2021 Interventional Radiology Coding Update

Coding for Endovascular and Interventional Procedures and Services

Society of Interventional Radiology (SIR)

American College of Radiology (ACR)

Edition 2021

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Disclaimer

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.
Acknowledgments

SOCIETY OF INTERVENTIONAL RADIOLOGY (FAIRFAX, VA.)

Timothy L. Swan, MD, FSIR, FACR, Marshfield Clinic, Marshfield, Wis.

Stephanie L. Dybul, MBA, RT(R)(VI), CIRCC, The Medical College of Wisconsin, Milwaukee, Wis.

Ammar Sarwar, MD, SIR CPT® Advisor Beth Israel Deaconess Medical Center/Harvard Medical School, Boston, Mass.

C. Matthew Hawkins, MD, FSIR, SIR Economics Committee Chair, Emory University, Atlanta, Ga.

Curtis Anderson, MD, PhD, SIR RUC Advisor, Florida Endovascular and Interventional, Miami Lakes, Fla.

AMERICAN COLLEGE OF RADIOLOGY (RESTON, VA.)

ACR Economics Committees on Coding and Nomenclature and Interventional Radiology
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## Glossary of acronyms

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<td>AAA</td>
<td>Abdominal aortic aneurysm</td>
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<tr>
<td>ACR</td>
<td>American College of Radiology</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>APC</td>
<td>Ambulatory payment classification</td>
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<td>APM</td>
<td>Advanced alternative payment model</td>
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<td>AV</td>
<td>Arteriovenous</td>
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<td>CF</td>
<td>Conversion factor</td>
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<tr>
<td>CMD</td>
<td>Carrier medical director</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
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<tr>
<td>CPT</td>
<td>Current procedural terminology</td>
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<tr>
<td>E/M</td>
<td>Evaluation and management</td>
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<td>EVLA</td>
<td>Endovenous laser ablation</td>
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<td>FDA</td>
<td>U.S. Food and Drug Administration</td>
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<td>GPCI</td>
<td>Geographic practice cost index</td>
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<td>GSV</td>
<td>Great saphenous vein</td>
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<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
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<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<td>HOPPS</td>
<td>Hospital Outpatient Prospective Payment System</td>
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<td>IDE</td>
<td>Investigational device exemption</td>
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<tr>
<td>IVUS</td>
<td>Intravascular ultrasound</td>
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<td>MAC</td>
<td>Medicare administrative contractor</td>
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<td>MACRA</td>
<td>Medicare Reauthorization and Children’s Health Act of 2015</td>
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<td>MIPS</td>
<td>Merit-based incentive payment system</td>
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<td>MOCA</td>
<td>Mechanicochemical ablation</td>
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<td>MP</td>
<td>Malpractice</td>
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<td>MPFS</td>
<td>Medicare Physician Fee Schedule</td>
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<td>MPPR</td>
<td>Multiple-procedure payment reduction</td>
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<td>MRgFUS</td>
<td>MR-guided focused ultrasound</td>
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<td>MUE</td>
<td>Medically unlikely edit</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>NCCI</td>
<td>National Correct Coding Initiative</td>
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<td>PE</td>
<td>Practice expense</td>
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<tr>
<td>PICC</td>
<td>Peripherally inserted central catheter</td>
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<td>PQRS</td>
<td>Physician quality reporting system</td>
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<td>PTA</td>
<td>Percutaneous transluminal angioplasty</td>
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<td>QPP</td>
<td>Quality payment program</td>
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<td>RAW</td>
<td>Relativity assessment workgroup</td>
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<td>RBRVS</td>
<td>Resource-based relative value scale</td>
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<td>RFA</td>
<td>Radiofrequency ablation</td>
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<td>RS&amp;I</td>
<td>Radiological supervision and interpretation</td>
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<td>RS&amp;I/S&amp;I</td>
<td>Radiological supervision and interpretation/imaging supervision and interpretation</td>
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<td>RUC</td>
<td>RVS Update Committee</td>
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<td>RVS</td>
<td>Relative value scale</td>
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<td>RVU</td>
<td>Relative value unit</td>
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<td>SIR</td>
<td>Society of Interventional Radiology</td>
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<td>US</td>
<td>Ultrasound</td>
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<td>VAS</td>
<td>Visual analogue scale</td>
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<td>VCSS</td>
<td>Venous clinical severity score</td>
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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/HCPCS CODING PROCESS.

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** = \[(\text{work RVU} \times \text{work GPCI}) + (\text{transitioned nonfacility PE RVU} \times \text{PE GPCI}) + (\text{MP (malpractice) RVU} \times \text{MP GPCI})]\] \times CF

**2021 facility pricing amount** = \[(\text{work RVU} \times \text{work GPCI}) + (\text{transitioned facility PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})]\] \times 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/](https://www.sirweb.org/practice-resources/coding-page/).


### 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](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/nationalcorrectcodinited/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/nationalcorrectcoding/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 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 specialty.

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/caregiver
• 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.
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 99213, 30-39 minutes of total time is spent on the date of the encounter.
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

<table>
<thead>
<tr>
<th>CPT® CODE</th>
<th>TOTAL TIME ON DATE OF ENCOUNTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>15-29 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>30-44 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>45-49 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>60-74 minutes</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT® CODE</th>
<th>TOTAL TIME ON DATE OF ENCOUNTER</th>
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</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
</tr>
<tr>
<td>99212</td>
<td>10-19 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>20-29 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>30-39 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40-54 minutes</td>
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</tbody>
</table>
### Table 2. Medical Decision Making as Determining Factor

<table>
<thead>
<tr>
<th>CODE</th>
<th>LEVEL OF MDM (BASED ON 2 OUT OF 3 ELEMENTS OF MDM)</th>
<th>ELEMENTS OF MEDICAL DECISION MAKING</th>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED</th>
<th>RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A N/A N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>Straight-forward</td>
<td>Minimal 1 self-limited or minor problem</td>
<td>Minimal or none</td>
<td>Minimal risk of morbidity from additional diagnostic testing or treatment</td>
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<td>99212</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>99203</td>
<td>Low</td>
<td>Low 2 or more self-limited or minor problems; OR 1 stable chronic illness; OR 1 acute, uncomplicated illness or injury</td>
<td>Limited (Must meet the requirements of at least 1 of the 2 categories) 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) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)</td>
<td>Low risk of morbidity from additional diagnostic testing or treatment</td>
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<tr>
<td>99213</td>
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<tr>
<th>CODE</th>
<th>LEVEL OF MDM (BASED ON 2 OUT OF 3 ELEMENTS OF MDM)</th>
<th>ELEMENTS OF MEDICAL DECISION MAKING</th>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED</th>
<th>RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT</th>
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</thead>
<tbody>
<tr>
<td>99204</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate (Must meet the requirements of at least 1 out of 3 categories)</td>
<td>Moderate risk of morbidity from additional diagnostic testing or treatment</td>
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<tr>
<td>99214</td>
<td></td>
<td>1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; OR 2 or more stable chronic illnesses; OR 1 undiagnosed new problem with uncertain prognosis; OR 1 acute illness with systemic symptoms; OR 1 acute complicated injury</td>
<td>Category 1: Tests, documents, or independent historian(s)</td>
<td>Examples only: Prescription drug management Decision regarding minor surgery with identified patient or procedure risk factors Decision regarding elective major surgery without identified patient or procedure risk factors Diagnosis or treatment significantly limited by social determinants of health</td>
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<td>Any combination of 3 from the following:</td>
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<td>• Review of prior external note(s) from each unique source*;</td>
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<td>• Review of the result(s) of each unique test*;</td>
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<td></td>
<td>• Ordering of each unique test*;</td>
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<td>• Assessment requiring an independent historian(s)</td>
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<td>OR</td>
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<td></td>
<td>Category 2: Independent interpretation of tests</td>
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<td>Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported);</td>
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<td>OR</td>
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<td>Category 3: Discussion of management or test interpretation</td>
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<td></td>
<td>Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)</td>
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</table>
### Table 2. Medical Decision Making as Determining Factor (continued)

<table>
<thead>
<tr>
<th>CODE</th>
<th>LEVEL OF MDM (BASED ON 2 OUT OF 3 ELEMENTS OF MDM)</th>
<th>ELEMENTS OF MEDICAL DECISION MAKING</th>
<th>AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED AND ANALYZED</th>
<th>RISK OF COMPLICATIONS AND/OR MORBIDITY OR MORTALITY OF PATIENT MANAGEMENT</th>
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</thead>
<tbody>
<tr>
<td>99205</td>
<td>High</td>
<td>High</td>
<td>Extensive (Must meet the requirements of at least 2 out of 3 categories)</td>
<td>High risk of morbidity from additional diagnostic testing or treatment</td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td></td>
<td>Category 1: Tests, documents, or independent historian(s)</td>
<td>Examples only: Drug therapy requiring intensive monitoring for toxicity</td>
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<td></td>
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<td></td>
<td>Any combination of 3 from the following:</td>
<td>Decision regarding elective major surgery with identified patient or procedure risk factors</td>
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<td>• Review of prior external note(s) from each unique source*;</td>
<td>Decision regarding emergency major surgery</td>
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<td>• Review of the result(s) of each unique test*;</td>
<td>Decision regarding hospitalization</td>
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<td>• Ordering of each unique test*;</td>
<td>Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
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<td>• Assessment requiring an independent historian(s)</td>
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<td>OR</td>
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<td>Category 2: Independent interpretation of tests</td>
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<td>Independent interpretation of a test performed by another physician/other qualified healthcare professional (not separately reported);</td>
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<td>OR</td>
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<td>Category 3: Discussion of management or test interpretation</td>
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<td></td>
<td>Discussion of management or test interpretation with external physician/other qualified healthcare professional/appropriate source (not separately reported)</td>
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**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 (e.g., 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.
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.

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.

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

<table>
<thead>
<tr>
<th>AMA CPT</th>
<th>CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>Office E/M, new patient 60-74 minutes 99205</td>
</tr>
<tr>
<td>99205, 99417</td>
<td>Office E/M, new patient 75-89 min 99205</td>
</tr>
<tr>
<td>99205, 99417, 99417</td>
<td>Office E/M, new patient 90-104 min 99205, G2212</td>
</tr>
<tr>
<td>99205, 99417X3 (add 99417 for each additional 15 minutes)</td>
<td>Office E/M, new patient ≥ 105 min 99205, G2212, G2212 (add G2212 for each additional 15 minutes)</td>
</tr>
<tr>
<td>99215</td>
<td>Office E/M, established patient 40-54 minutes 99215</td>
</tr>
<tr>
<td>99215, 99417</td>
<td>Office E/M, established patient 55-69 minutes 99215</td>
</tr>
<tr>
<td>99215, 99417, 99417</td>
<td>Office E/M, established patient 70-84 minutes 99215, G2212</td>
</tr>
<tr>
<td>99215, 99417X3 (add 99417 for each additional 15 minutes)</td>
<td>Office E/M, established patient ≥ 85 minutes 99215, G2212, G2212 (add G2212 for each additional 15 minutes)</td>
</tr>
</tbody>
</table>
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.
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 and 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>#99421</td>
<td>Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes</td>
</tr>
<tr>
<td>#99422</td>
<td>11-20 minutes</td>
</tr>
<tr>
<td>#99423</td>
<td>21 or more minutes</td>
</tr>
</tbody>
</table>

(Report #99421, #99422, #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 review

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

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.” 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. 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 treating 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
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)

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&l/S&l, 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 (BIOLOGY, 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.


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).
**INTERVENTIONAL RADIOLOGY CODING UPDATE**

**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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RS/I/S/I Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>23350</td>
<td>Injection for shoulder arthrogram.</td>
<td>73040.</td>
</tr>
<tr>
<td>24220</td>
<td>Injection for elbow arthrogram (for tennis elbow injection, see 20550).</td>
<td>73085.</td>
</tr>
<tr>
<td>27093</td>
<td>Injection for hip arthrogram without anesthesia.</td>
<td>73525.</td>
</tr>
<tr>
<td>27095</td>
<td>Injection for hip arthrogram with anesthesia.</td>
<td>73525.</td>
</tr>
<tr>
<td>27096</td>
<td>Sacroiliac joint injection (anesthetic or steroid), unilateral; includes image guidance (fluoroscopy or CT) and arthrogram when performed.</td>
<td>73525. for bilateral SI joint injection, report 27096 with modifier -50.</td>
</tr>
</tbody>
</table>

**LUNGS AND PLEURA**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>✔️32408</td>
<td>Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed.</td>
</tr>
</tbody>
</table>

(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
ABLAITION 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[es] 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.
Selective arterial catheter placement, initial second order thoracic or brachiocephalic branch, within a vascular family.

Selective arterial catheter placement, initial third order or greater thoracic or brachiocephalic branch, within a vascular family.

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.

Selective arterial catheterization placement, first order abdominal, pelvic or lower extremity branch, within a vascular family.

Selective arterial catheterization placement, initial second order abdominal, pelvic or lower extremity branch, within a vascular family.

Selective arterial catheterization placement, initial third order or greater selective abdominal, pelvic or lower extremity branch, within a vascular family.

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 36222, 36223, 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
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, 36420, 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, 36942, 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.

36557, 36558 Centrally inserted, tunneled CV catheter, no port/no pump. (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  Declotting 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

<table>
<thead>
<tr>
<th>DEVICE SITE</th>
<th>DEVICE TYPE</th>
<th>AGE</th>
<th>INSERTION</th>
<th>REPAIR</th>
<th>PARTIAL REPLACEMENT (CATH ONLY)</th>
<th>COMPLETE REPLACEMENT</th>
<th>REMOVAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrally Inserted</td>
<td>Nontunneled</td>
<td>under 5</td>
<td>36555</td>
<td>36575</td>
<td>36580</td>
<td>99XXX **</td>
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<tr>
<td></td>
<td></td>
<td>5 and older</td>
<td>36556</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Tunneled (no port, no pump)</td>
<td>under 5</td>
<td>36557</td>
<td>36575</td>
<td>36581</td>
<td>36589</td>
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<td>5 and older</td>
<td>36558</td>
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<tr>
<td></td>
<td>Tunneled port</td>
<td>under 5</td>
<td>36560</td>
<td>36576</td>
<td>36578</td>
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<td>5 and older</td>
<td>36561</td>
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<td></td>
<td>Tunneled pump</td>
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<td>36576</td>
<td>36578</td>
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<td>36590</td>
</tr>
<tr>
<td></td>
<td>Two tunneled cath, two access sites (no port, no pump)</td>
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<td>36575 (X 2)*</td>
<td>36581 (X 2)*</td>
<td>36589 (X 2)*</td>
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</tr>
<tr>
<td></td>
<td>Two tunneled cath, two access sites (port)</td>
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<td>36566</td>
<td>36576 (X 2)*</td>
<td>36578 (X 2)*</td>
<td>36582 (X 2)*</td>
<td>36590 (X 2)*</td>
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<tr>
<td>Peripherally Inserted</td>
<td>Nontunneled (PICC), without image guidance</td>
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<td>36568</td>
<td>36575</td>
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<td>37799</td>
<td>99XXX **</td>
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<td>36569</td>
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<td></td>
<td>Nontunneled (PICC), with image guidance</td>
<td>under 5</td>
<td>36572</td>
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<td></td>
<td>Tunneled port</td>
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<td>5 and older</td>
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</table>

**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 37191–39193.

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 contract 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 infrainguinal 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 endograft 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**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37220</td>
<td>Initial iliac artery revascularization, transluminal angioplasty.</td>
</tr>
<tr>
<td>37221</td>
<td>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)</td>
</tr>
<tr>
<td>+37222</td>
<td>Each additional ipsilateral iliac artery revascularization, transluminal angioplasty. (37222 is used in conjunction with 37220, 37221 for additional ipsilateral iliac segment PTA).</td>
</tr>
</tbody>
</table>
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.
Each additional artery, transluminal balloon angioplasty. (List separately in addition to code for primary procedure).

Initial vein, transluminal balloon angioplasty, open or percutaneous, within the same vein.

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.

Initial vessel, intravascular ultrasound.

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.


<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>47490</td>
<td>Image-guided percutaneous cholecystostomy catheter placement.</td>
</tr>
<tr>
<td>47531</td>
<td>Injection cholangiography, through an existing access (e.g., via biliary drainage catheter or cholecystostomy tube).</td>
</tr>
<tr>
<td>47532</td>
<td>Injection cholangiography, through a new access (e.g., percutaneous transhepatic cholangiogram), includes all associated imaging.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47533</td>
<td>Placement of external biliary drainage catheter, includes cholangiography and all associated imaging.</td>
</tr>
<tr>
<td>47534</td>
<td>Placement of internal-external biliary drainage catheter, includes cholangiography and all associated imaging.</td>
</tr>
<tr>
<td>47535</td>
<td>Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, includes cholangiography and all associated imaging.</td>
</tr>
<tr>
<td>47536</td>
<td>Exchange of biliary drainage catheter (e.g., external, internal-external or conversion of internal–external to external only), includes cholangiography and all associated imaging.</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>47537</td>
<td>Removal of biliary drainage catheter, requiring fluoroscopic guidance (e.g., with concurrent indwelling biliary stents); includes cholangiography.</td>
</tr>
</tbody>
</table>

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.
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.

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.

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.

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.
**Biliary endoscopy, with biopsy, single or multiple.**

**Biliary endoscopy, through skin with stone removal.**

**Biliary endoscopy, with dilation, no stent (Dilation without stent, percutaneous).**

For RS&I, see 74363.

**Biliary endoscopy, with dilation and stent (Dilation with stent, percutaneous; see also 47801).**

For RS&I, see 74363.

**Placement of bile duct stent (e.g., endoprosthesis) (see also code 47556).**

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**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.

**Sclerotherapy of a percutaneous fluid collection.**

Do not report 49424 or 76080 in combination with 49185.

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

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

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

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

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

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.

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

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

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

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).
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 ILEAL 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).
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).

Ureteral embolization or occlusion; includes all associated imaging. (List separately in addition to code for primary procedure).

Balloon dilation, ureteral stricture; includes all associated imaging. (List separately in addition to code for primary procedure).

## PERCUTANEOUS GENITOURINARY INTERVENTIONS

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## 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).

Percutaneous, radiofrequency ablation, renal tumor(s), unilateral.

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

For RS&I/S&I, see 74430, 74455.

51610  Injection for retrograde urethrocystography.

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.
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., spasmodyltics 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.
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/chemodenervation 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 chemodenervation 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).


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 supraselective, 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., LeVeen), RS&I.

75810  Splenoportography, RS&I.
Venography, extremity, unilateral, RS&I.  
Venography, extremity, bilateral, RS&I.  
Inferior vena cavography, RS&I.  
Superior vena cavography, RS&I.  
Venography, renal unilateral, selective, RS&I.  
Venography, renal bilateral, selective, RS&I.  
Venography, adrenal unilateral, selective, RS&I.  
Venography, adrenal bilateral, selective, RS&I.  
Venography, venous sinus or jugular, RS&I.  
Venography, superior sagittal, RS&I.  
Venography, epidural, RS&I.  
Venography, orbital, RS&I.  
Venography, portal (perc transhepatic with pressures), RS&I.  
Venography, portal (perc transhepatic without pressures), RS&I.  
Venography, hepatic (with pressures), RS&I.  
Venography, hepatic (without pressures).

**TRANSCANHETTER PROCEDURES**

Venous sampling by catheter, with or without angiography, per organ sampled, RS&I. (For procedure, see 36500).

Transcatheter therapy (embolization), RS&I. (For procedure, see 61624 or 61626).

Do not use 75894 in combination with 36909, 37241–37244, 50705.

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]).

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, 76377, 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-VENOUS 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**


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 be 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 is 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 supraselective [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 supraselective 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 supraselective 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&l 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.
Ablation, one or more liver tumor(s) percutaneous, radiofrequency; with appropriate image guidance code: 77013 (CT), 77022 (MRI), 76940 (US).

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).

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/percutaenous_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
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 oopherectomy of ovary on the side of an incomplete gonadal vein or bilateral oopherectomy) 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/OOF 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 in 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 hemosputum 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 ≤ 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.

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.

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 ± 15.3, the cancer-specific survival rate at 5 years was 56.6 percent ±16.5, and the 5-year progression-free survival rate was 87.9 percent ± 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]

References:


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 better than either method alone. The closure occurs with less pain 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. Several additional publications also support the safety and high rate of success of MOCA, similar to that following thermal ablation. I present below a summary of some of the highlights of this literature.

Bootun et al. 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 Ozen 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).

Boeersma 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. 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. 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]
Selected bibliography:


7. Elias S. Mechanochemical ablation: MOCA, 2 year follow up, lessons learned. SVS Annual Meeting, Washington, DC, June 2012


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.]
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**Notes:**

- **CPT:** Only Copyright 2020 American Medical Association. All Rights Reserved. Copyright 2021 Society of Interventional Radiology. All Rights Reserved

- **S&I:** 2020 American Medical Association. All Rights Reserved.

### ARTHROGRAMS

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<td>Hip w/o anestheisa</td>
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### ARTHROCENTESIS/ASPIRATION/INJECTION

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### VERTEBROPLASTY/ VERTEBRAL AUGMENTATION

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*Use modifier -22 when service is provided by co-surgeons.

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<tr>
<td>Inj. Ablative Agent, Liver</td>
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</tr>
<tr>
<td>Lung Tumor(s), RFA, Perc., Unilateral</td>
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</tr>
<tr>
<td>Lung Tumor(s), Cryoabl. Perc., Unilateral</td>
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</tr>
<tr>
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<tr>
<td>Renal Tumor(s), RFA, Perc.</td>
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<tr>
<td>Renal Tumor(s), Cryo, Open, w/ US</td>
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<tr>
<td>Peripheral nerve, Upper extr. distal, Cryoabl.</td>
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<td>Peripheral nerve, Lower extr. distal, Cryoabl.</td>
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<td>Nerve plexus or other truncal, Cryoabl.</td>
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<td>R.E. Ablation, 1 or more tumors per organ, Percutaneous</td>
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### Gastrointestinal Procedures

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<tbody>
<tr>
<td>G-Tube Placement, Perc.</td>
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<tr>
<td>J-Tube Placement, Perc.</td>
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<td>Cecostomy or other Colonic Tube</td>
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<tr>
<td>Convert G-Tube to G-J Tube</td>
<td>49446</td>
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<tr>
<td>Gastro Tube Change (with fluoro)</td>
<td>49450</td>
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<tr>
<td>Replacement Dislodged J-Tube</td>
<td>49451</td>
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<tr>
<td>Replacement GJ Tube, Perc.</td>
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<tr>
<td>Repl GJ Tube, Perc. incl remove w/o img./w revision tract</td>
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<tr>
<td>Reposition Naso or Oro-Gastric Feeding Tube</td>
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<tr>
<td>Contrast Inj. for any GI Tube</td>
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<tr>
<td>Esophageal Dilation Over Guide Wire</td>
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<tr>
<td>Nasogastric Tube Placement</td>
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<tr>
<td>Mech. Removal Obstructed Material</td>
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<tr>
<td>Injection of air or contrast into peritoneal cavity</td>
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### Biliary Procedures

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<td>Percutaneous Cholecystectomy</td>
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<td>Inj. for Cholangiogram, Existing Access</td>
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<tr>
<td>Inj. for Cholangiogram, New Access</td>
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<td>Perc. Placement Biliary Drainage (Ext.)</td>
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<td>Convert Ext. Biliary Drainage to Int-Ext</td>
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<td>Exchange of Biliary Drainage Catheter</td>
<td>47536</td>
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<tr>
<td>Removal of Biliary Drainage Catheter</td>
<td>47537</td>
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<td>Plcmt Bile Duct Stent(s), Existing Access</td>
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<td>Plcmt Bile Duct Stent(s), New w/o drainage</td>
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<td>Plcmt Bile Duct Stent(s), New w/drainage</td>
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<td>Plcmt access thru biliary tree, perc; new access</td>
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<tr>
<td>Balloon dilation biliary duct/ampulla, perc.</td>
<td>47542</td>
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<tr>
<td>Endoluminal Bx of biliary tree, perc</td>
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<tr>
<td>Removal calculi/debris fr. bile duct(s)/GB</td>
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<td>Intraoperative Cholangiogram</td>
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<td>Aspiration/inj of renal cyst or pelvis, perc</td>
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<td>Dilatation of exist tract, perc., incl img guid</td>
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<tr>
<td>Dilatation existing tract, perc. incl img guid; new access</td>
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<td>Inj. antegrade nephro/ureterogram; new access</td>
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<td>Plcmt nephro cath. perc. incl. diag nephrogram</td>
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<td>Plcmt nephroureteral cath, perc. incl. diag nephro</td>
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<td>Convert nephrostomy catheter</td>
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<td>Exchange nephrostomy catheter</td>
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<td>Endoluminal bx of ureter/ renal pelvis</td>
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<td>Plnt of ureteral stent; existing nephrostomy tract</td>
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<tr>
<td>Plnt of ureteral stent;new acc w/o sep nephro cath</td>
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<tr>
<td>Plnt of ureteral stent;new acc w/sep nephro cath</td>
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<td>Ureteral embolization or occlusion</td>
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<tr>
<td>Transurethral destruction of prostate; by RF</td>
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<td>74485</td>
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<tr>
<td>Balloon dilation, ureteral stricture</td>
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### Other Introduction (Injection, Change, Removal)

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<td>Whitaker Test</td>
<td>50396</td>
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<tr>
<td>Nephrostolithotomy &lt;2cm</td>
<td>50080</td>
<td>See note**</td>
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<tr>
<td>Nephrostolithotomy &gt;2cm</td>
<td>50081</td>
<td>See note**</td>
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<tr>
<td>Heocondit Injection</td>
<td>50690</td>
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<tr>
<td>Inj. Cystogram/Voiding Urethrocystogram</td>
<td>51600</td>
<td>See note***</td>
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<td>Cystography/VCU w/Chain</td>
<td>51605</td>
<td>74430</td>
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<tr>
<td>Urethrocystogram, Retrograde</td>
<td>51610</td>
<td>74450</td>
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<tr>
<td>Change Cystostomy Tube, Simple</td>
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<td>75984</td>
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<tr>
<td>Change Cystostomy Tube, Complex</td>
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### Fallopian Dilation

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<td>Hysterosalpingogram (HSG)</td>
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<tr>
<td>HSG. w/ or w/o color flow</td>
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<tr>
<td>Fallopian Dilatation</td>
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### TIPS

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### 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
# LOWER EXTREMITY ENDOVASCULAR REVASCULARIZATION

## Iliac Vascular Territory

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<th>Procedure</th>
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</tr>
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<tbody>
<tr>
<td>Percutaneous Transluminal Angioplasty (PTA), unilateral</td>
<td>37220</td>
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</tr>
<tr>
<td>Stent Placement(s) w/ PTA when performed, unilateral</td>
<td>37221</td>
<td>Included</td>
</tr>
<tr>
<td>PTA each add'l ipsilateral iliac vessel</td>
<td>37222</td>
<td>Included</td>
</tr>
<tr>
<td>Stent Placement(s) w/ PTA within same vessel when performed, ea. add'l vessel</td>
<td>37223</td>
<td>Included</td>
</tr>
<tr>
<td>EVAR iliac artery at the time of aortoiliac artery endograft placement, unilateral</td>
<td>+34717</td>
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<tr>
<td>EVAR iliac artery, not associated with placement of an aorto-iliac artery endograft, unilateral</td>
<td>34718</td>
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## Femoral/Popliteal Vascular Territory

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</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous Transluminal Angioplasty (PTA), unilateral</td>
<td>37224</td>
<td>Included</td>
</tr>
<tr>
<td>Atherectomy w/ PTA within same vessel when performed, unilateral</td>
<td>37225</td>
<td>Included</td>
</tr>
<tr>
<td>Stent Placement(s) w/ PTA within same vessel when performed, unilateral</td>
<td>37226</td>
<td>Included</td>
</tr>
<tr>
<td>Stent and Atherectomy w/ PTA within same vessel when performed, unilateral</td>
<td>37227</td>
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</table>

## Tibial/Peroneal Vascular Territory

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous Transluminal Angioplasty (PTA), unilateral</td>
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<tr>
<td>Atherectomy w/ PTA within same vessel when performed, unilateral</td>
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<tr>
<td>Stent Placement(s) w/ PTA within same vessel when performed, unilateral</td>
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<tr>
<td>Stent and Atherectomy w/ PTA within same vessel when performed, unilateral</td>
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<tr>
<td>PTA, each add'l ipsilateral tibial/peroneal vessel</td>
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<tr>
<td>Atherectomy w/ PTA within same vessel when performed, ea. add'l vessel</td>
<td>+37233 X_</td>
<td>Included</td>
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<td>Stent Placement(s) w/ PTA within same vessel when performed, ea. add'l vessel</td>
<td>+37234 X_</td>
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</tr>
<tr>
<td>Stent and Atherectomy w/ PTA within same vessel when performed, ea. add'l vessel</td>
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## Arterectomy Supra-Ingual Arteries

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<tr>
<td>Visceral Artery (except renal) each vessel</td>
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<tr>
<td>Abdominal Aorta</td>
<td>0236T</td>
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<tr>
<td>Brachiocephalic Trunk and Branches, each vessel</td>
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</tr>
<tr>
<td>Iliac Artery, each vessel</td>
<td>0238T</td>
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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
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<tr>
<th>SELECTIVE CATHETER PLACEMENTS</th>
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<th>2nd</th>
<th>3rd</th>
<th>Add'l 2nd &amp; 3rd Order</th>
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<td>Non-selective Aortic Arch inj w/ all Imaging</td>
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<td>Selective External Carotid Artery w/ Ext. Carotid Imaging</td>
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<td>Selective extracranial vertebral or subclavian branches</td>
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<td>IMA</td>
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</tr>
<tr>
<td>Right Adrenal</td>
<td>36011</td>
<td>36012</td>
<td>36012</td>
<td>56012</td>
</tr>
<tr>
<td>Epidural</td>
<td>36011</td>
<td>36012</td>
<td>36012</td>
<td>56012</td>
</tr>
<tr>
<td>Portal Venogram</td>
<td>36481</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Venous Vascular Family</td>
<td>36011</td>
<td>36012</td>
<td>36012</td>
<td>56012</td>
</tr>
<tr>
<td>Selective Venous Blood Sampling</td>
<td>36500</td>
<td>75893</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NON-SELECTIVE VASCULAR CATHETERIZATIONS</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aorta Catheter (Femoral, Brach., Axillary)</td>
<td>36200</td>
</tr>
<tr>
<td>Extremity Artery, Needle/Intracath, Uni</td>
<td>36140</td>
</tr>
<tr>
<td>Arterial Cath. Sampling</td>
<td>36620</td>
</tr>
<tr>
<td>Ext. Vein Needle/Intracath, Uni</td>
<td>36005</td>
</tr>
<tr>
<td>Aorta (Translumbar)</td>
<td>36160</td>
</tr>
<tr>
<td>Carotid/Vertebral, direct puncture</td>
<td>36100</td>
</tr>
<tr>
<td>Retrograde Brachial</td>
<td>36120</td>
</tr>
<tr>
<td>Superior or Inferior Vena Cava, Catheter</td>
<td>36010</td>
</tr>
<tr>
<td>Jugular Vein</td>
<td>36299</td>
</tr>
<tr>
<td>Injection, Lymphangiography</td>
<td>33790</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MISCELLANEOUS</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closure Device</td>
<td>G0269</td>
</tr>
<tr>
<td>CT, limited or localized follow-up</td>
<td>76380</td>
</tr>
<tr>
<td>US Guidance for Vascular Access</td>
<td>+76937</td>
</tr>
<tr>
<td>3D Reconstruction w/o Independent</td>
<td>76376</td>
</tr>
<tr>
<td>3D Reconstruction w/ Independent</td>
<td>76377</td>
</tr>
<tr>
<td>Anatomic model 3D-printed, 1st anatomic structure</td>
<td>65597T</td>
</tr>
<tr>
<td>Anatomic model 3D-printed, each additional anatomic structure</td>
<td>+6556T</td>
</tr>
<tr>
<td>Anatomic model 3D-printed, 1st anatomic guide</td>
<td>6561T</td>
</tr>
<tr>
<td>Anatomic model 3D-printed, each additional anatomic guide</td>
<td>+6562T</td>
</tr>
</tbody>
</table>

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
### CENTRALLY INSERTED DEVICE

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36555</td>
<td>Fluoro guidance for CVA device plcmt/replacement/removal Non-Tunneled (Child &lt; 5)</td>
</tr>
<tr>
<td>36556</td>
<td>Ultrasound guidance for vascular access Non-Tunneled (5 years or older)</td>
</tr>
<tr>
<td>36557</td>
<td>Tunneled (Child &lt;5) No Port, No Pump</td>
</tr>
<tr>
<td>36558</td>
<td>Tunneled (5 years or older) No Port, No Pump</td>
</tr>
<tr>
<td>36560</td>
<td>Tunneled Cath. w/ Port (Child &lt;5)</td>
</tr>
<tr>
<td>36561</td>
<td>Tunneled Cath. w/ Port (5 years or older)</td>
</tr>
<tr>
<td>36563</td>
<td>Tunneled Cath. w/ Pump</td>
</tr>
<tr>
<td>36565</td>
<td>2 Tunneled Cath, 2 Access sites, w/ Port</td>
</tr>
</tbody>
</table>

### PERIPHERALLY INSERTED DEVICE - WITHOUT IMAGE GUIDANCE

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36568</td>
<td>Non-Tunneled PICC w/o img guidance; (Child &lt; 5)</td>
</tr>
<tr>
<td>36569</td>
<td>Non-Tunneled w/o img guidance; (5 years or older)</td>
</tr>
</tbody>
</table>

### PERIPHERALLY INSERTED DEVICE - WITH IMAGE GUIDANCE

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36572</td>
<td>Peripherally-inserted central venous catheter, (w/o SQ port/pump) incl all img; (Child &lt; 5)</td>
</tr>
<tr>
<td>36573</td>
<td>Peripherally-inserted central venous catheter, (w/o SQ port/pump) incl all img; (5 years or older)</td>
</tr>
</tbody>
</table>

### PERIPHERALLY INSERTED DEVICE WITH PORT

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36570</td>
<td>Fluoro guidance for CVA device plcmt/replacement/removal Peripherally-inserted central venous access device (SQ port) (Child &lt; 5 years)</td>
</tr>
<tr>
<td>36571</td>
<td>Ultrasound guidance for vascular access Peripherally-inserted central venous access device (SQ port) w/ Port (5 years or older)</td>
</tr>
</tbody>
</table>

### REPAIR

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36575</td>
<td>Tunneled or non-tunneled CVA, w/o port or pump, central or peripheral</td>
</tr>
<tr>
<td>36576</td>
<td>Tunneled or non-tunneled CVA, w/ port or pump, central or peripheral</td>
</tr>
</tbody>
</table>

### REPLACEMENT

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36578</td>
<td>Fluoro guidance for CVA device plcmt/replacement/removal Replace, catheter only, of CVA device, w/ port or pump, central or peripheral</td>
</tr>
<tr>
<td>36580</td>
<td>Ultrasound guidance for vascular access Replace, complete, non-tunneled centrally inserted CVC, w/o port or pump, same access</td>
</tr>
<tr>
<td>36581</td>
<td>Replace, complete, tunneled, centrally inserted CVC, w/o port or pump, same access</td>
</tr>
<tr>
<td>36582</td>
<td>Replace, complete, tunneled, centrally inserted CVA device, w/ port, same access</td>
</tr>
<tr>
<td>36583</td>
<td>Replace, complete, tunneled, centrally inserted CVA device, w/ pump, same access</td>
</tr>
<tr>
<td>36584</td>
<td>Replace, complete, PICC, w/o port or pump, same access, incl all img guide, RS&amp;I</td>
</tr>
<tr>
<td>36585</td>
<td>Replace, complete, PICC, w/ port, same access</td>
</tr>
</tbody>
</table>

### REMOVAL

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E/M</td>
<td>Removal non-tunneled, no port no pump</td>
</tr>
<tr>
<td>36589+</td>
<td>Removal of tunneled central venous catheter, w/o port or pump</td>
</tr>
<tr>
<td>36590+</td>
<td>Removal of tunneled central venous access device, w/ port or pump, central or peripheral</td>
</tr>
</tbody>
</table>

### CENTRAL/PERIPHERAL CVA DEVICE MAINTENANCE

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36597</td>
<td>Repositioning central venous catheter under fluoroscopic guidance</td>
</tr>
<tr>
<td>36593</td>
<td>Thrombolytic declotting of vascular access</td>
</tr>
<tr>
<td>36595*</td>
<td>CVA maintenance fibrin stripping (sep access)</td>
</tr>
<tr>
<td>36596</td>
<td>CVA maintenance through lumen (brushing)</td>
</tr>
</tbody>
</table>

### OTHER IMAGING FOR CENTRAL/PERIPHERAL DEVICE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVC gram</td>
<td>76000</td>
</tr>
<tr>
<td>JVC gram</td>
<td>75827</td>
</tr>
<tr>
<td>Venography, extremity, unilateral</td>
<td>75820</td>
</tr>
<tr>
<td>Venography, extremity, bilateral</td>
<td>75822</td>
</tr>
</tbody>
</table>

* (For venous catheterization, see 36010-36012)
## EVALUATION & MANAGEMENT SERVICES

### OFFICE/OUTPATIENT VISITS - NEW PATIENT

<table>
<thead>
<tr>
<th>CPT</th>
<th>History and/or Exam</th>
<th>Medical Decision Making</th>
<th>Total Time on date of encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>Medically Appropriate</td>
<td>Straightforward</td>
<td>15-29 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>Medically Appropriate</td>
<td>Low</td>
<td>30-44 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>Medically Appropriate</td>
<td>Moderate</td>
<td>45-49 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>Medically Appropriate</td>
<td>High</td>
<td>60-74 minutes</td>
</tr>
</tbody>
</table>

### OFFICE/OUTPATIENT VISITS - ESTABLISHED PATIENT

<table>
<thead>
<tr>
<th>CPT</th>
<th>History and/or Exam</th>
<th>Medical Decision Making</th>
<th>Total Time on date of encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Medically Appropriate</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99212</td>
<td>Medically Appropriate</td>
<td>Straightforward</td>
<td>10-19 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Medically Appropriate</td>
<td>Low</td>
<td>20-29 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Medically Appropriate</td>
<td>Moderate</td>
<td>30-39 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>Medically Appropriate</td>
<td>High</td>
<td>40-54 minutes</td>
</tr>
</tbody>
</table>

### *OUTPATIENT PROLONGED SERVICES ADD-ON NEW OR ESTABLISHED PATIENT (WHEN USING Time-based only)

<table>
<thead>
<tr>
<th>CPT/HPCS</th>
<th>Add onto Level 5 visit</th>
<th>Total Add-on Time</th>
<th>Total Time on date of encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ 99417</td>
<td>99205 or 99215</td>
<td>Each additional 15 minutes</td>
<td>New Patient 75 minutes or longer, Established patient 55 minutes or longer</td>
</tr>
<tr>
<td>+ G2212</td>
<td>99205 or 99215</td>
<td>Each additional 15 minutes</td>
<td>New Patient 89 minutes or longer, Established patient 69 minutes or longer</td>
</tr>
</tbody>
</table>

### OUTPATIENT CONSULT - NEW OR ESTABLISHED PATIENT

<table>
<thead>
<tr>
<th>CPT</th>
<th>History and Exam</th>
<th>Medical Decision Making</th>
<th>Presenting Problem</th>
<th>Face-to-Face Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Problem-Focused</td>
<td>Straightforward</td>
<td>Self-Limited or Minor</td>
<td>15 minutes</td>
</tr>
<tr>
<td>99242</td>
<td>Expanded Problem-Focused</td>
<td>Straightforward</td>
<td>Low to Moderate</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99243</td>
<td>Detailed</td>
<td>Low</td>
<td>Moderate</td>
<td>40 minutes</td>
</tr>
<tr>
<td>99244</td>
<td>Comprehensive</td>
<td>Moderate</td>
<td>Moderate to High</td>
<td>60 minutes</td>
</tr>
<tr>
<td>99245</td>
<td>Comprehensive</td>
<td>High</td>
<td>Moderate to High</td>
<td>80 minutes</td>
</tr>
</tbody>
</table>

### INITIAL HOSPITAL CARE - NEW OR ESTABLISHED PATIENT

**Required Components: 3/3**

<table>
<thead>
<tr>
<th>CPT</th>
<th>History and Exam</th>
<th>Medical Decision Making</th>
<th>Presenting Problem</th>
<th>Face-to-Face Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>Detailed or Comprehensive</td>
<td>Straightforward or Low</td>
<td>Low</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99222</td>
<td>Comprehensive</td>
<td>Moderate</td>
<td>Moderate</td>
<td>50 minutes</td>
</tr>
<tr>
<td>99223</td>
<td>Comprehensive</td>
<td>High</td>
<td>High</td>
<td>70 minutes</td>
</tr>
</tbody>
</table>

### INPATIENT CONSULT- NEW OR ESTABLISHED PATIENT

**Required Components: 3/3**

<table>
<thead>
<tr>
<th>CPT</th>
<th>History and Exam</th>
<th>Medical Decision Making</th>
<th>Presenting Problem</th>
<th>Face-to-Face Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>Problem-Focused</td>
<td>Straightforward</td>
<td>Self-Limited or Minor</td>
<td>20 minutes</td>
</tr>
<tr>
<td>99252</td>
<td>Expanded Problem-Focused</td>
<td>Straightforward</td>
<td>Low to Moderate</td>
<td>40 minutes</td>
</tr>
<tr>
<td>99253</td>
<td>Detailed</td>
<td>Low</td>
<td>Moderate</td>
<td>55 minutes</td>
</tr>
<tr>
<td>99254</td>
<td>Comprehensive</td>
<td>Moderate</td>
<td>Moderate to High</td>
<td>80 minutes</td>
</tr>
<tr>
<td>99255</td>
<td>Comprehensive</td>
<td>High</td>
<td>Moderate to High</td>
<td>110 minutes</td>
</tr>
</tbody>
</table>

### POSTOPERATIVE FOLLOW-UP VISIT

<table>
<thead>
<tr>
<th>CPT</th>
<th>E/M was performed during a postop period for a reason(s) related to the original procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>99024</td>
<td>E/M was performed during a postop period for a reason(s) related to the original procedure</td>
</tr>
</tbody>
</table>

**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.*
### Catheterization: Selective

<table>
<thead>
<tr>
<th>Articular Vascular Family</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>Add'l 2nd &amp; 3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iliac, Iliofemoral</td>
<td>36245</td>
<td>36246</td>
<td>36247</td>
<td>+36248 X</td>
</tr>
<tr>
<td>Common Femoral, Iliofemoral</td>
<td>36245</td>
<td>36246</td>
<td>36247</td>
<td>+36248 X</td>
</tr>
<tr>
<td>Common Femoral, Contralateral</td>
<td>36245</td>
<td>36246</td>
<td>36247</td>
<td>+36248 X</td>
</tr>
<tr>
<td>Common Femoral, Iliofemoral</td>
<td>36245</td>
<td>36246</td>
<td>36247</td>
<td>+36248 X</td>
</tr>
</tbody>
</table>

### Catheterization: Non-Selective

<table>
<thead>
<tr>
<th>Report cath codes in addition to exposure</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of catheter, aorta (Femoral, Brachiual, Axillary)</td>
<td>36200*</td>
</tr>
<tr>
<td>Introduction of needle or intracatheter; extremity artery</td>
<td>36140</td>
</tr>
</tbody>
</table>

### Exposure for Endoprosthesis

| Open femoral artery exposure | 34812** |
| Placement of femoral-femoral prosthetic graft | 34813*** |

### Endovascular Repair of the Intradural Aorta

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVAR iliac/aorta w/o aorto-iliac tube endograft, other than rupture</td>
<td>34801</td>
</tr>
<tr>
<td>EVAR iliac/aorta w/o iliac-femoral (non-coronary) stent graft, other than rupture</td>
<td>34802</td>
</tr>
<tr>
<td>EVAR iliac/aorta w/o iliac-femoral (non-coronary) stent graft, other than rupture</td>
<td>34803</td>
</tr>
<tr>
<td>EVAR iliac/aorta w/o iliac-femoral (non-coronary) stent graft, other than rupture</td>
<td>34804</td>
</tr>
<tr>
<td>EVAR iliac/aorta w/o iliac-femoral (non-coronary) stent graft, other than rupture</td>
<td>34805</td>
</tr>
<tr>
<td>EVAR iliac/aorta w/o iliac-femoral (non-coronary) stent graft, other than rupture</td>
<td>34806</td>
</tr>
</tbody>
</table>

### Miscellaneous

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement of femoral-femoral prosthetic graft</td>
<td>34813</td>
</tr>
<tr>
<td>Thromboendarterectomy, incl. patch graft: iliofemoral</td>
<td>35354***</td>
</tr>
<tr>
<td>Thromboendarterectomy, incl. patch graft: common femoral</td>
<td>35371***</td>
</tr>
<tr>
<td>Thromboendarterectomy, incl. patch graft: deep femoral (profunda)</td>
<td>35372***</td>
</tr>
</tbody>
</table>

### Transluminal Balloon Angioplasty

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTA, initial artery</td>
<td>37246</td>
</tr>
<tr>
<td>PTA, additional artery</td>
<td>37247</td>
</tr>
<tr>
<td>PTA, initial vein</td>
<td>37248</td>
</tr>
<tr>
<td>PTA, additional vein</td>
<td>37249</td>
</tr>
</tbody>
</table>

### Intravascular Ultrasound

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravascular ultrasound, initial (non-coronary) vessel</td>
<td>37252</td>
</tr>
<tr>
<td>Intravascular ultrasound, add'l (non-coronary) vessel</td>
<td>37253</td>
</tr>
</tbody>
</table>

### 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
- 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.
<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>CPT</th>
<th>S&amp;I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BREAST CORE NEEDLE BIOPSY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stereotactic guidance, 1st lesion</td>
<td>19081</td>
<td>Included</td>
</tr>
<tr>
<td>Stereotactic guidance, each additional lesion</td>
<td>+19082</td>
<td>X</td>
</tr>
<tr>
<td>Ultrasound guidance, 1st lesion</td>
<td>19083</td>
<td>Included</td>
</tr>
<tr>
<td>Ultrasound guidance, each additional lesion</td>
<td>+19084</td>
<td>X</td>
</tr>
<tr>
<td>Magnetic resonance guidance, 1st lesion</td>
<td>19085</td>
<td>Included</td>
</tr>
<tr>
<td>Magnetic resonance guidance, each additional lesion</td>
<td>+19086</td>
<td>X</td>
</tr>
<tr>
<td>Tomosynthesis guidance without stereotactic</td>
<td>19499</td>
<td></td>
</tr>
</tbody>
</table>

*Breast Biopsy includes imaging, localization device, and imaging of biopsy specimen, when performed*

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>CPT</th>
<th>S&amp;I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BREAST LOCALIZATION DEVICE W/O BREAST BIOPSY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammographic guidance, 1st lesion</td>
<td>19281</td>
<td>Included</td>
</tr>
<tr>
<td>Mammographic guidance, each additional lesion</td>
<td>+19282</td>
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</tr>
<tr>
<td>Stereotactic guidance, 1st lesion</td>
<td>19283</td>
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</tr>
<tr>
<td>Stereotactic guidance, each additional lesion</td>
<td>+19284</td>
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</tr>
<tr>
<td>Ultrasound guidance, 1st lesion</td>
<td>19285</td>
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</tr>
<tr>
<td>Ultrasound guidance, each additional lesion</td>
<td>+19286</td>
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</tr>
<tr>
<td>Magnetic resonance guidance, 1st lesion</td>
<td>19287</td>
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</tr>
<tr>
<td>Magnetic resonance guidance, each additional lesion</td>
<td>+19288</td>
<td>X</td>
</tr>
<tr>
<td>Surgical specimen radiography</td>
<td>76098</td>
<td></td>
</tr>
</tbody>
</table>

*A diagnostic post-procedure mammogram may not be coded in addition to mammographic guided biopsies nor device localizations.

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>CPT</th>
<th>S&amp;I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OTHER BREAST PROCEDURES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound Guidance</td>
<td>76042</td>
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<tr>
<td>Computed Tomography Guidance</td>
<td>77012</td>
<td></td>
</tr>
<tr>
<td>Magnetic Resonance Guidance</td>
<td>77021</td>
<td></td>
</tr>
<tr>
<td>Puncture aspiration of cyst of breast</td>
<td>19000</td>
<td>By modality</td>
</tr>
<tr>
<td>Puncture aspiration of cyst of breast; each additional cyst</td>
<td>+19001</td>
<td>X, By modality</td>
</tr>
<tr>
<td>FNA Bx w/o Imaging, first lesion</td>
<td>10001</td>
<td>No image</td>
</tr>
<tr>
<td>FNA Bx w/o Imaging, ea add'l</td>
<td>+10004</td>
<td>No image</td>
</tr>
<tr>
<td>FNA Bx w/ Ultrasound, first lesion</td>
<td>10005</td>
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</tr>
<tr>
<td>FNA Bx w/ Ultrasound, ea add'l</td>
<td>+10006</td>
<td>Included</td>
</tr>
<tr>
<td>FNA Bx w/ Fluoro, first lesion</td>
<td>10007</td>
<td>Included</td>
</tr>
<tr>
<td>FNA Bx w/ Fluoro, ea add'l</td>
<td>+10008</td>
<td>Included</td>
</tr>
<tr>
<td>FNA Bx w/ CT, first lesion</td>
<td>10009</td>
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<tr>
<td>FNA Bx w/ CT, ea add'l</td>
<td>+10010</td>
<td>Included</td>
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<tr>
<td>FNA Bx w/ MR</td>
<td>10011</td>
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<tr>
<td>FNA Bx w/ MR, ea add'l</td>
<td>+10012</td>
<td>Included</td>
</tr>
<tr>
<td>Injection for Galactogram or Ductogram, Single Duct</td>
<td>19030</td>
<td>77053</td>
</tr>
<tr>
<td>Injection for Galactogram or Ductogram, Multiple Ducts</td>
<td>19030</td>
<td>X, 77054</td>
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<tr>
<td>Sentinel Node Injection</td>
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<tr>
<td>Lymphatics and Lymph Nodes Imaging (includes code 38792, if performed)</td>
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<td>78195</td>
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</table>

*Code 10022 has been deleted. To report, see 10005, 10006, 10007, 10008, 10009, 1010, 1011, 1012). Do not report 10004, 10021 in conjunction with 10005, 10006, 10007, 10008, 10009, 1010, 1011, 1012 for the same lesion.*

<table>
<thead>
<tr>
<th>Procedure Description</th>
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<th>S&amp;I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SOFTWARE MARKER PLACEMENT OTHER THAN BREAST TISSUE</strong></td>
<td></td>
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</tr>
<tr>
<td>Placement of soft tissue localization device(s), perc, 1st lesion</td>
<td>10035</td>
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</tr>
<tr>
<td>Placement of soft tissue localization device(s), perc, ea. add'l lesion</td>
<td>+10036</td>
<td>X</td>
</tr>
</tbody>
</table>

*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.*

<table>
<thead>
<tr>
<th>Procedure Description</th>
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<th>S&amp;I</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAMMOGRAM and TOMOSYNTHESIS</strong></td>
<td></td>
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</tr>
<tr>
<td>Diagnostic Unilateral</td>
<td>77065</td>
<td>Included</td>
</tr>
<tr>
<td>Diagnostic Bilateral</td>
<td>77066</td>
<td>Included</td>
</tr>
<tr>
<td>Screening</td>
<td>77067</td>
<td>Included</td>
</tr>
<tr>
<td>Digital breast tomosynthesis; unilateral</td>
<td>77061</td>
<td>N/A</td>
</tr>
<tr>
<td>Digital breast tomosynthesis; bilateral</td>
<td>77062</td>
<td>N/A</td>
</tr>
<tr>
<td>Screening digital breast tomosynthesis, bilateral</td>
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<td>N/A</td>
</tr>
</tbody>
</table>

*For Medicare, use G0279 to report diagnostic digital breast tomosynthesis.*

Mammogram codes 77065-77067 include computer-aided detection (CAD), when performed

+ = Add-on code