY TUMOR(S)

[DATE]

[CARRIER MEDICAL DIRECTOR]

[CARRIER NAME]

[COVERAGE RECONSIDERATION DEPARTMENT] [CARRIER ADDRESS] Sub:

[PATIENT NAME]

[PATIENT ID]

[GROUP NO.]

[CLAIM NO.]

Request for coverage for percutaneous cryoablation of pulmonary tumor(s)

[CARRIER MEDICAL DIRECTOR]:

On [INSERT DATE OF REQUEST DENIAL], an insurance coverage denial notice was received from your company that cryoablation of [TYPE OF PULMONARY TUMOR] is considered experimental and medically unnecessary, hence not covered by insurance. This is a formal request to extend coverage for cryoablation of pulmonary tumor(s) for [PATIENT NAME], who has been diagnosed with [INSERT DIAGNOSIS: lung cancer, lung metastases, lung malignancies, including stage].

[PATIENT NAME] has been seen and evaluated by a [SELECT REFERRING PHYSICIAN TYPE: thoracic surgeon/oncologist/oncology physician team] who [is/are] in agreement that pulmonary tumor cryoablation is the best treatment option for management of this lung tumor.

This letter is an appeal for approval of cryoablation for treatment of lung [and pleural metastatic disease] to be rendered at [CENTER]. The use of radiofrequency ablation (RFA) ablative techniques for treatment of lung cancer and metastasis has already been established. Once a candidate is deemed eligible for ablation, the choice of ablation

modality should lie with the performing physician to be able to use the modality to best serve the patient with comparable efficacy and equal safety.

This letter will describe in limited detail the technique of cryoablation for lung cancer or metastasis therapy and review the literature on efficacy and safety of cryoablation.

Technique

Cryoablation is a controlled interventional technique that implements high-pressure argon and helium gas for freezing and thawing, respectively on basis of the Joule-Thompson principle. Naturally, cells of targeted tissue die when exposed to subzero temperatures of -20 degrees centigrade achieved by the cryoprobe based on two modes of destruction: immediate postthaw freeze rupture (primary) and longer-term coagulative necrosis and apoptosis (secondary).¹

Advantages over other ablative modalities

Cryoablation has already established itself as an alternative for treatment of prostate cancer, bone tumors, renal cell carcinoma, hepatocellular carcinoma and fibroadenoma of the breast. The interest in use of cryoablation in lung tumors arises from advantages it holds over other heat-based ablative modalities.

Unlike heat-based modalities, which destroy the tissue architecture, cryoablation preserves the collagenous and other cellular architecture of virtually any frozen tissue, which is particularly beneficial in lung tumor ablations when treating lesions adjacent to the tracheobronchial tree and mediastinum.²⁻⁵ The ice ball formed by freezing correlates well with the pathologic zone of ablation, and because the low-attenuating ice ball is visible by CT as it covers soft tissues during the freezing cycle, the operator is able to control the ablation zone with more precision than can be obtained with heat-based modalities.⁶⁻¹⁰

While RF ablation in the lung is hindered by the cooling effect of circulating air, cryoablation is relatively resistant to the cold-sink effects of ventilation.¹¹

The ability to precisely control the ablation zone makes cryoablation especially advantageous for treating tumors that are relatively close to the mediastinum, chest wall or blood vessels, whereas RFA risks causing mechanical or thermal injury to these structures.¹²

Cryoablation is reported to have less procedure-associated pain than RF due to the analgesic effect of cold on the intercostal nerves.¹³⁻¹⁸

Safety

As with the emergence of any rapidly evolving technology and its application, early published literature regarding the clinical application of lung cryoablation consists of technical descriptions, case series and early procedural outcomes. Cryoablation has now matured enough with significant accumulated data to support a safe procedure with comparable and even better efficacy to RFA.

- Wang H et al. performed more than 200 cryoablations of the thorax on primary lung cancer (88 percent) and metastasis (12 percent) in nonsurgical candidates. Cases were followed up for 12 months to evaluate the post-cryoablation response. By 6 months, 86 percent of treated areas were smaller or stable than the original tumor. The study was too short to determine long-term benefit, but patients did experience palliative benefits—their general health, appetite and weight gain improved, and their Karnofsky Performance Status increased significantly ($p < 0.01$).¹⁹
- Kawamura M et al. evaluated the safety and efficacy of cryoablation in 35 tumors in 20 patients and showed 1-year survival of 89.4 percent. In this group only 25 percent of the nodules were lung cancer and the remaining 75 percent were metastatic disease. The most common complication was pneumothorax in 50 percent of the procedures and required chest tube placement in only 4.5 percent of the cases. Self-limited hemoptysis was seen in 41 percent of patients. None of the patients died of the procedure. There were no treatment-related deaths or conversion to surgical intervention.²⁰
- Inoue et al. (2012) evaluated feasibility and safety during cryoablation of 396 lung tumors in 117 patients (104 with metastatic disease) in 193 sessions, with a mean follow-up period of 899 ± 778 days. All patients tolerated the procedure well, with minimal pain. No CTCAE grade 4 or 5 events and only three grade 3 events were observed. The most common complication was pneumothorax, which was observed in 61.7 percent of the treatment sessions. Of these, 10.9 percent of the cases required chest tube insertion, comparable to that associated with RF ablation.

These percentages included delayed and recurrent pneumothorax that occurred in 15 of the treatment sessions, resulting in 17 chest tube insertions. Inoue et al.

concluded that percutaneous cryoablation is minimally invasive and associated with improved safety.²¹

- Bang et al. (2012) used cryoablation on 10 patients with colorectal lung metastases (33 tumors) and, during 2 years of follow-up, only 6 out of 33 tumors recurred. The authors also concluded that the cryoablation was safe and cost-effective.²²
- Pusceddu et al. (2013) performed cryoablation on 32 patients (34 tumors)—11 with NSCLC and 21 with pulmonary metastases (15 from colorectal cancer) with only minor complications. At 6 months, complete ablation was confirmed in 91 percent of the cases.²³
- In a multicenter clinical trial, “Evaluating Cryoablation of Metastatic Lung/Pleura Tumors in Patients—Safety and Efficacy (ECLIPSE) trial”, (*JVIR* 2015) 40 patients (24 men and 16 women) with 60 lung metastases less than 3.5 cm in size treated during 48 cryoablation sessions, with a minimum of 12 months of follow-up. One-year overall survival rate was 97.5 percent. There were three Common Terminology Criteria for Adverse Events (CTCAE) grade-3 procedural complications during the immediate follow-up period (pneumothorax requiring pleurodesis, noncardiac chest pain and thrombosis of an arterio-venous fistula), with no grade 4 or 5 complications. The authors concluded that percutaneous cryoablation for the treatment of lung metastases of 3.5 cm or less is safe and early local tumor control rates are promising.²⁴
- Recently, Moore et al. (*JVIR* 2015) published their 5-year survival on 47 T1N0M0 NSCLCs in 45 consecutive patients between 2006 and January 2011. Major complications occurred in only 6.4 percent of patients, including two cases of hemoptysis and a prolonged placement of a chest tube requiring mechanical sclerosis in one patient. There were no deaths in the first 30 days after treatment. In their conclusion, cryoablation is associated with a good overall long-term survival with minimally significant complications.²⁵

Efficacy

Many studies have now shown that cryoablation does produce benefits equivalent to RF ablation in the short and longer term (2–5 years).

Kawamura et al. (2006) treated 20 patients with 35 lung tumors with cryoablation and followed them for up to 28 months (median 21 months for 18 patients). The primary

endpoint of this study was the early outcome and feasibility of cryoablation for metastatic tumors <3 cm. The secondary endpoint was tumor control. There were no treatment-related deaths or conversion to surgical intervention. Two patients had complete response, eight had partial response, eight had stable disease and two had progressive disease, thus resulting in a 50 percent response rate with 90 percent tumor control rate. The overall tumor recurrence rate was 54.3 percent. During the 9–12 month period, seven of the 18 (35 percent) patients developed a local recurrence of seven (20 percent) tumors. Five patients underwent additional cryoablation treatments without complication or local recurrence. Pneumothorax was reported in 50 percent of the cases, 27 percent experienced pleural effusion, 41 percent hemoptysis and 4.5 percent phrenic nerve palsy. The Kaplan Meier survival was 89.4 percent at 1 year and 83 percent at 28 months.²⁶

- Yamauchi et al. (2011) reported the use of percutaneous cryoablation for colorectal pulmonary metastases in 24 patients with 55 tumors during 30 treatment sessions. Follow-up scans were performed every 3–4 months after treatment. Pneumothorax was reported in 19 sessions with only 1 session requiring insertion of a chest tube.

A small amount of pleural effusion occurred in 21 sessions, none of which required a chest tube. The 1- and 3-year local progression-free intervals were 90.8 percent and 59 percent, respectively, and the 1- and 3-year overall survival rates were 91 percent and 59.6 percent.²⁷

- Yamauchi et al. (2012) reported on 22 patients with inoperable stage 1 NSCLC who were treated with cryoablation. At 3-years post-procedure, local tumor-free progression was 91 percent, overall survival 88 percent, and disease-free survival 67 percent. Yashiro et al. (2013) reported that after cryoablation of 210 pulmonary tumors (11 NSCLC and 199 metastases) in 71 patients, 68 percent of patients were free from local progression at 3 years. Again, size of the target lesion was an important prognostic factor; freedom from local progression was greater (84 percent at 3 years) if the ablated lesions were \leq 20 mm.²⁸
- Chou et al. (2015) reported midterm results of CT-guided cryoablation of 45 malignant lung tumors in 26 patients; 12 patients had primary lung cancer, and the other 14 had pulmonary metastases from a variety of primary cancers, including colon cancer. Although there were some immediate and short-term complications, only two (2.4 percent) were CTCAE grade 3, and none were grade 4 or 5. The overall survival rates for 1, 2 and 3 years were 96 percent, 88 percent and 88 percent, respectively. For curative intent, local tumor control rates for 1, 2 and 3 years were 75 percent, 72 percent and 72 percent.²⁹

- At least two studies have directly compared outcomes for cryoablation of lung tumors with other ablative technologies or surgery. Choe et al. (2009) carried out 76 ablative procedures in 65 patients with NSCLC (stages I-IV); 67 procedures were RF ablations and 9 were percutaneous cryoablations. Efficacy was judged by contrast CT immediately after the procedure, 1 month later and at 3-month intervals. Complete ablation was attained for 43 percent of the RF ablation patients and 67 percent of the cryoablation patients. For both modalities complete ablation was more likely for smaller tumors. Complete RF ablation was 76 percent for tumors < 3 cm and 28 percent for tumors > 3 cm; cryoablations were complete for 86 percent of tumors < 3 cm and 0 percent for 2 tumors > 3 cm. Patients undergoing cryoablation had no pain after the day of the procedure, but 37 percent of patients undergoing RF ablation experienced pain for longer. Survival rates were not reported separately for the two modalities. For all patients 1-, 2- and 3-year overall survival rates were 67 percent, 46 percent and 27 percent. For patients whose tumors were completely ablated, 1- and 2-year progression-free survival rates were 72 percent and 39 percent, respectively, compared to 1- and 2-year rates of 31 percent and 16 percent for patients with partial ablations.³⁰
- Zemlyak et al. (2010) treated 64 patients with stage 1 NSCLC; 25 underwent single lobe lung resection (SLR), 12 had tumors treated with RF ablation (RFA) and 27 with percutaneous cryoablation (PCT). The probability of 3-year survival for the SLR, RFA and PCT groups of 87 percent, 88 percent and 77 percent, respectively, was not significantly different ($p > 0.05$). The 3-year cancer-specific and cancer-free survival for SLR, RFA and PCT groups was 91 percent and 61 percent versus 88 percent and 50 percent versus 90 percent and 46 percent, respectively, indicating that cryoablation is as effective as RF and nearly as effective as lung resection.³¹
- In the ECLIPSE (Evaluating Cryoablation of Metastatic Lung/Pleura Tumors in Patients—Safety and Efficacy) Trial, 40 patients (24 men and 16 women) with 60 lung metastases less than 3.5 cm in size were treated during 48 cryoablation sessions, with a minimum of 12 months of follow-up. The most common primary cancers were colon (40 percent), kidney (23 percent) and sarcomas (8 percent).

Metastases size was 1.4 ± 0.7 cm [0.3–3.4]. Metastases were bilateral in 20 percent of cases. Cryoablation was performed under general anesthesia (67 percent) or conscious sedation (33 percent). Local tumor control rates were 56/58 (96.6 percent) and 49/52 (94.2 percent) at 6 and 12 months, respectively. Patient quality of life was unchanged over the follow-up period. One-year overall survival rate

was 97.5 percent. Two-year follow-up data are currently being gathered, and data collection will continue for 60 months.³²

- Recently, Moore et al. published their 5-year survival on 47 T1N0M0 NSCLCs in 45 consecutive patients between 2006 and January 2011. The 5-year survival rate was 67.8 percent \pm 15.3, the cancer-specific survival rate at 5 years was 56.6 percent \pm 16.5, and the 5-year progression-free survival rate was 87.9 percent \pm 9. The combined local and regional recurrence rate was 36.2 percent. In their conclusion, cryoablation was associated with a good overall long-term survival with minimally significant complications. Cryoablation is a potentially curative, viable therapeutic option for patients with stage I NSCLC who are deemed medically inoperable.³³

Thus, multiple peer-reviewed articles indicate efficacy comparable to RF ablation and, notably, none of the studies suggest that pulmonary cryoablation is *less* effective than RF ablation, which is approved by Medicare and insurance companies.

Thus, it is in this regard that this appeal is written for reconsideration and ultimate reversal of the decision of ineligibility for cryoablation rendered by the [INSURANCE COMPANY]. Please contact me directly for questions and concerns at [CONTACT INFORMATION].

Sincerely, [PHYSICIAN'S NAME]

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LETTER FOR MECHANOCHEMICAL VENOUS ABLATION

[DATE]

[CARRIER MEDICAL DIRECTOR]

[COVERAGE and POLICY DEPARTMENT]

[CARRIER NAME]

[CARRIER ADDRESS]

[CARRIER CITY, STATE ZIP]

RE: [PATIENT NAME]

[PATIENT ID]

SUBJECT: **Request for coverage and reimbursement for mechanochemical venous ablation**

Dear Colleague:

I am writing this letter to request [PRE-AUTHORIZATION/APPEAL] for coverage for mechanochemical venous ablation for patient [PATIENT'S NAME] (DOB: [INSERT DATE OF BIRTH]); [PATIENT ID].

We respectfully ask you to reconsider your designation of mechanochemical venous ablation (MOCA) as investigational. Marketed in the United States as the ClariVein[®] system, the efficacy, safety and resultant improvement in quality-of-life that results from the use of this FDA-approved device is supported by a number of publications in peer-reviewed journals.

Procedure and mechanism of action

Endovenous MOCA is a procedure that is used to close refluxing saphenous veins and their primary tributaries utilizing a mechanism of direct intimal injury within the lumen of the vein which purposefully abrades the intima and causes venospasm to allow for better efficacy of the sclerosant which is simultaneously injected. Since this ablation method does not use thermal energy, the potential for saphenous or sural nerve damage is minimized.

Following ultrasound imaging and marking of the patient's anatomy on the skin and a sterile prep and draping of the patient's extremity, a disposable catheter connected to a disposable motor drive is inserted into the target vein and advanced to just below the

deep vein junction. As the catheter is slowly pulled back, a wire rotates at 3500 rpm within the lumen of the vein, abrading the intima. At the same time, a liquid sclerosant (sodium tetradecyl sulfate) is infused near the rotating wire. It has been demonstrated that the combination of the mechanical and chemical effect results in vein closure better¹ than either method alone. The closure occurs with less pain² and reduced risk of saphenous or sural nerve injury (since there is no heat to injure the nerves) without the need for the tumescent anesthesia used with thermal endovenous ablation techniques (radiofrequency ablation [RFA] and endovenous laser treatment [EVLT]).

In terms of evidence supporting MOCA, I would submit that the published data has demonstrated a high rate of success and low complication rate, and the procedure has some advantages over some of the alternate available treatments. ClariVein[®] achieved FDA clearance through the 510(k) process in March 2008.

Supporting data

Supporting publications include a randomized controlled trial for treatment of the refluxing great saphenous vein (GSV), comparing MOCA with radiofrequency ablation procedure that has been approved by the FDA since 2000.² Several additional publications also support the safety and high rate of success of MOCA, similar to that following thermal ablation.³⁻¹² I present below a summary of some of the highlights of this literature.

Bootun et al.² conducted a randomized, controlled trial to assess intra-operative pain between MOCA and RFA in 117 patients/119 limbs (MOCA: 59; RFA: 60). Pain scores were measured using a validated 100 mm visual analogue scale (VAS) with mean maximum results being 19.3 mm for MOCA and 34.5 mm for RFA. The study demonstrated less intraprocedural pain for MOCA with equivalent improvement in clinical and patient-reported quality of life measures at one month with similar occlusion rates as documented by Duplex US. MOCA showed a faster return to work and normal activities. MOCA was associated with no adverse events, while RFA patients had a 3.4 percent incidence of thrombophlebitis and 1.7 percent incidence of nonocclusive popliteal vein deep vein thrombosis.

A number of comparative trials and prospective cohort studies have drawn similar conclusions. Among these studies was one by Ozen³ which looked at the 2-year results for MOCA treatment of the refluxing great saphenous vein. At that time interval, the saphenous occlusion rate was 95 percent, which was seen along with a significant

decrease in a physician derived score of the severity of venous disease in the treated limb (venous clinical severity score or VCSS).

Boeersma⁵ demonstrated the safety and efficacy of MOCA in the small saphenous vein as well, with a 94 percent 1-year occlusion of the treated vein with no major complications and decrease in the VCSS and patient reported pain score.

Vun et al.¹² assessed procedural pain for MOCA, RFA and endovenous laser ablation (EVLA) in 127 patients/147 veins (MOCA: 57; RFA: 50; EVLA: 40). Pain scores were collected by a nurse, blinded to the procedure, using VAS. Median pain scores were as follows: MOCA-1, RFA-5, EVLA-6. Technical success as evidenced by occlusion was similar for all three modalities with no major complications reported.

Van Eekeren et al.¹⁰ studied postoperative pain and early quality of life after RFA and MOCA in 68 patients (34 to each group). Occlusion rates were over 90 percent in each group. Pain was assessed with a 100 mm VAS and found mean procedural pain to be 22 mm for MOCA and 27 mm for RFA. Postoperative pain was measured at days 3 and 14 with MOCA mean pain to be 6.2 mm and 4.8 mm, while RFA mean pain was 20.5 mm and 18.6 mm. This demonstrated a 74 percent comparative reduction in postoperative pain at day 14. RFA patients were shown to use postoperative analgesics for 2.8 days on average compared to 0.5 days for MOCA patients. The median VCSS at week 6 showed a decrease from 3.0 to 1.0 for MOCA, while the RFA group decreased from 4.0 to 3.0. Quality of life outcomes were measured using the Aberdeen Varicose Vein Questionnaire (AVVQ) at 6 weeks and showed a change for the MOCA group from 7.1 to 5.0, and 9.5 to 4.5 in the RFA group. The authors stated that this was not clinically significant. MOCA and RFA patients returned to normal activities in one day, but the RFA group tended to take an extra day before returning to work. There were no major complications in either group.

Finally, I would like to note that the Society of Interventional Radiology, in partnership with the Society of Vascular Surgery and the American College of Phlebology, presented supportive testimony at the October 2015 CPT[®] panel meeting for this procedure. The AMA CPT[®] panel decided that mechanochemical procedures (MOCA) met the criteria for a CPT[®] Category I code, and two new codes describing MOCA went into effect in 2017.

Thanks for the courtesy of your review of this request, and I am available to go into further detail at your convenience.

Respectfully,

[SIR MEMBER'S NAME]

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LETTER FOR REPORTING UNLISTED CPT® CODE

[DATE]

Attn: [CONTACT NAME]

[TITLE]

[INSURANCE COMPANY NAME]

[ADDRESS]

Re: [PATIENT'S NAME]

Date of Birth: [DATE OF BIRTH]

Dates of Service: [Dates of Service]

Group Number: [Group Number]

Subscriber/Policy Number: [Subscriber/Policy Number]

To whom it may concern:

On [DATE OF SERVICE], Dr. [DOCTOR'S NAME] performed a [NAME OF PROCEDURE] on the above-mentioned patient. [PATIENT'S NAME] was diagnosed with [DIAGNOSIS AND OTHER ASSOCIATED SYMPTOMS OR COMORBIDITIES]. (If applicable, include additional information such as potential alternative treatments considered, or failed treatments with subsequent problems that may have occurred if the patient did not undergo the procedure. Also describe anticipated outcomes and the medical benefits of the treatment).

There is no specific listed Category I CPT® code for this procedure; therefore, I am submitting the following unlisted procedure code [INSERT UNLISTED CPT® CODE NUMBER AND DESCRIPTOR]. When considering the procedural technique, time, intensity, effort and equipment needed to perform this procedure, it is most comparable to the existing CPT® code [COMPARATOR CPT® CODE NUMBER AND DESCRIPTION]. [DEFINE ANY ADDITIONAL CHARACTERISTICS BETWEEN THE CODES FOR COMPARISON SAKE.]

The charge amount being submitted for this unlisted procedure is \$_____. This charge amount was developed by giving consideration to the comparison of work, time, intensity and effort, as well as the supplies and equipment used in the comparison code of [COMPARATOR CPT® CODE NUMBER]. We estimate this unlisted procedure to be approximately [LIST PERCENTAGE THAT CURRENT PROCEDURE IS LESS OR MORE

DIFFICULT THAN THE COMPARATOR CODE] [**LESS/MORE**] difficult for the reasons mentioned above.

Sincerely,

[**PHYSICIAN'S SIGNATURE**]

[**PRACTICE NAME**]

[**ATTACHMENTS TO INCLUDE: PROCEDURAL REPORT, CLINIC NOTES, PUBLISHED ARTICLES SUPPORTING THIS PROCEDURE.**]

Charge sheets

Patient
Date
Referring Physician
Diagnosis

Radiologist
Technologist
Fluoroscopic Time
Moderate Sedation Time

Provided By Same Phy

Provided By Others

SPINAL PROCEDURES		
	CPT	S&I
Puncture Shunt Tubing	61070	75809
Cervical Puncture w/o Inj.	61050	77003
Lumbar Puncture Diagnostic	62270 X	No image
Lumbar Puncture Diagnostic w/ Fluoro or CT	62328	Included
Lumbar Puncture Therapeutic	62272 X	No image
Lumbar Puncture Therapeutic w/ Fluoro or CT	62329	Included
Inj. Epidural Blood or Clot Patch	62273	77003
Diskography (Lumbar) Ea. Level	62290 X	72295 X
Diskography (Cerv/Thoracic) Ea. Level	62291 X	72285 X
Aspiration Nucleus Pulposus	62267	77003
Celiac Nerve Block	64530	77003
Sinogram Diagnostic	20501	76080
Sinogram Therapeutic	20500	76080
Inj. Diag or Therapeutic, Cerv/Thor w/o Image	62320	No image
Inj. Diag or Therapeutic, Cerv/Thor w/ Image	62321	Included
Inj. Diag or Therapeutic, Lumb/Sac w/o Image	62322	No image
Inj. Diag or Therapeutic, Lumb/Sac w/ Image	62323	Included
Inj. Indwelling Cath, Cerv/Thor w/o Image	62324	No image
Inj. Indwelling Cath, Cerv/Thor w/ Image	62325	Included
Inj. Indwelling Cath, Lumb/Sac w/o Image	62326	No image
Inj. Indwelling Cath, Lumb/Sac w/ Image	62327	Included
Nerve Root Blk/Transforaminal C/T w/Image	64479	Included
Nerve Root Blk/Transforaminal C/T Ea. Add	+64480 X	Included
Nerve Root Blk/Transforaminal L/S w/Image	64483	Included
Nerve Root Blk/Transforaminal Ea. Add.	+64484 X	Included
Facet Inj Cerv/Thor 1st W/Imaging	64490	Included
Facet Inj Cerv/Thor 2nd W/Imaging	+64491	Included
Facet Inj Cerv/Thor 3rd & More	+64492	Included
Facet Inj Lumb/Sac 1st W/Imaging	64493	Included
Facet Inj Lumb/Sac 2nd W/Imaging	+64494	Included
Facet Inj Lumb/Sac 3rd & More	+64495	Included
Neurolytic Inj/Inf Subarachnoid	62280	77003
Neurolytic Inj/ Cerv. Or Thor	62281	77003
Neurolytic Inj/Inf Single Epidural	62282	77003
Intercostal Nerve Block, Single	64420	77003
Intercostal Nerve Block, Multiple	64421	77003
Stellate Ganglion Block (Cervical)	64510	77003
Trig Pt Inj Sing/Multi 1-2 Muscles	20552	77002
Trig Pt Inj Sing/Multi 3or > Muscles	20553	77002
Sphenopalatine Inj with Fluoro	64505	77002
Destruction cerv/thor facet jnt; single	64633	Included
Destruction cerv/thor facet jnt; each add'l	+64634	Included
Destruction lumbar/sacral facet jnt; single	64635	Included
Destruction lumbar/sacral facet jnt; each add'l	+64636	Included
Injection, paravert w/US; cerv/thoracic single	0213T	Included
Injection, paravert w/US; cerv/thor 2nd level	+0214T	Included
Injection, paravert w/US; cerv/thor 3rd + level	+0215T	Included
Injection, paravert w/US; lumbar/sacral	0216T	Included
Injection, paravert w/US; lumb/sac 2nd level	+0217T	Included
Injection, paravert w/US; lumb/sac 3rd + level	+0218T	Included
Paravertebral block (PVB); thoracic	64461	Included
PVB; 2nd & any additional injection site(s)	+64462	Included
PVB; thoracic; continuous infusion by catheter	64463	Included

+ = Add-on code

SPINAL PROCEDURES		
	CPT	S&I
Inj of allogeneic cellular, lumbar, uni or bilat, 1st level	0627T	Includes Fluoro
Inj of allogeneic cellular, lumbar, uni or bilat, ea. addi	0628T	Includes Fluoro
Inj of allogeneic cellular, lumbar, uni or bilat, 1st level	0629T	Includes CT
Inj of allogeneic cellular, lumbar, uni or bilat, ea. addi	0630T	Includes CT

ARTHROGRAMS		
	CPT	S&I
Ankle	27648	73615
Elbow	24220	73085
Hip w/ anesthesia	27095	73525
Hip w/o anesthesia	27093	73525
Knee Inj. (for arthrogram or CT/MRI arthro)	27369	73580
Shoulder	23350	73040
SI Joint Inj. (CT or Fluoro is included)	27096	Included
Temporomandibular Joint (TMJ)	21116	70332
Wrist	25246	73115

ARTHROCENTESIS/ASPIRATION/INJECTION		
	CPT	S&I
Fluoroscopic Guidance		77002
Ultrasound Guidance		76942
Computed Tomography Guidance		77012
Magnetic Resonance Guidance		77021
Small Joint or Bursa; w/o US	20600	By modality except US
Small Joint or Bursa; w/ US	20604	Includes US
Intermediate Joint or bursa; w/o US	20605	By modality except US
Intermediate Joint or bursa; w/ US	20606	Includes US
Major Joint or Bursa; w/o US	20610	By modality except US
Major Joint or Bursa; w/ US	20611	Included
Ganglion Cyst(s) Any Location	20612	By modality
Bone Cyst	20615	By modality

MYELOGRAM		
	CPT	S&I
Cisternal/lateral C1-C2 puncture w/o inj	61050*	
Cisternal/lateral C1-C2 puncture w/ inj	61055*	
Injection for myelogram, Lumbar	62284*	
Cervical myelogram, via lumbar inj.	62302	Included
Thoracic myelogram, via lumbar inj.	62303	Included
Lumbosacral myelogram, via lumbar inj	62304	Included
Myelogram, two or more regions	62305	Included

**For radiological supervision and interpretation, see the Radiology section in CPT.*

VERTEBROPLASTY/ VERTEBRAL AUGMENTATION		
	CPT	S&I
Vertebroplasty (Cervicothoracic)	22510	Included
Vertebroplasty (Lumbosacral)	22511	Included
Vertebroplasty ea add. C/T or L/S	22512	Included
Sacroplasty, unilateral (1 or more needles)	0200T	Included
Sacroplasty, bilateral (2 or more needles)	0201T	Included
Kypho Thoracic One Vert Body	22513	Included
Kypho Lumbar One Vert Body	22514	Included
Kypho Eac add T or L Vert Body	22515	Included

Patient
Date
Referring Physician
Diagnosis

Radiologist
Technologist
Fluoroscopic Time
Moderate Sedation Time

Provided By Same Phy
Provided By Others

BIOPSY PROCEDURES		
	CPT	S&I
Fluoroscopic Guidance		77002
Ultrasound Guidance		76942
Computed Tomography Guidance		77012
Magnetic Resonance Guidance		77021
Abdomen/Retroperitoneal Perc	49180	By modality
Bone, Deep	20225	By modality
Bone, Superficial, Percutaneous	20220	By modality
Diagnostic bone marrow; aspiration(s)	38220	By modality
Diagnostic bone marrow; biopsy(ies)	38221	By modality
DX bone marrow: biopsy(ies) and aspiration(s)	38222	By modality
Liver	47000	By modality
Lung, Percutaneous or Medastinum	32408	Included
Lymph nodes Sup. percutaneous	38505	By modality
Muscle, Percutaneous	20206	By modality
Pancreas Percutaneous	48102	By modality
Parotid Bx / Salivary Gland	42400	By modality
Pleura, Percutaneous	32400	By modality
Prostate	55700	By modality
Renal, Percutaneous	50200	By modality
Spinal Cord	62269	By modality
Thyroid, percutaneous	60100	By modality
Transcatheter Biopsy	37200	75970

DRAINAGE PROCEDURES		
	CPT	S&I
Fluoroscopic Guidance		77002
Ultrasound Guidance		76942
Computed Tomography Guidance		77012
Magnetic Resonance Guidance		77021
Abscessogram (Tube Check)	49424	76080
Asp Abscess, Bulla, or Cyst, by needle	10160	By modality
Asp. of Bladder by Intracatheter	51101	By modality
Asp. of Bladder w/ Insert Suprapubic Cath.	51102	By modality
Aspiration of Bladder by Needle	51100	By modality
Change of Abscess Drain	49423	75984
Drain Spinal Cord Cyst	62268	By modality
Drainage by Cath, Peritoneal or Retroperitoneal	49406	Included
Drainage by Catheter, Soft Tissue	10030	Included
Drainage by Catheter, Visceral	49405	Included
Fistula or Sinus Tract Study/Sinogram	20501	76080
FNA Bx w/o Imaging, first lesion	10021	No image
FNA Bx w/o Imaging, ea add'l	+10004	No image
FNA Bx w/ Ultrasound, first lesion	10005	Included
FNA Bx w/ Ultrasound, ea add'l	+10006	Included
FNA Bx w/Fluoro, first lesion	10007	Included
FNA Bx w/Fluoro, ea add'l	+10008	Included
FNA Bx w/CT, first lesion	10009	Included
FNA Bx w/CT, ea add'l	+10010	Included
FNA Bx w/MR	10011	Included
FNA Bx w/MR, ea add'l	+10012	Included
Insert Indwelling Tunneled Pleural	32550	75989
Pericardiocentesis including imaging	33016	Included
Pericardial drainage w/indwelling cath, (6 yrs or older)	33017	Incl. Fluoro/US
Pericardial drainage w/indwelling cath, (Child < 6)	33018	Incl. Fluoro/US
Pericardial drainage w/indwelling cath	33019	Incl. CT
Insert Peritoneal Tunneled Cathw/Imaging	49418	Included
Para/Peritonecentesis w/ Imaging	49083	Included
Para/Peritonecentesis w/o Imaging	49082	No image
Peritoneal Lavage	49084	Included
Pleural Drainage w/ tube w/o Imaging	32556	No image
Pleural Drainage w/ tube with Imaging	32557	Included
Renal Cyst Aspiration w/ Needle	50390	By modality
Sclerotherapy of a fluid collection	49185	Included
Thoracentesis with Imaging	32555	Included
Thoracentesis without Imaging	32554	No image
Install agent for fibrinolysis, initial day	32561	No image
Install agent for fibrinolysis, sub day	32562	No image
Wire Localization of soft tissue	10035	Included
Wire Localization of soft tissue, ea. add.	10036	Included

ABLATION PROCEDURES			
	CPT	S&I	
Computed Tomography Guidance		77013	
Magnetic Resonance Guidance		77022	
Ultrasound Guidance		76940	
Bone Tumor(s), Cryoablation, Perc.	20983	Included	
Bone Tumor(s), RFA, Perc.	20982	Included	
Breast Tumor(s), RFA, Perc.	19499	By Modality	
Liver Tumor(s), Cryoablation, Perc.	47383	By Modality	
Liver Tumor(s), RFA, Perc.	47382	By Modality	
Liver Tumor(s), RFA, Open, US guide	47380*	76940	
Inj. Ablative Agent, Liver	47399	By Modality	
Lung Tumor(s), RFA, Perc., Unilateral	32998	Included	
Lung Tumor(s), Cryoablation, Perc., Unilateral	32994	Included	
Renal Tumor(s), Cryoablation, Perc.	50593	By Modality	
Renal Tumor(s), RFA, Perc.	50592	By Modality	
Renal Tumor(s), Cryo, Open, w/ US	50250*	Included	
Peripheral nerve, Upper extr distal, Cryoablation	0440T	Included	
Peripheral nerve, Lower extr distal, Cryoablation	0441T	Included	
Nerve plexus or other truncal, Cryoablation	0442T	Included	
IRE, Ablation, 1 or more tumors per organ, Percutaneous	0600T	Included	

*Use modifier -62 when service is provided by co-surgeons.

Inpatient Only Procedures

ENDOVASCULAR VARICOSE VEIN TREATMENTS			
	CPT	S&I	
Inj of non-compounded foam sclerosant, single extr. truncal vein	36465	Included	
Inj of non-compounded foam sclerosant, multi extr. truncal veins, same leg	36466	Included	
Endovenous ablation by transtheath delivery of a chemical adhesive, first vein	36482	Included	
Endovenous ablation by transtheath delivery of a chemical adhesive, subseq vein	36483	Included	
RFA extremity, perc., 1st vein	36475	Included	
RFA ext. perc., 2nd & subs.vein(s)	+36476	Included	
Laser EVAT, extrem., perc., 1st vein	36478	Included	
Laser EVAT, perc., 2nd & subs.vein(s)	+36479	Included	
Endovenous mechanochemical; first vein	36473	Included	
Endovenous mechanochemical; ea. addtl vein(s)	+36474	Included	

Catheterization is considered inherent to EVAT

OTHER VARICOSE VEIN TREATMENTS			
	CPT	S&I	
Inj. of sclerosing sol.-spider vein, limb/trunk	36468	N/A	
Inj of sclerosant, single vein other than spider vein	36470	76942	
Inj. of sclerosant - multi veins, same leg, other than spider veins	36471	76942	
Stab phleb of var veins; 1 extremity; 10-20	37765	N/A	
Stab phleb of var veins; 1 extremity; 21+	37766	N/A	

Do not report 36470, 36471 in conjunction with 37241 in the same surgical field

+ = Add-on code

Patient
Date
Referring Physician
Diagnosis

Radiologist
Technologist
Fluoroscopic Time
Moderate Sedation Time

Provided By Same Phy
Provided By Others

GASTROINTESTINAL PROCEDURES			
	CPT	S&I	
G-Tube Placement, Perc.	49440	Included	
J-Tube Placement, Perc.	49441	Included	
Cecostomy or other Colonic Tube	49442	Included	
Convert G-Tube to G-J Tube	49446	Included	
Gastro Tube Change (with fluoro)	49450	Included	
Replacement Dislodged J-Tube	49451	Included	
Replacement GJ Tube, Perc.	49452	Included	
Repl GJ Tube, Perc. incl remove w/o img/w/o revision tract	43762	N/A	
Repl GJ Tube, Perc. incl remove w/o img/w revision tract	43763	N/A	
Reposition Naso or Oro-Gastric Feeding Tube	43761	76000	
Contrast Inj. for any GI Tube	49465	Included	
Esophageal Dilation Over Guide Wire	43453	74360	
Nasogastric Tube Placement	43752	Included	
Mech. Removal Obstructed Material	49460	Included	
Injection of air or contrast into peritoneal cavity	49400	74190	

BILIARY PROCEDURES			
	CPT	S&I	
Percutaneous Cholecystostomy	47490	Included	
Inj. for Cholangiogram, Existing Access	47531	Included	
Inj. for Cholangiogram, New Access	47532	Included	
Perc. Placement Biliary Drainage (Ext.)	47533	Included	
Perc. Plcmt Biliary Drainage (Int.-Ext.)	47534	Included	
Convert Ext. Biliary Drainage to Int-Ext	47535	Included	
Exchange of Biliary Drainage Catheter	47536	Included	
Removal of Biliary Drainage Catheter	47537	Included	
Plcmt Bile Duct Stent(s), Existing Access	47538	Included	
Plcmt Bile Duct Stent(s), New w/o drainage	47539	Included	
Plcmt Bile Duct Stent(s), New w/drainage	47540	Included	
Plcmt access thru biliary tree, perc; new access	47541	Included	
Balloon dilation biliary duct/ampulla, perc.	+47542	Included	
Endoluminal Bx of biliary tree, perc	+47543	Included	
Removal calculi/debris fr. bile duct(s)/GB	+47544	Included	
Intraoperative Cholangiogram		74300	
Intraoperative Cholangiogram Additional		+74301	

URINARY PROCEDURES			
	CPT	S&I	
Aspiration/inj of renal cyst or pelvis, perc	50390	See note*	
Dilation of exist tract, perc., incl img guid	50436	Included	
Dilation existing tract, perc, incl img guid; new access	50437	Included	
Inj. antegrade nephro/ureterogram; new access	50430	Included	
Inj. antegrade nephro/ureterogram; exist access	50431	Included	
Plcmt nephro cath, perc incl. diag nephrogram	50432	Included	
Plcmt nephroureteral cath, perc incl. diag nephro	50433	Included	
Convert nephrostomy catheter	50434	Included	
Exchange nephrostomy catheter	50435	Included	
Remove & replace ext. nephroureteral cath	50387	Included	
Endoluminal bx of ureter/ renal pelvis	50606	Included	
Plmt of ureteral stent; existing nephrostomy tract	50693	Included	
Plmt of ureteral stent;new acc w/o sep nephro cath	50694	Included	
Plmt of ureteral stent;new acc w/sep nephro cath	50695	Included	
Ureteral embolization or occlusion	+50705	Included	
Transurethral destruction of prostate; by RF	53854	74485	
Balloon dilation, ureteral stricture	+50706	Included	

ERCP			
ERCP Biliary Ducts RS&I		74328	
ERCP Pancreatic Ducts RS&I		74329	
ERCP Pancreatic and Biliary Ducts RS&I		74330	
ERCP	43260	See above	
ERCP w/ biopsy	43261	See above	
ERCP for Spinicterotomy/Papillotomy	43264	See above	
ERCP calculus/calculi Removal	43265	See above	
ERCP calculus/calculi Destruction	43266	See above	
ERCP Duct Stent Placement	43274	See above	
ERCP Remove Foreign Body/Stent from duct	43275	See above	
ERCP Stent Exchange with Dilation	43276	See above	
ERCP Dilation or Duct(s) or Ampulla, ea. Du	43277	See above	
Esophagus Dilation	43453	74360	

OTHER INTRODUCTION (INJECTION, CHANGE, REMOVAL)			
	CPT	S&I	
Chg of ureterostomy tube/ureteral stent	50688	75984	
Whitaker Test	50396	74425	
Nephrostolithotomy <2cm	50080	See note**	
Nephrostolithotomy >2cm	50081	See note**	
Ileoconduit Injection	50690	74425	
Inj. Cystogram/Voiding Urethrocytogram	51600	See note***	
Cystography/VCU w/Chain	51605	74430	
Urethrocytogram, Retrograde	51610	74450	
Change Cystostomy Tube, Simple	51705	75984	
Change Cystostomy Tube, Complex	51710	75984	

FALLOPIAN DILATATION			
	CPT	S&I	
Hysterosalpingogram (HSG)	58340	74740	
HSG, w/ or w/o color flow	58340	76831	
Fallopian Dilatation	58345	74742	

TIPS			
	CPT	S&I	
TIPS	37182	Included	
TIPS Revision	37183	Included	

Inpatient Only Procedures

Notes:

*Code 50390 for radiological S&I, see 74425, 74470, 76942, 77002, 77012, 77021

**Code 50080 and 50081, for fluoroscopic guidance, see 76000

***Code 51600, For radiological supervision and interpretation, see 74430, 74455)

+ = Add-on code

Patient
Date
Referring Physician
Diagnosis

Radiologist
Technologist
Fluoroscopic Time
Moderate Sedation Time
Provided By Same Phy
Provided By Others

LOWER EXTREMITY ENDOVASCULAR REVASCULARIZATION

ILIAC VASCULAR TERRITORY			
	CPT	S&I	
Percutaneous Transluminal Angioplasty (PTA), unilateral	37220	Included	
Stent Placement(s) w/ PTA when performed, unilateral	37221	Included	
PTA each add'l ipsilateral iliac vessel	37222	Included	
Stent Placement(s) w/ PTA within same vessel when performed, ea. add'l vessel	37223	Included	
EVAR iliac artery at the time of aortoiliac artery endograft plcmnt, unilateral	+34717	Included	
EVAR iliac artery, not associated with plcmnt of an aorto-iliac artery endograft, unilateral	34718	Included	

FEMORAL/ POPLITEAL VASCULAR TERRITORY			
	CPT	S&I	
Percutaneous Transluminal Angioplasty (PTA), unilateral	37224	Included	
Atherectomy w/ PTA within same vessel when performed, unilateral	37225	Included	
Stent Placement(s) w/ PTA within same vessel when performed, unilateral	37226	Included	
Stent and Atherectomy w/ PTA within same vessel when performed, unilateral	37227	Included	

TIBIAL/ PERONEAL VASCULAR TERRITORY			
	CPT	S&I	
Percutaneous Transluminal Angioplasty (PTA), unilateral	37228	Included	
Atherectomy w/ PTA within same vessel when performed, unilateral	37229	Included	
Stent Placement(s) w/ PTA within same vessel when performed, unilateral	37230	Included	
Stent and Atherectomy w/ PTA within same vessel when performed, unilateral	37231	Included	
PTA, each add'l ipsilateral tibial/peroneal vessel	+37232 X_	Included	
Atherectomy w/ PTA within same vessel when performed, ea. add'l vessel	+37233 X_	Included	
Stent Placement(s) w/ PTA within same vessel when performed, ea. add'l vessel	+37234 X_	Included	
Stent and Atherectomy w/ PTA within same vessel when performed, ea. add'l vessel	+37235 X_	Included	

ARTHRECTOMY SUPRA-INGUINAL ARTERIES			
	CPT	S&I	
Renal Artery	0234T	Included	
Visceral Artery (except renal) each vessel	0235T	Included	
Abdominal Aorta	0236T	Included	
Brachiocephalic Trunk and Branches, each vessel	0237T	Included	
Iliac Artery, each vessel	0238T	Included	

Category III codes to describe transluminal atherectomy above Inguinal ligaments percutaneously and/or through open surgical exposure (includes RS&I)

Inpatient Only Procedures

+ = **Add-on code**

Patient
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Technologist
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Provided By Same Phy
Provided By Others

SELECTIVE CATHETER PLACEMENTS	1st	2nd	3rd	Add'l 2nd &	
ARTERIAL	ORDER	ORDER	ORDER	3rd Order	
Non-selective Aortic Arch Inj w/ all Imaging	36221				
Selective Innominate or CCA w/ Cerv Carotid Imaging, uni	36222				
Selective Innominate or CCA w/ Cerv/Cerebral Imaging, uni	36223				
Selective ICA w/ Cerv/Cerebral Imaging, uni	36224				
Selective Innominate or Subclavian w/ Vertebral Imaging, uni	36225				
Selective Vertebral w/ Vertebral Imaging, uni	36226				
Selective External Carotid Artery w/ Ext. Carotid Imaging	+36227*	<i>*Do not code 36227 more than once per side</i>			
Selective Intracranial Branch of ICA or Vertebral w/ img, ea. add.	+36228**	<i>**Max 2X per side</i>			
Selective extracranial vertebral or subclavian branches	+36218***	<i>***Use in conjunction with 36225 or 36226 respectively</i>			
Selective Arterial, Spinal above Diaphragm	36215	36216	36217	+36218	
Selective Spinal/Lumbar below Diaphragm	36245	36246	36247	+36248	
Celiac	36245	36246	36247	+36248	
SMA	36245	36246	36247	+36248	
IMA	36245	36246	36247	+36248	
Renal, Selective, Unilateral, angiogram included	36251				
Renal, Selective, Bilateral, angiogram included	36252				
Renal, Superselective (one or more second order or higher renal artery branches); Unilateral	36253				
Renal, Superselective (one or more second order or higher renal artery branches); Bilateral	36254				
Iliac, Ipsilateral	36245	36246	36247	+36248	
Common Iliac, Contralateral	36245	36246	36247	+36248	
Common Femoral, Ipsilateral, Retrograde	36245	36246	36247	+36248	
Common Femoral, Contralateral	N/A	36246	36247	+36248	
Right Heart or Pulmonary ,Trunk only	36013	N/A	N/A	N/A	
Left Pulmonary (Includes Pressures)	N/A	36014	36015	36015	
Right Pulmonary (Includes Pressures)	N/A	36014	36015	36015	
Bronchial Intercostal Arteries & Branches	36215	36216	36217	36218	
Closure Device Placement Vascul	G0269				

SELECTIVE CATHETER PLACEMENTS	1st	2nd	3rd	Add'l 2nd &
VENOUS	ORDER	ORDER	ORDER	3rd Order
Right Renal	36011	36012	36012	36012
Left Renal	36011	36012	36012	36012
Jugular	36011	36012	36012	36012
Left Adrenal	N/A	36012	36012	36012
Right Adrenal	36011	36012	36012	36012
Epidural	36011	36012	36012	36012
Portal Venogram	36481			
Other Venous Vascular Family	36011	36012	36012	36012
Selective Venous Blood Sampling	36500	75893		

NON-SELECTIVE VASCULAR CATHETERIZATIONS	CPT
Aorta Catheter (Femoral, Brach., Axillary)	36200
Extremity Artery, Needle/Intracath. Uni	36140
Arterial Cath. Sampling	36620
Ext. Vein Needle/Intracath, Uni	36005
Aorta (Translumbar)	36160
Carotid/Vertebral, direct puncture	36100
Retrograde Brachial	36120
Superior or Inferior Vena Cava, Catheter	36010
Jugular Vein	36299
Injection; Lymphangiography	38790

MISCELLANEOUS	CPT
Closure Device	G0269
CT, limited or localized follow-up	76380
US Guidance for Vascular Access	+76937
3D Reconstruction w/o Independent	76376
3D Reconstruction w/ Independent	76377
Anatomic model 3D-printed; 1st anatomic structure	0559T
Anatomic model 3D-printed; each additional anatomic structure	+0560T
Anatomic model 3D-printed; 1st anatomic guide	0561T
Anatomic model 3D-printed; each additional anatomic guide	+0562T

+ = Add-on code

Notes: CATHETERIZATION CODING CONVENTIONS

- 1) Code multiple catheterizations in the same vascular family to the highest order
- 2) Use the "Each Additional" code for each additional second or third order vessel within the same vascular family
- 3) Code catheterizations of different vascular families separately

Patient
Date
Referring Physician
Diagnosis

Radiologist
Technologist
Fluoroscopic Time
Moderate Sedation Time

Provided By Same Phy
Provided By Others

ARTERIOGRAPHY SUPERVISION & INTERPRETATION S&I	
Thoracic Aortogram	75605
Abdominal Aortogram	75625
Abdominal Aortogram w/Run Offs	75630
Brachial, Retrograde	75658
Spinal, Intercostal, Lumbar (Selective)	75705 X
Extremity, Unilateral, Upper or Lower	75710
Extremity, Bilateral, Upper or Lower	75716
Visceral (w or w/o aorta) Ea. Vessel	75726 X
Adrenal Unilateral (Selective)	75731
Adrenal Bilateral (Selective)	75733
Pelvic, Each Vessel (Selective)	75736 X
Pulmonary, Unilateral (Selective)	75741
Pulmonary, Bilateral (Selective)	75743
Pulmonary, Non-Selective	75746
Internal Mammary	75756
Each Add Vessel After Basic	+75774 X

THROMBOLYSIS AND INFUSION THERAPY	CPT	S&I
Arterial thrombolytic infusion, other than coronary or intracranial	37211	Included
Venous infusion for thrombolysis	37212	Included
Continued thrombolytic infusions(s) on subsequent day(s)	37213	Included
Thrombolytic infusion(s) final day of therapy	37214	Included
Perc Art Mech Thrombectomy/Infusion for Thrombolysis, intracranial	61645	Included
Endovasc Intracranial Admin of Pharma agent, non-thrombolysis, initial	61650	Included
Endovasc Intracranial Admin of Pharma agent, non-thrombolysis, each add'l	+61651	Included
Thrombolysis, cerebral, by intravenous infusion	37195	Included

MECHANICAL THROMBECTOMY	CPT	S&I
Primary Arterial Mech Thromb - initial vessel	37184	Included
Primary Arterial Mech Thromb -2nd/and all subsequent vessel(s)	+37185	Included
Secondary Mech Thromb- "rescue", suction, snare basket	+37186	Included
Venous Mech Thromb - Day 1	37187	Included
Ven Mech Thromb - repeat thrombectomy on subs. day	37188 X	Included

VENOGRAPHY SUPERVISION & INTERPRETATION	S&I
Extremity, Unilateral	75820
Extremity, Bilateral	75822
IVC	75825
SVC	75827
Renal, Unilateral (Selective)	75831
Renal, Bilateral (Selective)	75833
Adrenal, Unilateral (Selective)	75840
Adrenal, Bilateral (Selective)	75842
Sinus or Jugular	75860
Superior Sagittal Sinus	75870
Epidural	75872
Orbital	75880
Hepatic w/Hemodynamic Eval	75889
Hepatic Wedge Pressure (no venogram)	75889-52
Hepatic w/o Hemodynamic Eval	75891
Transhepatic Portogram/Pressure	75885
Venous Sampling (eg. Renins)	75893 X

INTRAVASCULAR ULTRASOUND (IVUS)	CPT	S&I
IVUS initial noncoronary vessel	+37252	Included
IVUS Each additional vessel IVUS	+37253	Included

PERCUTANEOUS ANGIOPLASTY	CPT	S&I
Except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit		
PTA, initial artery	37246	Included
PTA, each additional artery	+37247	Included
PTA, initial vein	37248	Included
PTA, each additional vein	+37249	Included

EMBOLIZATION (NON-HEAD/NECK)	CPT	S&I
Venous, other than hemorrhage	37241	Included
Arterial, other than hemorrhage	37242	Included
Tumors, organ ischemia, or infarction	37243	Included
Arterial or venous hemorrhage or lymphatic extravasation	37244	Included
Chemotherapy administration, intra-arterial; push technique	96420	N/A
Radiopharmaceutical therapy, by intra-arterial particulate administration	79445	

INTRACRANIAL DILATION, ANGIOPLASTY, STENT	CPT
Intracranial angioplasty	61630
Intracranial angioplasty w/ stent	61635
Dilatation of intracranial vasospasm; initial vessel	61640
each add'l vessel same vascular territory	+61641 X
each add'l vessel different vascular territory	+61642 X

EMBOLIZATION (HEAD OR NECK)	CPT	S&I
Cerebral Balloon Occlusion Test (BOT), temporary	61623	Included
Embolization Central Nervous System (CNS), permanent	61624	75894
Embolization Non-CNS, head or neck	61626	75894
F/U Angio study for transcath therapy, embo or infusion, other than thrombo		75898

Includes selective catheterization and all imaging of target vessel

DIALYSIS ACCESS INTERVENTIONS	CPT	S&I
Intro Cath Dialysis Circuit	36901	Included
Intro Cath Dialysis Circuit w/ Angioplasty	36902	Included
Intro Cath Dialysis Circuit w/ Angioplasty and Stent	36903	Included
Mech Thrombectomy or Thrombolysis	36904	Included
Mech Thrombectomy or Thrombolysis w/ Angioplasty	36905	Included
Mech Thrombectomy or Thrombolysis w/ Angioplasty and Stent	36906	Included
Angioplasty, Central Dialysis Segment	+36907	Included
Angioplasty, Central Dialysis Segment w/ Stent	+36908	Included
Dialysis circuit permanent vascular embolization or occlusion	+36909	Included
Extremity Venogram	N/A	75820

INTRAVASCULAR STENTS (Non-Coronary/Non-Carotid/Non-Vertebral/Non-Intracranial/Non-Lower Ext.)	CPT
Intravascular Stent, open or perc., initial artery	37236
Intravascular Stent, open or perc., ea. add'l artery	+37237
Intravascular Stent, open or perc., initial vein	37238
Intravascular Stent, open or perc., ea. add'l vein	+37239
INTRAVASCULAR STENTS (Cervical Carotid)	
Intravascular Stent w/ distal embolic protection	37215*
Intravascular Stent w/o distal embolic protection	37216*
INTRAVASCULAR STENTS (Extracranial Vertebral/Intrathoracic Carotid)	
Intravascular Stent, open or perc; initial vessel	0075T*
Intravascular Stent, open or perc; each addl. vessel	+0076T*

TRANSCATHETER THERAPY MISC.	CPT	S&I
Foreign Body Retrieval	37197	Included
IVC Filter Insertion	37191	Included
IVC Filter Repositioning	37192	Included
IVC Filter Retrieval (Removal)	37193	Included

Stent codes include RS&I and angioplasty in the same vessel when performed
**Includes all ipsilateral selective cath, target vessel angiography and RS&I*

Inpatient Only Procedures

+ = Add-on code

Patient
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Technologist
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Provided By Others

CENTRALLY INSERTED DEVICE	CPT	S&I
Fluoro guidance for CVA device plcmt/replacement/removal		+77001
Ultrasound guidance for vascular access		+76937
Non-Tunneled (Child < 5)	36555	By modality(ies)
Non-Tunneled (5 years or older)	36556	By modality(ies)
Tunneled (Child <5) No Port, No Pump	36557	By modality(ies)
Tunneled (5 years or older) No Port, No Pump	36558	By modality(ies)
Tunneled Cath. w/ Port (Child <5)	36560	By modality(ies)
Tunneled Cath. w/ Port (5 years or older)	36561	By modality(ies)
Tunneled Cath. w/ Pump	36563	By modality(ies)
2 Tunneled Cath, 2 Access(no port/pump) (Tesio)	36565	By modality(ies)
2 Tunneled Cath, 2 Access Sites, w/ Port	36566	By modality(ies)

PERIPHERALLY INSERTED DEVICE - WITHOUT IMAGE GUIDANCE	CPT	S&I
Non-Tunneled PICC w/o img guidance; (Child < 5)	36568	N/A
Non-Tunneled w/o img guidance; (5 years or older)	36569	N/A

PERIPHERALLY INSERTED DEVICE - WITH IMAGE GUIDANCE	CPT	S&I
Peripherally-inserted central venous catheter, (w/o SQ port/pump) incl all img; (Child < 5)	36572	Included
Peripherally-inserted central venous catheter, (w/o SQ port/pump) incl all img; (5 years or older)	36573	Included

PERIPHERALLY INSERTED DEVICE WITH PORT	CPT	S&I
Fluoro guidance for CVA device plcmt/replacement/removal		+77001
Ultrasound guidance for vascular access		+76937
Peripherally-inserted central venous access device (SQ port) (Child < 5 years)	36570	By modality(ies)
Peripherally-inserted central venous access device (SQ port) w/ Port (5 years or older)	36571	By modality(ies)

REPAIR	CPT	S&I
Tunneled or non-tunneled CVA, w/o port or pump, central or peripheral	36575	N/A
Tunneled or non-tunneled CVA, w/ port or pump, central or peripheral	36576	N/A

REPLACEMENT	CPT	S&I
Fluoro guidance for CVA device plcmt/replacement/removal		+77001
Ultrasound guidance for vascular access		+76937
Replace, catheter only , of CVA device, w/ port or pump, central or peripheral	36578	By modality(ies)
Replace, complete, non-tunneled centrally inserted CVC, w/o port or pump, same access	36580	By modality(ies)
Replace, complete, tunneled, centrally inserted CVC, w/o port or pump, same access	36581	By modality(ies)
Replace, complete, tunneled, centrally inserted CVA device, w/ port,same access	36582	By modality(ies)
Replace, complete, tunneled, centrally inserted CVA device, w/ pump, same access	36583	By modality(ies)
Replace, complete, PICC, w/o port or pump, same access, incl all img guide, RS&I	36584	Included
Replace, complete, PICC, w/ port, same access	36585	By modality(ies)

REMOVAL	CPT	S&I if performed
Removal non-tunneled, no port no pump	E/M	N/A
Removal of tunneled central venous catheter, w/o port or pump	36589	+77001
Removal of tunneled central venous access device, w/ port or pump, central or peripheral	36590	+77001

CENTRAL/PERIPHERAL CVA DEVICE MAINTENANCE	CPT	S&I
Repositioning central venous catheter under fluoroscopic guidance	36597	76000
Thrombolytic declotting of vascular access	36593	N/A
CVA maintenance fibrin stripping (sep access)	36595*	75901
CVA maintenance through lumen (brushing)	36596	75902

OTHER IMAGING FOR CENTRAL/PERIPHERAL DEVICE	S&I
Computed tomography, limited or localized follow-up study	76380
Fluoroscopy (separate procedure), up to 1 hour	76000
SVC gram	75827
IVC gram	75825
Venography, extremity, unilateral	75820
Venography, extremity, bilateral	75822

+ = Add-on code

* (For venous catheterization, see 36010-36012)

Patient
Date
Diagnosis

Radiologist
Referring Physician

EVALUATION & MANAGEMENT SERVICES

OFFICE/OUTPATIENT VISITS - NEW PATIENT

CPT	History and/or Exam	Medical Decision Making	Total Time on date of encounter
99202	Medically Appropriate	Straightforward	15-29 minutes
99203	Medically Appropriate	Low	30-44 minutes
99204	Medically Appropriate	Moderate	45-49 minutes
99205	Medically Appropriate	High	60-74 minutes

OFFICE/OUTPATIENT VISITS - ESTABLISHED PATIENT

CPT	History and/or Exam	Medical Decision Making	Total Time on date of encounter
99211	Medically Appropriate	N/A	N/A
99212	Medically Appropriate	Straightforward	10-19 minutes
99213	Medically Appropriate	Low	20-29 minutes
99214	Medically Appropriate	Moderate	30-39 minutes
99215	Medically Appropriate	High	40-54 minutes

***OUTPATIENT PROLONGED SERVICES ADD-ON NEW OR ESTABLISHED PATIENT (WHEN USING Time-based only)**

CPT/HCPCS	Add onto Level 5 visit	Total Add-on Time	Total Time on date of encounter
+ 99417	99205 or 99215	Each additional 15 minutes	New Patient 75 minutes or longer, Established patient 55 minutes or longer
+ G2212	99205 or 99215	Each additional 15 minutes	New Patient 89 minutes or longer, Established patient 69 minutes or longer

OUTPATIENT CONSULT - NEW OR ESTABLISHED PATIENT

CPT	History and Exam	Medical Decision Making	Presenting Problem	Face-to-Face Time
99241	Problem-Focused	Straightforward	Self-Limited or Minor	15 minutes
99242	Expanded Problem-Focused	Straightforward	Low to Moderate	30 minutes
99243	Detailed	Low	Moderate	40 minutes
99244	Comprehensive	Moderate	Moderate to High	60 minutes
99245	Comprehensive	High	Moderate to High	80 minutes

INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

Required Components: 3/3

CPT	History and Exam	Medical Decision Making	Presenting Problem	Face-to-Face Time
99221	Detailed or Comprehensive	Straightforward or Low	Low	30 minutes
99222	Comprehensive	Moderate	Moderate	50 minutes
99223	Comprehensive	High	High	70 minutes

***INPATIENT CONSULT- NEW OR ESTABLISHED PATIENT**

Required Components: 3/3

CPT	History and Exam	Medical Decision Making	Presenting Problem	Face-to-Face Time
99251	Problem-Focused	Straightforward	Self-Limited or Minor	20 minutes
99252	Expanded Problem-Focused	Straightforward	Low to Moderate	40 minutes
99253	Detailed	Low	Moderate	55 minutes
99254	Comprehensive	Moderate	Moderate to High	80 minutes
99255	Comprehensive	High	Moderate to High	110 minutes

POSTOPERATIVE FOLLOW-UP VISIT

99024	E/M was performed during a postop period for a reason(s) related to the original procedure
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Modifier 25- To report a separate and distinct E/M service with a non-E/M service performed on the same date

*Local Medicare Part B contractors and/or A/B MACs will no longer recognize consultation codes (ranges 99241-99245, and 99251-99255) for inpatient facility and office/outpatient settings.

Patient
Date
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Diagnosis

Radiologist
Physician # 2
Technologist
Fluoroscopic Time
Moderate Sedation Time
Provided By Same Phy
Provided By Others

AAA-TA-IA ENDOVASCULAR REPAIR

CATHETERIZATION: SELECTIVE	1st	2nd	3rd	Add'l 2nd & 3rd Order
Arterial Vascular Family	ORDER	ORDER	ORDER	
Iliac, Ipsilateral	36245	36246	36247	+36248 X_
Common Iliac, Contralateral	36245	36246	36247	+36248 X_
Common Femoral, Ipsilateral	36245	36246	36247	+36248 X_
Common Femoral, Contralateral	36245	36246	36247	+36248 X_
Common Iliac or Femoral, Axillary or Brachial Approach	36245	36246	36247	+36248 X_
Other Abdominal Aorta Vascular Family	36245	36246	36247	+36248 X_

ENDOASCULAR REPAIR OF THE INTRARENAL AORTA	CPT	S&I
EVAR infrarenal aorta w/ aorto-aortic tube endograft, other than rupture	34701	Included
EVAR infrarenal aorta w/ aorto-aortic tube endograft, rupture	34702	Included
EVAR infrarenal aorta w/ aorto-uni-iliac endograft, other than rupture	34703	Included
EVAR infrarenal aorta w/ aorto-uni-iliac endograft, rupture	34704	Included
EVAR infrarenal aorta w/ aorto-bi-iliac endograft, other than rupture	34705	Included
EVAR infrarenal aorta w/ aorto-bi-iliac endograft, rupture	34706	Included
EVAR iliac artery at the time of aortoiliac artery endograft plemnt, unilateral	+34717	Included
EVAR iliac artery, not associated with plemnt of an aorto-iliac artery endograft, unilateral	34718	Included
EVAR iliac artery w/ ilio-iliac tube endograft, other than rupture	34707	Included
EVAR iliac artery w/ ilio-iliac tube endograft, rupture	34708	Included
Plemnt of ext endograft dist common iliac/ prox renal artery(ies) same set as init plemnt	+34709	Included
Delayed plemnt of extension(s) in a different setting	34710	Included
Delayed plemnt of extension(s) in a different setting; each add'l vessel treated	+34711	Included
Placement of endoanchors	34712	Included
Percutaneous closure of femoral artery from large (12 French or greater) sheath	+34713	Included

TA ENDOPROTHESIS DEPLOYMENT	CPT	S&I
TA endo repair w/ coverage of subclavian origin	33880**	75956
TA endo repair w/o coverage of subclavian origin	33881**	75957
Open subcl. to carotid transpositio in conj w/ TA endo repair, neck incision	33889***	N/A
Graft other than vein, transcervical retropharyngeal carotid-carotid with TA	33891***	N/A

TA EXTENSIONS/CUFFS DEPLOYMENT	CPT	S&I
Placement of proximal extension prosthesis; initial extension	33883**	75958
Placement of proximal extension prosthesis; each add'l proximal extension	+33884** X_	75958
Placement of distal extension prosthesis delayed after desc TA endo repair	33886**	75959

TRANSLUMINAL BALLOON ANGIOPLASTY	CPT	S&I
PTA, initial artery	37246	Included
PTA, each additional artery	+37247	Included
PTA, initial vein	37248	Included
PTA, each additional vein	+37249	Included

INTRAVASCULAR ULTRASOUND	CPT	S&I
Intravascular ultrasound; initial (non coronary) vessel	+37252	N/A
Intravascular ultrasound; each add'l (non coronary) vessel	+37253	N/A

INTRAVASCULAR STENTS	CPT	S&I
Other than lower ext., for occlusive disease, cervical carotid, extra/intracranial or coronary		
Transcath placement of intravascular stent, open or percutaneous; initial artery	37236*	N/A
Transcath placement of intravascular stent, open or percutaneous; each add'l artery	+37237* X_	N/A
Transcath placement of intravascular stent, open or percutaneous; initial vein	37238*	N/A
Transcath placement of intravascular stent, open or percutaneous; each add'l vein	+37239* X_	N/A
Transcath placement of intravascular stent, open ipsilateral cervical carotid artery expos	37217*	N/A

OTHER	CPT	S&I
US guidance for vascular access		+76937
CT, limited or localized follow-up		76380

+ = Add-on code

CATHETERIZATION: NON-SELECTIVE	CPT
Report cath codes in addition to exposure	
Introduction of catheter, aorta (Femoral, Brachial, Axillary)	36200*
Introduction of needle or intracatheter; extremity artery	36140*
EXPOSURE FOR ENDOPROSTHESIS	CPT
Open femoral artery exposure	34812***
Placement of femoral-femoral prosthetic graft	+34813**
Open iliac artery exposure	34820***

FENESTRATED ENDOVAS REPAIR VISCERAL/INFRARENAL AORTA	CPT
Endo repair of visceral aorta; incl. one visceral artery endoprosth.	34841
Endo repair of visceral aorta; incl. two visceral artery endoprosth.	34842
Endo repair of visceral aorta; incl. three visceral artery endoprosth.	34843
Endo repair of visceral aorta; incl. four or more visceral artery endoprosth.	34844
Endo repair visel aorta/infrarenal abd aorta; one visel artery endoprosth.	34845
Endo repair visel aorta/infrarenal abd aorta; two visel artery endoprosth.	34846
Endo repair visel aorta/infrarenal abd aorta; three visel artery endoprosth.	34847
Endo repair visel aorta/infrarenal abd aorta; four + visel artery endoprosth.	34848
Phys. plan patient-specific fen visel aortic endograft- min. 90mins. phys. time	34839

OCCCLUSION DEVICE	CPT
Endovascular placement iliac occlusion device	+34808

OPEN CONVERSION	CPT
Open repair infrarenal aortic aneurysm endo repair; tube prosthesis	34830**
Open repair infrarenal aortic aneurysm endo repair; aorto-bi-iliac prosthesis	34831**
Open repair infrarenal aortic aneurysm endo repair; aorto-bifem prosthesis	34832**

BYPASS	CPT
Bypass graft, with vein; femoral-popliteal	35556***
Bypass graft, with other than vein; femoral-popliteal	35656***

THROMBOENDARTERECTOMY	CPT
Thromboendarterectomy, incl. patch graft; iliofemoral	35355***
Thromboendarterectomy, incl. patch graft; common femoral	35371***
Thromboendarterectomy, incl. patch graft; deep femoral (profunda)	35372***

EMBOLECTOMY THROMBECTOMY	CPT
Embolectomy/thrombectomy, w/ w/o catheter; fem-pop, aortoiliac artery, leg incision	34201***
Embolectomy/thrombectomy, w/ w/o catheter; pop-tibio-peroneal artery, leg incision	34203***

ARTERIAL REPAIR	CPT
Repair blood vessel, direct; lower extremity	35226***
Repair blood vessel with vein graft; lower extremity	35256***
Repair blood vessel with graft other than vein; lower extremity	35286***

Inpatient Only Procedures

*For bilateral procedure, use modifier 50

**For two Surgeons (Co-Surgeons), use modifier 62

***For bilateral procedure and two surgeons, use modifiers 50 and 62

-Stents placed inside the endoprosthesis treatment zone are not separately reportable.

-Balloon dilatation of endoprosthesis is not separately reportable.

-Multiple cuffs in the same vessel are not reportable beyond the first.

-Code caths of different vascular families separately per standard catheter coding conventions.

-Code Multiple Caths in the Same Vascular Family to the Highest Order.

-Use the "Each Additional" Code for Each Add'l 2nd or 3rd Order Vessel.

Patient
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Technologist
Moderate Sedation Time
Provided By Same Phy
Provided By Others

BREAST CORE NEEDLE BIOPSY	CPT	S&I	
Stereotactic guidance, 1st lesion	19081	Included	
Stereotactic guidance, each additional lesion	+19082 X	Included	
Ultrasound guidance, 1st lesion	19083	Included	
Ultrasound guidance, each additional lesion	+19084 X	Included	
Magnetic resonance guidance, 1st lesion	19085	Included	
Magnetic resonance guidance, each additional lesion	+19086 X	Included	
Tomosynthesis guidance without stereotactic	19499		

Breast Biopsy includes imaging, localization device, and imaging of biopsy specimen, when performed

BREAST LOCALIZATION DEVICE W/O BREAST BIOPSY	CPT	S&I	
Mammographic guidance, 1st lesion	19281	Included	
Mammographic guidance, each additional lesion	+19282 X	Included	
Stereotactic guidance, 1st lesion	19283	Included	
Stereotactic guidance, each additional lesion	+19284 X	Included	
Ultrasound guidance, 1st lesion	19285	Included	
Ultrasound guidance, each additional lesion	+19286 X	Included	
Magnetic resonance guidance, 1st lesion	19287	Included	
Magnetic resonance guidance, each additional lesion	+19288 X	Included	
Surgical specimen radiography		76098	

A diagnostic post-procedure mammogram may not be coded in addition to mammographic guided biopsies nor device localizations.

OTHER BREAST PROCEDURES	CPT	S&I	
Ultrasound Guidance		76942	
Computed Tomography Guidance		77012	
Magnetic Resonance Guidance		77021	
Puncture aspiration of cyst of breast	19000	By modality	
Puncture aspiration of cyst of breast; each additional cyst	+19001 X	By modality	
FNA Bx w/o Imaging, first lesion	10021	No image	
FNA Bx w/o Imaging, ea add'l	+10004	No image	
FNA Bx w/ Ultrasound, first lesion	10005	Included	
FNA Bx w/ Ultrasound, ea add'l	+10006	Included	
FNA Bx w/Fluoro, first lesion	10007	Included	
FNA Bx w/Fluoro, ea add'l	+10008	Included	
FNA Bx w/CT, first lesion	10009	Included	
FNA Bx w/CT, ea add'l	+10010	Included	
FNA Bx w/MR	10011	Included	
FNA Bx w/MR, ea add'l	+10012	Included	
Injection for Galactogram or Ductogram, Single Duct	19030	77053	
Injection for Galactogram or Ductogram, Multiple Ducts	19030 X	77054	
Sentinel Node Injection	38792		
Lymphatics and Lymph Nodes Imaging (includes code 38792, if performed)		78195	

Code 10022 has been deleted. To report, see 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012. Do not report 10004, 10021 in conjunction with 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012 for the same lesion).

SOFT TISSUE-MARKER PLACEMENT OTHER THAN BREAST TISSUE	CPT	S&I	
Placement of soft tissue localization device(s), perc, first lesion	10035	Included	
Placement of soft tissue localization device(s), perc, ea. add'l lesion	+10036X	Included	

Use 10035 and 10036 for soft tissue localization other than breast(s). See codes 19081 - 19088 and 19281 - 19288 for breast tissue device localization with or without biopsy.

MAMMOGRAM and TOMOSYNTHESIS	CPT	CAD	
Diagnostic Unilateral	77065	Included	
Diagnostic Bilateral	77066	Included	
Screening	77067	Included	
Digital breast tomosynthesis; unilateral	77061	N/A	
Digital breast tomosynthesis; bilateral	77062	N/A	
Screening digital breast tomosynthesis, bilateral	+77063	N/A	

For Medicare, use G0279 to report diagnostic digital breast tomosynthesis.

Mammogram codes 77065-77067 include computer-aided detection (CAD), when performed

+ = Add-on code