SVS 2015 Coding Guide

4th Edition, Version 2015.0.1

Introduction

The Society for Vascular Surgery has developed this *Vascular Surgery Coding Guide* in response to the numerous coding questions that we receive from our members. The *Guide* is designed to assist vascular surgeons and their coding and billing staff with accurate reporting of vascular procedures.

The Centers for Medicare and Medicaid Services (CMS) changed payment from "customary, prevailing, and reasonable" charge to a standardized schedule called the Resource Based Relative Value Scale (RBRVS) in 1992. This system was created to better manage and control Medicare reimbursement using a basic element termed the Relative Value Unit or RVU. All codes for procedures and services have a unique five-digit identifier within the Current Procedural Terminology (CPT®) manual and each of these codes has been assigned specific RVUs by CMS. Each CPT code has been assigned physician work RVUs, practice expense RVUs, and malpractice expense RVUs by CMS, and the total RVU value for a single procedures is the sum of these three. For purposes of Medicare payment, the total RVUs are multiplied by a variable referred to as the "conversion factor" which is a dollar value that Medicare Part B pays for each RVU. The conversion factor is determined annually by Congress. Additionally, many private payers use the RBRVS schedule and their own conversion factor for payment.

In this 2015 Edition, each code is presented separately with coding tips, frequently asked questions (FAQs), and other relevant data, including 2015 Medicare RVUs and payment policy relative to the use of modifiers for multiple procedures, bilateral procedures, assistants at surgery, co-surgery, and team surgery.

We are confident that users will find the SVS® Vascular Surgery Coding Guide, 2015 Edition a practical adjunct to their own clinical judgment and coding experience.

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Important Notice

Important Notice

The SVS Vascular Surgery Coding Guide, 2015 Edition ("Guide") has been developed as a practical adjunct to a vascular professional's own clinical judgment and coding experience. The Guide is presented by SVS for educational and informational purposes only. SVS is not undertaking to render specific billing or coding advice. You must rely solely on your own judgment to determine what billing practices and procedures, whether included in the Guide or not, are appropriate for your institution or practice.

The coding tips and FAQs are not intended to present the only coding method, but rather are intended to represent an approach, view, statement, or opinion of the authors, which may be helpful to others who face similar situations. SVS does not "approve" or "endorse" any specific methods, practices, or sources of information. Insurance carrier policies vary; accordingly, none of the information contained in the Guide should be relied on as a substitute for the specific policy of a particular carrier or the specific policies established by your practice or your institution's compliance department. Each practice and institution must establish its own policies and procedures regarding appropriate billing for vascular services in compliance with its carrier policy and all applicable state and federal laws.

The Guide is explicitly not intended to present a standard of care or a practice parameter.

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Payment Policy and Modifier Guidelines

PAYMENT POLICY AND MODIFIER GUIDELINES

GLOBAL PERIOD

Every code in the Medicare fee schedule is assigned a global period indicator by CMS.

The assignment of 000, 010, or 090 includes physician services provided within 24 hours prior to the primary service; provision of the primary service; and other inherent physician services, including visits, for a specified number of days after the service (ie, 0, 10, or 90 days), as determined by CMS for Medicare payment purposes.

A global period of XXX is typically assigned to non-invasive services, such as codes for imaging and diagnostic services, vascular lab studies, pathology services, and evaluation and management services. There is no specific number of care days related to codes with a global period designation of XXX. Pre-service and post-service activities directly related to the provision of the service are included in the total work for the service independent of when these activities occur. For example, post-service work for diagnostic imaging such as signing a transcribed report for the medical record or discussion with the referring physician may occur on the day of the service or on a subsequent day, but this work is included in the total work for the imaging service.

A global period of ZZZ is assigned to "add-on" codes that are always performed in conjunction with another procedure or service. In most instances, the work for these codes is related only to the additional intra-service work required, since all or most of the pre- and post-service work is already included in the primary service.

The assignment of YYY is placed on codes that are carrier-priced. The global period, coverage determination, and payment is set by the contractor (for example, unlisted surgery codes).

MODIFIERS

Modifiers are two digit numbers appended to CPT codes when a claim is submitted to the insurance carrier. They help describe circumstances where payment should be altered from standard reimbursement or rendered in a situation normally denied.

Modifiers TC (technical component) and 26 (professional component) are specific modifiers important in the accurate reporting of imaging and diagnostic services such as vascular lab studies. When the equipment to perform a service is owned by a practice and the service is performed in an office setting, the practice would submit a claim with no modifier appended to the code for the service. This is termed "global billing" since both the technical and professional components for a given test are provided. On the other hand, if a test is performed in a facility (eg, hospital or ASC), where the facility owns the equipment, a physician would submit a claim with modifier 26 appended to the code for the service. This signifies that the physician has provided the professional interpretation of the test but does not own the equipment or necessary supplies (eg, duplex scanner or in the case of interventional procedures, the catheters, stents, balloons, contrast), and does not employ the staff required to perform the technical portion of the procedure.

Modifier 51 (multiple procedures) is appended to procedure codes that are reported on the same day during the same session. When reporting multiple codes, rank the codes by fee schedule total RVUs and apply the appropriate reduction to each code (100%, 50%, 50%, 50%, 50%). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. Do not append modifier 51 to codes with a ZZZ global period or to codes for E/M services, physical medicine and rehabilitation services, or provision of supplies (eg, vaccines). Also do not append modifier 51 to other select codes that are exempt, as designated in Appendix E of the CPT manual (eg, 36620). **Important note:** Many payers (including Medicare) recommend against reporting modifier 51 on claims. Their processing systems have hard-coded logic to append the modifier automatically to the appropriate codes on each claim.

Modifier 50 (bilateral procedures). When reporting bilateral procedures, most payers (including Medicare) require that the procedure code be reported on one line, the unit be listed as 1, and modifier 50 be appended (eg, XXXXX-50, units = 1). For instances where procedures can be performed on contralateral anatomic sites (such as bones, joints), paired organs (such as ears, eyes, kidneys, lungs, ovaries), or extremities (such as arms or legs), it may be appropriate to use HCPCS modifiers LT and RT. However, the same convention of reporting on one line, with one unit is followed (eg, XXXXX-LT,RT, units = 1). The payment for bilateral procedures is the lower of: (a) the total actual charge for both sides; or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

Modifier 59 (distinct procedure service) . The addition of this modifier to a code indicates to the carriers or fiscal intermediaries that the procedure or service represents a distinct procedure or service from others billed on the same date of service. In other words, this may represent a different session, different anatomical site or organ system, separate incision/excision, different lesion, or different injury or area of injury (in extensive injuries). CPT® indicates that when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Modifiers 80, 81, or 82 (assistant surgeon) . Some surgical procedures require a primary surgeon and an assistant surgeon. CMS has identified those surgical procedures for which an assistant surgeon may be reimbursed for Medicare patients. Payment is generally not made for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service. Medicare payment for an assistant surgeon is limited to 16% of the fee schedule amount for the surgical procedure.

Independent of the CMS Medicare fee schedule designation of codes approved for assistant surgeon billing, the American College of Surgeons publishes a report on the need for a physician as an assistant at surgery for all codes listed in the "Surgery" section of CPT®. Twenty-two national surgical societies (including SVS) participate in this effort. This document is often helpful when the need to submit a report for assistant surgeon payment is necessary.

Modifier 62 (co-surgery). Under some circumstances, the individual skills of two surgeons are required to perform surgery on the same patient during the same

operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physician is not acting as an assistant-at-surgery. It is not always co-surgery when two doctors perform surgery on the same patient during the same operative session. Co-surgery has been performed if the procedure(s) performed are part of and would be billed under the same surgical code, (eg, 22558 performed by a vascular surgeon and orthopaedic surgeon). In this case, each physician reports code 22558 with modifier 62 appended. Medicare payment for each surgeon is 62.5% of the Medicare Fee Schedule amount. If co-surgeons are of the same specialty, operative reports must be submitted. When performing co-surgery, it is important to communicate with the other surgeon's office to be certain that the claims are submitted properly.

Modifier 66 (team surgery). Similar to co-surgery, team surgery also refers to a single procedure; however, it requires the skills of more than two surgeons of different specialties, working together to carry out various portions of a complicated surgical procedure. For example, a kidney transplant could involve the services of a general surgeon, a urologist and/or a vascular surgeon to remove the diseased kidney, to revise vessels prior to implantation of the donated kidney and to transplant the ureters. Payment for codes defined as eligible for team surgery will be reimbursed on an individual consideration basis by report.

Discussion: Component Coding and Bundled Coding

DISCUSSION: Component Coding and Bundled Coding

In the past few years, the Centers for Medicare and Medicaid services have required bundling of services that are typically reported together to create new "bundled" codes. This is in contrast to historic "component coding." Keep in mind that even if a code has been created or revised to bundle some services, there may still be "component" codes that can be separately reported. The following discussion addresses component coding and highlights new or revised bundled codes.

Component coding is used for diagnostic angiography as well as some interventional procedures. In general, component coding requires that for diagnostic angiographic procedures at least one catheter placement code and one radiological supervision and interpretation (S&I) code are reported. Thorough documentation is required such that each code that is reported can be identified as a specific service within the formal procedure report. Catheterization coding requires description of the arterial entry site, the vessels traversed within the body, and final resting point of the catheter tip at the time of imaging. Any movement of the catheter should be noted, including the subsequent imaging and/or intervention. An important topic in endovascular coding is selective and non-selective catheterization with respect to a vascular family. Non-selective implies that the puncture vessel itself is cannulated for imaging or that a catheter is advanced along the artery retrograde from the puncture into the aorta. For non-selective catheterization, it does not matter whether the access site is the brachial artery or the femoral artery as long as the catheter is advanced into the aorta. This non-selective catheterization of the aorta is reported with code 36200.

Selective catheterization occurs when a catheter is maneuvered into the desired vessel by traversing a branch point. In most circumstances, a first order catheterization will occur when a named vessel is entered from the aorta. A vascular family is a network of vessels that originates from an arterial branch arising from a non-selective vessel. Typically the non-selective vessel is the aorta, and as an example, selective catheterization of the celiac artery from the aorta is a first order catheterization. As further branching occurs within a vascular family, the arteries are designated second order and third order. Since there is work involved manipulating the catheter to access the desired second and third order vessels, the physician work relative value units of a second order catheterization is greater than that for a first order, and a third order selective catheterization has a greater relative value than a second order. Branch point negotiation beyond third order is not recognized in component coding. When selective catheterizations occur below the diaphragm, codes 36245, 36246, and 36247 describe first, second, and third order catheterizations, respectively. When selective catheters are placed within vascular families above the diaphragm, codes 36215, 36216, and 36217 describe the first, second, and third order catheterizations, respectively. Every vascular family that is selected during an angiogram for imaging and/or intervention purposes will generate a separate and distinct catheter code with the exception that the lower extremity interventional codes include (ie, bundle) the catheterization.

If a catheter is brought back into a non-selective position and a separate vascular family is catheterized, this will necessitate an additional catheterization code. For example, if the right common femoral artery is punctured, the non-selective catheterization code 36140 would be reported. This includes retrograde femoral artery access. If the catheter is advanced into the aorta, the non-selective catheterization code 36200 would be reported and not code 36140. Code 36200 includes the work described within code 36140 as well as the additional work required to advance the catheter into the aorta. Similarly, if the celiac artery is cannulated as a first order catheterization, code 36245 would be reported instead of code 36200. Code 36245 includes the physician work associated with the work required to not only get the catheter into the aorta but also to select the celiac artery. If the catheter is pulled back into the aorta and then placed in the superior mesenteric artery which is an entirely different vascular family, reporting a separate and distinct code (36245) would be appropriate. If a catheter is further advanced within a given vascular family, branch points will need to be negotiated. A selective catheterization of the celiac artery would be termed “first order” and reported with code 36245. However, if the catheter is advanced into the common hepatic artery past the left gastric and splenic artery branch points, the catheter is now in a “second order” vessel. Second order catheterization below the diaphragm is reported with code 36246 and includes the work of 36245 plus the work to enter the second order vessel. Further advancement of the catheter into the proper hepatic artery past the gastroduodenal artery branch point is a “third order” catheterization. Third order catheterization is reported with code 36247 and, following the previous examples, supersedes code 36246.

If the physician enters a vascular family and proceeds to second or third order catheterization, there are times when the catheter is pulled back within that family (but not back into the aorta) and a separate second or third order branch is selected for further angiography. An example is selective catheterization through the innominate artery into the right common carotid artery for carotid imaging. This is a second order catheterization above the diaphragm, reported with code 36216. The catheter is pulled back into the innominate artery and then into the right subclavian artery for further imaging. Placement of the catheter into the right subclavian artery is a “subsequent second or third order” catheterization and is reported with the add-on code 36218. Similarly, if this occurred below the diaphragm, code 36248 would be reported.

IMAGING

Imaging includes image intensifier manipulation, table positioning, contrast injection, and interpretation of the angiography in a specific vascular bed. All hospital based imaging necessitates appending modifier 26 to the code to designate only the professional component of the imaging. As a general rule, when a catheter is repositioned and imaging occurs, another code is generated. Some imaging requires a selective catheter placement. Therefore, non-selective catheterizations such as 36200 could never be used at the same time as any of these imaging codes. Examples include visceral, spinal, adrenal, and pelvic arteriography. Coding these imaging services with a non-selective catheterization would be a red flag to insurance carriers for inappropriate billing practices.

To start, the basic exam is coded first, followed by subsequent exams. Abdominal aortography (75625) and bilateral lower extremity arterial runoff (75716) are standard basic imaging codes for vascular surgeons. However, some subsequent exams include the basic exam. An example of this is a visceral artery selective arteriogram. The visceral arteriogram code (75726) includes selective visceral angiography as well as flush aortography. Therefore, a basic abdominal aortogram (75625) would never be coded at the same time as a selective visceral arteriogram (75726) since the renal study includes the work for interpreting the aortogram as well as the selective renal images.

In previous years, many practices performed a diagnostic angiogram and identified a lesion that could be treated with an endovascular therapy. Anywhere from one day to several days later, the same angiogram was repeated at the time of percutaneous intervention. This allowed for payment of the angiography twice for the same clinical condition. To discourage this practice and to ensure that Medicare would only pay once for angiography, version 10.3 of the National Correct Coding Initiative created an edit in the policy manual that bundled imaging with intervention unless modifier 59 (distinct service) is appended to the imaging code. Therefore, a physician must

dictate into the operative report at the time of endovascular intervention if no prior angiography was done in a given clinical situation which then allows addition of modifier 59 to the imaging code(s) for reimbursement. The CPT manual now has introductory wording with guidelines on reporting imaging at the time of endovascular intervention as well. CPT and CMS differ in their interpretation of prior angiography. CPT states this is catheter-based contrast angiography whereas CMS feels that a CTA also counts. Since many patients come to the angiography suite based on a CTA, this is important when billing Medicare beneficiaries in such a situation. Both CMS and CPT agree that MRA does not qualify as "prior imaging" in this discussion.

ENDOVASCULAR INTERVENTION

The last component of endovascular billing is the concept of intervention, including embolization, transluminal angioplasty, stent placement, atherectomy, thrombolysis, transcatheter foreign body retrieval, or endograft deployment. Many "complete" procedures are described by reporting two codes: one code which begins with a "3" (what you did in the angiography suite) and another code that begins with a "7" (what you saw on the monitor in the angiogram). The latter code is the radiological supervision and interpretation (S&I) code submitted with modifier 26 appended to signify professional component billing in the hospital (or facility) setting. Some codes, however, bundle the procedure and radiologic S&I (eg, endovascular arterial stent placement outside the lower extremity). You should always read the code descriptor thoroughly to determine what services cannot be separately reported because they are inherent (or "bundled").

ANGIOPLASTY

Percutaneous transluminal angioplasty (PTA) involves inflation of a balloon within a stenotic or occluded vessel. The procedure is coded per vessel treated and grouped into "renal or other visceral," "aortic," "brachiocephalic trunk or branches," and "venous" for coding purposes. An additional radiological S&I code is reported for each vessel treated (75962-75968, 75978). The first peripheral artery PTA includes reporting 75962 while all *subsequent* peripheral vessels treated with PTA allow for the add-on code 75964. Codes 75962 and 75964 are only appropriate for upper extremity PTA at present. Similarly, the initial renal, visceral, or aortic PTA permits reporting 75966 while all *subsequent* renal, visceral, or aortic PTA require the add-on code 75968. If several inflations are performed at varying locations along a given vessel, only one intervention can be submitted for reimbursement. There is one set of codes to report open angioplasty (35450-35460) and another set to report the percutaneous approach (35471-35476) to the same vessel. It is important to differentiate between these two approaches since they refer to the arterial access and not the therapy itself. Percutaneous implies a needle is inserted through the skin and the artery is not visualized directly while "open" refers to surgical dissection of the puncture site, direct puncture into the vessel (eg, common femoral artery) and then direct suture repair of the artery. A hard copy image of the inflation must be preserved for documentation purposes in all cases.

INTRAVASCULAR STENT

For CPT 2014, four new codes were created to report bundled intravascular services (37236-37239). These new codes do not differentiate approach and instead state open or percutaneous.

Codes 37236-37239 continue the convention of one code to report first vessel treated by stenting and a separate code to report each additional vessel stented. In addition, the specialties involved in creating these new codes agreed there was a difference in the physician work associated with placement of a stent in the arterial system compared to the venous system, and therefore separate codes were created to differentiate arterial and venous stenting (ie, initial arterial stent, subsequent arterial stent, initial venous stent, subsequent venous stent). Despite reporting "per vessel" treated, the intervention should be reported only once if a lesion extends across the margins of one vessel into another, but can be treated with a single therapy.

Codes 37236-37239 bundle the surgical procedure with the radiologic supervision and interpretation. These services describe placement of a stent outside the lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary arteries. **Included** with each procedure are: all balloon angioplasty performed in the treated vessel including treatment of a lesion outside the stented segment but in the same vessel; any pre-dilation (whether performed as a primary or secondary angioplasty – ie, failed angioplasty requiring stent salvage); post-dilation following stent deployment; radiological supervision and interpretation directly related to the intervention performed; and closure of the arteriotomy by pressure, application of an arterial closure device or standard closure of the puncture by suture; and completion angiography. **Excluded** and separately reportable are: angioplasty in a separate and distinct vessel; non-selective and/or selective catheterization (unlike in the lower extremity where the catheter is bundled); extensive repair or replacement of an artery (eg, 35226, 35286, 35371); ultrasound guidance (eg, 76937) for vascular access; intravascular ultrasound (ie, 37250, 37251); and the initial diagnostic angiogram (as defined under "Vascular Procedures" in the CPT manual Radiology section).

37236 Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

37237 each additional artery (List separately in addition to code for primary procedure)

37238 Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein

37239 each additional vein (List separately in addition to code for primary procedure)

These code changes officially eliminate the "intent rule" for angioplasty services. Covered stents are considered identical to bare metal implants from a coding perspective in these locations when treating atherosclerotic arterial occlusive disease. Despite bundling, mechanical thrombectomy and thrombolysis are still reported using component coding guidelines, in addition to the endovascular intervention, when clinically appropriate. Specific advice has been added for the treatment of arterial aneurysms by thrombo-exclusion: when an endovascular stent is deployed as a cage to trap embolization coils, the embolization code is reported and not the stent code. Alternatively, the stent deployment code should be reported and not the embolization code if a covered stent is inserted as the sole treatment of the vascular abnormality.

LOWER EXTREMITY ARTERIAL ENDOVASCULAR INTERVENTION

The bundled lower extremity intervention codes are based on anatomic location and type of vessel treatment with progressive hierarchies that describe more intensive endovascular services that are inclusive of lesser therapies. These codes do not differentiate the approach and apply to both open or percutaneous access. That means femoral artery exposure to facilitate access and subsequent direct arterial repair after deployment of a stent is bundled. The coding guidelines state "these lower extremity endovascular revascularization codes all include the work of accessing and selectively catheterizing the vessel, traversing the lesion, radiological S&I directly related to the intervention(s) performed, embolic protection if used, closure of the arteriotomy by pressure and application of an arterial closure device or standard closure of the puncture by suture, and imaging performed to document completion of the intervention in addition to the intervention(s) performed." In essence, all work necessary after diagnostic angiography required to complete the procedure has been included in a single code except extensive open surgical arterial repair, endarterectomy, patch closure, or bypass, which may be separately reported (eg, 35226 or 35286). Diagnostic angiography has not been included or valued as part of the bundled work. The radiology coding for aortography (75625) and lower extremity angiography (75710, 75716) are still reportable, but require appending modifier 59 when submitted at the time of lower extremity arterial intervention provided three other provisions exist: 1) No prior catheter-based angiographic study is available; 2) A full diagnostic study is performed; and 3) The decision to intervene is based on this study. This also assumes that the medical record justifies the above stipulations.

The patient's lower extremity arterial tree has been divided into three specific territories: iliac, femoropopliteal, and tibial/peroneal. These all refer to the ipsilateral leg. *Iliac* incorporates intervention on the common, external, or internal iliac arteries. *Femoropopliteal* comprises treatment of the common, superficial, and deep femoral arteries as well as the popliteal artery both above and below the knee. *Tibial/peroneal* accounts for the posterior tibial, anterior tibial, and peroneal arteries. The common tibioperoneal trunk, for coding purposes, is included as an extension of either the posterior tibial or peroneal artery for intervention and is not considered a separate vessel.

The four intervention groups are listed as: 1) PTA; 2) intravascular stent placement with or without PTA; 3) atherectomy with or without PTA; and 4) both intravascular stent placement and atherectomy with or without PTA. The most comprehensive treatment is reported for each territory. Primary stent placement is coded identical to pre-dilatation followed by deployment of a stent which is also reported similar to failure of an angioplasty that requires stent salvage. This eliminates the "intent rule" for PTA services in the lower extremity. Covered stents are considered identical to bare metal implants from a coding perspective in these locations when treating atherosclerotic arterial occlusive disease. Despite bundling, mechanical thrombectomy and thrombolysis are still reported using component coding guidelines in addition to the endovascular intervention where clinically appropriate.

Prior to 2011, angioplasty of the common femoral, superficial femoral, and deep femoral arteries in the same setting could be reported using at least three separate surgical codes and three radiological S&I submissions. With the new scheme, intervention upon the femoropopliteal territory results in only one code submission to the insurance carrier. Therefore, treatment of one vessel such as the superficial femoral artery (SFA) is identical from a coding perspective to a case where simultaneous intervention on the deep femoral, common femoral, superficial femoral, and popliteal arteries are all performed. The "highest" level of treatment in this vascular bed is most appropriate to bill. That is, PTA of one part of the SFA and stenting within another area of the SFA should be reported using the "stent" code and not the "PTA" code. "Stent" placement is a more comprehensive procedure, includes use of an angioplasty balloon as needed, and has a higher relative value in both the facility and non-facility.

Unlike the femoropopliteal region which bundles all vessel therapy into a single description, the other two territories have a base code as well as an add-on code option. Endovascular intervention within the iliac and the tibial/peroneal locations requires use of a base code for the initial vessel treated. If an additional ipsilateral artery (as defined above) is treated within that same territory, the add-on code is submitted in addition to the base CPT code. Since there are a total of three vessels in each of these two locations for a given extremity, the add-on code in a given territory can be reported a maximum of twice: once when two vessels in total are treated or twice when three vessels are addressed. In the latter scenario, the second submission requires use of modifier 59 to indicate it is a distinct service and not duplicative. If more than one vessel is treated in a given territory, the more comprehensive treatment is reported using the base code and the lesser intense therapy is billed using the add-on code. Each territory in the ipsilateral extremity subject to intervention requires one base code. If a bilateral procedure is reported in similar territories, the base code for each is reported because the new descriptions are based on ipsilateral therapy and therefore refer to one side of the body. The add-on code is only used on the same side as the associated base code. For example, "kissing" common iliac stents would require reporting the iliac stent base code twice. If different therapies are performed in same territory of the right and left lower extremity arterial circulation, the lesser intense base code necessitates modifier 59 be appended for reimbursement. A special notation was added to the introductory wording for instruction on reporting therapy when a single intervention crosses territories or spans two vessels in an area that has add-on coding available. It states, "If a lesion extends across the margins of one vessel vascular territory into another, but can be opened with a single therapy, this intervention should be reported with a single code despite treating more than one vessel and/or vascular territory." In contrast, more extensive lesions with plaque burden in both the common and external iliac arteries do not fall under these guidelines since the vascular specialist must plan his/her therapy for each vessel.

The table below outlines the lower extremity endovascular arterial intervention coding structure:

FIRST VESSEL TREATED (000-GLOBAL)				
	Angioplasty	**Atherectomy includes all angioplasty in same vessel**	**Stent includes all angioplasty in same vessel**	**Stent & Atherectomy includes all angioplasty in same vessel**
Iliac	**37220**	**0238T**	**37221**	N/A
Fem-Pop	**37224**	**37225**	**37226**	**37227**
Tibial	**37228**	**37229**	**37230**	**37231**

ADDITIONAL VESSEL TREATED IN SAME TERRITORY (ZZZ-GLOBAL)				
	Angioplasty	**Atherectomy**	**Stent**	**Stent &**

		includes all angioplasty in same vessel	includes all angioplasty in same vessel	Atherectomy includes all angioplasty in same vessel
Iliac	**37222**	N/A	**37223**	N/A
Fem-Pop	N/A	N/A	N/A	N/A
Tibial	**37232**	**37233**	**37234**	**37235**

Supra-inguinal atherectomy was converted from Category I to Category III due to a lack of supporting peer-reviewed literature validating its use in these vessels. Additionally, the surgical procedure code was bundled with the radiological S&I code. However, unlike the Category I lower extremity coding changes; the catheterization was left separate for the time being because all other interventions in these regions follow a similar convention. These codes are listed as "*Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation*":

0234T Renal artery

0235T Visceral artery (except renal), each vessel

0236T Abdominal aorta

0237T Brachiocephalic trunk and branches, each vessel

0238T Iliac artery, each vessel

IVC FILTER

There are three bundled codes for reporting IVC filter insertion, revision, and removal. Code 37191 includes introduction of a catheter into the inferior vena cava, deployment of the vena cava filter, and IVC venography. Code 37191 (insertion) bundles all venous non-selective and selective catheterization(s) required to insert an IVC filter, as well as radiological S&I and all imaging guidance. Codes 37192 (revision) and 37193 (removal) include vascular access, vessel selection, radiological S&I, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy). Do not report ultrasound guidance (76937, 76942, 76998), IVUS (37250, 37251), fluoroscopic guidance (76000, 76001), or IVC angiography (75825) with any of these three new IVC filter codes.

EMBOLIZATION

Embolization implies percutaneous placement of a thrombogenic material through a selective catheter in an attempt to occlude an aneurysm, arteriovenous malformation, or bleeding site. Glue and coils are typical agents employed in the process. Additionally, most embolization procedures are followed by contrast angiography to evaluate the adequacy of the thrombosis. Outside the head and neck region, this therapy is reported with four codes. Code 37241 is used to report embolization or occlusion procedures performed for venous conditions other than hemorrhage. An example would include AV access branch embolization. Code 37242 describes embolization or occlusion performed for arterial conditions other than hemorrhage or tumor. Examples include translumbar AAA sac coil embolization or splenic artery aneurysm embolization. Code 37243 denotes embolization for the purpose of tissue ablation and organ infarction or ischemia. Examples include uterine fibroid embolization, tumor embolization, or chemoembolization. Code 37244 encompasses embolization for treatment of hemorrhage or vascular or lymphatic extravasation. Examples include embolization of vessel perforation or GI bleeding source embolization. In the head and neck region, code 61626 (*Transcatheter permanent occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; non-central nervous system, head or neck (extracranial, brachiocephalic branch)*) is reported instead of code 37241, 37242, 37243, or 37244. This is important for vascular surgeons when treating carotid body tumors. The radiological S&I codes 75894 and 75898 remain appropriate for the head/neck scenario, but not elsewhere in the body. All procedure codes have a 0-day global assignment.

Several techniques for treatment of persistent type II endoleaks after endovascular infrarenal aortic aneurysm repair may be employed, but translumbar aortic sac puncture with embolization is most common. If a catheter is advanced from transfemoral or transbrachial access into the aorta, code 36200 is appropriate to report. However, if the catheter is inserted through a translumbar puncture into the aorta, code 36160 is the correct code to report. Either approach leaves the catheter in a non-selective position. If the inferior mesenteric artery (IMA) or a lumbar artery is purposely selected for imaging or intervention, each vascular family is separately reported. In most instances, code 36245 would replace the non-selective code (ie, 36200 or 36160) to indicate a first order position. For example, if the IMA and one lumbar artery require selection, code 36245 would be reported twice (36245 and 36245-59). Modifier 59 is appended to clarify the procedure as separate and distinct (not duplicative). Code 37242 describes this transcatheter embolization procedure. When the occlusive material is in place, follow-up angiography to assess for the adequacy of thrombosis is bundled.

The imaging usually begins with a standard abdominal aortogram (75625). When selective angiography is performed within a lumbar artery, code 75705 (*Angiography, spinal, selective, radiological supervision and interpretation*) is reported for each lumbar selected in addition to the aortogram. Visceral artery imaging using contrast angiography as described by code 75726 must involve selective catheterization into visceral artery proper. In this case, that requires a catheter in the IMA. Visceral imaging also specifically includes any flush aortography, if performed by the interventionalist, in the same session. Reporting visceral angiography (75726) with non-selective aortic catheterization (36200 or 36160) is always inappropriate. Additionally, reporting aortography (75625) and visceral angiography (75726) in the same setting is incorrect given that the visceral imaging descriptor states "with or without flush aortogram." Reporting these codes is dependent upon the presence or absence of prior imaging. Remember that one must dictate into the operative report at the time of endovascular intervention if no prior angiography was done in a given clinical situation which then allows appending modifier 59 to the imaging codes for reimbursement.

ENDOVASCULAR FOREIGN BODY RETRIEVAL

A single bundled code is reported for endovascular foreign body retrieval: 37197 *(Transcatheter retrieval, percutaneous, of intravascular foreign body (eg,*

fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed) .

Endovascular retrieval of a foreign body can occur in any vessel, both arterial and venous. The work required for retrieval will depend on the specific vessel that needs to be non-selectively or selectively catheterized. Therefore, it is anticipated that reporting such a procedure will include one or more vascular catheterization codes in addition to the bundled retrieval code. This reflects current coding practice and appropriately accounts for the highly variable work required for different retrievals.

Code 37197 includes: snaring of the foreign body; imaging guidance through fluoroscopy and/or ultrasound; radiological S&I; and moderate sedation. Therefore, intravascular ultrasound (37250, 37251) is bundled into 37197 as is ultrasound guidance for vascular access (76937) and fluoroscopic guidance for vascular access (77001), when performed. Code 37197 excludes: arterial or venous catheterization; any associated interventional procedures (eg, embolization, angioplasty, and endovascular stent placement); open surgical repair of the artery or vein where the foreign body is extracted; and any diagnostic imaging as outlined in the "Vascular Procedures" section of the CPT manual.

In the strictest sense, a vena cava filter is an endovascular foreign body. However, bundled code 37197 is specifically not appropriate for vena cava filter retrieval. Instead, code 37193 should be reported for endovascular removal of a vena cava filter through any approach (eg, jugular or femoral).

THROMBOLYSIS

Thrombolysis is the administration of a clot dissolving agent through a catheter which may open a clotted artery or vein. It is important to note that there is a difference between *injection* and *infusion* in the CPT manual. The codes for thrombolysis necessitate an actual prolonged *infusion* by pump of the agent in an area outside the angiography suite. Instilling a thrombolytic drug through a catheter as a bolus by hand is termed "injection" and therefore not reimbursable. Thrombolysis is usually administered in a hospital setting and a follow-up study is performed to evaluate the effectiveness of the treatment.

Four CPT codes describe the bundled work associated with endovascular thrombolytic infusion and its associated radiological S&I based on day of treatment:

37211 Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day

37212 Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

37213 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;

37214 Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method

Thrombolysis infusion can occur in any vessel, both arterial and venous. The work required for thrombolysis infusion will depend on the specific vessel that needs to be catheterized. Therefore, coding for the procedure will include one or more vascular catheterization codes in addition to the arterial or venous thrombolysis infusion code. This reflects current coding practice and appropriately represents the highly variable work required for thrombolysis of different vessels. The "treatment day" spans from midnight to midnight (ie, a single calendar day). Only one of these four new codes may be reported on a given date of service.

The initial day of arterial or venous treatment is reported with one of two codes: 37211 (arterial) or 37212 (venous). Once a decision is made to institute thrombolytic therapy, code 37211 or 37212 are reported and include exchange of the diagnostic catheter over a guidewire for a multi-hole infusion catheter and attachment to the infusion pump. Any return to the interventional suite for follow-up angiography or catheter repositioning / exchange on the same day is bundled into these codes. This was previously reported with 75898 *(Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion)* and/or codes 37209/75900 (Exchange of a previously placed intravascular catheter during thrombolytic therapy). If a patient requires bilateral thrombolytic infusion through separate access sites, modifier 50 is appended to either code 37211 or 37212, as appropriate. Non-selective or selective vascular catheterization to initially cross the thrombosed vessel is separately reported. If no prior angiography exists for the current clinical situation, it is often appropriate to report the imaging codes for diagnostic evaluation of the vascular tree (eg, 75625 and 75710 for aortogram with unilateral lower extremity runoff). Modifier 59 would be appended to the imaging codes to certify the lack of prior diagnostic angiography. Ultrasound guidance to establish vascular access remains separately reportable. Evaluation and management services related to the thrombolysis treatment after the institution of therapy are included and not separately reportable.

Codes 37211 (arterial) or 37212 (venous) are used to report initiation and termination of thrombolytic therapy when both occur on one calendar day. If the infusion continues overnight into the following calendar day, two additional CPT codes have been created for continued therapy and termination of therapy. Only one of these two codes may be reported per subsequent day of therapy. Code 37213 is used to report all follow-up angiography through the existing catheter, all infusion catheter exchanges, and continuation of thrombolytic infusion on a day other than the initial calendar day of therapy or other than the final day of infusion. For example, code 37213 would be reported on day 2 of a 3-day course of therapy or days 2 and 3 of a 4-day course of therapy.

Code 37214 is used to report all follow-up angiography through the existing catheter, all infusion catheter exchanges, and termination of thrombolytic infusion on a day subsequent to the initial calendar day of therapy. For example, code 37214 would be reported on day 2 of a 2-day course of therapy or day 4 on a 4-day course of therapy.

Codes 37213 and 37214 encompass any return to the interventional suite for follow-up angiography or catheter repositioning / exchange on the same day (ie, if two trips to the interventional suite for follow-up imaging / catheter manipulation are undertaken on the same date of service, no additional billing is allowed for the second imaging session). Exchange of a previously placed intravascular catheter during thrombolytic therapy is also bundled into the work of codes 37213 and 37214. Ongoing

evaluation and management services related to thrombolysis are also included in the work of codes 37213 and 37214. However, mechanical thrombectomy, percutaneous angioplasty, intravascular stent deployment, and placement of an inferior vena cava filter remain separately reportable.

EVAR / TEVAR / FEVAR

Both thoracic (TEVAR) and infrarenal (EVAR) aortic aneurysm repair by endograft follow similar coding conventions. In a stepwise fashion, report the main device deployment first. This is based on the type of endograft implanted. EVAR is reported based on the main body graft configuration: aorta-to-aorta tube graft (34800); modular with one docking limb (34802); modular with two docking limbs (34803); bifurcated unibody graft (34804); or aorto-uniiliac graft (34805). The association radiological S&I code for EVAR codes 34800, 34802, 34803, and 34805 is 75952. Placement of the initial docking limb(s) is bundled into the main body code. When a modular bifurcated graft is transformed into an aorta-uniiliac prosthesis with either a formal graft converter or an aortic cuff placed proximally, the two devices are collectively reported with code 34805.

Additional extensions both proximally and distally per vessel treated are reported separately. Report the first extension with 34825 and 75953. Each additional vessel treated by endograft extension is reported with 34826 and 75953. The radiological S&I code 75953 is the same for the first as well as the subsequent extensions such that subsequent submissions would require appending modifier 59 to identify that the replication of an identical code is not an accidental duplicate bill.

For TEVAR, the appropriate main body code is selected based on coverage of the left subclavian artery (LSA). If the main body does not cover the LSA, code 33881 and the radiological S&I code 75957 are appropriate. All distal extensions in the same session are bundled to the level of the celiac artery origin. Proximal thoracic aorta extension stentgraft deployment is reported with code 33883 and the radiological S&I code 75958 for the initial device. Subsequent thoracic aorta proximal stentgraft extensions are reported with the add-on code 33884 accompanied by the radiological S&I code 75958 for each implant. The radiological S&I code 75958 is the same for the first as well as the subsequent extensions such that subsequent submissions would require appending modifier 59 to identify that the replication of an identical code is not an accidental duplicate bill. When a third or more proximal extension is placed, code 33884 is reported with modifier 59 appended.

If the TEVAR main body is deployed in a manner that covers the LSA, code 33880 and the radiological S&I code 75956 are reported. Any thoracic aorta stentgraft extension deployment further proximal (potentially covering the left common carotid artery origin) follows the convention described above. Distal extensions in the same session are again not appropriate to report up to the celiac artery origin. There is one caveat to the TEVAR coding scheme that is often confusing. In the specific scenario where a proximal thoracic aortic extension stentgraft causes the LSA to be covered when the implanted TEVAR main body was originally placed distal to the LSA, the “distal to the LSA” main body (33881 and 75957) and proximal stentgraft extension coding (33883, 33884, and 75958) are voided. Instead, codes 33880 and 75956 are reported. For example, a TEVAR main body is placed distal to the LSA. Three proximal thoracic aortic stentgraft extensions are necessary to complete the endovascular exclusion of the aneurysm but the last stentgraft implant covers the LSA origin. In this scenario, codes 33880 and 75956 are reported for all the covered graft devices. If a further proximal extension is required in this example that approaches the left common carotid artery origin, codes 33883 and 75958 are then valid to report.

Any open arterial exposure is described. Usually femoral artery exposure and simple repair is reported with 34812, but complex primary repair (35226), prosthetic patch angioplasty (35286), and common femoral endarterectomy (35371) may supersede an exposure code. Cross femoral bypass with prosthetic conduit at the time of EVAR is reported with the add-on code 34813. Code 34820 denotes iliac artery exposure as necessary and 34833 conveys iliac artery exposure with the additional creation of a prosthetic graft conduit to assist in sheath insertion when small or heavily diseased external iliac arteries are encountered. When a brachial artery exposure (and repair) is warranted, code 34834 is reported.

The arterial catheter placements are next considered. Most patients undergoing standard EVAR and TEVAR will have two non-selective catheters (36200x2); one in each femoral artery that extends into the aorta. However, selective catheterization of a vascular family may be necessary (eg, celiac artery or LSA). Any separately reportable services are then added, such as stenting or percutaneous transluminal angioplasty outside of the infrarenal endograft landing zone (eg, renal artery), embolization of arteries that do not contain an endograft (eg, internal iliac, accessory renal, or inferior mesenteric artery), or deployment of an aneurysm pressure sensor (34806).

Upper extremity and cerebral revascularization procedures need to be addressed with TEVAR. Open subclavian to carotid artery transposition by itself is reported with code 35694. However, when this arm reconstruction is done in conjunction with TEVAR, code 33889 is correctly reported. The alternative, carotid to subclavian bypass with “other than vein,” is reported with code 35606. There is no difference in coding of this bypass based on whether it is performed in conjunction with TEVAR. Lastly, carotid-to-carotid artery retropharyngeal crossover bypass with “other than vein” carried out at the time of TEVAR is reported with code 33891.

If the arm reconstruction is performed days prior to the TEVAR, the arm revascularization coding may have a global period to take into consideration. In the case of code 33889, the global is 0-day while code 35606 has a 90-day global. The subsequent aneurysm repair would then necessitate appending modifier 58 (staged procedure) to all of the surgical TEVAR codes (ie, codes that begin with a "3") but not the radiological S&I codes (ie, codes that begin with a "7") after prosthetic carotid-subclavian artery bypass but not with a subclavian to carotid transposition. This would ensure payment for the aneurysm repair procedures that occurred within the 90-day postoperative period.

One cannot report distal thoracic aorta stentgraft extension codes at the time of primary repair. However, there are occasions where graft migration may occur or a patient may develop aneurysmal degeneration of the aorta distal to a previously implanted thoracic stentgraft. If a patient returns to operating room on a separate day for revision or extension of the original repair, codes 33886 and 75959 are reported, and only once, regardless of the number of distal extension prostheses implanted to the celiac artery origin. All other coding as described above applies.

Eight CPT codes exist for reporting fenestrated endovascular repair (FEVAR) of the visceral aorta. Codes 34841-34844 are used to report treatment of the visceral aorta alone and codes 34845-34848 are used to report concomitant repair of the visceral aorta and the infrarenal aorta.

The FEVAR codes are based on the number of fenestrations in the visceral segment and whether or not the aortic device extends into the common iliac arteries or terminates in the aorta above the aortic bifurcation. The fenestrations allow for selective catheterization of the visceral and/or renal arteries and subsequent placement of an endoprosthesis. The codes were constructed on the presence of one, two, three, or four or more fenestrations. Unlike the infrarenal aortic aneurysm endovascular

repair (EVAR) and thoracic aortic aneurysm endovascular repair codes (TEVAR), these eight codes bundle the introduction of catheters non-selectively into the aorta; selective arterial catheterization into the visceral and/or renal arteries that receive a stentgraft; and the radiology supervision and interpretation for the FEVAR procedure. Similar to EVAR and TEVAR, balloon angioplasty within the target treatment zone of the endograft, either before or after endograft deployment, is also bundled.

Codes 34841-34844 are used to report deployment of a fenestrated endoprosthesis that spans from the visceral aorta through the infrarenal aorta and does NOT extend into the common iliac arteries. Alternatively, codes 34845-34848 are used to report deployment of a fenestrated endoprosthesis that spans from the visceral aorta through the infrarenal aorta INTO the common iliac arteries. Codes 34845-34848 include placement of unilateral or bilateral docking limbs (depending on the device) into the iliac system similar to infrarenal EVAR. Proximal abdominal aortic stentgraft extension prostheses are never separately reported with FEVAR. If a concomitant TEVAR is performed, thoracic stentgraft prosthesis placement is billed following standard TEVAR coding guidelines. Any additional distal stentgraft extensions that terminate in the infrarenal aorta (ie, when codes 34841-34844 are performed) or in the common iliac arteries (ie, when codes 34845-34848 are performed) are bundled. However, distal stentgraft extension prostheses that terminate in the internal iliac, external iliac, or common femoral artery may be reported with codes 34825 and 34826.

Catheterization of the hypogastric artery(s) and/or arterial families outside the treatment zone of the graft may be reported separately as well interventional procedures performed at the time of FEVAR outside the treatment zone (eg, embolization of the hypogastric artery, stent placement in the distal native artery for dissection, etc.). Lastly, exposure of the access vessels (eg, 34812), extensive repair of an artery (eg, 35226 and 35286), or endarterectomy (eg, 35371) are not bundled into 34841-34848 and may be separately reported.

For CPT 2015, a new FEVAR planning code (34839) was approved to report the extensive pre-service time for endograft planning that occurs over the course of several days or weeks prior to the date of surgery and is outside the guidelines for the 90-day global period for the FEVAR procedure.

Code 34839 is used to report the physician planning and sizing for a patient-specific fenestrated visceral aortic endograft. The planning includes review of high resolution cross-sectional images (eg, CT, CTA, MRI) and utilization of 3D software for iterative modeling of the aorta and device in multiplanar views and center line of flow analysis. Codes 76376 and 76377 for 3D rendering may not be reported with 34839. Code 34839 may only be reported when the physician spends a minimum of 90 total minutes performing patient-specific fenestrated endograft planning. Physician planning time does not need to be continuous and should be clearly documented in the patient record. Code 34839 is reported on the date that planning work is complete and may not include time spent on the day before or the day of the FEVAR procedure.

All nine FEVAR codes (34839 & 34841-34848) are "Carrier Priced." As you may know, the AMA RUC utilizes a survey process to develop work RVU recommendations for new codes. Unfortunately, the SVS effort to survey the FEVAR codes resulted in an inadequate response. In view of the RUC emphasis on adequate survey sample size, SVS recommended "Carrier-Pricing" be extended at least through 2015 for the FEVAR Planning and Procedures codes (34839 & 34841-34848).

Carrier pricing may be variable depending upon the number of visceral/renal vessels included in the fenestrated repair as well as the need for other adjunctive maneuvers such as iliac conduit and extensive femoral artery reconstruction which are separately reportable.

SVS has prepared guidelines for requesting reimbursement for FEVAR in a table on the SVS website. The guidelines utilize a building block methodology to capture all of the steps included in these complex procedures. In addition, a surrogate value for the fenestrated main body stent was created by a blend of the codes for distal TEVAR extension and a proximal EVAR extension as this stent occupies the anatomy that lies between the two extensions. A blended S&I code was also created with the same rationale. This combination of endovascular infrarenal aneurysm code and selective renal/visceral interventions depending upon number of vessels will serve as building blocks to base reimbursement until the FEVAR codes can be appropriately surveyed and valued.

34839 Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time

34841 Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)

34842 including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

34843 including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

34844 including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

34845 Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)

34846 including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

34847 including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

34848 including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

CAROTID ANGIOGRAPHY

Codes 36221-36228 describe bundled non-selective and selective arterial catheter placement and diagnostic imaging of the aortic arch, carotid, and vertebral arteries

36221 Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

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

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

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

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

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

+36227 Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

+36228 Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)

The bundled work in these eight codes includes: accessing the vessel; non-selective aortic and selective innominate, carotid, and vertebral artery catheterization; contrast injection(s) of the aortic arch and carotid/vertebral systems including both arterial and venous phase; fluoroscopy; radiological S&I; and closure of the arteriotomy by pressure or application of an arterial closure device. The new codes specifically exclude: interventional procedures (eg, embolization, angioplasty, and endovascular stent placement); ultrasound guidance for vascular access (eg, 76937); selective arterial catheterization of vascular families outside the carotid and vertebral arteries; and 3D rendering (eg, 76376 or 76377).

The most basic service in this family of codes is the arch aortogram (36221). This service encompasses non-selective aortic catheterization as well as aortic arch angiography. Code 36221 can be reported as a stand-alone procedure. However, all subsequent bundled codes in this family include the work of 36221. Remember that all the codes in this series include at least non-selective aortic catheterization (36200). Therefore, angiography of the aortic arch and the abdominal aorta is now reported with codes 36221 and 75625. Finally, selective catheterization in a separate and distinct vascular family will require appending modifier 59.

Selective carotid artery imaging is reported based on several new unilateral codes. There is a hierarchy for these services based on level of catheter selection and the amount of imaging performed. Code 36222 includes a catheter in either the innominate artery or the common carotid artery with unilateral extracranial carotid imaging. If additional imaging is performed of the intracranial carotid system, code 36223 is reported. Lastly, the catheter may be introduced further into the internal carotid artery itself as described by code 36224. Only one of these three codes is applicable per side in the following order: 36224 > 36223 > 32222. Bilateral identical procedures append modifier 50. Bilateral procedures with different hierarchies append modifier 59 on the "lesser" hierarchical code. Angiography of carotid arteries without selective catheterization of the great vessels is reported only with code 36221. Follow-up imaging without further catheter selection (higher order) is bundled such that code 75774 is never used with this codeset.

Code 36227 is an add-on code for reporting external carotid artery selective catheterization and imaging. Since the external carotid artery is always selected after the common carotid artery is selected, code 36227 can only be reported with code 36222, 36223, or 36224. Further catheter selection (higher order) within the external carotid artery is bundled. Follow-up imaging within the external carotid artery is bundled such that code 75774 is never used with 36227.

Selective vertebral artery imaging is reported based on two new unilateral codes 36225 and 36226. There is a hierarchy of these services based on level of catheter selection and the amount of imaging performed. Code 36225 includes a catheter in either the innominate artery or the subclavian artery with unilateral vertebral artery imaging. The catheter may be advanced into the vertebral artery itself. Such a scenario is encompassed in code 36226. Only one of these two codes is applicable per side in the following order: 36226 > 36225. Bilateral identical procedures append modifier 50. Bilateral procedures with different hierarchies append modifier 59 on the "lesser" code in this hierarchy. Angiography of vertebral arteries without selective catheterization of the great vessels is reported only with code 36221. Follow-up imaging without further catheter selection (higher order) is bundled such that code 75774 is never used with this codeset.

Code 36228 is an add-on code to report selective intracranial catheterization. This may be performed in either the anterior (intracranial internal carotid artery branches) or the posterior (vertebrobasilar system) circulation with a maximum reporting of two per side (overall maximum reporting for 36228 is four per session). Unlike the add-on catheterization code 36218 which is used for selection of an additional branch after the first branch, code 36228 is appropriate for use in both the initial as well as an additional branch. Further selection within each branch is bundled. Code 36228 requires concurrent reporting of either 36223, 36224, 36225 or 36226. For example, selective catheterization of the internal carotid artery in which the catheter is advanced into the middle cerebral artery plus all associated imaging is reported with 36224 and 36228.

CAROTID ARTERY STENTING (CAS)

Two bundled codes are used to report endovascular treatment of extracranial carotid bifurcation occlusive disease. The codes are differentiated based on the use of embolic protection: carotid stent with embolic protection (37215), and carotid stent without embolic protection (37216). These bundled services have a 90-day global

period and include all selective catheterization, pre-stent angioplasty, post-stent angioplasty and all S&I except the great vessel origins. The CAS code is reported once regardless of the number of stents implanted. However, diagnostic catheterization and imaging on the opposite side or within the vertebral arteries is separately reportable. Code 37216 is currently a non-covered Medicare service (ie, not reimbursed).

CAS for non-research patients has strict coverage limitations. There is a March 15, 2005 CMS Coverage Memo which approves reimbursement only if a patient has all of four requirements: lateralizing transient ischemic attack or minor stroke (Rankin score < 3); "high risk" for carotid endarterectomy; 70% or worse stenosis confirmed by angiography; and use of an embolic protection device. That implies that if a carotid stent is planned but the embolic protection device cannot be advanced appropriately, the procedure, according to CMS guidelines, should be aborted and consideration for open endarterectomy be discussed. Private insurers, for the most part, have followed CMS's lead.

Additionally, CMS requires facility accreditation. To comply, each hospital must certify that it possesses an adequate imaging and equipment inventory, maintains appropriate consult support services, oversees a provider credentialing venue, ensures a data collection mechanism, and manages an internal analysis of outcomes at an interval less than every six months. The provider must also report his or her outcomes at least every two years including any patient treated outside of the coverage criteria on a FDA-approved trial.

For 2015, codes 37215 and 37216 were revised to include both "open or percutaneous" approach and to add text that clearly indicates that angioplasty and S&I are bundled. These codes only apply to extrathoracic carotid artery stenting.

For 2015, bundled Category III codes 0075T *(Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel)* and 0076T *(Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure))* were revised to include both the open or percutaneous approach and to apply only to extracranial vertebral artery stenting.

Bundled code 37217 (*Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation)* is used to report retrograde treatment of the intrathoracic common carotid artery and/or the innominate artery through an open cervical carotid artery exposure where the catheter is advanced from the common carotid artery in the neck toward the aortic arch. This bundled service includes open surgical exposure of the cervical carotid artery and standard closure of the arteriotomy by suture; all retrograde access and catheterization of the vessel to traverse the lesion; any radiological supervision and interpretation directly related to the intervention when performed (ie, includes the diagnostic angiogram); and the intervention(s) itself (ie, the stenting and angioplasty) with completion angiography.

Code 37217 specifically does not include other carotid artery revascularization services that may be performed during the same session such as carotid endarterectomy or carotid-subclavian artery bypass grafting. If a patient undergoes both carotid endarterectomy and retrograde intrathoracic common carotid artery stent placement in the same session, both codes 35301 and 37217 are reported. Parentheticals under the code description in the CPT manual list several examples of procedures that may be separately reported when performed in the same setting as code 37217. This includes, but is not limited to, codes: 33891 *(Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision)*, 35301 *(Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision)*, 35509*(Bypass graft, with vein; carotid-contralateral carotid)*, 35510 *(Bypass graft, with vein; carotid-brachial)*, 35601*(Bypass graft, with other than vein; common carotid-ipsilateral internal carotid)*, and 35606 *(Bypass graft, with other than vein; carotid-subclavian)*.

Codes 35201 *(Repair blood vessel, direct; neck)*, 35458*(Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel)*, 36221-36227 *(Diagnostic Studies of Cervicocerebral Arteries)*, and 75962 *(Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation)* are inherent to the service and cannot be reported with code 37217 in the same session for the ipsilateral carotid artery.

For 2015, a new bundled code was created to report antegrade stent placement in the innominate and intrathoracic carotid artery: 37218 *(Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation)* . Similar to CPT code 37215, this bundled code description includes ninety-day global services, includes all selective catheterization to perform the procedure, includes pre-stent angioplasty, includes post-stent angioplasty, and includes all ipsilateral radiology supervision and interpretation. It is reported once regardless of the number of stents implanted and allows for either percutaneous or open vascular access. Of note, diagnostic catheterization and imaging on the opposite side or within the vertebral arteries is separately reportable.

CPT codes 35458 (*Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel*), 35475 (*Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel*), 36221-36227 (Diagnostic studies of cervicocerebral arteries), 37236 (*Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery*) and 75962 (*Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation*) are inherent to the service and cannot be reported with CPT code 37218 in the same session for the ipsilateral carotid artery.

ENDOVASCULAR MESENTERIC ARTERY REVASCULARIZATION

Endovascular treatment of mesenteric arterial occlusive disease is governed by component coding for the use of catheters, imaging, and intervention. First, catheter placement is usually transfemoral but may be transbrachial and requires selection of the visceral artery origin. Advancement of the catheter beyond first order is generally not required and code 36245 would be reported. If the celiac and the superior mesenteric arteries are separate and distinct vessels each originating off the aorta, they belong to separate vascular families and each allow for a separate catheter code. The second catheter would require appending modifier 59 to clarify it as separate and distinct (ie, 36245 and 36245-59). If the vessels share a common trunk, each visceral vessel cannulation would be second order but within the same vascular family. The first vessel would be reported with code 36246 and the second vessel reported with code 36248 (subsequent second or third order catheterization in a given

vascular family). Second, inserting a catheter into the aorta and injecting contrast to evaluate the visceral arteries is simply coded as an aortogram (75625). Visceral artery imaging using contrast angiography as described by code 75726 must involve selective catheterization into either the celiac or superior mesenteric artery proper. Visceral imaging also specifically includes any flush aortography, if performed by the interventionalist, in the same session. Reporting visceral angiography (75726) with non-selective aortic catheterization (36200) is always inappropriate. Additionally, reporting aortography (75625) and visceral angiography (75726) in the same setting is incorrect given that the visceral imaging descriptor states "with or without flush aortogram." After the initial selective visceral angiogram is performed, some situations require more selective advancement of the catheter within a vascular family and further contrast injection. The catheter code would be reported based on the highest level of selection as described above. However, follow-up imaging after catheter "supraselection" is reported with add-on code 75774 (selective angiography, each additional vessel after the basic examination). Third, endovascular treatment is more complicated from a coding perspective. If a stent is deployed percutaneously across the arterial lesion, code 37236 would be reported for the intravascular stent insertion. However, percutaneous transluminal angioplasty (PTA) of a visceral artery is reported with codes 35471 and 75966, while treatment through an open femoral exposure is reported with 35450 and 75966. If one attempts angioplasty with the intent of PTA as the sole treatment and this intervention produces a suboptimal result necessitating stent salvage, only the stent code is reported and not the PTA code(s).

Wound Care and Amputations

Wound Care and Amputations

Discussion: Debridement

In 2014, a new code (97610) has been approved to report debridement using an ultrasonic mist device. This code has an XXX global period and can only be reported once per day. This code is different than other debridement codes (97597-97598 and 11042-11047) which are based on depth of tissue removed and total area of wound debrided.

97610 Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

Codes 97597-97598 and 11042-11047 are reported for sharp debridement. When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths.

Codes11045, 11046, 11047 are used to report debridement of each additional 20 sq cm at the three different depths: subcutaneous tissue, muscle/fascia, and bone. The global period for these three codes is ZZZ. These three add-on codes can be reported multiple times, as appropriate. The add-on code descriptors all include the phrase "or part thereof", which means that one does not need to debride an entire additional 20 sq cm to report the code. For example, if 30 sq cm of skin is debrided, report the primary code (97597) plus the add-on code (97598).

Thus, the entire family of debridement codes, arranged in terms of depth of treatment is the following:

97597	Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less
+97598	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11042	Debridement, subcutaneous tissue (**includes** epidermis and dermis, if performed); first 20 sq cm or less
+11045	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11043	Debridement, muscle and/or fascia (**includes** epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
+11046	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
11044	Debridement, bone (**includes** epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
+11047	each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Debridement Coding Example:

A young man who was rollerblading fell and suffered injuries to the palmar surface of both hands and the anterior aspect of his right leg. No bones were fractured. His left hand required extensive debridement of devitalized and contaminated epidermis in a 4 cm x 4 cm area. His right hand required debridement through the subcutaneous tissue of a 3 cm x 10 cm area. His right leg required debridement down to and including bone of a 5 cm x 10 cm area.

Debridement (11042-11047)

Debridement (11042-11047)

CPT Code 11042

Debridement subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) at the same anatomic site (97597-97598)
- Ultrasonic mist therapy (97610)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Negative wound pressure therapy (eg, vacuum assisted drainage system) (97605)
- Unna Boot (29580)
- Multi-layer compression system (29581-29582)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**1.01**
Total RVUs - OFFICE	**3.30**
Total RVUs - FACILITY	**1.76**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

The debridement codes are now based on the total area of the treatment. When only one wound is addressed, report based on the extent of tissue removal and the surface area. For example, a 50 sq cm wound that requires debridement of skin and subcutaneous tissue would be reported using CPT base code 11042 for the first 20 sq cm, and the add-on code 11045 twice for the additional 30 sq cm – once for an additional 20 sq cm and again for the remaining 10 sq cm. If multiple wounds are treated in the same session, report the total area treated at each depth level.

For example, four wounds are debrided.

Two wounds are debrided of skin, subcutaneous tissue and muscle – one is 10 sq cm and the second is 25 sq cm. Report 11043 and 11046 for the 35 sq cm

Two wounds are debrided of skin and subcutaneous tissue – one is 15 sq cm and the second is 15 sq cm. Report 11042 and 11045 for the 30 sq cm.

FAQs

Q: **Is it correct to report 11042 for debridement of skin only (ie,epidermis and/or dermis)?**

A: No. For debridement of skin, use the active wound care codes 97597 and 97598.

CPT Code 11043

Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) at the same anatomic site (97597-97598)
- Ultrasonic mist therapy (97610)
- Debridement, subcutaneous tissue, first 20 sq cm at the same anatomic site (11042)
- When performed in an office all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Repair of traumatic wounds or injured nerves, blood vessels, tendons, ligaments, joints, and other traumatically injured anatomical structures
- Fasciotomy(ies) for elevated interstitial compartment pressures (25020, 25024, 27600-27602)
- Negative wound pressure therapy (eg, vacuum assisted drainage system) (97605)
- Unna Boot (29580)
- Multi-layer compression system (29581-29582)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**2.70**
Total RVUs - OFFICE	**6.45**
Total RVUs - FACILITY	**4.44**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

For traumatic wounds that undergo repair (closure), debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed. When immediate primary closure is not performed, appropriate debridement code(s) should be reported.

Coding Tips

The debridement codes are now based on the total area of the treatment. When only one wound is addressed, report based on the extent of tissue removal and the surface area. For example, a 50 sq cm wound that requires debridement of skin and subcutaneous tissue would be reported using CPT base code 11042 for the first 20 sq cm, and the add-on code 11045 twice for the additional 30 sq cm – once for an additional 20 sq cm and again for the remaining 10 sq cm. If multiple wounds are treated in the same session, report the total area treated at each depth level.

For example, four wounds are debrided.

Two wounds are debrided of skin and subcutaneous tissue – one is 15 sq cm and the second is 15 sq cm. Report 11042 and 11045 for the 30 sq cm.

Two wounds are debrided of skin, subcutaneous tissue and muscle – one is 10 sq cm and the second is 25 sq cm. Report 11043 and 11046 for the 35 sq cm

FAQs

Q: **I debrided one wound with 15 sq cm total surface area and 7 sq cm of that area required muscle debridement. How is this reported?**

A: When performing debridement of a single wound, report depth using the deepest level of tissue removed. For this patient, report 11043.

CPT Code 11044

Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) at the same anatomic site (97597-97598)
- Ultrasonic mist therapy (97610)
- Debridement, subcutaneous tissue, first 20 sq cm at the same anatomic site (11042)
- Debridement, muscle and/or fascia, first 20 sq cm at the same anatomic site (11043)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Repair of traumatic wounds or injured nerves, blood vessels, tendons, ligaments, joints, and other traumatically injured anatomical structures
- Fasciotomy(ies) for elevated interstitial compartment pressures (25020, 25024, 27600-27602)
- Negative wound pressure therapy (eg, vacuum assisted drainage system) (97605)
- Unna Boot (29580)
- Multi-layer compression system (29581-29582)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**4.10**
Total RVUs - OFFICE	**8.94**
Total RVUs - FACILITY	**6.64**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

When performing debridement of a single wound, report depth using the deepest level of tissue removed. In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths.

FAQs

Q: **Patient undergoes debridement of a 30 sq cm deep wound. Ten sq cm of this wound involve bone debridement. How is this reported?**

A: Report code 11044 for the first 20 sq cm and code 11047 for the additional 10 sq cm. Remember that the principle of this coding algorithm requires reporting asingle wound at the depth level of the deepest portion.

CPT Code 11045

Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) at the same anatomic site (97597-97598)
- Ultrasonic mist therapy (97610)
- Debridement, subcutaneous tissue, first 20 sq cm at the same anatomic site (11042)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Negative wound pressure therapy (eg, vacuum assisted drainage system) (97605)
- Unna Boot (29580)
- Multi-layer compression system (29581-29582)

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**0.50**
Total RVUs - OFFICE	**1.16**
Total RVUs - FACILITY	**0.75**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The debridement codes are now based on the total area of the treatment. When only one wound is addressed, report based on the extent of tissue removal and the surface area. For example, a 50 sq cm wound that requires debridement of skin and subcutaneous tissue would be reported using CPT base code 11042 for the first 20 sq cm, and the add-on code 11045 twice for the additional 30 sq cm – once for an additional 20 sq cm and again for the remaining 10 sq cm. If multiple wounds are treated in the same session, report the total area treated at each depth level.

For example, four wounds are debrided.

Two wounds are debrided of skin and subcutaneous tissue – one is 15 sq cm and the second is 15 sq cm. Report 11042 and 11045 for the 30 sq cm.

Two wounds are debrided of skin, subcutaneous tissue and muscle – one is 10 sq cm and the second is 25 sq cm. Report 11043 and 11046 for the 35 sq cm

FAQs

Q: **Two subcutaneous wounds were debrided. One wound was 2 cm x 4 cm on the left leg. The second wound was 6 cm x 6 cm on the right leg. How is this reported?**

A: All wounds at the same depth are summed. The left leg wound is 8 sq cm. The right leg wound is 36 sq cm. The total wound surface area is 44 sq cm. Report code 11042 for the first 20 sq cm and code 11045 x 2 for the remaining 24 sq cm.

CPT Code 11046

Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) at the same anatomic site (97597-97598)
- Ultrasonic mist therapy (97610)
- Debridement, subcutaneous tissue at the same anatomic site (11042, 11045)
- Debridement, muscle and/or fascia, first 20 sq cm at the same anatomic site (11043)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Repair of traumatic wounds or injured nerves, blood vessels, tendons, ligaments, joints, and other traumatically injured anatomical structures
- Fasciotomy(ies) for elevated interstitial compartment pressures (25020, 25024, 27600-27602)
- Negative wound pressure therapy (eg, vacuum assisted drainage system) (97605)
- Unna Boot (29580)
- Multi-layer compression system (29581-29582)

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**1.03**
Total RVUs - OFFICE	**2.08**
Total RVUs - FACILITY	**1.61**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 11046 is a new add-on code for 2011 that is used to report debridement of each additional 20 sq cm of subcutaneous tissue after the first 20 sq cm reported with 11043.

The debridement codes are now based on the total area of the treatment. When only one wound is addressed, report based on the extent of tissue removal and the surface area. For example, a 50 sq cm wound that requires debridement of skin and subcutaneous tissue would be reported using CPT base code 11042 for the first 20 sq cm, and the add-on code 11045 twice for the additional 30 sq cm – once for an additional 20 sq cm and again for the remaining 10 sq cm. If multiple wounds are treated in the same session, report the total area treated at each depth level.

For example, four wounds are debrided.

Two wounds are debrided of skin and subcutaneous tissue – one is 15 sq cm and the second is 15 sq cm. Report 11042 and 11045 for the 30 sq cm.

Two wounds are debrided of skin, subcutaneous tissue and muscle – one is 10 sq cm and the second is 25 sq cm. Report 11043 and 11046 for the 35 sq cm

CPT Code 11047

Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) at the same anatomic site (97597-97598)
- Ultrasonic mist therapy (97610)
- Debridement, subcutaneous tissue at the same anatomic site (11042, 11045)
- Debridement, muscle and/or fascia at the same anatomic site (11043, 11046)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Repair of traumatic wounds or injured nerves, blood vessels, tendons, ligaments, joints, and other traumatically injured anatomical structures
- Fasciotomy(ies) for elevated interstitial compartment pressures (25020, 25024, 27600-27602)
- Negative wound pressure therapy (eg, vacuum assisted drainage system) (97605)
- Unna Boot (29580)
- Multi-layer compression system (29581-29582)

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**1.80**
Total RVUs - OFFICE	**3.51**
Total RVUs - FACILITY	**2.84**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient undergoes debridement of a 30 sq cm deep wound. Ten sq cm of this wound involve bone debridement. How is this reported?**

A: Report code 11044 for the first 20 sq cm and code 11047 for the additional 10 sq cm. Remember that the principle of this coding algorithm requires reporting a single wound at the depth level of the deepest portion.

Split-Thickness Autograft (15100-15121)

Split-Thickness Autograft (15100-15121)

CPT Code 15100

Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) (97597-97602)
- Ultrasonic mist therapy (97610)
- Simple or intermediate repair of donor site (12001-12007, 12031-12037)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Surgical preparation of recipient site (15002- 15003)
- Repair of donor site requiring skin graft or local flaps

Medicare Payment Rules

Global Period	**090**
Work RVUs	**9.90**
Total RVUs - OFFICE	**24.40**
Total RVUs - FACILITY	**20.51**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report skin grafting in the adult based on the total area of the recipient site. CPT code 15100 is appropriate for treatment of up to 100 sq cm on the trunk, arms, or legs. If more than 100 sq cm is treated, the add-on code 15101 is reported for each additional 100 sq cm or part thereof.

CPT Code 15101

Split-thickness autograft, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) (97597-97602)
- Ultrasonic mist therapy (97610)
- Simple or intermediate repair of donor site (12001-12007, 12031-12037)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Surgical preparation of recipient site (15002- 15003)
- Repair of donor site requiring skin graft or local flaps

Medicare Payment Rules

Global Period	***ZZZ***
Work RVUs	**1.72**
Total RVUs - OFFICE	**5.27**
Total RVUs - FACILITY	**3.18**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report skin grafting in the adult based on the total area of the recipient site. CPT code 15100 is appropriate for treatment of up to 100 sq cm on the trunk, arms, or legs. If more than 100 sq cm is treated, the add-on code 15101 is reported for each additional 100 sq cm or part thereof.

FAQs

Q: **A patient sustains a full thickness burn to his thigh measuring 20 cm x 8 cm. He is treated with a splitthickness autograft. How is this reported?**

A: The total graft is 160 sq cm, therefore code 15100 would be reported for the first 100 sq cm along with add-on code 15101 for the remaining 60 sq cm

CPT Code 15120

Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) (97597-97602)
- Ultrasonic mist therapy (97610)
- Simple or intermediate repair of donor site (12001-12057)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Surgical preparation of recipient site (15004- 15005)
- Repair of donor site requiring skin graft or local flaps

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.15**
Total RVUs - OFFICE	**24.15**
Total RVUs - FACILITY	**19.98**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report skin grafting in the adult based on the total area of the recipient site. CPT code 15120 is appropriate for treatment of up to 100 sq cm on the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits. If more than 100 sq cm is treated, the add-on code 15121 is reported for each additional 100 sq cm or part thereof.

CPT Code 15121

Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Debridement of skin (ie, epidermis/dermis) (97597-97602)
- Ultrasonic mist therapy (97610)
- Simple or intermediate repair of donor site (12001-12057)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Surgical preparation of recipient site (15004- 15005)
- Repair of donor site requiring skin graft or local flaps

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**2.00**
Total RVUs - OFFICE	**5.90**
Total RVUs - FACILITY	**3.80**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report skin grafting in the adult based on the total area of the recipient site. CPT code 15120 is appropriate for treatment of up to 100 sq cm on the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits. If more than 100 sq cm is treated, the add-on code 15121 is reported for each additional 100 sq cm or part thereof.

Unna Boot, Multi-Layer Compression System (29580-29584)

Unna Boot, Multi-Layer Compression System (29580-29584)

CPT Code 29580

Strapping; Unna boot

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Simple wound cleansing
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Active wound management and frank debridement (11042-11047, 97597-97598, and 97610)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.55**
Total RVUs - OFFICE	**1.49**
Total RVUs - FACILITY	**1.02**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Typical cleansing of a venous ulcer is included in 29580, but if significant debridement is needed for removal of nonviable tissue/debris in a chronic venous ulcer, report the appropriate active wound management code (97597-97598, 97610) or debridement code (11042-11047).

Coding Tips

E&M coding would require the use of modifier 25 for reimbursement from the insurance carrier and is fitting when a separately identifiable issue is addressed or an overall patient assessment occurs that leads to institution or change of therapy.

For example, a patient with a venous ulcer returns to the office for an Unna boot reapplication and reports a recent transient ischemic attack. Workup of carotid atherosclerotic disease is required. The E&M for cerebrovascular evaluation would be reported with modifier 25 and the Unna boot change would be reported with 29580

In a second situation, a patient referred with new lower extremity ulceration requires evaluation for arterial occlusive disease, infection, the degree of venous insufficiency, and proper therapy to ensure wound healing. This clearly meets the criteria for a separate E&M that would be reported with modifier 25. The provider concludes that the patient has a venous ulcer appropriate for Unna boot therapy. A boot is applied and 29580 is reported. Periodic planned follow-up for subsequent change of the Unna boot should only be reported with the CPT code 29580 unless there is a significant change in patient condition that requires repeat evaluation.

CPT Code 29581

Application of multi-layer compression system; leg (below knee), including ankle and foot

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Simple wound cleansing
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Active wound management and frank debridement (11042-11047, 97597-97598, and 97610)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.25**
Total RVUs - OFFICE	**1.77**
Total RVUs - FACILITY	**0.38**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Typical cleansing of a venous ulcer is included in 29581, but if significant debridement is needed for removal of nonviable tissue/debris in a chronic venous ulcer, report the appropriate active wound management code (97597-97598, 97610) or debridement code (11042-11047).

CPT Code 29582

Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Simple wound cleansing
- When performed in an office, all necessary supplies for the procedure
- Application of multi-layer venous wound compression system, below knee compression system; leg (below knee), including ankle and foot (29581)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Active wound management and frank debridement (11042-11047, 97597-97598, and 97610)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.35**
Total RVUs - OFFICE	**2.01**
Total RVUs - FACILITY	**0.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 29583

Application of multi-layer compression system; upper arm and forearm

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Simple wound cleansing
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Active wound management and frank debridement (11042-11047, 97597-97598, and 97610)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.25**
Total RVUs - OFFICE	**1.26**
Total RVUs - FACILITY	**0.34**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 29584

Application of multi-layer compression system; upper arm, forearm, hand, and fingers

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Simple wound cleansing
- When performed in an office, all necessary supplies for the procedure
- Application of multi-layer compression system; upper arm and forearm (29583)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Active wound management and frank debridement (11042-11047, 97597-97598, and 97610)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.35**
Total RVUs - OFFICE	**2.01**
Total RVUs - FACILITY	**0.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Active Wound Care Management (97597-97610)

Active Wound Care Management (97597-97610)

CPT Code 97597

Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.51**
Total RVUs - OFFICE	**2.14**
Total RVUs - FACILITY	**0.68**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 11040, 11041 have been deleted for CPT 2011. For debridement of skin (ie, epidermis and/or dermis), report 97597, 97598 as appropriate.

CPT Code 97598

Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	***ZZZ***
Work RVUs	**0.24**
Total RVUs - OFFICE	**0.71**
Total RVUs - FACILITY	**0.33**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 11040, 11041 have been deleted for CPT 2011. For debridement of skin (ie, epidermis and/or dermis), report 97597, 97598 as appropriate.

CPT Code 97602

Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Do not report 97602 in conjunction with 11042-11047 for the same wound.

CPT Code 97605

Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.55**
Total RVUs - OFFICE	**1.22**
Total RVUs - FACILITY	**0.77**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report codes 97605 or 97606 when durable medical equipment is used to provide negative pressure wound therapy. Report codes 97607 or 97608 when disposable equipment is used to provide negative pressure wound therapy.

CPT Code 97606

Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.60**
Total RVUs - OFFICE	**1.45**
Total RVUs - FACILITY	**0.85**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report codes 97605 or 97606 when durable medical equipment is used to provide negative pressure wound therapy. Report codes 97607 or 97608 when disposable equipment is used to provide negative pressure wound therapy.

CPT Code 97607

Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity*.

Coding Tips

Report codes 97605 or 97606 when durable medical equipment is used to provide negative pressure wound therapy. Report codes 97607 or 97608 when disposable equipment is used to provide negative pressure wound therapy.

CPT Code 97608

Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

* *Supporting documentation required to establish medical necessity*.

Coding Tips

Report codes 97605 or 97606 when durable medical equipment is used to provide negative pressure wound therapy. Report codes 97607 or 97608 when disposable equipment is used to provide negative pressure wound therapy.

CPT Code 97610

Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.35**
Total RVUs - OFFICE	**3.43**
Total RVUs - FACILITY	**0.51**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Discussion: Amputation

In the foot, closed amputations are reported identical to those in which the skin is left open for drainage of infection. However, in the thigh and lower leg, there are several scenarios with specific CPT codes to consider. Amputations in the foot are typically "unrelated" to any recent arterial bypass procedures that may have been performed. They are reported with modifier 79 to indicate as such. Major amputations through the tibia/fibula or femur after limb salvage arterial reconstruction are "related" and therefore should be submitted to the insurance carrier with modifier 78 appended, provided they are within the global period of the revascularization.

Amputation (27590-28825)

Amputation (27590-28825)

CPT Code 27590

Amputation, thigh, through femur, any level;

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Immediate prosthetic fitting technique (27591)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**13.47**
Total RVUs - OFFICE	**23.31**
Total RVUs - FACILITY	**23.31**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report 27590 for a standard closed above-knee amputation

CPT Code 27592

Amputation, thigh, through femur, any level; open, circular (guillotine)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This procedure is typically reported with a single CPT code, although multiple codes may be reported appropriately in unusual clinical situations.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.98**
Total RVUs - OFFICE	**19.82**
Total RVUs - FACILITY	**19.82**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with diabetes and foot sepsis that has progressed to infection at the knee level requires an emergent guillotine amputation above the knee. How is this reported?**

A: Report 27592 for a guillotine amputation through the femur.

CPT Code 27594

Amputation, thigh, through femur, any level; secondary closure or scar revision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Skin graft or tissue flap procedure if required to complete the closure

Medicare Payment Rules

Global Period	**090**
Work RVUs	**7.29**
Total RVUs - OFFICE	**14.61**
Total RVUs - FACILITY	**14.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient with diabetes and foot sepsis that has progressed to infection at the knee level requires an emergent guillotine amputation above the knee. Five days later after the sepsis is controlled and the transected tissue is beginning to granulate, he returns to the operating room for secondary closure. How are the two operations reported?**

A: Report 27592 for the initial guillotine amputation through the femur. Report 27594-58 for the staged second procedure involving higher amputation and closure of the wound.

CPT Code 27602

Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Simultaneously performed revascularization procedures such as embolectomy, thrombectomy, open bypass, or stent placement
- Negative pressure wound therapy (97605-97606)
- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**7.82**
Total RVUs - OFFICE	**14.19**
Total RVUs - FACILITY	**14.19**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

To report decompression fasciotomy with debridement, use 27892-27894.

Coding Tips

Report 27602, when performed, in addition to the appropriate CPT codes for lower extremity arterial revascularization.

CPT Code 27880

Amputation, leg, through tibia and fibula;

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**15.37**
Total RVUs - OFFICE	**26.71**
Total RVUs - FACILITY	**26.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 27880 is reported for a onestage closed amputation below the knee (or BKA).

CPT Code 27882

Amputation, leg, through tibia and fibula; open, circular (guillotine)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**9.79**
Total RVUs - OFFICE	**17.46**
Total RVUs - FACILITY	**17.46**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

After amputation, the wound is left open. Closure will occur at a later date.

FAQs

Q: **A diabetic patient with uncontrolled foot infection undergoes an emergent guillotine amputation below the knee. Five days later he undergoes a planned secondary revision and closure below the knee. How is this reported?**

A: The guillotine below-knee amputation is reported with 27882. The planned secondary revision and closure below the knee is reported with 27884-58.

CPT Code 27884

Amputation, leg, through tibia and fibula; secondary closure or scar revision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Skin graft or tissue flap procedure if required to complete the closure
- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**8.76**
Total RVUs - OFFICE	**16.71**
Total RVUs - FACILITY	**16.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

This code is used to report closure of the wound on a date other than the day of initial amputation. Append modifier 58 if performed in a staged fashion by the same surgeon within the 90-day global period of the primary procedure.

CPT Code 27888

Amputation, ankle, through malleoli of tibia and fibula (eg, Syme, Pirogoff type procedures), with plastic closure and resection of nerves

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Neuroplasty for surgical exposure
- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Arthrotomy of ankle (27610, 27620)
- Talectomy (28130)
- Partial excision of calcaneus (28120)
- Osteotomy or bone contouring of tibia and/or fibula
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.37**
Total RVUs - OFFICE	**19.85**
Total RVUs - FACILITY	**19.85**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 28111

Ostectomy, complete excision; first metatarsal head

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Arthrotomy (28022, 28052)
- Tenotomy (28232, 28234)
- Synovectomy (28072)
- Release of joint contractures
- Excision of bursa, ganglion, or synovial cyst (28090)
- Internal fixation
- Excision of plantar skin (11420-11426)
- Tenolysis and/or tenosynovectomy, except for a different pathologic diagnosis (28086, 28088, 28220, 28226)
- Application of initial splint or cast
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Tenolysis and/or tenosynovectomy for a different pathologic diagnosis (28086, 28088, 28220, 28226)
- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**5.15**
Total RVUs - OFFICE	**14.30**
Total RVUs - FACILITY	**9.43**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 28111 for a great toe metatarsal head resection performed either through an ulcer on the plantar/medial aspect of the foot or through a dorsal foot incision

CPT Code 28112

Ostectomy, complete excision; other metatarsal head (second, third or fourth)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Arthrotomy (28022, 28052)
- Tenotomy (28234)
- Synovectomy (28072)
- Release of joint contractures
- Excision of bursa, ganglion, or synovial cyst (28090)
- Internal fixation
- Excision of plantar skin (11420-11426)
- Tenolysis, except for a different pathologic diagnosis (28220, 28226)
- Application of initial splint or cast
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Tenolysis for a different pathologic diagnosis (28220, 28226)
- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**4.63**
Total RVUs - OFFICE	**14.20**
Total RVUs - FACILITY	**9.05**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 28112 for a second, third, or fourth toe metatarsal head resection performed either through an ulcer on the plantar aspect of the foot or through a dorsal foot incision

CPT Code 28113

Ostectomy, complete excision; fifth metatarsal head

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Arthrotomy (28022, 28052)
- Tenotomy (28234)
- Synovectomy (28072)
- Release of joint contractures
- Excision of bursa, ganglion, or synovial cyst (28090)
- Internal fixation
- Excision of plantar skin (11420-11426)
- Tenolysis and/or tenosynovectomy, except for a different pathologic diagnosis (28086, 28088, 28220, 28226)
- Application of initial splint or cast
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Tenolysis and/or tenosynovectomy for a different pathologic diagnosis (28086, 28088, 28220, 28226)
- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**6.11**
Total RVUs - OFFICE	**17.16**
Total RVUs - FACILITY	**12.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 28113 for a fifth toe metatarsal head resection performed either through an ulcer on the plantar/lateral aspect of the foot or through a dorsal foot incision

CPT Code 28800

Amputation, foot; midtarsal (eg, Chopart type procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Tenotomy, same incision (28230, 28234)
- Neuroplasty for surgical exposure
- Nerve excision (28055)
- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Metatarsal osteotomy (28306-28308)
- Arthrotomy of tarsometacarpal, metatarsophalangeal, or interphalangeal joints (28020-28024, 28050-28054)
- Capsular release, repair, or reconstruction (28260-28264)
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Tendon lengthening or tenotomy, separate incision (27685, 28230, 28234)
- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**8.79**
Total RVUs - OFFICE	**15.71**
Total RVUs - FACILITY	**15.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 28805

Amputation, foot; transmetatarsal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Implantation of nerve end into bone or muscle (64787)
- Tenotomy, same incision (28230, 28234)
- Neuroplasty for surgical exposure
- Nerve excision (28055)
- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Metatarsal osteotomy (28306-28308)
- Arthrotomy of tarsometacarpal, metatarsophalangeal, or interphalangeal joints (28020-28024, 28050-28054)
- Capsular release, repair, or reconstruction (28260-28264)
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Tendon lengthening or tenotomy, separate incision (27685, 28230, 28234)
- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**12.71**
Total RVUs - OFFICE	**21.14**
Total RVUs - FACILITY	**21.14**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 28810

Amputation, metatarsal, with toe, single

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Implantation of nerve end into bone or muscle (64787)
- Tenotomy, same incision (28230, 28234)
- Neuroplasty for surgical exposure
- Nerve excision (28055)
- Ligation, major artery (eg, post-traumatic, rupture); extremity (37618)
- Metatarsal osteotomy (28306-28308)
- Arthrotomy of tarsometacarpal, metatarsophalangeal, or interphalangeal joints (28020-28024, 28050-28054)
- Capsular release, repair, or reconstruction (28260-28264)
- Application of initial splint or cast

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**6.64**
Total RVUs - OFFICE	**12.47**
Total RVUs - FACILITY	**12.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient undergoes a femoraltibial leg bypass for arterial occlusive disease. Five days later, he undergoes an elective great toe transmetatarsal amputation. How is this reported?**

A: Report code 28810-58 or 28810- 79 for the great toe transmetatarsal amputation. The 90-day global period for the leg bypass requires appending a modifier. In this case, the procedure is a staged intervention unrelated to the prior arterial reconstruction. Therefore, either modifier -58 or -79 is appropriate for use on the second procedure

CPT Code 28820

Amputation, toe; metatarsophalangeal joint

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Tenotomy (28232, 28234)
- Capsulotomy (28270)
- Condylectomy (28288)
- Ostectomy, partial (28122)
- Application of initial splint or cast
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**5.82**
Total RVUs - OFFICE	**16.35**
Total RVUs - FACILITY	**11.43**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 28825

Amputation, toe; interphalangeal joint

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Implantation of nerve end into bone or muscle (64787)
- Tenotomy (28232, 28234)
- Capsulotomy (28272)
- Condylectomy (28124)
- Ostectomy, partial, phalangeal (28126)
- Application of initial splint or cast
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Subsequent splinting, strapping, or casting

Medicare Payment Rules

Global Period	**090**
Work RVUs	**5.37**
Total RVUs - OFFICE	**15.63**
Total RVUs - FACILITY	**10.73**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Aneurysm Repair

Aneurysm Repair

DISCUSSION: TEVAR – Thoracic Endovascular Aneurysm Repair

When reporting placement of an endovascular graft for repair of the descending thoracic aorta (TEVAR), report the main device deployment first. This is based on the type of endograft implanted. The appropriate main body code is based on whether or not the left subclavian artery (LSA) is covered. If the main body does not cover the LSA, CPT code 33881 and the S&I code 75957 are appropriate. All distal extensions in the same session are bundled (i.e. not separately reportable) to the level of the celiac artery origin. Proximal thoracic aorta extension is reported by CPT code 33883 and the S&I code 75958 for the initial device. Subsequent proximal thoracic aortic extensions are reported by the add-on CPT code 33884 accompanied by the S&I code 75958 for each implant. The S&I code 75958 is the same for the first and all subsequent proximal extensions such that multiple deployments may require the use of a -59 modifier for some payers to identify that the replication of an identical code is not an accidental duplicate bill. When a third or more proximal extension is placed, the CPT code 33884 will also require the -59 modifier appended.

If the TEVAR main body is deployed in a manner that covers the LSA, CPT code 33880 and the S&I code 75956 are reported. Any thoracic aorta stent-graft extension deployment more proximally follows the convention just described above.

There is one caveat in TEVAR reporting that is often confusing. In the specific scenario where a proximal thoracic aortic extension causes the LSA to be covered when the implanted TEVAR main body was originally placed distal to the LSA, the "distal to the LSA" main body codes (33881 and 75957) and proximal stentgraft extension codes (33883, 33884, and 75958) are no longer used. In their stead, CPT codes 33880 and 75956 are reported. For example, a TEVAR main body is placed distal to the LSA. Three proximal thoracic aortic stent-graft extensions are necessary to complete the endovascular exclusion of the aneurysm, and the last stent-graft implant covers the LSA origin. In this scenario, CPT codes 33880 and 75956 are appropriate for reporting all the devices. If a further proximal extension is required in this example, CPT codes 33883 and 75958 are appropriately reported.

Open arterial exposure is separately reported during TEVAR. Typically the femoral artery exposure and associated closure is reported with 34812. If functional femoral arteriotomy closure requires a complex repair, procedures reported by codes 35226, 35286, or 35371 may supersede 34812. CPT code 34820 denotes iliac artery exposure as necessary and 34833 conveys iliac artery exposure with the additional creation of a prosthetic graft conduit to assist in sheath insertion when small or heavily diseased external iliac arteries are encountered. When a brachial artery exposure is warranted, CPT code 34834 is appropriate.

The arterial catheter placements are reportable during TEVAR. Most patients will require two non-selective catheters (CPT code 36200 twice): one entering each femoral artery and extending into the aorta. However, selective catheterization of a vascular family may be necessary (eg, celiac artery or LSA).

Additional services such as stenting or percutaneous transluminal angioplasty outside of the endograft landing zone are separately reportable. Open subclavian to carotid artery transposition performed in conjunction with TEVAR is reported by CPT code 33889. Carotid to subclavian bypass with "other than vein" is reported by CPT code 35606. Lastly, carotid-to-carotid artery retropharyngeal crossover bypass with "other than vein" carried out at the time of TEVAR is described by CPT code 33891.

If a carotid-subclavian bypass is performed prior to the TEVAR the arm revascularization global period may impact the TEVAR. CPT code 35606 has a 90-day global. The subsequent aneurysm repair would then necessitate appending the -58 "staged" modifier to all of the surgical TEVAR CPT codes (i.e., codes that begin with a 3) but not the radiology S&I codes (i.e., codes that begin with a 7). This would ensure payment for the aneurysm repair procedures that occurred within the 90-day postoperative period.

One cannot report distal thoracic aorta stent-graft extension codes at the time of primary repair. However, there are occasions where graft migration may occur or a patient may develop aneurysmal degeneration of the aorta distal to a previously implanted thoracic stent-graft. If a patient returns to operating room on a separate day for revision or extension of the original repair, distal extension CPT codes 33886 and 75959 are utilized. These codes are reported once, regardless of the number of distal extension prostheses implanted to the celiac artery origin.

Two Provider TEVAR Coding Example

Dr. A exposes the right iliac artery through the retroperitoneum and places a conduit. Dr. B. places two catheters in the aorta, one percutaneous from the left groin, the other through the just-placed conduit. Drs. A & B are co-surgeons for descending thoracic aortic endograft, not covering the left subclavian. Drs. A & B are co-surgeons on three distal extensions. A proximal extension is required and is performed by both physicians as co-surgeons. Dr. B performs the S&I for the proximal extension. The extension does cover the left subclavian artery. Dr. A performs a subclavian to carotid transposition. Dr. B performs the radiological S&I for main TEVAR device and all extensions. Dr. A seals the conduit and closes all incisions.

Dr. A		**Dr. B**	
Procedure	**Code**	**Procedure**	**Code**
Main body deployment	33880-62	Main body deployment	33880-62
Proximal extension	Not reportable	Proximal extension	Not reportable
Distal Extension	Not reportable	Distal extension	Not reportable
Iliac exposure with conduit	34833	Catheter	36200-50

Sub-car transposition	33889	Main body rad S&I	75957-26
		Proximal extension rad S&I	Not reportable
		Distal extension rad S&I	Not reportable

Endovascular Thoracic Aortic Repair, TEVAR (33880-33891)

Endovascular Thoracic Aortic Repair, TEVAR (33880-33891)

CPT Code 33880

Endovascular repair of descending thoracic aorta (eg, 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

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- All device introduction, manipulation, positioning, and deployment
- All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open arterial exposure and associated closure of the arteriotomy sites (34812)
- Introduction of guidewires and catheters (36140)
- All angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the primary endovascular devices (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75956-26)
- Other interventional procedures performed at the time of endovascular repair of the descending thoracic aorta (eg, innominate, carotid, subclavian, visceral, or iliac artery transluminal angioplasty or stenting, arterial embolization, intravascular ultrasound) when performed before or after deployment of the aortic prostheses
- Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (33889, 33891)
- Extensive repair or replacement of an artery (35226, 35286)
- Transcatheter placement of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**34.58**
Total RVUs - OFFICE	**52.70**
Total RVUs - FACILITY	**52.70**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

Five Typical Steps to Report TEVAR:

1. Report main device deployment

2. Report radiological S&I

3. Report open arterial exposure(s)

4. Report arterial catheter placement(s)

5. Report all other separately reportable services including all appropriate S&I codes

Coding Tips

The appropriate S&I code for TEVAR involving coverage of the left subclavian artery origin is 75956- 26.

FAQs

Q: **Dr. A performs open exposure of one femoral artery, advances a catheter from both groins (one open & one percutaneously) into the thoracic aorta, places a descending thoracic aorta endograft that covers the left subclavian, and performs the radiological S&I. A proximal extension is required which covers the left common carotid. A prosthetic carotid to carotid bypass and a prosthetic carotid to subclavian bypass are also performed**

A: Report 33880 as the primary procedure; 34812 for exposure; 75956-26 for related S&I; 36200-50 for catheterization; 33891 for carotid-carotid bypass; 35606 for carotid-subclavian bypass; 33883 for proximal extension and 75958-26 for related S&I.

CPT Code 33881

Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- All device introduction, manipulation, positioning, and deployment
- All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open arterial exposure and associated closure of the arteriotomy sites (34812)
- Introduction of guidewires and catheters (36140)
- All angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the primary endovascular devices (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75957-26)
- Other interventional procedures performed at the time of endovascular repair of the descending thoracic aorta (eg, innominate, carotid, subclavian, visceral, or iliac artery transluminal angioplasty or stenting, arterial embolization, intravascular ultrasound) when performed before or after deployment of the aortic prostheses
- Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (33889, 33891)
- Extensive repair or replacement of an artery (35226, 35286)
- Transcatheter placement of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**29.58**
Total RVUs - OFFICE	**45.27**
Total RVUs - FACILITY	**45.27**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

The appropriate S&I code for TEVAR not involving coverage of left subclavian artery origin is 75957- 26.

Five Typical Steps to Report TEVAR:

1. Report main device deployment

2. Report radiological S&I

3. Report open arterial exposure(s)

4. Report arterial catheter placement(s)

5. Report all other separately reportable services including all appropriate S&I codes

FAQs

Q: **Dr. A performs open exposure of one femoral artery, advances a catheter from both groins (one open & one percutaneously) into the thoracic aorta, places a descending thoracic aorta endograft that does not cover the left subclavian, and performs the radiological S&I. She then adds two proximal extensions which do not cover the left subclavian artery. How is this reported?**

A: Report 33881 as the primary procedure; 34812 for exposure; 75957-26 for related S&I; 36200-50 for catheter placement in aorta from bilateral groins; 33883 for proximal extension and 75958-26 for related S&I; and 33884 for additional proximal extension and 75958-26-59 for related S&I.

CPT Code 33883

Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); initial extension

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- All device introduction, manipulation, positioning, and deployment
- All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft extension deployment

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open arterial exposure and associated closure of the arteriotomy sites (34812, 34820, 34833, 34834)
- Introduction of guidewires and catheters (36140, 36200-36218)
- All angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the proximal thoracic endovascular extension, fluoroscopic guidance in the delivery of the endovascular component, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75958-26)
- Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (33889, 33891)
- Extensive repair or replacement of an artery (35226, 35286)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.09**
Total RVUs - OFFICE	**32.80**
Total RVUs - FACILITY	**32.80**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

If placement of a proximal extension at the time of primary repair covers the left subclavian artery origin, do not report 33883 or 33881. The primary procedure should correctly be reported as 33880.

FAQs

Q: **A patient develops a proximal Type I endoleak six months after initial TEVAR. A proximal extension is deployed to fix the endoleak. How is this reported?**

A: Code 33883 has a 90-day global period and is correctly reported for this service, along with radiological S&I (75958-26), open arterial exposure, and aortic catheterization, as performed.

CPT Code 33884

Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); each additional proximal extension (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- All device introduction, manipulation, positioning, and deployment
- All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open arterial exposure and associated closure of the arteriotomy sites (34812, 34820, 34833, 34834)
- Introduction of guidewires and catheters (36140, 36200-36218)
- All angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the proximal thoracic endovascular extension, fluoroscopic guidance in the delivery of the endovascular component, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75958-26)
- Transposition of subclavian artery to carotid, and carotid-carotid bypass performed in conjunction with endovascular repair of the descending thoracic aorta (33889, 33891)
- Extensive repair or replacement of an artery (35226, 35286)

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	8.20
Total RVUs - OFFICE	12.11
Total RVUs - FACILITY	12.11
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes
Team Surgery (mod 66)	no

Coding Tips

If placement of an additional proximal extension at the time of primary repair covers the left subclavian artery origin, do not report 33883, 33884 or 33881. The primary procedure should correctly be reported as 33880.

FAQs

Q: **During primary TEVAR a patient requires two proximal extensions to achieve hemostatic seal. How are the extensions reported?**

A: The first proximal extension is reported with code 33883 and the second proximal extension with code 33884. Radiological S&I would be reported twice (75958-26 and 75958-26-59). Note that some payers may require 75958 to be reported in units (eg, 75958 (2)).

The primary TEVAR, open arterial exposure, and aortic catheterization would also be reported, when performed.

CPT Code 33886

Placement of distal extension prosthesis(s) delayed after endovascular repair of descending thoracic aorta

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- All device introduction, manipulation, positioning, and deployment
- All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open arterial exposure and associated closure of the arteriotomy sites (34812, 34820, 34833, 34834)
- Introduction of guidewires and catheters (36140, 36200-36218)
- All angiography of the thoracic aorta and its branches for diagnostic imaging prior to deployment of the distal thoracic endovascular extension, fluoroscopic guidance in the delivery of the endovascular component(s), and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75959-26)
- Extensive repair or replacement of an artery (35226, 35286)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.09**
Total RVUs - OFFICE	**28.33**
Total RVUs - FACILITY	**28.33**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

Do not report 33886 with 33880 or 33881. (ie, you cannot report distal extensions at the time of primary repair) The only time you can report distal extension is if patient returns on a separate day for revision or extension of the original repair.

FAQs

Q: **A patient required placement of two distal extension prostheses to repair a Type I endoleak that developed 6 months after the primary repair. How is this reported?**

A: Report 33886 once, regardless of the number of modules deployed. Radiological S&I (75959-26) would also be reported. Open arterial exposure and aortic catheterization would also be reported, when performed

CPT Code 33889

Open subclavian to carotid artery transposition performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision, unilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- All open surgical maneuvers to achieve transposition and/or reimplantation; subclavian to carotid artery

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Any other procedures involved in thoracic endovascular thoracic aortic repair (eg, 33880-33886)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**15.92**
Total RVUs - OFFICE	**23.23**
Total RVUs - FACILITY	**23.23**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

Code 33889 has a 000-day global period. The TEVAR procedures performed on a later date will NOT require modifier 58 (staged or related procedure).

CPT Code 33891

Bypass graft, with other than vein, transcervical retropharyngeal carotid-carotid, performed in conjunction with endovascular repair of descending thoracic aorta, by neck incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- All open surgical maneuvers to achieve transposition and/or reimplantation; subclavian to carotid artery

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Any other procedures involved in thoracic endovascular thoracic aortic repair (eg, 33880-33886)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**20.00**
Total RVUs - OFFICE	**28.47**
Total RVUs - FACILITY	**28.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

Code 33891 has a 000-day global period. The TEVAR procedures performed on a later date will NOT require modifier 58 (staged or related procedure).

Endovascular Infrarenal Aortic Repair, EVAR (34800-34826)

Endovascular Infrarenal Aortic Repair, EVAR (34800-34826)

CPT Code 34800

Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

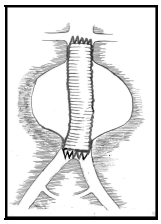
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Introduction of guidewires and catheters (36200, 36245-36248, 36140)
- Angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75952)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Place of proximal or distal extension prosthesis (34825, 34826)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.54**
Total RVUs - OFFICE	**33.16**
Total RVUs - FACILITY	**33.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Images



Coding Tips

Five Typical Steps to Report EVAR:

1. Report main device deployment

2. Report open arterial exposure

3. Report arterial catheter placement(s)

4. Report radiological S&I

5. Report separately reportable procedures, including associated S&I codes

CPT Code 34802

Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

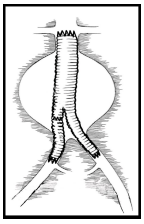
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Introduction of guidewires and catheters (36200, 36245-36248, 36140)
- Angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75952)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Place of proximal or distal extension prosthesis (34825, 34826)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.79**
Total RVUs - OFFICE	**36.67**
Total RVUs - FACILITY	**36.67**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Images



Coding Tips

Five Typical Steps to Report EVAR:

1. Report main device deployment

2. Report open arterial exposure(s)

3. Report arterial catheter placement(s)

4. Report radiological S&I

5. Report separately reportable procedures, including associated S&I codes

FAQs

Q: **A patient with AAA involving visceral vessels requires endovascular repair using a fenestrated endoprosthesis. How is this reported?**

A: This new technology is correctly reported using codes 34841-34848.

CPT Code 34803

Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Introduction of guidewires and catheters (36200, 36245-36248, 36140)
- Angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75952)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Place of proximal or distal extension prosthesis (34825, 34826)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.82**
Total RVUs - OFFICE	**37.85**
Total RVUs - FACILITY	**37.85**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

Five Typical Steps to Report EVAR:

1. Report main device deployment

2. Report open arterial exposure(s)

3. Report arterial catheter placement(s)

4. Report radiological S&I

5. Report separately reportable procedures, including associated S&I codes

FAQs

Q: **A patient with AAA involving visceral vessels requires endovascular repair using a fenestrated endoprosthesis. How is this reported?**

A: This new technology is correctly reported using codes 34841-34848.

CPT Code 34804

Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

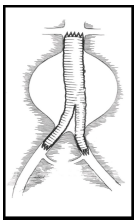
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Introduction of guidewires and catheters (36200, 36245-36248, 36140)
- Angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75952)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Place of proximal or distal extension prosthesis (34825, 34826)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.79**
Total RVUs - OFFICE	**36.61**
Total RVUs - FACILITY	**36.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Images



CPT Code 34805

Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Introduction of guidewires and catheters (36200, 36245-36248, 36140)
- Angiography of the aorta and its branches for diagnostic imaging prior to deployment of the endovascular device (including all routine components of modular devices), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75952)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Place of proximal or distal extension prosthesis (34825, 34826)
- Other interventional procedures performed at the time of endovascular AAA repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**22.67**
Total RVUs - OFFICE	**35.29**
Total RVUs - FACILITY	**35.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Images

Coding Tips

All grafts can be converted to this type with the help of an aortic cuff or a second main body although deployment of such a stent-graft converter is NOT separately reportable

FAQs

Q: **A patient undergoes endovascular repair of a AAA. A modular bifurcated device is placed initially. The stent graft is transformed into an aorta uni-iliac configuration by deployment of a converter. Crossfemoral bypass is performed, along with placement of an iliac occlusion device. How is this reported?**

A: Report code 34805 for deployment of the main body, which includes the converter; code 75952 for radiological S&I of the main body; code 34812-50 for bilateral femoral exposure; code 34813 for the crossfemoral bypass at the time of EVAR; code 34808 for placement of the iliac occlusion device; code. 36200 for catheterization from the main body and code 36140 for catheterization of the extremity on the side of the occlusion device.

CPT Code 34806

Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Initial analysis, interpretation and report of implanted wireless pressure sensor in aneurysmal sac (93982)

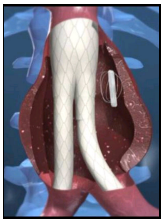
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- All associated EVAR codes would be reported separately

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	2.06
Total RVUs - OFFICE	2.94
Total RVUs - FACILITY	2.94
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes
Team Surgery (mod 66)	no

Images



FAQs

Q: **EVAR patient with implanted wireless physiologic sensor returns one month postoperatively for aneurysmal sac pressure data collection, including interpretation and report. How is this reported?**

A: Code 34806 includes only the implantation and initial analysis, interpretation and report at the time of the primary procedure. This one month post-op study would be reported with code 93982, although coverage for this service is at the discretion of the individual carriers.

CPT Code 34808

Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

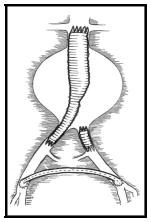
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- All other services associated with EVAR would be separately reportable.

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	4.12
Total RVUs - OFFICE	6.13
Total RVUs - FACILITY	6.13
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes
Team Surgery (mod 66)	no

Images



Coding Tips

There is no separate radiological S&I code to report with code 34808. Code 34808 is typically reported in conjunction with 34805 (AUI) and 34813 (fem-fem graft during EVAR)

CPT Code 34812

Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Surgical approach, with necessary identification, isolation, and protection of anatomic structures
- Standard closure of arterial puncture site
- Closure of wound and repair of tissues divided for initial surgical exposure

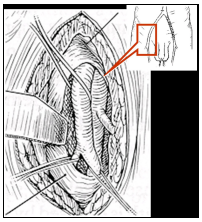
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- If required, extensive repair, endarterectomy, or replacement of an artery would be reported with appropriate code (eg, 35226, 35286, 35371) INSTEAD OF 34812

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.74**
Total RVUs - OFFICE	**9.91**
Total RVUs - FACILITY	**9.91**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Images



FAQs

Q: **A surgeon performs open exposure of both femoral arteries, advances a catheter from both groins into the abdominal aorta, places the main body of a modular bifurcated infrarenal aortic endograft with one docking limb, deploys the contralateral limb, performs the radiological supervision and interpretation, and primarily closes both femoral arteries. How is this reported?**

A: Report 34802 as the primary procedure; 34812-50 for exposure; 36200-50 for catheterization; and 75952-26 for S&I.

FAQs

Q: **After completing an EVAR, a severe focal dissection was identified in the common femoral artery blocking blood flow. Do I report both the exposure code (34812) and repair code (eg, 35226)?**

A: No. Code 34812 includes exposure and standard closure of arterial puncture site. If a more extensive repair or replacement of an artery is required, you would only report the more extensive procedure for that side (35226, 35286). However, for open exposure of the contralateral side report 34812-59.

CPT Code 34813

Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

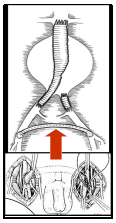
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Femoral artery exposure (34812)

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	4.79
Total RVUs - OFFICE	6.97
Total RVUs - FACILITY	6.97
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes
Team Surgery (mod 66)	no

Images



Coding Tips

Add-on code 34813 is only to be reported during a primary endovascular aneurysm repair (34800-34805), typically also with 34812-50.

CPT Code 34820

Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Surgical approach, with necessary identification, isolation, and protection of anatomic structures
- Standard closure of arterial puncture site
- Closure of wound and repair of tissues divided for initial surgical exposure

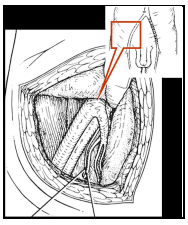
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- All other steps associated with EVAR would be separately reported

Medicare Payment Rules

Global Period	**000**
Work RVUs	**9.74**
Total RVUs - OFFICE	**14.41**
Total RVUs - FACILITY	**14.41**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Images



CPT Code 34825

Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

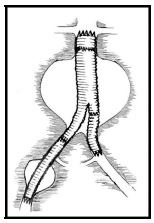
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Angiography of the aorta and its branches for diagnostic imaging prior to deployment of the proximal or distal endovascular extension device, fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75953)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**12.80**
Total RVUs - OFFICE	**20.44**
Total RVUs - FACILITY	**20.44**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Images



Coding Tips

This 90-day global procedure can be performed either during primary EVAR or as a stand alone procedure performed on a later date. When performed on a later date within the 90-day global period, append modifier 78 (unplanned return to OR for a related procedure).

FAQs

Q: **A patient undergoes open exposure of both femoral arteries, advancement of a catheter from both groins into the abdominal aorta, deployment of a main body of a modular bifurcated infrarenal aortic endograft with one docking limb and deployment of the contralateral limb. Bilateral distal extension grafts are required to treat distal type 1 endoleaks. How is this reported?**

A: Report 34802 for the main body and docking limb deployment; 34812-50 for bilateral femoral artery exposure; 36200-50 for catheterization of the aorta from both femoral arteries; 34825 for right distal extension; 34826 for left distal extension; 75952-26 for primary endograft S&I, 75953-26 for S&I related to right distal extension; and 75953-26-59 for S&I related to left distal extension.

FAQs

Q: **A patient who underwent a prior infrarenal aortic aneurysm repair by endograft develops a left common iliac aneurysm. This is treated by stent graft extension. How is this reported?**

A: Because this is an extension of the original endoprosthesis, the correct code to report is 34825, along with associated codes for S&I, femoral artery exposure, and aortic catherization.

CPT Code 34826

Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

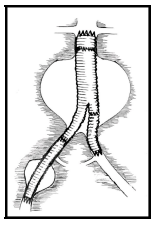
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Angiography of the aorta and its branches for diagnostic imaging prior to deployment of the proximal or distal endovascular extension device, fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) (75953)

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	4.12
Total RVUs - OFFICE	6.03
Total RVUs - FACILITY	6.03
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes
Team Surgery (mod 66)	no

Images



Coding Tips

Report extensions "per vessel", NOT "per stent"

FAQs

Q: **Patient A requires two extensions in the right external iliac artery.**

Patient B requires one extension in the right external iliac artery and one extension in the left external iliac artery. How is this reported?

A: Patient A: The extensions are in the same vessel, so 34825 would be reported once, along with S&I code 75953-26.

Patient B: The extensions are in two different vessels, so you would report 34825 and add-on code 34826, along with S&I codes 75953-26 and 75953-26-59. Keep in mind these codes would typically be reported in conjunction with a primary EVAR code (eg, 34802), a primary EVAR S&I code (eg, 75952-26), bilateral open femoral exposures (34812-50), and catheter insertions in the aorta from both femoral arteries (36200-50).

DISCUSSION FEVAR - Fenestrated Endovascular Aortic Repair

DISCUSSION FEVAR – Fenestrated Endovascular Visceral Aortic Repair

The FEVAR CPT codes are based on the number of fenestrations in the visceral segment and whether or not the aortic device extends into the common iliac arteries or terminates in the aorta above the aortic bifurcation. The fenestrations allow for selective catheterization of the visceral and/or renal arteries and subsequent placement of an endoprosthesis. The codes were constructed on the presence of one, two, three, or "four or more" fenestrations. Unlike the infrarenal aortic aneurysm endovascular repair (EVAR) and thoracic aortic aneurysm endovascular repair codes (TEVAR), these eight codes bundle the introduction of catheters non-selectively into the aorta, selective arterial catheterization into the visceral and/or renal arteries that receive a stentgraft, and the radiology supervision and interpretation for the FEVAR procedure. Similar to EVAR and TEVAR, balloon angioplasty within the target treatment zone of the endograft, either before or after endograft deployment is also included.

CPT codes 34841-34844 report deployment of a fenestrated endoprosthesis that spans from the visceral aorta through the infrarenal aorta and does NOT extend into the common iliac arteries. Alternatively, CPT codes 34845-34848 report deployment of a fenestrated endoprosthesis that spans from the visceral aorta through the infrarenal aorta into the common iliac arteries. CPT codes 34845-34848 include placement of unilateral or bilateral docking limbs (depending on the device) into the iliac system similar to infrarenal EVAR. Proximal abdominal aortic stentgraft extension prostheses are never separately reported with FEVAR. If a concomitant TEVAR is performed, thoracic stentgraft prosthesis placement is billed following standard TEVAR coding guidelines. Any additional distal stentgraft extensions that terminate in the infrarenal aorta (when codes 34841-34844 are performed) or in the common iliac arteries (when codes 34845-34848 are performed) are bundled. However, distal stentgraft extension prostheses that terminate in the internal iliac, external iliac, or common femoral artery may be billed by codes 34825 and 34826.

Catheterization of the hypogastric artery(s) and/or arterial families outside the treatment zone of the graft may be reported separately as well interventional procedures performed at the time of FEVAR outside the treatment zone (eg, embolization of the hypogastric artery, stent placement in the distal native artery for dissection, etc.). Lastly, exposure of the access vessels (eg, CPT code 34812), extensive repair of an artery (eg, CPT codes 35226 and 35286), or endarterectomy (eg, CPT code 35371) are not bundled into the new coding proposal.

The new codes include CPT code 34841 which states "Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) by deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)." CPT code 34842 is similar but involves two visceral artery endoprostheses, CPT code 34843 requires three visceral artery endoprostheses, and CPT code 34844 involves four or more visceral artery endoprostheses.

The second set of FEVAR codes includes CPT code 34845 which states "Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)." CPT code 34846 is similar but involves two visceral artery endoprostheses, CPT code 34847 requires three visceral artery endoprostheses, and CPT code 34848 involves four or more visceral artery endoprostheses.

The FEVAR planning code (34839) is used to report the extensive pre-service time for endograft planning that occurs over the course of several days or weeks prior to the date of surgery and is outside the guidelines for the 90-day global period for the FEVAR procedure. Code 34839 includes the physician planning and sizing for a patient-specific fenestrated visceral aortic endograft. The planning includes review of high resolution cross-sectional images (eg, CT, CTA, MRI) and utilization of 3D software for iterative modeling of the aorta and device in multiplanar views and center line of flow analysis. Codes 76376 and 76377 for 3D rendering may not be reported with 34839. Code 34839 may only be reported when the physician spends a minimum of 90 total minutes performing patient-specific fenestrated endograft planning. Physician planning time does not need to be continuous and should be clearly documented in the patient record. Code 34839 is reported on the date that planning work is complete and may not include time spent on the day before or the day of the FEVAR procedure.

All nine FEVAR codes (34839-34848) are "Carrier Priced" which will be variable depending upon the number of visceral/renal vessels included in the fenestrated repair as well as the need for other adjunctive maneuvers such as iliac conduit and extensive femoral artery reconstruction which are separately reportable.

SVS has prepared guidelines for requesting reimbursement for FEVAR in a table on the SVS website. The guidelines utilize a building block methodology to capture all of the steps included in these complex procedures. In addition, a surrogate value for the fenestrated main body stent was created by a blend of the codes for distal TEVAR extension and a proximal EVAR extension as this stent occupies the anatomy that lies between the two extensions. A blended S&I code was also created with the same rationale. This combination of endovascular infrarenal aneurysm code and selective renal/visceral interventions depending upon number of vessels will serve as building blocks to base reimbursement until the FEVAR codes can be appropriately surveyed and valued.

Fenestrated Endovascular Aortic Repair, FEVAR (34839, 34841-34848)

Fenestrated Endovascular Visceral Aortic Repair, FEVAR (34839, 34841-34848)

CPT Code 34839

Physician planning of a patient-specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes of physician time

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Review of high resolution cross-sectional images (eg, CT, CTA, MRI) (76376, 76377)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 34839 may NOT be reported on the same day or the day before the FEVAR procedure (34841-34848). Code 34839 may only be reported when the work of planning the FEVAR procedure is completed at least 2 days prior to the actual FEVAR implantation procedure.

Sum the hours that the physician spends on planning and document this in the medical record. Report code 34839 to the insurance carrier on the final day of planning. Typically, this is the date that the graft is ordered from the manufacturer.

CPT Code 34841

Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment
- Any additional stent graft extensions in the infrarenal aorta
- Proximal and distal stentgraft extension prostheses in the abdominal aorta
- Guide wires and catheters non-selectively into the aorta and selectively into the visceral and/or renal arteries that receive fenestrated endoprostheses
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open infrarenal aortic aneurysm repair in the same setting as FEVAR of the visceral aorta (35081, 35082, 35102, 35103)
- Catheterization of the hypogastric artery(s) or arterial families outside the treatment zone (36245-36248)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- TEVAR endoprosthesis placement (33880-33881)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft) (37236-37237, 37220-37223)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34842

Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment
- Any additional stent graft extensions in the infrarenal aorta
- Proximal and distal stentgraft extension prostheses in the abdominal aorta
- Guide wires and catheters non-selectively into the aorta and selectively into the visceral and/or renal arteries that receive fenestrated endoprostheses
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open infrarenal aortic aneurysm repair in the same setting as FEVAR of the visceral aorta (35081, 35082, 35102, 35103)
- Catheterization of the hypogastric artery(s) or arterial families outside the treatment zone (36245-36248)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- TEVAR endoprosthesis placement (33880-33881)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft) (37236-37237, 37220-37223)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34843

Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment
- Any additional stent graft extensions in the infrarenal aorta
- Proximal and distal stentgraft extension prostheses in the abdominal aorta
- Guide wires and catheters non-selectively into the aorta and selectively into the visceral and/or renal arteries that receive fenestrated endoprostheses
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open infrarenal aortic aneurysm repair in the same setting as FEVAR of the visceral aorta (35081, 35082, 35102, 35103)
- Catheterization of the hypogastric artery(s) or arterial families outside the treatment zone (36245-36248)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- TEVAR endoprosthesis placement (33880-33881)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft) (37236-37237, 37220-37223)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34844

Endovascular repair of visceral aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, deployment of a fenestrated visceral aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior Mesenteric, celiac and/or renal artery[s])

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment
- Any additional stent graft extensions in the infrarenal aorta
- Proximal and distal stentgraft extension prostheses in the abdominal aorta
- Guide wires and catheters non-selectively into the aorta and selectively into the visceral and/or renal arteries that receive fenestrated endoprostheses
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Open infrarenal aortic aneurysm repair in the same setting as FEVAR of the visceral aorta (35081, 35082, 35102, 35103)
- Catheterization of the hypogastric artery(s) or arterial families outside the treatment zone (36245-36248)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- TEVAR endoprosthesis placement (33880-33881)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft) (37236-37237, 37220-37223)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34845

Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including one visceral artery endoprosthesis (superior mesenteric, celiac or renal artery)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment
- Unilateral or bilateral docking limbs into the iliac arteries similar to infrarenal EVAR
- Any additional stent graft extensions that terminate in the common iliac arteries
- Proximal stentgraft extension prostheses in the abdominal aorta
- Guide wires and catheters non-selectively into the aorta and selectively into the visceral and/or renal arteries that receive fenestrated endoprostheses
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization of the hypogastric artery(s) or arterial families outside the treatment zone (36245-36248)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Distal stentgraft extension prostheses that terminate in the internal iliac, external iliac, or common femoral artery(s)
- TEVAR endoprosthesis placement (33880-33881)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft) (37236, 37237, 37220-37223)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34846

Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including two visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment
- Unilateral or bilateral docking limbs into the iliac arteries similar to infrarenal EVAR
- Any additional stent graft extensions that terminate in the common iliac arteries
- Proximal stentgraft extension prostheses in the abdominal aorta
- Guide wires and catheters non-selectively into the aorta and selectively into the visceral and/or renal arteries that receive fenestrated endoprostheses
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization of the hypogastric artery(s) or arterial families outside the treatment zone (36245-36248)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Distal stentgraft extension prostheses that terminate in the internal iliac, external iliac, or common femoral artery(s)
- TEVAR endoprosthesis placement (33880-33881)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft) (37236, 37237, 37220-37223)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34847

Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including three visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment
- Unilateral or bilateral docking limbs into the iliac arteries similar to infrarenal EVAR
- Any additional stent graft extensions that terminate in the common iliac arteries
- Proximal stentgraft extension prostheses in the abdominal aorta
- Guide wires and catheters non-selectively into the aorta and selectively into the visceral and/or renal arteries that receive fenestrated endoprostheses
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization of the hypogastric artery(s) or arterial families outside the treatment zone (36245-36248)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Distal stentgraft extension prostheses that terminate in the internal iliac, external iliac, or common femoral artery(s)
- TEVAR endoprosthesis placement (33880-33881)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft) (37236, 37237, 37220-37223)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34848

Endovascular repair of visceral aorta and infrarenal abdominal aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption) with a fenestrated visceral aortic endograft and concomitant unibody or modular infrarenal aortic endograft and all associated radiological supervision and interpretation, including target zone angioplasty, when performed; including four or more visceral artery endoprostheses (superior mesenteric, celiac and/or renal artery[s])

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment
- Unilateral or bilateral docking limbs into the iliac arteries similar to infrarenal EVAR
- Any additional stent graft extensions that terminate in the common iliac arteries
- Proximal stentgraft extension prostheses in the abdominal aorta
- Guide wires and catheters non-selectively into the aorta and selectively into the visceral and/or renal arteries that receive fenestrated endoprostheses
- Fluoroscopic guidance and radiological supervision and interpretation in conjunction with fenestrated endovascular aortic repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization of the hypogastric artery(s) or arterial families outside the treatment zone (36245-36248)
- Extensive repair or replacement of an artery (35226, 35286)
- Endovascular placement of iliac artery occlusion device (34808)
- Open arterial exposure (34812, 34820, 34833, 34834)
- Distal stentgraft extension prostheses that terminate in the internal iliac, external iliac, or common femoral artery(s)
- TEVAR endoprosthesis placement (33880-33881)
- Other interventional procedures performed at the time of endovascular abdominal aortic aneurysm repair (eg, renal transluminal angioplasty, arterial embolization, intravascular ultrasound, balloon angioplasty or stenting of native artery[s] outside the endoprosthesis target zone, when done before or after deployment of graft) (37236, 37237, 37220-37223)
- Transcatheter placement with interpretation and report of wireless physiologic sensor in aneurysmal sac (34806)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Open Aneurysm Repair (34830-34834, 34900-35152)

Open Aneurysm Repair (34830-34834, 34900-35152)

CPT Code 34830

Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Surgical approach, with necessary identification, isolation, and protection of anatomic structures
- Closure of wound and repair of tissues divided for initial surgical exposure
- Prior unsuccessful EVAR if performed during same surgical session

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**35.23**
Total RVUs - OFFICE	**52.00**
Total RVUs - FACILITY	**52.00**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

When an attempt at EVAR fails and the patient is converted to an open procedure with a tube prosthesis in the same setting, only report code 34830. Do NOT report arterial catheterization, femoral artery exposure, main body deployment, stent-graft extension placement, or radiology S&I.

CPT Code 34831

Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Surgical approach, with necessary identification, isolation, and protection of anatomic structures
- Closure of wound and repair of tissues divided for initial surgical exposure
- Prior unsuccessful EVAR if performed during same surgical session

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**37.98**
Total RVUs - OFFICE	**55.91**
Total RVUs - FACILITY	**55.91**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

When an attempt at EVAR fails and the patient is converted to an open procedure with an aorto-bi-iliac prosthesis in the same setting, only report code 34831. Do NOT report arterial catheterization, femoral artery exposure, main body deployment, stent-graft extension placement, or radiology S&I.

CPT Code 34832

Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Surgical approach, with necessary identification, isolation, and protection of anatomic structures
- Closure of wound and repair of tissues divided for initial surgical exposure
- Prior unsuccessful EVAR if performed during same surgical session

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**37.98**
Total RVUs - OFFICE	**55.91**
Total RVUs - FACILITY	**55.91**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

When an attempt at EVAR fails and the patient is converted to an open procedure with an aorto-bifemoral prosthesis in the same setting, only report code 34832. Do NOT report arterial catheterization, femoral artery exposure, main body deployment, stent-graft extension placement, or radiology S&I.

CPT Code 34833

Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Surgical approach, with necessary identification, isolation, and protection of anatomic structures
- Closure of wound and repair of tissues divided for initial surgical exposure
- Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (34820)

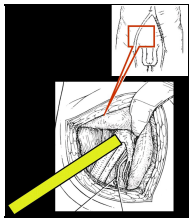
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- All associated EVAR steps except open iliac artery exposure.

Medicare Payment Rules

Global Period	**000**
Work RVUs	**11.98**
Total RVUs - OFFICE	**17.98**
Total RVUs - FACILITY	**17.98**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Images



Coding Tips

When an open iliac exposure with creation of conduit is used for EVAR/TEVAR and the conduit is then converted into an ipsilateral iliofemoral bypass, report 35665. Do NOT report codes 34812, 34820, or 34833 on that side.

FAQs

Q: **During EVAR, a patient requires an open iliac artery exposure with creation of conduit on the left side and an open iliac artery exposure without creation of conduit on the right side. How is this reported?**

A: Report code 34833 for iliac exposure with creation of conduit on the left side and code 34820-59 for iliac exposure on the right side without creation of conduit. Modifier 59 is appended to indicate that the procedures are not performed on the same side.

CPT Code 34834

Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis by arm incision, unilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Surgical approach, with necessary identification, isolation, and protection of anatomic structures
- Standard closure of arterial puncture site
- Closure of wound and repair of tissues divided for initial surgical exposure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Extensive repair or replacement of the artery
- All other associated EVAR or TEVAR procedures

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.34**
Total RVUs - OFFICE	**8.01**
Total RVUs - FACILITY	**8.01**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

FAQs

Q: **After completing an EVAR, a severe focal dissection was identified in the left brachial artery blocking blood flow. Do I report both the exposure code (34834) and repair code (eg, 35206)?**

A: No. Code 34834 includes exposure and standard closure of arterial puncture site. If a more extensive repair or replacement of an artery is required, you would report the more extensive procedure only (eg, 35206, 35236).

CPT Code 34900

Endovascular repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using ilio-iliac tube endoprosthesis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- All balloon angioplasty and/or stent deployments within the target treatment zone for the endoprosthesis, either before or after endograft deployment

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Angiography of the aorta and iliac arteries for diagnostic imaging prior to deployment of the endovascular device (including all routine components), fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography to confirm appropriate position of the graft, detect endoleaks, and evaluate the status of the runoff vessels (eg, evaluation for dissection, stenosis, thrombosis, distal embolization, or iatrogenic injury) (75954)
- Open femoral or iliac artery exposure (34812, 34820)
- Introduction of guidewires and catheters (36200, 36245-36248)
- Extensive repair or replacement of an artery (35226, 35256, 35286)
- Place of proximal or distal extension prosthesis (34825 34826)
- Other interventional procedures performed at the time of endovascular iliac aneurysm repair should be additionally reported (eg, transluminal angioplasty outside the aneurysm target zone, arterial embolization, intravascular ultrasound).

Medicare Payment Rules

Global Period	**090**
Work RVUs	**16.85**
Total RVUs - OFFICE	**26.29**
Total RVUs - FACILITY	**26.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient who underwent a prior infrarenal aortic aneurysm repair by endograft develops a left common iliac aneurysm. This is treated by stent graft extension. How is this reported?**

A: Because this is an extension of the original endoprosthesis, the correct code to report is 34825, along with associated codes for S&I, femoral artery exposure, and aortic catherization. Code 34900 would not be reported for this procedure because is a primary repair and not an extension of a previous repair.

CPT Code 35001

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.81**
Total RVUs - OFFICE	**33.24**
Total RVUs - FACILITY	**33.24**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35002

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, carotid, subclavian artery, by neck incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**22.23**
Total RVUs - OFFICE	**33.47**
Total RVUs - FACILITY	**33.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35005

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, vertebral artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.29**
Total RVUs - OFFICE	**33.80**
Total RVUs - FACILITY	**33.80**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35011

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, axillary-brachial artery, by arm incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.58**
Total RVUs - OFFICE	**29.46**
Total RVUs - FACILITY	**29.46**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient A presents with aneurysm in the brachial artery at the arterial anastomosis of his AV fistula.**

Patient B presents with aneurysm in the AV fistula itself, distal to the arterial anastomosis. How are these reported?

A: For Patient A, reconstruction of the native brachial artery is required and correctly reported with code 35011.

For Patient B, the AV access graft or fistula requires revision; therefore code 36832 would be reported.

CPT Code 35013

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, axillary-brachial artery, by arm incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.23**
Total RVUs - OFFICE	**36.62**
Total RVUs - FACILITY	**36.62**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35021

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**22.17**
Total RVUs - OFFICE	**36.93**
Total RVUs - FACILITY	**36.93**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35022

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, innominate, subclavian artery, by thoracic incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.70**
Total RVUs - OFFICE	**42.31**
Total RVUs - FACILITY	**42.31**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35045

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.01**
Total RVUs - OFFICE	**29.19**
Total RVUs - FACILITY	**29.19**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35081

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**33.53**
Total RVUs - OFFICE	**51.45**
Total RVUs - FACILITY	**51.45**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For endovascular infrarenal abdominal aortic aneurysm repair, see codes 34800-34805.

Coding Tips

There is no CPT coding distinction between transabdominal and retroperitoneal approach. Open AAA repair with a tube graft repair would be reported with code 35081 when using either of these two approaches

FAQs

Q: **A patient with a 6.5 cm infrarenal abdominal aortic aneurysm has undergone extensive pre-op work. Standard open aortic aneurysmectomy with a tube graft is performed. The patient is in the ICU on a ventilator for 48 hours postoperatively and requires real-time hemodynamic monitoring, close monitoring of urinary output, diuretic support, and fluid management. The patient is transferred to the floor after 72 hours. The remainder of his postoperative course is uneventful and he is discharged to home on the 10th postoperative day. How is this reported?**

A: Open aortic aneurysm repair is a 90-day global service reportable by code 35081. No additional codes are reportable in the clinical example described above.

CPT Code 35082

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**42.09**
Total RVUs - OFFICE	**64.60**
Total RVUs - FACILITY	**64.60**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

There is no CPT coding distinction between transabdominal and retroperitoneal approach. Open AAA repair with a tube graft repair would be reported with code 35081 when using either of these two approaches.

FAQs

Q: **A patient with CAD and COPD arrives by ambulance with a onehour history of excruciating abdominal and back pain. His blood pressure is 70/40, heart rate is 140, and he has a distended abdomen with a tender pulsatile mass. Emergent open repair of ruptured infrarenal abdominal aortic aneurysm is performed by placement of a tube graft. How isthis reported?**

A: Report code 35082.

CPT Code 35091

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**35.35**
Total RVUs - OFFICE	**52.84**
Total RVUs - FACILITY	**52.84**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

There is no CPT coding distinction between transabdominal and retroperitoneal approach. Open aneurysm repair involving the visceral segment of the aorta would be reported with code 35091 when using either of these two approaches

Coding Tips

Juxta-renal or para-renal AAA repair is describe by CPT code 35091 electively and by 35092 when the aneurysm is ruptured. The CPT descriptor states: "abdominal aorta involving visceral vessels (mesenteric, celiac, renal)."

FAQs

Q: **A patient with a 6.5 cm abdominal aortic aneurysm undergoes extensive pre-op work-up, including a CT scan. The studies reveal that the aneurysm extends proximally to involve the renal arteries. Aortic crossclamp is required above the renal origins. How is this reported?**

A: Report code 35091.

CPT Code 35092

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**50.97**
Total RVUs - OFFICE	**76.91**
Total RVUs - FACILITY	**76.91**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

There is no CPT coding distinction between transabdominal and retroperitoneal approach. Open aneurysm repair involving the visceral segment of the aorta would be reported with code 35091 when using either of these two approaches.

Coding Tips

Juxta-renal or para-renal AAA repair is describe by CPT code 35091 electively and by 35092 when the aneurysm is ruptured. The CPT descriptor states: "abdominal aorta involving visceral vessels (mesenteric, celiac, renal)."

FAQs

Q: **A patient with a ruptured 6.5 cm AAA undergoes emergent open repair. Exploration reveals that the aneurysm extends proximally to involve the renal arteries. Aortic cross-clamp is required above the renal origins. How is this reported?**

A: Report code 35092.

CPT Code 35102

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**36.53**
Total RVUs - OFFICE	**55.70**
Total RVUs - FACILITY	**55.70**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient has an asymptomatic 6.5 cm diameter infrarenal abdominal aortic aneurysm. Extensive pre-op work-up has been done, including a CT scan that revealed anatomy not suitable for endovascular aneurysm repair. Open aneurysm repair with a bifurcated graft is performed. How is this reported?**

A: Infrarenal aortic aneurysms that require placement of a bifurcated aortic prosthesis and iliac anastomoses should be reported with code 35102.

CPT Code 35103

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**43.62**
Total RVUs - OFFICE	**66.36**
Total RVUs - FACILITY	**66.36**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with CAD and COPD arrives by ambulance with a onehour history of excruciating abdominal and back pain. His blood pressure is 70/40, heart rate is 140, and his abdomen is distended with a tender pulsatile mass. Emergent open repair of a ruptured infrarenal abdominal aortic aneurysm involving the iliac vessels is performed by placement of a bifurcated graft. How is this reported?**

A: Report code 35103.

CPT Code 35111

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, splenic artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.28**
Total RVUs - OFFICE	**39.17**
Total RVUs - FACILITY	**39.17**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Endovascular splenic artery aneurysm repair is an embolization procedure that includes: 36246 (2nd order selective catheterization); 37242 (embolization); and 75726-59 (angiogram if no prior angiogram had been performed).

CPT Code 35112

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, splenic artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**32.57**
Total RVUs - OFFICE	**54.91**
Total RVUs - FACILITY	**54.91**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35121

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, hepatic, celiac, renal, or mesenteric artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**31.52**
Total RVUs - OFFICE	**48.41**
Total RVUs - FACILITY	**48.41**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report code 35121 for either plication of the renal or visceral artery aneurysm sac (aneurysmorrhaphy) or interposition grafting with autogenous or prosthetic conduit.

CPT Code 35122

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, hepatic, celiac, renal, or mesenteric artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**37.89**
Total RVUs - OFFICE	**63.36**
Total RVUs - FACILITY	**63.36**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35131

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, iliac artery (common, hypogastric, external)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.40**
Total RVUs - OFFICE	**40.92**
Total RVUs - FACILITY	**40.92**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35132

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, iliac artery (common, hypogastric, external)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**32.57**
Total RVUs - OFFICE	**48.21**
Total RVUs - FACILITY	**48.21**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35141

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, common femoral artery (profunda femoris, superficial femoral)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.91**
Total RVUs - OFFICE	**32.63**
Total RVUs - FACILITY	**32.63**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For injection repair of an extremity pseudoaneurysm see code 36002

CPT Code 35142

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, common femoral artery (profunda femoris, superficial femoral)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.16**
Total RVUs - OFFICE	**38.84**
Total RVUs - FACILITY	**38.84**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For injection repair of an extremity pseudoaneurysm see code 36002

CPT Code 35151

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, popliteal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.72**
Total RVUs - OFFICE	**36.62**
Total RVUs - FACILITY	**36.62**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 35151 for open repair of a patent popliteal artery aneurysm by exclusion and bypass. If the popliteal artery is occluded and the lower extremity requires revascularization, use the appropriate infrainguinal bypass code (eg, 35556, 35566, 35583, 35585, 35656, 35666).

CPT Code 35152

Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, popliteal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of artery for anastomosis including focal endarterectomy at the anastomotic site(s)
- Saphenous or arm vein harvest, if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**27.66**
Total RVUs - OFFICE	**41.23**
Total RVUs - FACILITY	**41.23**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Open Arterial Revascularization

Open Arterial Revascularization

Embolectomy & Thrombectomy, Open (34001-34203)

Embolectomy & Thrombectomy, Open (34001-34203)

CPT Code 34001

Embolectomy or thrombectomy, with or without catheter; carotid, subclavian or innominate artery, by neck incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram

Medicare Payment Rules

Global Period	**090**
Work RVUs	**17.88**
Total RVUs - OFFICE	**29.01**
Total RVUs - FACILITY	**29.01**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34001-34203 are used to report open embolectomy or thrombectomy. For percutaneous mechanical arterial thrombectomy, see codes 37184-37186

CPT Code 34051

Embolectomy or thrombectomy, with or without catheter; innominate, subclavian artery, by thoracic incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram

Medicare Payment Rules

Global Period	**090**
Work RVUs	**16.99**
Total RVUs - OFFICE	**26.24**
Total RVUs - FACILITY	**26.24**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34001-34203 are used to report open embolectomy or thrombectomy. For percutaneous mechanical arterial thrombectomy, see codes 37184-37186.

CPT Code 34101

Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram
- Fasciotomy(ies) (25020-25025)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.93**
Total RVUs - OFFICE	**17.70**
Total RVUs - FACILITY	**17.70**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34001-34203 are used to report open embolectomy or thrombectomy. For percutaneous mechanical arterial thrombectomy, see codes 37184-37186

CPT Code 34111

Embolectomy or thrombectomy, with or without catheter; radial or ulnar artery, by arm incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram
- Fasciotomy(ies) (25020-25025)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.93**
Total RVUs - OFFICE	**17.61**
Total RVUs - FACILITY	**17.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34001-34203 are used to report open embolectomy or thrombectomy. For percutaneous mechanical arterial thrombectomy, see codes 37184-37186.

CPT Code 34151

Embolectomy or thrombectomy, with or without catheter; renal, celiac, mesentery, aortoiliac artery, by abdominal incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram
- Bowel resection

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.52**
Total RVUs - OFFICE	**41.25**
Total RVUs - FACILITY	**41.25**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34001-34203 are used to report open embolectomy or thrombectomy. For percutaneous mechanical arterial thrombectomy, see codes 37184-37186.

CPT Code 34201

Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram
- Fasciotomy(ies) (27301, 27600-27602, 27892-27894)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.48**
Total RVUs - OFFICE	**30.36**
Total RVUs - FACILITY	**30.36**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34001-34203 are used to report open embolectomy or thrombectomy. For percutaneous mechanical arterial thrombectomy, see codes 37184-37186.

Report fasciotomy code 27602, when performed in addition to code 34201.

When an open balloon catheter thrombectomy is performed in the same setting through the same incision as an endarterectomy, only report the endarterectomy. The latter procedure is termed "thromboendarterectomy" in the CPT manual and includes both services.

CPT Code 34203

Embolectomy or thrombectomy, with or without catheter; popliteal-tibio-peroneal artery, by leg incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram
- Fasciotomy(ies) (27301, 27600-27602, 27892-27894)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**17.86**
Total RVUs - OFFICE	**28.05**
Total RVUs - FACILITY	**28.05**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34001-34203 are used to report open embolectomy or thrombectomy. For percutaneous mechanical arterial thrombectomy, see codes 37184-37186.

Report fasciotomy code 27602, when performed in addition to code 34203.

When an open balloon catheter thrombectomy is performed in the same setting through the same incision as an endarterectomy, only report the endarterectomy. The latter procedure is termed "thromboendarterectomy" in the CPT manual and includes both services.

Aortic Circulation Assist (33971)

Aortic Circulation Assist (33971)

CPT Code 33971

Removal of intra-aortic balloon assist device including repair of femoral artery, with or without graft

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Lower extremity patch angioplasty (35256, 35286)
- Lower extremity artery direct repair (35226)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This service is typically reported with a single CPT code, but situations could arise wherein reporting multiple codes would be appropriate. For instance, if embolization of material into the arteries of the thigh or calf resulted in performance of an embolectomy for limb salvage, the embolectomy would be separately reportable.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**11.99**
Total RVUs - OFFICE	**20.58**
Total RVUs - FACILITY	**20.58**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

When removal of the balloon pump requires a femoral artery endarterectomy with or without patch, report the endarterectomy code (eg, 35371) INSTEAD of code33971.

Repair Congenital & Acquired A-V Fistula (35180-35190)

Repair Congenital & Acquired A-V Fistula (35180-35190)

CPT Code 35180

Repair, congenital arteriovenous fistula; head and neck

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Transcatheter therapy, infusion other than for thrombolysis, any type (eg vasoconstrictive)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Bypass graft placement if required to restore perfusion

Medicare Payment Rules

Global Period	**090**
Work RVUs	**15.10**
Total RVUs - OFFICE	**26.38**
Total RVUs - FACILITY	**26.38**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35182

Repair, congenital arteriovenous fistula; thorax and abdomen

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Transcatheter therapy, infusion other than for thrombolysis, any type (eg vasoconstrictive)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Bypass graft placement if required to restore perfusion

Medicare Payment Rules

Global Period	**090**
Work RVUs	**31.71**
Total RVUs - OFFICE	**47.59**
Total RVUs - FACILITY	**47.59**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35184

Repair, congenital arteriovenous fistula; extremities

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Transcatheter therapy, infusion other than for thrombolysis, any type (eg vasoconstrictive)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Bypass graft placement if required to restore perfusion

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.82**
Total RVUs - OFFICE	**32.70**
Total RVUs - FACILITY	**32.70**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35188

Repair, acquired or traumatic arteriovenous fistula; head and neck

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Transcatheter therapy, infusion other than for thrombolysis, any type (eg vasoconstrictive)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.00**
Total RVUs - OFFICE	**31.13**
Total RVUs - FACILITY	**31.13**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient has previously undergone placement of a right internal jugular central venous catheter. The attempt was complicated by inadvertent arterial puncture. The patient now presents with a bruit at the base of his neck and a duplex that demonstrated an arteriovenous fistula. Preoperative angiography confirms an arteriovenous communication situated between the common carotid artery and internal jugular vein. The fistula is repaired through an incision using an open surgical approach. How is this reported?**

A: Report with code 35188.

CPT Code 35189

Repair, acquired or traumatic arteriovenous fistula; thorax and abdomen

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Transcatheter therapy, infusion other than for thrombolysis, any type (eg vasoconstrictive)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Bypass graft placement if required to restore perfusion

Medicare Payment Rules

Global Period	**090**
Work RVUs	**29.98**
Total RVUs - OFFICE	**44.54**
Total RVUs - FACILITY	**44.54**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35190

Repair, acquired or traumatic arteriovenous fistula; extremities

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Transcatheter therapy, infusion other than for thrombolysis, any type (eg vasoconstrictive)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.
- Bypass graft placement if required to restore perfusion

Medicare Payment Rules

Global Period	**090**
Work RVUs	**13.42**
Total RVUs - OFFICE	**22.32**
Total RVUs - FACILITY	**22.32**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When an arteriovenous fistula develops in the groin after femoral artery catheterization, report code 35190 to describe the combined repair of both vein and artery.

Repair Blood Vessel (eg, trauma) (35201-35286)

Repair Blood Vessel (eg, trauma) (35201-35286)

CPT Code 35201

Repair blood vessel, direct; neck

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Exploration for postoperative hemorrhage, thrombosis, or infection; neck (35800)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**16.93**
Total RVUs - OFFICE	**28.04**
Total RVUs - FACILITY	**28.04**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35206

Repair blood vessel, direct; upper extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Exploration for postoperative hemorrhage, thrombosis or infection; extremity (35860)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**13.84**
Total RVUs - OFFICE	**22.70**
Total RVUs - FACILITY	**22.70**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35207

Repair blood vessel, direct; hand, finger

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.94**
Total RVUs - OFFICE	**21.69**
Total RVUs - FACILITY	**21.69**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35211

Repair blood vessel, direct; intrathoracic, with bypass

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.58**
Total RVUs - OFFICE	**40.02**
Total RVUs - FACILITY	**40.02**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35216

Repair blood vessel, direct; intrathoracic, without bypass

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**36.61**
Total RVUs - OFFICE	**59.60**
Total RVUs - FACILITY	**59.60**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35221

Repair blood vessel, direct; intra-abdominal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.62**
Total RVUs - OFFICE	**42.47**
Total RVUs - FACILITY	**42.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair

CPT Code 35226

Repair blood vessel, direct; lower extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**15.30**
Total RVUs - OFFICE	**24.44**
Total RVUs - FACILITY	**24.44**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 35226 instead of 34812 during EVAR when the surgically exposed femoral artery puncture site requires an extensive direct repair instead of standard transverse closure by suture.

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35231

Repair blood vessel with vein graft; neck

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.16**
Total RVUs - OFFICE	**35.83**
Total RVUs - FACILITY	**35.83**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When a carotid artery endarterectomy requires vein patch closure of the arteriotomy, do not report code 35231 in addition to code 35301.

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35236

Repair blood vessel with vein graft; upper extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.02**
Total RVUs - OFFICE	**28.79**
Total RVUs - FACILITY	**28.79**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair

CPT Code 35241

Repair blood vessel with vein graft; intrathoracic, with bypass

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.58**
Total RVUs - OFFICE	**41.92**
Total RVUs - FACILITY	**41.92**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35246

Repair blood vessel with vein graft; intrathoracic, without bypass

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**28.23**
Total RVUs - OFFICE	**46.01**
Total RVUs - FACILITY	**46.01**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35251

Repair blood vessel with vein graft; intra-abdominal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**31.91**
Total RVUs - OFFICE	**50.04**
Total RVUs - FACILITY	**50.04**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35256

Repair blood vessel with vein graft; lower extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Saphenous or arm vein harvest if used for this repair

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.
- Femoropopliteal vein harvest if used for this repair (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.06**
Total RVUs - OFFICE	**29.92**
Total RVUs - FACILITY	**29.92**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 35884 instead of 35256 when autogenous vein is used in the groin to patch a prior synthetic bypass graft stenosis.

Coding Tips

Report code 35256 instead of 34812 during EVAR when the surgically exposed femoral artery puncture site requires vein patch angioplasty closure.

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35261

Repair blood vessel with graft other than vein; neck

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.96**
Total RVUs - OFFICE	**31.47**
Total RVUs - FACILITY	**31.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When a carotid artery endarterectomy requires prosthetic patch closure of the arteriotomy, do not report code 35261 in addition to code 35301. Patch placement during CEA, when performed, is an inherent component of this operation

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35266

Repair blood vessel with graft other than vein; upper extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**15.83**
Total RVUs - OFFICE	**25.43**
Total RVUs - FACILITY	**25.43**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35271

Repair blood vessel with graft other than vein; intrathoracic, with bypass

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.58**
Total RVUs - OFFICE	**40.26**
Total RVUs - FACILITY	**40.26**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35276

Repair blood vessel with graft other than vein; intrathoracic, without bypass

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.83**
Total RVUs - OFFICE	**42.71**
Total RVUs - FACILITY	**42.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair

CPT Code 35281

Repair blood vessel with graft other than vein; intra-abdominal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**30.06**
Total RVUs - OFFICE	**47.65**
Total RVUs - FACILITY	**47.65**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

CPT Code 35286

Repair blood vessel with graft other than vein; lower extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This repair is typically reported with a single CPT code, although a patient who has suffered extensive trauma will likely require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**17.19**
Total RVUs - OFFICE	**27.45**
Total RVUs - FACILITY	**27.45**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 35883 instead of 35286 when a prosthetic material is used in the groin to patch a prior synthetic bypass graft stenosis.

Coding Tips

Report code 35286 instead of 34812 during EVAR when the surgically exposed femoral artery puncture site requires prosthetic patch angioplasty closure.

Coding Tips

The typical clinical application of the "Repair Blood Vessel" code family (35201-35286) is in the trauma setting (blunt, penetrating, iatrogenic, etc.), when vascular injuries other than arteriovenous fistulae require open surgical arterial or venous repair.

Thromboendarterectomy (35301-35390)

Thromboendarterectomy (35301-35390)

CPT Code 35301

Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Placement of intra-arterial shunt
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.16**
Total RVUs - OFFICE	**33.32**
Total RVUs - FACILITY	**33.32**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When performing a redo carotid endarterectomy at least one month after the original surgery, report addon code 35390 in addition to 35301.

CPT Code 35302

Thromboendarterectomy, including patch graft, if performed; superficial femoral artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.35**
Total RVUs - OFFICE	**33.19**
Total RVUs - FACILITY	**33.19**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35303

Thromboendarterectomy, including patch graft, if performed; popliteal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.60**
Total RVUs - OFFICE	**36.58**
Total RVUs - FACILITY	**36.58**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35304

Thromboendarterectomy, including patch graft, if performed; tibioperoneal trunk artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.60**
Total RVUs - OFFICE	**37.84**
Total RVUs - FACILITY	**37.84**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35305

Thromboendarterectomy, including patch graft, if performed; tibial or peroneal artery, initial vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.60**
Total RVUs - OFFICE	**36.04**
Total RVUs - FACILITY	**36.04**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35306

Thromboendarterectomy, including patch graft, if performed; each additional tibial or peroneal artery (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**9.25**
Total RVUs - OFFICE	**13.17**
Total RVUs - FACILITY	**13.17**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When performing tibial endarterectomy in 2 distinct vessels, report add-on code 35306 in addition to primary code 35305.

CPT Code 35311

Thromboendarterectomy, including patch graft, if performed; subclavian, innominate, by thoracic incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**28.60**
Total RVUs - OFFICE	**45.73**
Total RVUs - FACILITY	**45.73**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35321

Thromboendarterectomy, including patch graft, if performed; axillary-brachial

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**16.59**
Total RVUs - OFFICE	**26.16**
Total RVUs - FACILITY	**26.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35331

Thromboendarterectomy, including patch graft, if performed; abdominal aorta

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**27.72**
Total RVUs - OFFICE	**42.84**
Total RVUs - FACILITY	**42.84**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35341

Thromboendarterectomy, including patch graft, if performed; mesenteric, celiac, or renal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.21**
Total RVUs - OFFICE	**40.05**
Total RVUs - FACILITY	**40.05**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35351

Thromboendarterectomy, including patch graft, if performed; iliac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.61**
Total RVUs - OFFICE	**37.71**
Total RVUs - FACILITY	**37.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35355

Thromboendarterectomy, including patch graft, if performed; iliofemoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram
- Iliac endarterectomy (35351)
- Common femoral endarterectomy (35371)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.86**
Total RVUs - OFFICE	**30.50**
Total RVUs - FACILITY	**30.50**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with extensive iliac and common femoral artery occlusive disease is treated with an open iliofemoral endarterectomy, prosthetic patch angioplasty, and retrograde deployment of a common iliac artery stent, followed by an external iliac artery stent. How is this reported?**

A: Report code 35355 for the iliofemoral endarterectomy; 37221 for placement of the first iliac artery stent; and add-on code 37223 for the stent in an additional iliac vessel. These bundled iliac stent codes include the work of catheterization, stent deployment, and radiological S&I. There is no additional reporting for the prosthetic patch angioplasty.

CPT Code 35361

Thromboendarterectomy, including patch graft, if performed; combined aortoiliac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram
- Iliac endarterectomy (35351)
- Common femoral endarterectomy (35371)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**30.24**
Total RVUs - OFFICE	**44.89**
Total RVUs - FACILITY	**44.89**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35363

Thromboendarterectomy, including patch graft, if performed; combined aortoiliofemoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram
- Iliac endarterectomy (35351)
- Common femoral endarterectomy (35371)
- Iliofemoral endarterectomy (35355)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**32.35**
Total RVUs - OFFICE	**51.63**
Total RVUs - FACILITY	**51.63**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35371

Thromboendarterectomy, including patch graft, if performed; common femoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**15.31**
Total RVUs - OFFICE	**24.16**
Total RVUs - FACILITY	**24.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 35371 instead of 34812 during EVAR when the surgically exposed femoral artery puncture site requires a common femoral endarterectomy with or without patch closure to ensure adequate reperfusion of the extremity after the very large sheaths have been disrupted the plaque

CPT Code 35372

Thromboendarterectomy, including patch graft, if performed; deep (profunda) femoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of autogenous vein, when performed
- Closure of arteriotomy by placement of patch
- Plication, when performed
- Embolectomy or thrombectomy through the endarterectomy site
- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open endarterectomy code is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.58**
Total RVUs - OFFICE	**28.92**
Total RVUs - FACILITY	**28.92**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35390

Reoperation, carotid, thromboendarterectomy, more than 1 month after original operation (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Carotid endarterectomy (35301)

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**3.19**
Total RVUs - OFFICE	**4.71**
Total RVUs - FACILITY	**4.71**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When performing a redo carotid endarterectomy at least one month after the original surgery, report addon code 35390 in addition to 35301.

Angioscopy (35400)

Angioscopy (35400)

CPT Code 35400

Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**3.00**
Total RVUs - OFFICE	**4.40**
Total RVUs - FACILITY	**4.40**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Add-on code 35400 is typically reported in addition to bypass grafts performed with vein.

Bypass Graft (35500-35686)

Bypass Graft (35500-35686)

CPT Code 35500

Harvest of upper extremity vein, 1 segment, for lower extremity or coronary artery bypass procedure (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest, vein preparation, valve lysis if performed, additional anastomosis to incorporate into lower extremity bypass, if required.

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of more than one continuous segment of vein

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**6.44**
Total RVUs - OFFICE	**9.39**
Total RVUs - FACILITY	**9.39**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For harvest of more than one segment, see 35682, 35683.

Coding Tips

Use 35500 in conjunction with codes for lower extremity bypass with vein 33510-33536, 35556, 35566, 35570, 35571, 35583-35587.

CPT Code 35501

Bypass graft, with vein; common carotid-ipsilateral internal carotid

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**29.09**
Total RVUs - OFFICE	**44.31**
Total RVUs - FACILITY	**44.31**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35506

Bypass graft, with vein; carotid-subclavian or subclavian-carotid

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.33**
Total RVUs - OFFICE	**37.62**
Total RVUs - FACILITY	**37.62**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with subclavian steal symptoms is found to have complete occlusion of the left subclavian artery at its origin. Blood flow in the left vertebral artery is retrograde, filling the distal subclavian and thereby perfusing the arm. Prior attempts to recanalize the subclavian origin by interventional techniques have been unsuccessful. A carotidsubclavian bypass graft is performed using vein conduit. How is this reported?**

A: Report code 35506.

CPT Code 35508

Bypass graft, with vein; carotid-vertebral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.09**
Total RVUs - OFFICE	**39.22**
Total RVUs - FACILITY	**39.22**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35509

Bypass graft, with vein; carotid-contralateral carotid

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**28.09**
Total RVUs - OFFICE	**41.74**
Total RVUs - FACILITY	**41.74**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with with right hemispheric TIAs and a severe sense of lightheadedness is found to have complete occlusion of her innominate artery. The right internal carotid artery is patent, fed by retrograde flow in the external carotid. The left common carotid artery is widely patent. A left-to-right carotid-carotid bypass graft is performed using vein conduit. How is this reported?**

A: Report code 35509.

CPT Code 35510

Bypass graft, with vein; carotid-brachial

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.39**
Total RVUs - OFFICE	**36.32**
Total RVUs - FACILITY	**36.32**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

All vein harvest (saphenous or arm) except femoropopliteal vein is included in the work of upper extremity bypass graft placement

FAQs

Q: **Patient undergoes left carotidbrachial bypass with vein harvested from same arm, plus completion duplex exam. How is this reported?**

A: Report code 35510 for the bypass graft and 93931-26 for the duplex exam.

Note: The arm vein harvest (+35500) add-on code is NOT additionally reported because all vein harvest except femoropopliteal is included in upper extremity bypass graft work.

CPT Code 35511

Bypass graft, with vein; subclavian-subclavian

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**22.20**
Total RVUs - OFFICE	**33.07**
Total RVUs - FACILITY	**33.07**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35512

Bypass graft, with vein; subclavian-brachial

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.89**
Total RVUs - OFFICE	**40.61**
Total RVUs - FACILITY	**40.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35515

Bypass graft, with vein; subclavian-vertebral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.09**
Total RVUs - OFFICE	**44.94**
Total RVUs - FACILITY	**44.94**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35516

Bypass graft, with vein; subclavian-axillary

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.21**
Total RVUs - OFFICE	**36.02**
Total RVUs - FACILITY	**36.02**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with disabling left arm pain is found to have occlusion of the distal subclavian and proximal axillary arteries. Prior attempts to recanalize the vessel by percutaneous interventional techniques have been unsuccessful. A subclavian-axillary bypass graft is performed using vein conduit. How is this reported?**

A: Report code 35516

CPT Code 35518

Bypass graft, with vein; axillary-axillary

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**22.65**
Total RVUs - OFFICE	**33.71**
Total RVUs - FACILITY	**33.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35521

Bypass graft, with vein; axillary-femoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.13**
Total RVUs - OFFICE	**36.20**
Total RVUs - FACILITY	**36.20**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For bypass graft performed with synthetic graft, use 35621.

CPT Code 35522

Bypass graft, with vein; axillary-brachial

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.15**
Total RVUs - OFFICE	**35.81**
Total RVUs - FACILITY	**35.81**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35523

Bypass graft, with vein; brachial-ulnar or -radial

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.13**
Total RVUs - OFFICE	**38.08**
Total RVUs - FACILITY	**38.08**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For bypass graft performed with synthetic graft, use 37799.

Coding Tips

For distal revascularization and interval ligation (DRIL) in the upper extremity for hemodialysis access steal syndrome, report 36838 and do NOT report 35523

CPT Code 35525

Bypass graft, with vein; brachial-brachial

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.69**
Total RVUs - OFFICE	**33.86**
Total RVUs - FACILITY	**33.86**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For distal revascularization and interval ligation (DRIL) in the upper extremity for hemodialysis access steal syndrome, report 36838 and do NOT report 35525

CPT Code 35526

Bypass graft, with vein; aortosubclavian, aortoinnominate, or aortocarotid

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**31.55**
Total RVUs - OFFICE	**50.92**
Total RVUs - FACILITY	**50.92**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For aortosubclavian, aortoinnominate or aortocarotid bypass graft performed with synthetic graft, use 35626.

CPT Code 35531

Bypass graft, with vein; aortoceliac or aortomesenteric

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**39.11**
Total RVUs - OFFICE	**59.59**
Total RVUs - FACILITY	**59.59**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient presents with a 3-month history of postprandial epigastric abdominal pain and 50-lb. weight loss. Diagnostic mesenteric angiogram revealed completely occluded superior mesenteric artery and critically stenotic celiac artery. She undergo operative bypass. How is this reported?**

A: There are three different ways to report this depending on the exact operation performed. Report code 35531 for a single vein bypass graft from supra-celiac aorta to the SMA. Report 35631 and 35631-59 for a bifurcated synthetic graft from the aorta with one limb anastomosed to the celiac and the other limb anastomosed to the SMA. Report 35633 for a right common iliac artery to SMA bypass with prosthetic conduit.

CPT Code 35533

Bypass graft, with vein; axillary-femoral-femoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular statu

Medicare Payment Rules

Global Period	**090**
Work RVUs	**29.92**
Total RVUs - OFFICE	**44.45**
Total RVUs - FACILITY	**44.45**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For bypass graft performed with synthetic graft, use 35654.

CPT Code 35535

Bypass graft, with vein; hepatorenal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**38.13**
Total RVUs - OFFICE	**56.16**
Total RVUs - FACILITY	**56.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35536

Bypass graft, with vein; splenorenal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**33.73**
Total RVUs - OFFICE	**49.87**
Total RVUs - FACILITY	**49.87**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For a direct splenic to renal arterial anastomosis without use of a vein conduit, report 35636.

CPT Code 35537

Bypass graft, with vein; aortoiliac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**41.88**
Total RVUs - OFFICE	**69.81**
Total RVUs - FACILITY	**69.81**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For an aortoiliac bypass graft performed with synthetic graft, use 35637.

CPT Code 35538

Bypass graft, with vein; aortobi-iliac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**47.03**
Total RVUs - OFFICE	**68.90**
Total RVUs - FACILITY	**68.90**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For an aortobi-iliac bypass graft performed with synthetic graft, use 35638.

CPT Code 35539

Bypass graft, with vein; aortofemoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**44.11**
Total RVUs - OFFICE	**64.71**
Total RVUs - FACILITY	**64.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For an aortofemoral bypass graft performed with synthetic graft, use 35647.

CPT Code 35540

Bypass graft, with vein; aortobifemoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**49.33**
Total RVUs - OFFICE	**75.66**
Total RVUs - FACILITY	**75.66**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For an aortobifemoral bypass graft performed with synthetic graft, use 35646

CPT Code 35548

(35548 has been deleted. To report, see 35537, 35539, 35565)

CPT Code 35549

(35549 has been deleted. To report, see 35537, 35538, 35539, 35540, 35565)

CPT Code 35551

(35551 has been deleted. To report, see 35539, 35540, 35556, 35583)

CPT Code 35556

Bypass graft, with vein; femoral-popliteal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of ipsilateral or contralateral saphenous vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Harvest of an upper extremity vein (35500)
- Harvest of a femoropopliteal vein segment (35572)
- Harvest and construction of an autogenous composite graft of two segments from two distant locations (35682)
- Harvest and construction of an autogenous composite graft of three or more segments from distant locations (35683)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.75**
Total RVUs - OFFICE	**41.29**
Total RVUs - FACILITY	**41.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For femoral-popliteal bypass using in-situ saphenous vein, report 35583 instead of 35556.

FAQs

Q: **Patient with prior aortobifemoral bypass now requires femoral-popliteal bypass. The proximal anastomosis is performed at the femoral limb of the prior aorto-bifemoral bypass. How is this reported?**

A: Reporting the bypass procedure does not differ based on whether the bypass is sewn to the native femoral artery or a graft at the femoral level. Code 35556 would correctly be reported. In addition, the add-on code 35700 for reoperation would be reported if performed more than 1 month after the original operation.

CPT Code 35558

Bypass graft, with vein; femoral-femoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.13**
Total RVUs - OFFICE	**36.18**
Total RVUs - FACILITY	**36.18**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 35558 when venous conduit is used for bypass from the common femoral artery to either the contralateral femoral system OR the ipsilateral superficial/deep femoral artery.

CPT Code 35560

Bypass graft, with vein; aortorenal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**34.03**
Total RVUs - OFFICE	**50.29**
Total RVUs - FACILITY	**50.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35563

Bypass graft, with vein; ilioiliac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.12**
Total RVUs - OFFICE	**44.68**
Total RVUs - FACILITY	**44.68**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35565

Bypass graft, with vein; iliofemoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of saphenous vein or a segment of upper extremity vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of a femoropopliteal vein segment (35572)
- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.13**
Total RVUs - OFFICE	**39.16**
Total RVUs - FACILITY	**39.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For bypass graft performed with synthetic graft, use 35665.

CPT Code 35566

Bypass graft, with vein; femoral-anterior tibial, posterior tibial, peroneal artery or other distal vessels

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of ipsilateral or contralateral saphenous vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Harvest of an upper extremity vein (35500)
- Harvest of a femoropopliteal vein segment (35572)
- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)
- Harvest and construction of an autogenous composite graft of two segments from two distant locations (35682)
- Harvest and construction of an autogenous composite graft of three or more segments from distant locations (35683)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**32.35**
Total RVUs - OFFICE	**49.29**
Total RVUs - FACILITY	**49.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For femoral-tibial bypass using insitu saphenous vein, report 35585 instead of 35566.

FAQs

Q: **Patient requires femoral-tibial bypass graft, but ipsilateral saphenous vein was harvested for a previous CABG requiring harvest of contralateral saphenous vein for the bypass graft. Is harvest of the contralateral vein separately reportable?**

A: No. Lower extremity vein bypass grafting includes harvest and preparation of a single segment of saphenous vein from the same or the contralateral leg.

CPT Code 35570

Bypass graft, with vein; tibial-tibial, peroneal-tibial, or tibial/peroneal trunk-tibial

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of ipsilateral or contralateral saphenous vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Harvest of an upper extremity vein (35500)
- Harvest of a femoropopliteal vein segment (35572)
- Harvest and construction of an autogenous composite graft of two segments from two distant locations (35682)
- Harvest and construction of an autogenous composite graft of three or more segments from distant locations (35683)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**29.15**
Total RVUs - OFFICE	**44.76**
Total RVUs - FACILITY	**44.76**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient with prior femoral-tibial bypass now requires a jump bypass with vein to treat a distal anastomotic stenosis. The proximal anastomosis is performed to the distal portion of the prior femoral-tibial bypass and the distal anastomosis includes a tibial artery. How is this reported?**

A: Reporting the bypass procedure does not differ based on whether the bypass is sewn to a native tibial artery or a graft at the tibial level. Code 35570 would correctly be reported. In addition, the add-on code 35700 for reoperation would be reported if performed more than 1 month after the original operation.

CPT Code 35571

Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of ipsilateral or contralateral saphenous vein for use as bypass conduit
- Completion arteriogram
- Vein valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Harvest of an upper extremity vein (35500)
- Harvest of a femoropopliteal vein segment (35572)
- Harvest and construction of an autogenous composite graft of two segments from two distant locations (35682)
- Harvest and construction of an autogenous composite graft of three or more segments from distant locations (35683)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.52**
Total RVUs - OFFICE	**39.21**
Total RVUs - FACILITY	**39.21**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For popliteal-tibial bypass using insitu saphenous vein, report 35587 instead of 35571.

FAQs

Q: **Patient with prior femoral-popliteal bypass now requires a jump bypass with vein to treat a distal anastomotic stenosis. The proximal anastomosis is performed to the distal portion of the prior femoralpopliteal bypass and the distal anastomosis includes a tibial artery. How is this reported?**

A: Reporting the bypass procedure does not differ based on whether the bypass is sewn to a native popliteal artery or a graft at the popliteal level. Code 35571 would correctly be reported. In addition, the add-on code 35700 for reoperation would be reported if performed more than 1 month after the original operation.

CPT Code 35572

Harvest of femoropopliteal vein, 1 segment, for vascular reconstruction procedure (eg, aortic, vena caval, coronary, peripheral artery) (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Harvest of bilateral femoropopliteal vein segments (report 35572-50 or 35572 plus 35572-59 depending on individual carrier instruction)

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	6.81
Total RVUs - OFFICE	10.16
Total RVUs - FACILITY	10.16
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	no
Team Surgery (mod 66)	no

Coding Tips

When reporting harvest of deep vein from both the left and right leg, report 35572 and 35572-59 (distinct procedural service) in addition to the bypass procedure. Because 35572 is an add-on code, there is no duplication of pre- or post-work and there should be no reduction in payment.

CPT Code 35583

In-situ vein bypass; femoral-popliteal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of the saphenous vein graft
- Valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Harvest of an upper extremity vein (35500)
- Harvest of a femoropopliteal vein segment (35572)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**27.75**
Total RVUs - OFFICE	**42.81**
Total RVUs - FACILITY	**42.81**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

To correctly report an in-situ bypassm graft (35583-35587) the majority of the bypass must be constructed with the greater saphenous vein left in its native bed with the valves in this segment lysed using standard techniques. If a segment of arm vein is needed to complete a bypass graft that is primarily in-situ but for a segment of inadequate saphenous vein that must be replaced, report 35500 for the arm vein harvest. Likewise, in the unusual situation wherein a segment of femoropopliteal vein is harvested in order to complete a primarily in-situ bypass, report 35572 in addition to the primary in-situ bypass code.

FAQs

Q: **A patient undergoes a left to right cross femoral bypass with synthetic conduit as well as a right femoral to popliteal artery in situ bypass. How is this reported?**

A: Report 35661 for the femoral-femoral bypass with "other than vein" and 35583 for the femoral to popliteal artery in situ bypass.

CPT Code 35585

In-situ vein bypass; femoral-anterior tibial, posterior tibial, or peroneal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of the saphenous vein graft
- Valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Harvest of an upper extremity vein (35500)
- Harvest of a femoropopliteal vein segment (35572)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**32.35**
Total RVUs - OFFICE	**49.57**
Total RVUs - FACILITY	**49.57**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

To correctly report an in-situ bypass graft (35583-35587) the majority of the bypass must be constructed with the greater saphenous vein left in its native bed with the valves in this segment lysed using standard techniques. If a segment of arm vein is needed to complete a bypass graft that is primarily in-situ but for a segment of inadequate saphenous vein that must be replaced, report 35500 for the arm vein harvest. Likewise, in the unusual situation wherein a segment of femoropopliteal vein is harvested in order to complete a primarily in-situ bypass, report 35572 in addition to the primary in-situ bypass code.

FAQs

Q: **Patient undergoes a left to right cross femoral bypass with synthetic conduit as well as a right femoral to tibial artery in situ bypass. How is this reported?**

A: Report 35661 for the femoral-femoral bypass with "other than vein" and 35585 for the femoral to tibial artery in situ bypass.

FAQs

Q: **Patient requires a femoral-dorsalis pedis bypass, but 10 inches of the greater saphenous vein in the thigh is thrombosed or was previously harvested. A single piece of arm vein is harvested to complete the reconstruction. How is this reported?**

A: Since the majority of the procedure was performed using an in-situ technique, you would correctly report in-situ bypass code 35585 as the primary procedure along with add-on code 35500 for the harvest of arm vein.

CPT Code 35587

In-situ vein bypass; popliteal-tibial, peroneal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Preparation of the saphenous vein graft
- Valve lysis

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Harvest of an upper extremity vein (35500)
- Harvest of a femoropopliteal vein segment (35572)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.21**
Total RVUs - OFFICE	**40.46**
Total RVUs - FACILITY	**40.46**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

To correctly report an in-situ bypass graft (35583-35587) the majority of the bypass must be constructed with the greater saphenous vein left in its native bed with the valves in this segment lysed using standard techniques. If a segment of arm vein is needed to complete a bypass graft that is primarily in-situ but for a segment of inadequate saphenous vein that must be replaced, report 35500 for the arm vein harvest. Likewise, in the unusual situation wherein a segment of femoropopliteal vein is harvested in order to complete a primarily in-situ bypass, report 35572 in addition to the primary in-situ bypass code.

CPT Code 35601

Bypass graft, with other than vein; common carotid-ipsilateral internal carotid

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**27.09**
Total RVUs - OFFICE	**41.36**
Total RVUs - FACILITY	**41.36**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient who underwent carotid artery stenting two years ago has since required three separate percutaneous retreatments. She returns three months after the most recent intervention with another critically severe restenosis and hemispheric transient ischemic attacks. A bypass graft using synthetic conduit is performed. It extends from her proximal cervical common carotid artery to the distal extracranial internal carotid artery beyond the region of multiply recurrent stenosis. How is this reported?**

A: Report code 35601.

CPT Code 35606

Bypass graft, with other than vein; carotid-subclavian

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**22.46**
Total RVUs - OFFICE	**34.72**
Total RVUs - FACILITY	**34.72**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For open transcervical common carotid-common carotid bypass performed in conjunction with endovascular repair of descending thoracic aorta, use 33891.

CPT Code 35612

Bypass graft, with other than vein; subclavian-subclavian

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.35**
Total RVUs - OFFICE	**30.81**
Total RVUs - FACILITY	**30.81**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient A undergoes a right subclavian to left subclavian artery bypass with prosthetic conduit. Patient B undergoes a proximal right subclavian to distal right subclavian artery bypass with prosthetic conduit. How are these procedures reported?**

A: Code 35612 would correctly be reported for both of these procedures

CPT Code 35616

Bypass graft, with other than vein; subclavian-axillary

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.82**
Total RVUs - OFFICE	**32.54**
Total RVUs - FACILITY	**32.54**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35621

Bypass graft, with other than vein; axillary-femoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.03**
Total RVUs - OFFICE	**32.47**
Total RVUs - FACILITY	**32.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For axillo-unifemoral bypass with prosthetic conduit, report 35621. For axillo-bifemoral bypass with prosthetic conduit, report 35654.

CPT Code 35623

Bypass graft, with other than vein; axillary-popliteal or -tibial

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.92**
Total RVUs - OFFICE	**38.74**
Total RVUs - FACILITY	**38.74**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35626

Bypass graft, with other than vein; aortosubclavian, aortoinnominate, or aortocarotid

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significantchange in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**29.14**
Total RVUs - OFFICE	**46.21**
Total RVUs - FACILITY	**46.21**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with complex advanced great vessel occlusive disease undergoes thoracotomy with proximal anastomosis of a bifurcated synthetic bypass graft performed at the ascending aorta. One of the outflow limbs is anastomosed to the right subclavian artery while the other is anastomosed to the right common carotid artery. How is this reported?**

A: Report 35626 for the aortosubclavian bypass and 35626-59 for the aorto-common carotid bypass.

CPT Code 35631

Bypass graft, with other than vein; aortoceliac, aortomesenteric, aortorenal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**36.03**
Total RVUs - OFFICE	**54.61**
Total RVUs - FACILITY	**54.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient undergoes a supraceliac aorta to superior mesenteric artery and hepatic artery bypass using a bifurcated prosthetic conduit. How is this reported?**

A: This procedure involves two separate bypasses with two separate outflow vessels and would correctly be reported as 35631 and 35631-59.

CPT Code 35632

Bypass graft, with other than vein; ilio-celiac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**36.13**
Total RVUs - OFFICE	**53.32**
Total RVUs - FACILITY	**53.32**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When performing a debranching procedure, do not report code 37617 (Ligation, major artery; abdomen) if the celiac artery is ligated proximally during an ilio-celiac bypass graft. Report 35632 to reflect the ilio-celiac bypass and the celiac ligation

CPT Code 35633

Bypass graft, with other than vein; ilio-mesenteric

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**39.11**
Total RVUs - OFFICE	**59.41**
Total RVUs - FACILITY	**59.41**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When performing a debranching procedure, do not report code 37617 (Ligation, major artery; abdomen) if the mesenteric artery is ligated proximally during an ilio-mesenteric bypass graft. Report 35633 to reflect the work of the bypass and the mesenteric artery ligation.

CPT Code 35634

Bypass graft, with other than vein; iliorenal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**35.33**
Total RVUs - OFFICE	**54.03**
Total RVUs - FACILITY	**54.03**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When performing a debranching procedure, do not report code 37617 (Ligation, major artery; abdomen) if the renal artery is ligated proximally during an iliorenal bypass graft. Report code 35634 to reflect the work of the bypass and the renal artery origin ligation.

CPT Code 35636

Bypass graft, with other than vein; splenorenal (splenic to renal arterial anastomosis)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**31.75**
Total RVUs - OFFICE	**47.05**
Total RVUs - FACILITY	**47.05**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35636 involves direct arterial anastomosis of the patient's splenic artery to his/her left renal artery. This is the only procedure in the "other than vein" bypass graft family of codes that does not actually utilize prosthetic conduit.

CPT Code 35637

Bypass graft, with other than vein; aortoiliac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**33.05**
Total RVUs - OFFICE	**51.34**
Total RVUs - FACILITY	**51.34**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35638

Bypass graft, with other than vein; aortobi-iliac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**33.60**
Total RVUs - OFFICE	**52.04**
Total RVUs - FACILITY	**52.04**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

CPT code 35638 involves the use of a prosthetic conduit. If the procedure is performed with venous conduit, report CPT code 35538 (oftentimes with add-on code 35572 for femoropopliteal vein harvest).

If a patient undergoes an attempt at endovascular repair of an abdominal aortic aneurysm followed by conversion to an open aortobi-iliac bypass, do not report 35638. Instead, report 34831.

CPT Code 35642

Bypass graft, with other than vein; carotid-vertebral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.94**
Total RVUs - OFFICE	**33.78**
Total RVUs - FACILITY	**33.78**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35645

Bypass graft, with other than vein; subclavian-vertebral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.43**
Total RVUs - OFFICE	**27.90**
Total RVUs - FACILITY	**27.90**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35646

Bypass graft, with other than vein; aortobifemoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**32.98**
Total RVUs - OFFICE	**50.66**
Total RVUs - FACILITY	**50.66**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

CPT code 35646 involves the use of aprosthetic conduit. If the procedure is performed with venous conduit, report CPT code 35540 (oftentimes with add-on code 35572 for femoropopliteal vein harvest).

If a patient undergoes an attempt at endovascular repair of an abdominal aortic aneurysm followed by conversion to an open aortobifemoral bypass, do not report 35646. Instead, report 34832.

CPT Code 35647

Bypass graft, with other than vein; aortofemoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**29.73**
Total RVUs - OFFICE	**45.74**
Total RVUs - FACILITY	**45.74**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For aortofemoral bypass graft performed with vein conduit, use 35539 (oftentimes with the add-on code 35572 to represent femoropopliteal vein harvest).

CPT Code 35650

Bypass graft, with other than vein; axillary-axillary

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.16**
Total RVUs - OFFICE	**32.11**
Total RVUs - FACILITY	**32.11**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient A undergoes a right axillary to left axillary artery bypass with prosthetic conduit.**

Patient B undergoes a proximal right axillary to distal right axillary artery bypass with prosthetic conduit. How are these procedures reported?

A: Code 35650 is the correct code to report for both of these procedures.

CPT Code 35651

(35651 has been deleted. To report, see 35646, 35647, 35656)

CPT Code 35654

Bypass graft, with other than vein; axillary-femoral-femoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.28**
Total RVUs - OFFICE	**40.48**
Total RVUs - FACILITY	**40.48**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Keep in mind that axillaryfemoralfemoral bypass is synonymous with axillarybifemoral bypass.

CPT Code 35656

Bypass graft, with other than vein; femoral-popliteal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (35685)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.47**
Total RVUs - OFFICE	**31.97**
Total RVUs - FACILITY	**31.97**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient who had a recent diagnostic angiogram undergoes left fem-pop bypass using prosthetic, left common iliac stent placement that is post-dilated with an angioplasty balloon, and completion arteriogram. How is this reported?**

A: Report codes 35656 (fem-pop bypass, other than vein) and 37221 (open transcatheter iliac artery stent placement). Do NOT report codes 37236 (arterial stent) or 36200 (non-selective aortic catheterization. The completion angiogram is NOT separately reportable and the post-stent balloon angioplasty is NOT reportable.

CPT Code 35661

Bypass graft, with other than vein; femoral-femoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.35**
Total RVUs - OFFICE	**32.01**
Total RVUs - FACILITY	**32.01**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient A undergoes a right femoral to left femoral artery bypass with prosthetic conduit. Patient B undergoes a right common femoral to right superficial femoral artery bypass with prosthetic conduit. How are these procedures reported?**

A: Code 35661 is the correct code to report in both of these clinical situations.

CPT Code 35663

Bypass graft, with other than vein; ilioiliac

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.93**
Total RVUs - OFFICE	**37.24**
Total RVUs - FACILITY	**37.24**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35665

Bypass graft, with other than vein; iliofemoral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status

Medicare Payment Rules

Global Period	**090**
Work RVUs	**22.35**
Total RVUs - OFFICE	**34.58**
Total RVUs - FACILITY	**34.58**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 35665 when prosthetic conduit is used for bypass from an iliac artery to either the contralateral OR ipsilateral femoral artery.

CPT Code 35666

Bypass graft, with other than vein; femoral-anterior tibial, posterior tibial, or peroneal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (35685)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.66**
Total RVUs - OFFICE	**37.30**
Total RVUs - FACILITY	**37.30**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35671

Bypass graft, with other than vein; popliteal-tibial or -peroneal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion arteriogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic arteriogram if there is no recent prior clinically adequate arteriogram, or if a patient with recent prior arteriogram has suffered a significant change in clinical vascular status
- Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (35685)
- Creation of distal arteriovenous fistula during lower extremity bypass surgery (35686)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.77**
Total RVUs - OFFICE	**32.95**
Total RVUs - FACILITY	**32.95**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35681

Bypass graft; composite, prosthetic and vein (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Additional anastomosis required to complete this procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	1.60
Total RVUs - OFFICE	2.36
Total RVUs - FACILITY	2.36
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes*
Team Surgery (mod 66)	no

** Supporting documentation required to establish medical necessity.*

CPT Code 35682

Bypass graft; autogenous composite, 2 segments of veins from 2 locations (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of upper extremity vein, 1 segment, for lower extremity or coronary artery bypass procedure (35500)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- The primary bypass graft to which this code is appended

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**7.19**
Total RVUs - OFFICE	**10.41**
Total RVUs - FACILITY	**10.41**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35682 is reported in addition to an open lower extremity bypass code (fem-pop, fem-tib, pop-tib, or tib-tib) to describe the additional work associated with harvest of two pieces of vein from two separate locations to construct a spliced vein conduit.

Coding Tips

Code 35682 includes harvest of arm vein, if performed. Therefore, do not report code 35500 (arm vein harvest) in addition to 35682.

CPT Code 35683

Bypass graft; autogenous composite, 3 or more segments of vein from 2 or more locations (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of upper extremity vein, 1 segment, for lower extremity or coronary artery bypass procedure (35500)
- Creation of autogenous composite conduit using 2 segments of veins from 2 distant sites (35682)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- The primary bypass graft to which this code is appended

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**8.49**
Total RVUs - OFFICE	**12.08**
Total RVUs - FACILITY	**12.08**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35683 is reported in addition to an open lower extremity bypass code (fem-pop, fem-tib, pop-tib, or tib-tib) to describe the additional work associated with harvest of three or more pieces of vein from two or more separate locations to construct a spliced vein conduit.

Coding Tips

Code 35683 includes harvest of arm vein, if performed. Therefore, do not report 35500 (arm vein harvest) in addition to 35683.

Code 35683 includes 3 or more pieces of vein harvest and therefore code 35682 should not be reported simultaneously

CPT Code 35685

Placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of vein for patch or cuff
- Closure of donor site

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	4.04
Total RVUs - OFFICE	5.85
Total RVUs - FACILITY	5.85
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes*
Team Surgery (mod 66)	no

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35685 is reported in addition to an open lower extremity bypass code using prosthetic conduit (fem-pop, fem-tib, pop-tib) to describe the additional work associated with harvest of vein to construct a vein patch or a vein cuff at the distal anastomosis.

FAQs

Q: **A patient with critical limb ischemia and a non-healing foot ulcer requires a femoral-popliteal bypass graft for limb salvage. He has no superficial autogenous vein that could be used as a conduit. A synthetic bypass graft is utilized and a vein cuff is placed at the distal anastomosis to maximize patency. How is this reported?**

A: Report code 35656 for placing the synthetic fem-pop bypass conduit along with add-on code 35685 for the vein cuff.

CPT Code 35686

Creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- The primary bypass code to which this add-on is appended

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**3.34**
Total RVUs - OFFICE	**4.76**
Total RVUs - FACILITY	**4.76**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35686 is reported in addition to an open lower extremity bypass code (fem-pop, fem-tib, pop-tib, tib-tib with either autogenous or synthetic conduit) to describe the additional work associated with creation of an arteriovenous fistula distal to the distal anastomosis of the bypass.

Discussion: Open Bypass Surgery

Reporting open arterial revascularization surgery is based on inflow artery, outflow artery, and conduit. For example, a synthetic bypass graft placed across an occluded segment of the superior mesenteric artery (SMA), with inflow from the aorta and outflow to the patent mid-segment of the SMA would be called an aortomesenteric bypass with other than vein, and would be reported with CPT code 35631. Likewise, a bypass constructed with autogenous saphenous vein placed in the upper extremity with proximal anastomosis at the brachial artery and distal anastomosis at the radial artery would be reported as 35523, Bypass graft, with vein; brachial-radial.

In the current CPT nomenclature system there is no difference between the above-knee and the below-knee popliteal artery for bypass reporting purposes. Additionally, the term "femoral" in CPT bypass descriptors denotes either the common, superficial, or deep femoral artery. Conduit options include "vein", "in-situ saphenous vein", and "other than vein". Vein harvest and preparation is not separately reportable when saphenous vein from the same or opposite leg is reversed or left in an orthograde configuration. No extra coding is available for rendering valves incompetent. "Other than vein" is appropriate when prosthetic material (e.g., Dacron or expanded polytetrafluoroethylene), umbilical vein, or cryopreserved vein is utilized. Based on the introductory wording in the subsection entitled "Arteries and Veins" within the "Cardiovascular System" segment of the CPT manual, all manipulation for the purpose of "establishing both inflow and outflow by whatever procedures necessary" is bundled. This phrase is interpreted as meaning that endarterectomy or patch angioplasty at the inflow and outflow vessel anastomosis is not separately reportable. NCCI edit pairs have been created to that end.

Completion angiography is also included in the bypass codes. However, diagnostic angiography performed at the time of an interventional procedure is separately reportable if: no prior catheter-based angiographic study is available, a full diagnostic study is performed, and clinical decisions are based on the results of the angiogram. The addition of the -59 modifier to the imaging codes is required for reimbursement in this situation. Completion duplex scanning is not excluded in the introductory wording nor is it excluded by current NCCI edit pairs. CPT code 93926 (Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study) is usually appropriate in this circumstance with the -26 (professional fee only) modifier.

A femoral artery to popliteal artery bypass using in-situ greater saphenous vein is described by CPT code 35583. If the outflow artery is more distal, a femoral artery to tibial (or dorsalis pedis) artery bypass would be reported by CPT code 35585. When the inflow artery is the popliteal artery, an in-situ saphenous vein bypass to a tibial (or dorsalis pedis artery) artery bypass requires CPT code 35587. When vein is excised and reversed, or when vein is excised translocated and the valves are lysed, venous bypass codes 35556 (femoral-popliteal), 35566 (femoral-tibial), 35570 (tibial-tibial), or 35571 (popliteal-tibial) would be reported depending on the inflow and outflow arteries. Prosthetic bypass codes include 35656 (femoral-popliteal), 35666 (femoral-tibial), and 35671 (popliteal-tibial).

When veins are harvested for lower extremity bypass from certain locations, several "add-on" CPT codes have been created to report the additional work involved in the arterial reconstruction. Add-on codes are not subject to multiple procedure payment reduction. If a single piece of arm vein is harvested from the upper extremity for use in a lower extremity bypass graft, CPT code 35500 is reported as well as the primary "with vein" lower extremity bypass code. If the bypass requires harvest and splicing of two segments from two separate locations, CPT code 35682 is added to the base "with vein" code. If the bypass requires that vein be spliced using three pieces from two or more separate locations, CPT code 35683 is added to the base "with vein" code. Remember only one of the above three codes can be reported in any given clinical situation; CPT code 35500 is not reported in addition to CPT codes 35682 or 35683 and CPT code 35682 is not submitted in addition to CPT code 35683. Lastly, if femoral vein is harvested from one thigh, CPT code 35572 is used to describe such an extensive dissection.

Redo surgery with scar tissue surrounding the prior dissection imparts additional physician time and increases the intensity of the operation. CPT code 35700 is an add-on code that denotes "reoperation, femoral-popliteal or femoral (popliteal)-anterior tibial, posterior tibial, peroneal artery or other distal vessels, more than 1 month after original operation (List separately in addition to code for primary procedure)". This code provides additional relative value for the added labor involved with redo surgery. CPT code 35700 may be submitted to the insurance carrier in addition to the arm vein harvest or spliced vein descriptions previously discussed.

Two adjuncts are available to help increase the long-term patency of the reconstruction. CPT code 35685 is an add-on used exclusively for prosthetic revascularizations which states "placement of vein patch or cuff at distal anastomosis of bypass graft, synthetic conduit (List separately in addition to code for primary procedure)." Alternatively, CPT code 35686 is an option regardless of conduit material and denotes "creation of distal arteriovenous fistula during lower extremity bypass surgery (non-hemodialysis) (List separately in addition to code for primary procedure)." These two add-on codes are submitted in addition to the base bypass CPT code.

When a patient has had a prior inflow reconstruction (e.g., aortofemoral, iliofemoral, or axillofemoral), a bypass that is anastomosed to the hood of the prosthetic graft at the "femoral" level proximally and extends distally to the popliteal artery qualifies as a "femoral-popliteal" bypass for coding purposes. Likewise, some patients may have had a prior infrainguinal revascularization and then develop outflow arterial occlusive disease at the popliteal or tibial segment. Autogenous bypasses which augment the outflow from the "popliteal" graft level to a tibial artery are considered "popliteal-tibial" (CPT code 35571) and those which originate at the "tibial" graft level to a more distal outflow source would be "tibial-tibial" (CPT code 35570).

Overall Coding Strategy

- Report the main bypass code by using:
  - Inflow artery
  - Outflow artery
  - Conduit
- Report all ancillary procedures
- Report coincident intervention if done at a different site but BE CAREFUL to document what the different site is.

Conduit Options

- **"With Vein"** means the patient's own vein is used as the "tubing". Vein is surgically excised and moved to a new location or tunnel (ie, "reversed vein" or "excised vein")
- **"In-Situ Vein"** means the patient's own vein is used in its native bed and this includes rendering the valves incompetent
- **"Other than Vein"** includes all prosthetic conduits (ie, Dacron, ePTFE, umbilical or cryopreserved vein, etc.)

Conduit Harvest

- Bypass grafts "with vein" include harvest & preparation of saphenous vein from the same or opposite leg
- Bypass grafts "with vein in-situ" include preparation of saphenous vein from the same leg with any form of valve lysis
- Veins harvested from other sites may be separately reportable

Arterial Transposition (35691-35697)

Arterial Transposition (35691-35697)

CPT Code 35691

Transposition and/or reimplantation; vertebral to carotid artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery; neck (37615)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This arterial transposition and/or reimplantation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.41**
Total RVUs - OFFICE	**27.88**
Total RVUs - FACILITY	**27.88**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35693

Transposition and/or reimplantation; vertebral to subclavian artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery; neck (37615)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This arterial transposition and/or reimplantation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**15.73**
Total RVUs - OFFICE	**24.60**
Total RVUs - FACILITY	**24.60**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35694

Transposition and/or reimplantation; subclavian to carotid artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery; extremity (37618)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This arterial transposition and/or reimplantation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.28**
Total RVUs - OFFICE	**29.11**
Total RVUs - FACILITY	**29.11**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35694 describes a subclavian artery to carotid artery transposition. If this same procedure is accomplished during TEVAR, report 33889 instead of 35694.

CPT Code 35695

Transposition and/or reimplantation; carotid to subclavian artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation, major artery; neck (37615)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This arterial transposition and/or reimplantation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.06**
Total RVUs - OFFICE	**30.22**
Total RVUs - FACILITY	**30.22**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35697

Reimplantation, visceral artery to infrarenal aortic prosthesis, each artery (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	3.00
Total RVUs - OFFICE	4.36
Total RVUs - FACILITY	4.36
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes
Team Surgery (mod 66)	no

Coding Tips

Add-on code 35697 is reported in addition codes for either open aortic aneurysm repair or aorto-iliac reconstruction for occlusive disease.

FAQs

Q: **Patient undergoes open aorta biiliac reconstruction for repair of an abdominal aortic and iliac artery aneurysm. The inferior mesenteric artery is sewn to one limb of the aortic prosthesis. How is this reported?**

A: The primary procedure would be reported with code 35102 (aorto-iliac aneurysm repair) along with add-on code 35697 for visceral artery reimplantation.

Excision, Exploration, Repair, Revision (35700-35907)

Excision, Exploration, Repair, Revision (35700-35907)

CPT Code 35700

Reoperation, femoral-popliteal or femoral (popliteal)-anterior tibial, posterior tibial, peroneal artery, or other distal vessels, more than 1 month after original operation (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	3.08
Total RVUs - OFFICE	4.51
Total RVUs - FACILITY	4.51
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	yes
Co-Surgeons (mod 62)	yes*
Team Surgery (mod 66)	no

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35700 is reported in addition to an open lower extremity bypass code (fem-pop, fem-tib, pop-tib, tib-tib with either autogenous or synthetic conduit) to describe the additional work associated with redo infrainguinal arterial bypass surgery. Code 35700 may be submitted to the insurance carrier in addition to the arm vein harvest or spliced vein descriptions.

FAQs

Q: **Patient with prior aorto-bifemoral bypass now requires femoral-popliteal bypass. The proximal anastomosis includes the femoral limb of the prior aorto-bifemoral bypass. How is this reported?**

A: Reporting the bypass procedure does not differ based on whether the bypass is sewn to the native femoral artery or a graft at the femoral level. Code 35556 would correctly be reported. In addition, the add-on code 35700 for reoperation would be reported if performed more than 1 month after the original operation.

CPT Code 35701

Exploration (not followed by surgical repair), with or without lysis of artery; carotid artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**9.19**
Total RVUs - OFFICE	**16.53**
Total RVUs - FACILITY	**16.53**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35721

Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**7.72**
Total RVUs - OFFICE	**13.39**
Total RVUs - FACILITY	**13.39**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35741

Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**8.69**
Total RVUs - OFFICE	**15.00**
Total RVUs - FACILITY	**15.00**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35761

Exploration (not followed by surgical repair), with or without lysis of artery; other vessels

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**5.93**
Total RVUs - OFFICE	**11.46**
Total RVUs - FACILITY	**11.46**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35800

Exploration for postoperative hemorrhage, thrombosis or infection; neck

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**12.00**
Total RVUs - OFFICE	**20.83**
Total RVUs - FACILITY	**20.83**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If exploration for postoperative hemorrhage, thrombosis, or infection is performed within the global period of a procedure, append modifier 78 to code 35800.

FAQs

Q: **A patient one-day following a right carotid endarterectomy develops severe swelling and pain at the incision site and has difficulty breathing. Postoperative hemorrhage is diagnosed and he is taken to the operating room for exploration and drainage of the hematoma and identification and repair of the bleeding site. How is this reported?**

A: Report code 35800-78.

CPT Code 35820

Exploration for postoperative hemorrhage, thrombosis or infection; chest

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**36.89**
Total RVUs - OFFICE	**58.29**
Total RVUs - FACILITY	**58.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If exploration for postoperative hemorrhage, thrombosis, or infection is performed within the global period of a procedure, append modifier 78 to code 35820.

CPT Code 35840

Exploration for postoperative hemorrhage, thrombosis or infection; abdomen

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.75**
Total RVUs - OFFICE	**34.43**
Total RVUs - FACILITY	**34.43**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If exploration for postoperative hemorrhage, thrombosis, or infection is performed within the global period of a procedure, append modifier 78 to code 35840.

FAQs

Q: **A patient underwent open repair of an abdominal aortic aneurysm with a prosthetic aortobi-iliac graft one day ago. Postoperatively, he required multiple blood transfusions but despite this, his hemoglobin remained low. His abdomen is distended, and he is now oliguric with labile blood pressure. The decision is made to explore his abdomen for the diagnosis of ongoing hemorrhage. How is this reported?**

A: Report code 35840-78.

CPT Code 35860

Exploration for postoperative hemorrhage, thrombosis or infection; extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**15.25**
Total RVUs - OFFICE	**24.65**
Total RVUs - FACILITY	**24.65**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If exploration for postoperative hemorrhage, thrombosis, or infection is performed within the global period of a procedure, append modifier 78 to code 35860.

Coding Tips

If exploration for postoperative hemorrhage, thrombosis or infection is performed in the groin and the surgeon creates a sartorius muscle flap, report code 15738 instead of 35860. Append the 78 modifier when this secondary procedure is within the 90-day global period of the original procedure.

FAQs

Q: **A patient underwent transpopliteal embolectomy one day prior for an acutely ischemic limb due to a cardiogenic embolus. Postoperatively, the patient was maintained on therapeutic levels of anticoagulation with heparin. The day following surgery, his calf has become markedly swollen and very painful. Postoperative hemorrhage is diagnosed, and the patient is brought back to the operating room for identification and repair of the bleeding site. How is this reported?**

A: Report code 35860-78.

CPT Code 35870

Repair of graft-enteric fistula

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Excision of infected graft; abdomen (35907)
- Repair of graft-enteric fistula (35870)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.50**
Total RVUs - OFFICE	**36.71**
Total RVUs - FACILITY	**36.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For removal of infected aortic vascular prosthesis and repair of a graft-enteric fistula, report both codes 35907 and 35870. In addition, the patient will almost certainly need a revascularization procedure to perfuse the lower extremities, and that would also be reported separately.

CPT Code 35875

Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula);

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.72**
Total RVUs - OFFICE	**17.50**
Total RVUs - FACILITY	**17.50**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient has an embolus in the femoral bifurcation causing thrombosis of the femoralpopliteal prosthetic bypass graft. A thrombectomy of the native vessels in the groin and the bypass graft itself is performed. How is this reported?**

A: Report code 34201 (embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision) since the native femoral vessels are treated with thrombectomy as well.

CPT Code 35876

Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula); with revision of arterial or venous graft

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest and/or insertion of vessel graft (any type)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**17.82**
Total RVUs - OFFICE	**27.83**
Total RVUs - FACILITY	**27.83**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35879

Revision, lower extremity arterial bypass, without thrombectomy, open; with vein patch angioplasty

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest and insertion of vein patch

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This bypass graft revision is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**17.41**
Total RVUs - OFFICE	**27.19**
Total RVUs - FACILITY	**27.19**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35879 is reported when a leg bypass stenosis is treated with autogenous patch. The work for this code also includes harvest of the vein.

CPT Code 35881

Revision, lower extremity arterial bypass, without thrombectomy, open; with segmental vein interposition

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest and insertion of vein graft

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This bypass graft revision is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.35**
Total RVUs - OFFICE	**29.99**
Total RVUs - FACILITY	**29.99**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 35881 is reported when a leg bypass graft stenosis is treated with an autogenous interposition. The work for this code includes harvest of the vein.

If treatment of a bypass graft stenosis requires a jump graft to a more distal anastomotic site, do not use 35881. Instead, this distal jump graft would be reported as a pop-tib or tib-tib bypass graft. Specifically, reporting a jump bypass procedure does not differ based on whether the bypass is sewn to a native popliteal/tibial artery or a graft at the popliteal/tibial level.

CPT Code 35883

Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, Dacron, ePTFE, bovine pericardium)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children (15430)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision (34201)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.15**
Total RVUs - OFFICE	**35.65**
Total RVUs - FACILITY	**35.65**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient with sudden onset thrombosis of femoral limb of an aorto-bifemoral bypass graft undergoes emergent thrombectomy of the graft limb. It is discovered that a critical outflow stenosis caused the thrombosis. The femoral anastomosis is revised. How is this reported?**

A: Report both codes 35883 and code 34201 (Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision).

CPT Code 35884

Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with autogenous vein patch graft

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest and insertion of vein patch (any autogenous source)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision (34201)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**24.65**
Total RVUs - OFFICE	**36.61**
Total RVUs - FACILITY	**36.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35901

Excision of infected graft; neck

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Bypass graft for cerebral revascularization (35501) or other operations performed to revascularize the brain or cover an open wound

Medicare Payment Rules

Global Period	**090**
Work RVUs	**8.38**
Total RVUs - OFFICE	**14.50**
Total RVUs - FACILITY	**14.50**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35903

Excision of infected graft; extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Bypass graft for extremity revascularization (35523, 35525, 35556)
- Any type of tissue flap required to cover an exposed revascularization

Medicare Payment Rules

Global Period	**090**
Work RVUs	**9.53**
Total RVUs - OFFICE	**16.61**
Total RVUs - FACILITY	**16.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35905

Excision of infected graft; thorax

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Vessel repair for revascularization (35246)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**33.52**
Total RVUs - OFFICE	**51.81**
Total RVUs - FACILITY	**51.81**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35907

Excision of infected graft; abdomen

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Repair of graft-enteric fistula (35870)
- Bypass graft, with vein; aortobi-iliac (35538)
- Bypass graft, with other than vein; axillaryfemoral- femoral (35654)
- Harvest of a femoropopliteal vein segment (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**37.27**
Total RVUs - OFFICE	**56.33**
Total RVUs - FACILITY	**56.33**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient with infected aortic aneurysm repair performed many years ago requires excision of infected graft and aortic reconstruction with aortobi-iliac graft using deep vein harvested from both thighs. How is this reported?**

A: Code 35538 for the bypass graft will be reported with 35907 for excision of the infected graft. For harvesting the vein segments from both thighs, also report 35572 and 35572-59 (some carriers will require 35572-50, or two units of 35572 to report harvest femoropopliteal vein from both lower extremities)

Carotid Body Tumor Excision (60600-60605)

Carotid Body Tumor Excision (60600-60605)

CPT Code 60600

Excision of carotid body tumor; without excision of carotid artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**25.09**
Total RVUs - OFFICE	**40.45**
Total RVUs - FACILITY	**40.45**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

When carotid reconstruction is required, report 60605.

CPT Code 60605

Excision of carotid body tumor; with excision of carotid artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Excision of carotid body tumor; without excision of carotid artery (60600)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Bypass graft (35501, 35601)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**31.96**
Total RVUs - OFFICE	**57.69**
Total RVUs - FACILITY	**57.69**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient undergoes excision of an advanced carotid body tumor (eg, Shamblin Stage III) with reconstruction of internal carotid artery and ligation of external carotid artery. How is this reported?**

A: Report code 60605 for tumor resection and code 35501 for ipsilateral carotid arterial reconstruction with vein or 35601 for reconstruction using prosthetic conduit.

Portal Decompression

Portal Decompression

Portal Decompression (37140-37181)

Portal Decompression (37140-37181)

CPT Code 37140

Venous anastomosis, open; portocaval

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open portocaval shunt operation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services

Medicare Payment Rules

Global Period	**090**
Work RVUs	**40.00**
Total RVUs - OFFICE	**66.90**
Total RVUs - FACILITY	**66.90**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with cirrhosis presents with active upper GI bleeding that is refractory to endoscopic sclerotherapy and medical management. Two previous TIPS procedures have failed, and he is not a liver transplant candidate. A portocaval shunt is performed. How is this reported?**

A: Report code 37140

CPT Code 37145

Venous anastomosis, open; renoportal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open portocaval shunt operation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**37.00**
Total RVUs - OFFICE	**62.04**
Total RVUs - FACILITY	**62.04**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient with Child-Pugh B cirrhosis has recurrent bleeding esophageal varices despite medical and endoscopic treatment. Two previous TIPS procedures have failed. He is awaiting liver transplantation, but is not expected to receive a liver in the near future. A renoportal shunt is performed. How is this reported?**

A: Report code 37145.

CPT Code 37160

Venous anastomosis, open; caval-mesenteric

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open portocaval shunt operation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**38.00**
Total RVUs - OFFICE	**63.71**
Total RVUs - FACILITY	**63.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with Child-Pugh B cirrhosis has had previous upper GI bleeds that were managed medically and endoscopically. He is now bleeding, but not a candidate for TIPS or liver transplantation. A cavalmesenteric shunt is urgently performed. How is this reported?**

A: Report code 37160.

CPT Code 37180

Venous anastomosis, open; splenorenal, proximal

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open portocaval shunt operation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services

Medicare Payment Rules

Global Period	**090**
Work RVUs	**36.50**
Total RVUs - OFFICE	**61.30**
Total RVUs - FACILITY	**61.30**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with Child-Pugh B cirrhosis has had recurrent episodes of upper GI bleeding that was managed medically and endoscopically. He is awaiting liver transplantation, but is not expected to receive a liver in the near future. A proximal splenorenal shunt is performed. How is this reported?**

A: Report code 37180.

CPT Code 37181

Venous anastomosis, open; splenorenal, distal (selective decompression of esophagogastric varices, any technique)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open portocaval shunt operation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**40.00**
Total RVUs - OFFICE	**66.90**
Total RVUs - FACILITY	**66.90**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with Child-Pugh alcoholic cirrhosis has repeated episodes of bleeding esophageal varices temporarily remedied by endoscopic therapy. To prevent recurrent esophageal bleeding and decrease the risk of encephalopathy, a distal splenorenal shunt with coronary vein ligation (Warren shunt) is performed. How is this reported?**

A: Report code 37181.

Transcatheter Therapy

Transcatheter Therapy

Discussion: Transluminal Angioplasty

Most transluminal angioplasty procedures are performed percutaneously and, until 2011, have followed the long-established conventions for component coding. Traditional percutaneous component coding rules require reporting of one code for catheterization, another for the angioplasty itself, and a third for radiological supervision and interpretation (S&I). Please see the introductory section of this manual for a thorough discussion of the principles involved in component coding. This coding approach remains in effect during 2011 for visceral, renal, aortic, brachiocephalic, and venous percutaneous angioplasty.

The large new family of lower extremity vascular intervention codes introduced in 2011 does not follow component coding guidelines in that catheterization and radiological S&I are bundled into the primary procedure code. The result is that angioplasty performed on the iliac, femoral, popliteal and tibial arteries, if done in the absence of stent or atherectomy, will now typically be reported with a single code. In addition, angioplasty performed on the iliac, femoral, popliteal, and tibial arteries in conjunction with stent or atherectomy will always be included in those greater magnitude procedures. Please see the introductory section of this coding manual for a more detailed description of component coding rules and idiosyncrasies.

In 2011 the familiar CPT codes for lower extremity angioplasty (35454, 35456, 35459, 35470, 35473, and 35474) were deleted. Endovascular intervention for lower extremity arterial revascularization has been moved to a new section (see codes 37220-37235). The remaining angioplasty codes for aortic, brachiocephalic (upper extremity arterial tree), visceral, renal, and venous intervention remain unchanged. They will continue to be reported using traditional component coding guidelines. Unlike the new descriptions for lower extremity arterial intervention which have bundled services, the remaining CPT codes listed below still require separate reporting of arterial (or venous) catheterization, diagnostic imaging, endovascular intervention, and the radiology supervision & interpretation (S&I) for the procedure.

The designation “open” implies the puncture site for vascular access is a surgically exposed vessel whereas “percutaneous” designates a needle is advanced through the skin and subcutaneous tissue into a vessel for vascular access. “Open” includes surgical dissection of the vessel for access, simple repair of the puncture site, and closure of the incision. For the new family of vascular intervention (37220-37235) the distinction between percutaneous and open approach has been eliminated. The correct choice of interventional code depends on the modality of treatment (eg, angioplasty, stent, atherectomy, stent plus atherectomy) and on the anatomic location (iliac, femoropopliteal, tibial), but not on whether the procedure is performed through a percutaneous or open approach.

Remaining Angioplasty Codes

Open Angioplasty

35450 Transluminal balloon angioplasty, open; renal or other visceral artery
35452 aortic
(35454, 35456 have been deleted. To report, see 37220-37227)
35458 brachiocephalic trunk or branches, each vessel
(35459 has been deleted. To report, see 37228-37235)
35460 venous

Percutaneous Angioplasty

(35470 has been deleted. To report, see 37228-37235)
35471 Transluminal balloon angioplasty, percutaneous; renal or visceral artery
&nb

Transluminal Angioplasty Other Than Lower Extremity Arteries (35450-35476)

Transluminal Angioplasty Other Than Lower Extremity Arteries (35450-35476)

CPT Code 35450

Transluminal balloon angioplasty, open; renal or other visceral artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation (75966)
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**10.05**
Total RVUs - OFFICE	**14.74**
Total RVUs - FACILITY	**14.74**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35452

Transluminal balloon angioplasty, open; aortic

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation (75966)
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.90**
Total RVUs - OFFICE	**10.04**
Total RVUs - FACILITY	**10.04**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35458

Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation (75966)
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**9.48**
Total RVUs - OFFICE	**14.38**
Total RVUs - FACILITY	**14.38**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35460

Transluminal balloon angioplasty, open; venous

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation (75978)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.03**
Total RVUs - OFFICE	**9.22**
Total RVUs - FACILITY	**9.22**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35471

Transluminal balloon angioplasty, percutaneous; renal or visceral artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire(s), catheter(s))

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation (75966)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**10.05**
Total RVUs - OFFICE	**72.83**
Total RVUs - FACILITY	**15.25**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 35472

Transluminal balloon angioplasty, percutaneous; aortic

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire(s), catheter(s))

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.90**
Total RVUs - OFFICE	**53.30**
Total RVUs - FACILITY	**10.43**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 35475

Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire(s), catheter(s))

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation (75962)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.60**
Total RVUs - OFFICE	**44.42**
Total RVUs - FACILITY	**9.75**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report 35475 and associated radiology S&I (75962) when treating a stenosis in an AV access specifically at the arterial anastomosis. The AV access is considered one vessel from the arterial anastomosis up to and including the axillary vein.

CPT Code 35476

Transluminal balloon angioplasty, percutaneous; venous

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire(s), catheter(s))

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation (75978)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.10**
Total RVUs - OFFICE	**40.61**
Total RVUs - FACILITY	**7.88**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report 35476 and associated radiology S&I 75978 when treating a stenosis in an AV access separate and distinct from the arterial anastomosis. The AV access is considered one vessel from the arterial anastomosis up to and including the axillary vein.

Percutaneous Mechanical Thrombectomy (37184-37188)

Percutaneous Mechanical Thrombectomy (37184-37188)

CPT Code 37184

Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including guidewires and a percutaneous thrombolytic device
- Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug (96374)
- Fluoroscopic guidance (76000, 76001)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Thrombolytic infusion (37211, 37213, 37214)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**8.66**
Total RVUs - OFFICE	**64.78**
Total RVUs - FACILITY	**13.46**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

An injection of thrombolytic occurs when the practitioner attaches a syringe to the catheter and delivers a drug by push or slow push technique. This is inherent to code 37184.

However, a continuous infusion of thrombolytic drugs over a prolonged period is NOT inherent and may be reported with code 37201.

Coding Tips

Arterial mechanical thrombectomy is primary when the patient is brought to the interventional suite with plans to treat an arterial thrombus. Alternatively, treatment is secondary if occlusive material is identified on completion imaging after endovascular arterial intervention is performed and the newly discovered distal embolus is extracted.

Reporting of primary arterial mechanical thrombectomy is based on a vascular family. Code 37184 describes the initial vessel treated, whereas code 37185 is appropriate for the second and subsequent vessels in that family. Note that code 37185 can only be reported once per vascular family regardless of the number of vessels treated in that family.

FAQs

Q: **Arterial mechanical thrombectomy is primary when the patient is brought to the interventional suite with plans to treat an arterial thrombus. Alternatively, treatment is secondary if occlusive material is identified on completion imaging after endovascular arterial intervention is performed and the newly discovered distal embolus is extracted. Reporting of primary arterial mechanical thrombectomy is based on a vascular family. Code 37184 describes the initial vessel treated, whereas code 37185 is appropriate for the second and subsequent vessels in that family. Note that code 37185 can only be reported once per vascular family regardless of the number of vessels treated in that family.**

A: Report:

Fem-pop Angioplasty 37224

Mechanical Thrombectomy 37184

Diagnostic Aortogram S&I 75625-59

Diagnostic Left Leg Angio S&I 75710-59

CPT Code 37185

Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Fluoroscopic guidance (76000, 76001)
- Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug (96375)
- When performed in an office, all necessary supplies for the procedure, including additional guidewires

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Thrombolytic infusion (37211, 37213, 37214)

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	3.28
Total RVUs - OFFICE	20.50
Total RVUs - FACILITY	4.90
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	no
Co-Surgeons (mod 62)	yes
Team Surgery (mod 66)	no

Coding Tips

Code 37185 can ONLY be reported in conjunction with code 37184.

Coding Tips

Arterial mechanical thrombectomy is primary when the patient is brought to the interventional suite with plans to treat an arterial thrombus. Alternatively, treatment is secondary if occlusive material is identified on completion imaging after endovascular arterial intervention is performed and the newly discovered distal embolus is extracted.

Reporting of primary arterial mechanical thrombectomy is based on a vascular family. Code 37184 describes the initial vessel treated, whereas code 37185 is appropriate for the second and subsequent vessels in that family. Code 37185 can only be reported once per vascular family regardless of the number of vessels treated in that family.

FAQs

Q: **A patient with acute thrombosis of left fem-posterior tibial bypass graft undergoes aortogram and runoff from right groin puncture with mechanical thrombectomy of bypass graft stenosis and posterior tibial artery, followed by angioplasty of the distal posterior tibial artery. How is this reported?**

A: Report codes:

Tibial Angioplasty 37228

Mechanical Thrombec BPG 37184

Mechanical Thrombec tibial 37185

Diagnostic Aortogram S&I 75625-59

Diagnostic Left Leg Angio S&I 75710-59

CPT Code 37186

Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Fluoroscopic guidance (76000, 76001)
- Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug (96375)
- When performed in an office, all necessary supplies for the procedure, including guidewires and a percutaneous thrombolytic device

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Thrombolytic infusion (37201)
- Radiological S&I for thrombolytic infusion (75896)

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	4.92
Total RVUs - OFFICE	39.28
Total RVUs - FACILITY	7.28
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	no
Assistant (mods 80-82)	no
Co-Surgeons (mod 62)	yes
Team Surgery (mod 66)	no

Coding Tips

Arterial mechanical thrombectomy is primary when the patient is brought to the interventional suite with plans to treat an arterial thrombus.

Alternatively, treatment is secondary if occlusive material is identified on completion imaging after endovascular arterial intervention is performed, and the newly discovered distal embolus is extracted.

FAQs

Q: **A patient presents with rest pain of the left lower extremity. A diagnostic angiogram shows a focal highgrade stenosis of the distal SFA. A percutaneous balloon angioplasty is performed. Follow-up angiography demonstrates excellent angioplasty result, but there is now a distal embolus in the popliteal artery. Secondary percutaneous mechanical thrombectomy of the popliteal is employed. How is the endovascular removal of the embolus reported?**

A: Report code 37186 for removal of this embolus in addition to the codes required to report the angioplasty procedure

CPT Code 37187

Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Fluoroscopic guidance (76000, 76001)
- Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug (96375)
- When performed in an office, all necessary supplies for the procedure, including guidewires and a percutaneous thrombolytic device

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Thrombolytic infusion (37201)
- Radiological S&I for thrombolytic infusion (75896)
- Venous access (36010)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**000**
Work RVUs	**8.03**
Total RVUs - OFFICE	**58.83**
Total RVUs - FACILITY	**11.90**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

Code 37187 can only be reported once on the initial day of therapy. For repeat treatment on a subsequent day during a course of thrombolytic therapy, use 37188.

FAQs

Q: **A patient presents with a lower extremity iliofemoral venous thrombosis. Venous access is obtained from the popliteal vein and the catheter is advanced centrally into the IVC. Diagnostic ascending lower extremity angiography and IVC angiography is performed. Venous mechanical thrombectomy is used to lyse the clot. How is this reported?**

A: Report codes 37187 for venous mechanical thrombectomy; 36010 for IVC catheterization; 75820-59 for unilateral extremity venography; and 75825-59 for IVC angiography.

CPT Code 37188

Percutaneous transluminal mechanical thrombectomy, vein(s), including intraprocedural pharmacological thrombolytic injections and fluoroscopic guidance, repeat treatment on subsequent day during course of thrombolytic therapy

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Fluoroscopic guidance (76000, 76001)
- Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug (96375)
- When performed in an office, all necessary supplies for the procedure, including guidewires and a percutaneous thrombolytic device

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Thrombolytic infusion (37212, 37213, 37214)
- Venous access (36010)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.71**
Total RVUs - OFFICE	**50.22**
Total RVUs - FACILITY	**8.57**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

The second day of percutaneous mechanical thrombectomy (code 37188) would typically be reported with code 37213 (second day of thrombolytic infusion) or 37214 (final day of thrombolytic infusion and removal of catheter).

Code 37212 is reported only on the first day of venous thrombolytic infusion. Therefore it would be unusual to report 37212 on the same day as 37188.

FAQs

Q: **A patient presents with a lower extremity iliofemoral venous thrombosis. Venous access is obtained from the popliteal vein and the catheter is advanced centrally into the IVC. Diagnostic ascending lower extremity angiography and IVC angiography is performed. Venous mechanical thrombectomy is used to lyse the clot. Venous thrombolytic infusion is initiated. The patient is brought back to the angiography suite the following day. Angiography is performed through the existing catheter. Further venous mechanical thrombectomy is required. An adequate treatment is achieved and the catheter is removed. How is this reported?**

A: On the first day, report catheter placement (36010), diagnostic venography (75820 and 75825), venous mechanical thrombectomy (37187), and initiation of venous thrombolytic infusion (37212).

On the second day, report code 37188 for repeat treatment of venous mechanical thrombectomy and 37214 for follow-up angiography, discontinuation of infusion, and removal of catheter.

Percutaneous Procedures Including Carotid Stent (37197-37216)

Percutaneous Procedures Including Carotid Stent (37197-37216)

CPT Code 37197

Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), includes radiological supervision and interpretation, and imaging guidance (ultrasound or fluoroscopy), when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Ultrasound guidance (76937, 76942, 76998)
- IVUS (37250, 37251)
- Fluoroscopic guidance (76000, 76001)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.29**
Total RVUs - OFFICE	**43.33**
Total RVUs - FACILITY	**9.25**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Do not report 37197 for removal of an IVC filter. The correct code to report IVC filter removal is 37193.

CPT Code 37201

(37201 has been deleted. To report see 37211, 37212, 37213, 37214.)

CPT Code 37202

Transcatheter therapy, infusion other than for thrombolysis, any type (eg, spasmolytic, vasoconstrictive)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Catheter repositioning
- Subsequent days of infusion if via the same catheter

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Radiological S&I (75896)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.67**
Total RVUs - OFFICE	**8.74**
Total RVUs - FACILITY	**8.74**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 37203

(37203 has been deleted. To report, see 37197.)

CPT Code 37204

(37204 has been deleted. To report, see 37241, 37242, 37243, 37244. For transcatheter occlusion or embolization in the central nervous system, use 61624. For transcatheter occlusion or embolization for noncentral nervous system in the head and neck, use 61626)

CPT Code 37205

(37205-37208 have been deleted. To report, see 37236-37239)

CPT Code 37206

(37205-37208 have been deleted. To report, see 37236-37239)

CPT Code 37207

(37205-37208 have been deleted. To report, see 37236-37239)

CPT Code 37208

(37205-37208 have been deleted. To report, see 37236-37239)

CPT Code 37209

(37209 has been deleted. For exchange of a previously placed intravascular catheter during thrombolytic therapy, see 37211, 37212, 37213, 37214.)

CPT Code 37211

Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Follow-up angiography through existing catheter during transcatheter therapy
- Exchange of previous placed intravascular catheter during thrombolytic therapy and radiological S&I
- All on-going evaluation and management services, excluding initial evaluation for institution of therapy

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Arterial mechanical thrombectomy, before or after infusion (37184, 37185, 37186)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**8.00**
Total RVUs - OFFICE	**11.66**
Total RVUs - FACILITY	**11.66**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 37211 includes institution of arterial thrombolytic infusion, as well as all follow-up angiography through the existing catheter and all infusion catheter exchanges (when performed) on this initial calendar day of treatment.

Code 37211 is also used to report initiation and termination of arterial thrombolytic therapy when both occur on one calendar day.

For subsequent calendars days of treatment, codes 37213-37214 would be reported.

CPT Code 37212

Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Radiological S&I
- Follow-up angiography through existing catheter during transcatheter therapy
- Exchange of previous placed intravascular catheter during thrombolytic therapy and radiological S&I
- All on-going evaluation and management services, excluding initial evaluation for institution of therapy

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Venous mechanical thrombectomy, before or after infusion (37187, 37188)
- IVC filter insertion (37191)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**7.06**
Total RVUs - OFFICE	**10.23**
Total RVUs - FACILITY	**10.23**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 37212 includes institution of venous thrombolytic infusion, as well as all follow-up angiography through the existing catheter and all infusion catheter exchanges (when performed) on this initial calendar day of treatment.

Code 37212 is also used to report initiation and termination of venous thrombolytic therapy when both occur on one calendar day.

For subsequent calendars days of treatment, codes 37213-37214 would be reported.

CPT Code 37213

Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Radiological S&I
- All follow-up angiography through existing catheter during transcatheter therapy
- Exchange of previous placed intravascular catheter during thrombolytic therapy and radiological S&I
- All on-going evaluation and management services, excluding initial evaluation for institution of therapy

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Mechanical thrombectomy, before or after infusion (37184, 37185, 37186, 37187, 37188)
- IVC filter insertion (37191) or removal (37193)
- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.00**
Total RVUs - OFFICE	**7.22**
Total RVUs - FACILITY	**7.22**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 37213 is used to report all follow-up angiography through the existing catheter, all infusion catheter exchanges, and continuation of thrombolytic infusion on a day other than the initial calendar day of therapy or the final day of infusion. For example, code 37213 would be reported on day 2 of a 3-day course of therapy or days 2 and 3 of a 4-day course of therapy.

CPT Code 37214

Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Radiological S&I
- All follow-up angiography through existing catheter during transcatheter therapy
- Exchange of previous placed intravascular catheter during thrombolytic therapy and radiological S&I
- All on-going evaluation and management services, excluding initial evaluation for institution of therapy

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Mechanical thrombectomy, before or after infusion (37184, 37185, 37186, 37187, 37188)
- IVC filter insertion (37191) or removal (37193)
- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**2.74**
Total RVUs - OFFICE	**3.98**
Total RVUs - FACILITY	**3.98**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 37214 is used to report all follow-up angiography through the existing catheter, all infusion catheter exchanges, and termination of thrombolytic infusion on a day subsequent to the initial calendar day of therapy.

Codes 37211 (arterial) or 37212 (venous) are used to report initiation and termination of thrombolytic therapy when both occur on one calendar day.

Code 37213 is used to report all follow-up angiography through the existing catheter, all infusion catheter exchanges, and continuation of thrombolytic infusion on a day other than the initial calendar day of therapy or the final day of infusion. For example, code 37213 would be reported on day 2 of a 3-day course of therapy or days 2 and 3 of a 4-day course of therapy.

CPT Code 37215

Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All ipsilateral carotid imaging, including completion angiography
- Ipsilateral selective carotid catheterization
- Placement of embolic protection device
- Pre- and post-stenting balloon angioplasty
- Completion angiogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.68**
Total RVUs - OFFICE	**31.73**
Total RVUs - FACILITY	**31.73**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If carotid stenting is aborted, then the appropriate codes for carotid catheterization and diagnostic imaging should be reported in lieu of 37215 and 37216. If embolic protection is not used, report 37216.

FAQs

Q: **A patient undergoes carotid stent placement using a retrograde flow embolic protection system. How is this reported?**

A: Report code 37215. CMS has acknowledged that retrograde flow embolic protection systems fall under the definition of distal embolic protection.

CPT Code 37216

Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous, including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All ipsilateral carotid imaging, including completion angiography
- Ipsilateral selective carotid catheterization
- Pre- and post-stenti
- Completion angiogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

If carotid stent placement is intended, but aborted for technical reasons, the appropriate codes for carotid catheterization and diagnostic imaging should be reported in lieu of 37215 or 37216. If embolic protection is intended during carotid stent but for technical reasons is not possible, report 37216 if the stent is placed without protection.

Endovascular Stent Placement (37236-37239)

Endovascular Stent Placement (37236-37239)

CPT Code 37236

Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- PTA performed in the treated vessel including lesions outside the stent but within the same vessel
- Closure of the arteriotomy by pressure, application of an arterial closure device or standard closure of the puncture by suture
- Completion angiography
- Road mapping
- When performed in an office, all necessary supplies for the procedure, including guidewires and a percutaneous thrombolytic device

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- PTA in a separate and distinct vessel
- Extensive repair or replacement of an artery (e.g., 35226 or 35286)
- Ultrasound guidance for vascular access (e.g., 76937)
- Intravascular ultrasound (37250, 37251)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**9.00**
Total RVUs - OFFICE	**117.62**
Total RVUs - FACILITY	**12.80**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Do not report code 37236 when placing a stent in the carotid artery or in any artery below the aortic bifurcation.

FAQs

Q: **Patient undergoes percutaneous selective catheterization of the superior mesenteric artery with stent placement. There is no recent angiogram available. How is this reported?**

A: Report 37236 for percutaneously placing the non-coronary stent; 36245 for a first order catheterization; and 75726-75759 for selective visceral angiography S&I.

CPT Code 37237

Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- PTA performed in the treated vessel including lesions outside the stent but within the same vessel
- Closure of the arteriotomy by pressure, application of an arterial closure device or standard closure of the puncture by suture
- Completion angiography
- Road mapping
- When performed in an office, all necessary supplies for the procedure, including guidewires and a percutaneous thrombolytic device

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- PTA in a separate and distinct vessel
- Extensive repair or replacement of an artery (e.g., 35226 or 35286)
- Ultrasound guidance for vascular access (e.g., 76937)
- Intravascular ultrasound (37250, 37251)

- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	***ZZZ***
Work RVUs	**4.25**
Total RVUs - OFFICE	**70.79**
Total RVUs - FACILITY	**6.29**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37238

Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Completion angiography
- PTA performed in the treated vessel including lesions outside the stent but within the same vessel
- Closure of the venotomy by pressure or standard closure of the puncture by suture
- Road mapping
- When performed in an office, all necessary supplies for the procedure, including guidewires and a percutaneous thrombolytic device

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- PTA in a separate and distinct vessel
- Ultrasound guidance for vascular access (e.g., 76937)
- Intravascular ultrasound (37250, 37251)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.29**
Total RVUs - OFFICE	**117.08**
Total RVUs - FACILITY	**9.31**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The hemodialysis circuit distal to the peri-anastomotic region is considered a vein for reporting purposes. Therefore, use 37237 when placing a stent in the venous outflow tract.

CPT Code 37239

Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Completion angiography
- PTA performed in the treated vessel including lesions outside the stent but within the same vessel
- Closure of the venotomy by pressure or standard closure of the puncture by suture
- Road mapping
- When performed in an office, all necessary supplies for the procedure, including guidewire and stent

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- PTA in a separate and distinct vessel
- Ultrasound guidance for vascular access (eg, 76937)
- Intravascular ultrasound (37250, 37251)

- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**2.97**
Total RVUs - OFFICE	**58.04**
Total RVUs - FACILITY	**4.66**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Endovascular Embolization (37241-37244)

Endovascular Embolization (37241-37244)

CPT Code 37241

Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Radiological S&I (75894)
- Follow-up angiography (75898)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**9.00**
Total RVUs - OFFICE	**130.75**
Total RVUs - FACILITY	**12.93**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Regardless of the technique, ablation of the saphenous vein(s) in the lower extremity are never reported with code 37241.

FAQs

Q: **A patient with a poorly functioning brachiocephalic AVF undergoes diagnostic angiography and embolization of multiple side branches to promote maturation. How is this reported?**

A: Report 36011 for each side branch selectively cannulated, 37241 once for the embolization(s), and 75791 for the AV access angiography. Despite multiple side branches treated, code 37241 is reported only once per operative field.

CPT Code 37242

Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Radiological S&I (75894)
- Follow-up angiography (75898)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**10.05**
Total RVUs - OFFICE	**220.41**
Total RVUs - FACILITY	**14.44**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

When performing embolization of an extracranial brachiocephalic branch (eg, carotid body tumor), report code 61626 INSTEAD of 37242.

Coding Tips

When placing an intravascular stent to trap or cage embolization of an arterial aneurysm, only report the embolization code and NOT the stent code.

Coding Tips

Translumbar coil embolization of a Type II endoleak after EVAR is typically reported with code 37242.

CPT Code 37243

Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Radiological S&I (75894)
- Follow-up angiography (75898)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**11.99**
Total RVUs - OFFICE	**278.23**
Total RVUs - FACILITY	**17.19**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 37244

Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheter repositioning
- Radiological S&I (75894)
- Follow-up angiography (75898)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**14.00**
Total RVUs - OFFICE	**194.69**
Total RVUs - FACILITY	**20.07**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Embolization of vessel perforation or GI bleeding source embolization would be reported with 37244.

Retrograde or Antegrade Intrathoracic Common Carotid and/or /Innominate Artery Stent (37217-37218)

Retrograde or Antegrade Intrathoracic Common Carotid and/or /Innominate Artery Stent (37217-37218)

CPT Code 37217

Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery by retrograde treatment, open ipsilateral cervical carotid artery exposure, including angioplasty, when performed, and radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All ipsilateral carotid imaging, including completion angiography (36221-36228)
- Retrograde non-selective aortic catheterization (36200)
- Any associated PTA within the innominate artery or common carotid artery including pre- and post-stent angioplasty (35458, 75962)
- Completion angiogram
- Carotid artery open exposure and standard closure of the arteriotomy by suture (35201)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Carotid-carotid bypass with TEVAR (33891)
- Carotid Endarterectomy (35301)
- Carotid-(contra) carotid bypass with vein (35509)
- Carotid-brachial bypass with vein (35510)
- CCA-(ipsilat) ICA bypass with OTV (35601)
- Carotid-subclavian bypass with OTV (35606)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**20.38**
Total RVUs - OFFICE	**33.20**
Total RVUs - FACILITY	**33.20**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient undergoes both left CEA and retrograde left intrathoracic common carotid artery stenting from the open neck in the same setting. How is this reported?**

A: Report 35301 for the CEA and report 37217 for the retrograde stent placement.

CPT Code 37218

Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All ipsilateral carotid imaging, including completion angiography
- Ipsilateral selective carotid catheterization
- Pre- and post-stenting balloon angioplasty
- Completion angiogram

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**15.00**
Total RVUs - OFFICE	**23.33**
Total RVUs - FACILITY	**25.03**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report 37218 when the ipsilateral extracranial intrathoracic carotid arteriogram (including imaging and selective catheterization) confirms the need for stenting. If stenting is not indicated, report the appropriate codes for selective catheterization and imaging)

Lower Extremity Angioplasty, Stent, Atherectomy (37220-37235)

Lower Extremity Angioplasty, Stent, Atherectomy (37220-37235)

CPT Code 37220

Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, and angioplasty balloons

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

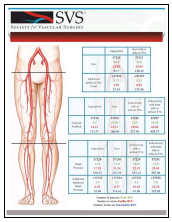
  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**8.15**
Total RVUs - OFFICE	**89.92**
Total RVUs - FACILITY	**12.15**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Images



Coding Tips

Angioplasty includes all types of balloons (eg, low-profile, cutting balloon, cryoplasty).

Atherectomy includes all device modalities (eg, directional, rotational, laser).

Stenting includes all device modalities (eg, balloonexpandable, self-expanding, bare metal, covered, drug-eluting)

CPT Code 37221

Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, angioplasty balloons, and stents

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**10.00**
Total RVUs - OFFICE	**132.64**
Total RVUs - FACILITY	**14.94**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

To report iliac atherectomy, use code 0238T.

FAQs

Q: **Patient with claudication and no femoral pulses has inflow disease by non-invasive arterial imaging. No other imaging is performed. Left brachial arterial access is obtained and a non-selective aortic catheterization is performed with diagnostic aortography. Bilateral femoral punctures are performed with deployment of kissing common iliac artery stents. How is this reported?**

A: Report codes 37221 (right CIA stent); 37221-59 (left CIA stent); 36200-59 (arm non-selective catheterization; and 75625-59 (S&I). The femoral artery based catheters are bundled into the stent codes, but in this case a separate catheterization was required for the diagnostic study, reportable with 36200-59.

CPT Code 37222

Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- When performed in an office, all necessary supplies for the procedure, including additional guidewires, catheters, and angioplasty balloons

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	3.73
Total RVUs - OFFICE	25.23
Total RVUs - FACILITY	5.49
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	yes
Assistant (mods 80-82)	yes*
Co-Surgeons (mod 62)	no
Team Surgery (mod 66)	no

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient A undergoes common iliac artery stenting and an ipsilateral external iliac artery balloon angioplasty. Patient B undergoes common iliac artery balloon angioplasty and ipsilateral external iliac artery stenting. How is this reported?**

A: Lower extremity intervention codes are built on progressive hierarchies with more intensive services inclusive of lesser intensive services. Use the code inclusive of the most intensive service provided as the primary code, not the anatomic location within the territory or the sequence of performing the procedures. Therefore, for both patients, the iliac stenting procedure (37221) is the more intensive service, and the iliac angioplasty add-on code (37222) would be reported as an additional procedure.

CPT Code 37223

Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure, including additional guidewires, catheters, angioplasty balloons, and stents

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	**4.25**
Total RVUs - OFFICE	**73.91**
Total RVUs - FACILITY	**6.28**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

To report iliac atherectomy, use code 0238T.

FAQs

Q: **Patient A undergoes common iliac artery stenting followed by ipsilateral external iliac artery stenting. Patient B undergoes bilateral common iliac artery stent placement. How is this reported?**

A: For Patient , report codes 37221 and 37223. For patient B, report 37221 and 37221-59. The lower extremity endovascular interventional codes are for ipsilateral therapy. Patient A had two ipsilateral vessels treated by stent placement so the add-on code 37223 for an additional ipsilateral stent is appropriate. Patient B had vessels treated bilaterally with stents. Therefore two base codes are required – one for the initial vessel stent placement and one for the contralateral vessel stent placement.

CPT Code 37224

Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, and angioplasty balloons

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**9.00**
Total RVUs - OFFICE	**109.13**
Total RVUs - FACILITY	**13.39**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The common, deep, and superficial femoral arteries, as well as the popliteal artery are contained within the femoral/popliteal territory. Only one code is reported in this territory, regardless of the number of vessels treated in this anatomic region.

CPT Code 37225

Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**12.00**
Total RVUs - OFFICE	**314.00**
Total RVUs - FACILITY	**18.13**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The common, deep, and superficial femoral arteries as well as the popliteal artery are contained within the femoral/popliteal territory. Only one code is reported in this territory, regardless of the number of vessels treated in this anatomic region..

CPT Code 37226

Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, angioplasty balloons, and stents

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**10.49**
Total RVUs - OFFICE	**258.19**
Total RVUs - FACILITY	**15.72**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient with a non-healing foot ulcer has a palpable femoral pulse but no pedal pulses. Recent prior angiography revealed a SFA stenosis and an above-knee popliteal occlusion. Contralateral CFA retrograde access is obtained and the SFA/popliteal artery is selected. The SFA disease is treated with PTA. The popliteal occlusion is treated initially with PTA and then intravascular stent. How is this reported?**

A: Report only one code, 37226. Multiple therapies in one vessel are reported using the most intense service for that vascular territory. Selective catheterization and radiological supervision and interpretation are bundled in 37226.

CPT Code 37227

Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, angioplasty balloons, stents, and atherectomy devices

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**14.50**
Total RVUs - OFFICE	**424.06**
Total RVUs - FACILITY	**21.80**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient undergoes stent placement in the mid-portion of the superficial femoral artery and an atherectomy of the below-knee popliteal artery. How is this reported?**

A: Because only one service is reportable per vascular territory, report the most intensive procedure, in this case, stent plus atherectomy (37227).

CPT Code 37228

Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, and angioplasty balloons

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**11.00**
Total RVUs - OFFICE	**155.20**
Total RVUs - FACILITY	**16.35**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The tibial/peroneal territory is comprised of three vessels: posterior tibial, anterior tibial, and peroneal arteries. The common tibio-peroneal trunk is considered an extension of the posterior tibial and peroneal arteries. Therefore, it is not considered a separate fourth vessel. If a lesion in the common tibio-peroneal trunk is treated at the same time as a lesion in the posterior tibial artery, a single code is reported. However, treatment of the common tibio-peroneal trunk and the anterior tibial artery would qualify as two vessels for reporting purposes since the anterior tibial artery origin lies proximal to the tibio-peroneal trunk.

CPT Code 37229

Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- C Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
-
    - When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, angioplasty balloons, and atherectomy devices

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**14.05**
Total RVUs - OFFICE	**309.75**
Total RVUs - FACILITY	**21.14**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient with forefoot gangrene has advanced 3-vessel tibial artery occlusive disease by angiography performed at a separate prior session. Antegrade femoral access is obtained. The PT, AT, and peroneal arteries are selectively catheterized. The TP trunk, PT, AT, and peroneal arteries are approached with atherectomy. PTA is used to treat diffuse residual stenosis in each of the vessels. How is this reported?**

A: Report codes 37229 (AT artery atherectomy); 37233 (additional tibial vessel atherectomy-PT artery); and 37233-59 (additional tibial vessel atherectomy peroneal artery). TP trunk atherectomy is bundled into the peroneal or posterior tibial artery intervention. Angioplasty is bundled into atherectomy and therefore not separately reportable. Selective catheterization is bundled into the lower extremity interventional codes and not separately reportable

CPT Code 37230

Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, angioplasty balloons, and stents

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**13.80**
Total RVUs - OFFICE	**236.82**
Total RVUs - FACILITY	**20.87**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The tibial/peroneal territory is comprised of three vessels: posterior tibial, anterior tibial, and peroneal arteries. The common tibio-peroneal trunk is considered an extension of the posterior tibial and peroneal arteries. Therefore, it is not considered a separate fourth vessel. If a lesion in the common tibio-peroneal trunk is treated at the same time as a lesion in the posterior tibial artery, a single code is reported. However, treatment of the common tibio-peroneal trunk and the anterior tibial artery would qualify as two vessels for reporting purposes since the anterior tibial artery origin lies proximal to the tibio-peroneal trunk.

CPT Code 37231

Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, angioplasty balloons, stents, and atherectomy devices

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**15.00**
Total RVUs - OFFICE	**380.55**
Total RVUs - FACILITY	**22.67**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The tibial/peroneal territory is comprised of three vessels: posterior tibial, anterior tibial, and peronealm arteries. The common tibio-peroneal trunk is considered an extension of the posterior tibial and peroneal arteries. Therefore, it is not considered a separate fourth vessel. If a lesion in the common tibio-peroneal trunk is treated at the same time as a lesion in the posterior tibial artery, a single code is reported. However, treatment of the common tibio-peroneal trunk and the anterior tibial artery would qualify as two vessels for reporting purposes since the anterior tibial artery origin lies proximal to the tibio-peroneal trunk.

CPT Code 37232

Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- When performed in an office, all necessary supplies for the procedure, including additional guidewires, catheters, and angioplasty balloons

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	4.00
Total RVUs - OFFICE	34.62
Total RVUs - FACILITY	5.94
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	yes
Assistant (mods 80-82)	yes*
Co-Surgeons (mod 62)	no
Team Surgery (mod 66)	no

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient undergoes angioplasty of the tibio-peroneal trunk and the anterior tibial artery. How is this reported?**

A: The common tibio-peroneal trunk is considered an intrinsic portion of the posterior tibial and peroneal arteries, but it is not considered part of the anterior tibial artery. The correct codes to report are 37228 (initial angioplasty) and add-on code 37232 (additional angioplasty) because two separate vessels were treated.

CPT Code 37233

Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure, including additional guidewires, catheters, and angioplasty balloons

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	6.50
Total RVUs - OFFICE	41.87
Total RVUs - FACILITY	9.66
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	yes
Assistant (mods 80-82)	yes*
Co-Surgeons (mod 62)	no
Team Surgery (mod 66)	no

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient undergoes atherectomy of the tibio-peroneal trunk and the anterior tibial artery. How is this reported?**

A: The common tibio-peroneal trunk is considered an intrinsic portion of the posterior tibial and peroneal arteries, but it is not considered part of the anterior tibial artery. The correct codes to report are 37229 (initial atherectomy) and add-on code 37233 (additional tibial vessel treated with atherectomy) because two separate vessels were treated.

CPT Code 37234

Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	**5.50**
Total RVUs - OFFICE	**110.47**
Total RVUs - FACILITY	**8.35**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **Patient undergoes atherectomy of the posterior tibial artery and stenting of the anterior tibial artery. How is this reported?**

A: Lower extremity intervention codes are built on progressive hierarchies with more intensive services inclusive of lesser intensive services. Report the most intensive service provided as the primary code, not the code sequence of performing the procedures. Atherectomy is more intensive than stenting. For this patient, treatment was performed in two separate vessels. Therefore, report code 37229 (atherectomy) as the primary procedure on the posterior tibial artery and add-on code 37234 for stenting a separate additional tibial vessel.

CPT Code 37235

Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, pre-dilatation and post-dilatation)
- When performed in an office, all necessary supplies for the procedure, including additional guidewires, catheters, angioplasty balloons, and stents

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)

- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Catheterization for the diagnostic lower extremity angiogram if an arterial puncture site is necessary that is separate from the therapeutic arterial puncture site
- Mechanical thrombectomy and/or thrombolysis

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**7.80**
Total RVUs - OFFICE	**118.61**
Total RVUs - FACILITY	**11.47**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Discussion: Selective Catheterization during Lower Extremity Intervention

The lower extremity endovascular interventional revascularization codes describing services performed for occlusive disease (37220-37235) include the work of nonselective and selective catheterization (36200, 36140, 36245-36248). Therefore, in most circumstances no separate catheterization codes should be reported when performing iliac, femoropopliteal or tibial intervention. However, as an exception, catheterization for the diagnostic lower extremity angiogram may be reported separately if an arterial puncture site is necessary for the diagnostic procedure distinct from that for the therapeutic procedure.

IVUS (37250-37251)

IVUS (37250-37251)

CPT Code 37250

Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Catheter repositioning

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Radiological S&I (75945)
- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**2.10**
Total RVUs - OFFICE	**3.13**
Total RVUs - FACILITY	**3.13**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 37250 includes everything done with the IVUS probe within one vessel. Code 37250 includes the work of positioning the ultrasound catheter and code 75945 includes the work of interpreting the acquired images. If a second vessel is evaluated using IVUS, report code 37251 and S&I code 75946.

CPT Code 37251

Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Catheter repositioning

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Radiological S&I (75946)
- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**1.60**
Total RVUs - OFFICE	**2.33**
Total RVUs - FACILITY	**2.33**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 37251 includes the work of positioning the ultrasound catheter and 75946 includes the work of interpreting the acquired images.

Vascular Endoscopy / SEPS (37500)

Vascular Endoscopy / SEPS (37500)

CPT Code 37500

Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Stab phlebectomy (37765-37766)
- Duplex scan of extremity veins (93971)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**11.67**
Total RVUs - OFFICE	**18.78**
Total RVUs - FACILITY	**18.78**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Ligation of venous perforating veins can be accomplished by different surgical techniques:

Code 37760 describes a radical open surgical approach.

Code 37500 describes an endoscopic approach.

Code 37761 describes subfascial ligation through a limited skin exposure.

Venous

Venous

Venous Thrombectomy, Open (34401-34490)

Venous Thrombectomy, Open (34401-34490)

CPT Code 34401

Thrombectomy, direct or with catheter; vena cava, iliac vein, by abdominal incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Venous stent placement

Medicare Payment Rules

Global Period	**090**
Work RVUs	**26.52**
Total RVUs - OFFICE	**42.85**
Total RVUs - FACILITY	**42.85**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34401-34490 are used to report open venous thrombectomy. For percutaneous mechanical venous thrombectomy, see codes 37187, 37188.

CPT Code 34421

Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by leg incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Venous stent placement

Medicare Payment Rules

Global Period	**090**
Work RVUs	**13.37**
Total RVUs - OFFICE	**21.40**
Total RVUs - FACILITY	**21.40**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34401-34490 are used to report open venous thrombectomy. For percutaneous mechanical venous thrombectomy, see codes 37187, 37188.

CPT Code 34451

Thrombectomy, direct or with catheter; vena cava, iliac, femoropopliteal vein, by abdominal and leg incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Venous stent placement

Medicare Payment Rules

Global Period	**090**
Work RVUs	**28.52**
Total RVUs - OFFICE	**48.33**
Total RVUs - FACILITY	**48.33**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34401-34490 are used to report open venous thrombectomy. For percutaneous mechanical venous thrombectomy, see codes 37187, 37188.

CPT Code 34471

Thrombectomy, direct or with catheter; subclavian vein, by neck incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access (36595)
- Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen (36596)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Venous stent placement

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.11**
Total RVUs - OFFICE	**31.80**
Total RVUs - FACILITY	**31.80**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Codes 34401-34490 are used to report open venous thrombectomy. For percutaneous mechanical venous thrombectomy, see codes 37187, 37188.

CPT Code 34490

Thrombectomy, direct or with catheter; axillary and subclavian vein, by arm incision

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access (36595)
- Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen (36596)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Venous stent placement

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.91**
Total RVUs - OFFICE	**17.94**
Total RVUs - FACILITY	**17.94**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Codes 34401-34490 are used to report open venous thrombectomy. For percutaneous mechanical venous thrombectomy, see codes 37187, 37188.

Venous Reconstruction (34501-34530)

Venous Reconstruction (34501-34530)

CPT Code 34501

Valvuloplasty, femoral vein

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This procedure is commonly reported by a single CPT code, but unusual situations may arise in which other distinct surgical or interventional procedures are simultaneously performed. Unless specific correct coding edits exist, these separate procedures would be separately reportable in most circumstances.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**16.85**
Total RVUs - OFFICE	**26.33**
Total RVUs - FACILITY	**26.33**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34502

Reconstruction of vena cava, any method

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This procedure is commonly reported by a single CPT code, but unusual situations may arise in which other distinct surgical or interventional procedures are simultaneously performed. Unless specific correct coding edits exist, these separate procedures would be separately reportable in most circumstances.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**28.07**
Total RVUs - OFFICE	**44.79**
Total RVUs - FACILITY	**44.79**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **When the vascular surgeon assists a urologist with a radical nephrectomy and removal of IVC clot followed by repair of the IVC, can the vascular surgeon report 34502 (Reconstruction of vena cava, any method)?**

A: No. Removal of clot from the IVC followed by repair of the IVC is inherent to code 50230 (Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy).

Therefore, both surgeons must use the co-surgeon modifier and report 50230-62. However, if vena cava replacement is necessary, the vascular surgeon should report 37799 INSTEAD of 50230 as per the parenthetical listed below code 50230 in the CPT manual.

CPT Code 34510

Venous valve transposition, any vein donor

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Harvest of the donor vein, repair of the donor vein harvest site

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This procedure is commonly reported by a single CPT code, but unusual situations may arise in which other distinct surgical or interventional procedures are simultaneously performed. Unless specific correct coding edits exist, these separate procedures would be separately reportable in most circumstances.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.91**
Total RVUs - OFFICE	**34.65**
Total RVUs - FACILITY	**34.65**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34520

Cross-over vein graft to venous system

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This procedure is commonly reported by a single CPT code, but unusual situations may arise in which other distinct surgical or interventional procedures are simultaneously performed. Unless specific correct coding edits exist, these separate procedures would be separately reportable in most circumstances.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**19.18**
Total RVUs - OFFICE	**29.16**
Total RVUs - FACILITY	**29.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 34530

Saphenopopliteal vein anastomosis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This procedure is commonly reported by a single CPT code, but unusual situations may arise in which other distinct surgical or interventional procedures are simultaneously performed. Unless specific correct coding edits exist, these separate procedures would be separately reportable in most circumstances.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**17.93**
Total RVUs - OFFICE	**32.18**
Total RVUs - FACILITY	**32.18**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

IVC Filter (37191-37193)

IVC Filter (37191-37193)

CPT Code 37191

Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Ultrasound guidance (76937, 76942, 76998)
- IVUS (37250-37251)
- Fluoroscopic guidance (76000-76001)
- Catheterization
- IVC angiography (75825)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**000**
Work RVUs	**4.71**
Total RVUs - OFFICE	**75.02**
Total RVUs - FACILITY	**6.98**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient with head trauma suffers a pulmonary embolism. A vena cave filter is inserted. A selective catheter placement is performed to locate the right renal vein prior to filter deployment. How is this reported?**

A: Report code 37191 for introduction of catheter into the inferior vena cava, deployment of the vena cava filter, and IVC venography. Code 37191 bundles all venous non-selective and selective catheterization(s) required to insert an IVC filter, as well as radiological S&I and all imaging guidance. Do NOT report 36010, 36011, and/or 75825 in addition to 37191

CPT Code 37192

Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Ultrasound guidance (76937, 76942, 76998)
- IVUS (37250-37251)
- Fluoroscopic guidance (76000-76001)
- Catheterization
- IVC angiography (75825)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**000**
Work RVUs	**7.35**
Total RVUs - OFFICE	**47.85**
Total RVUs - FACILITY	**10.92**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 37193

Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Ultrasound guidance (76937, 76942, 76998)
- IVUS (37250-37251)
- Fluoroscopic guidance (76000-76001)
- Catheterization
- IVC angiography (75825)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**000**
Work RVUs	**7.35**
Total RVUs - OFFICE	**45.65**
Total RVUs - FACILITY	**10.68**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Do not report 37191for IVC filter removal. Code 37191 is used to report transcatheter retrieval of intravascular foreign bodies other than an IVC filter.

Ligation, Vein Excision, Stripping, Phlebectomy (37565-37785)

Ligation, Vein Excision, Stripping, Phlebectomy (37565-37785)

CPT Code 37565

Ligation, internal jugular vein

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**12.05**
Total RVUs - OFFICE	**21.31**
Total RVUs - FACILITY	**21.31**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37600

Ligation; external carotid artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**12.42**
Total RVUs - OFFICE	**21.09**
Total RVUs - FACILITY	**21.09**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37605

Ligation; internal or common carotid artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**14.28**
Total RVUs - OFFICE	**23.15**
Total RVUs - FACILITY	**23.15**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37606

Ligation; internal or common carotid artery, with gradual occlusion, as with Selverstone or Crutchfield clamp

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**8.81**
Total RVUs - OFFICE	**14.16**
Total RVUs - FACILITY	**14.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 37607

Ligation or banding of angioaccess arteriovenous fistula

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This procedure is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services

Medicare Payment Rules

Global Period	**090**
Work RVUs	**6.25**
Total RVUs - OFFICE	**11.01**
Total RVUs - FACILITY	**11.01**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For ligation of branch veins in an A-V access to promote maturation, report such a revision with 36832.

FAQs

Q: **A patient with steal syndrome undergoes ligation or banding of an A-V access. How is this reported?**

A: Report code 37607.

CPT Code 37609

Ligation or biopsy, temporal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This procedure is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**010**
Work RVUs	**3.05**
Total RVUs - OFFICE	**8.89**
Total RVUs - FACILITY	**6.00**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 37615

Ligation, major artery (eg, post-traumatic, rupture); neck

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Closure of wound and repair of tissues divided for initial surgical exposure, partial or complete

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Complex wound closure, or closure requiring local or distant flap coverage and/or skin graft, when appropriate

Medicare Payment Rules

Global Period	**090**
Work RVUs	**7.80**
Total RVUs - OFFICE	**14.69**
Total RVUs - FACILITY	**14.69**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For ligation external carotid artery, report 37600.

For ligation of internal or common carotid artery, report 37605

CPT Code 37616

Ligation, major artery (eg, post-traumatic, rupture); chest

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Closure of wound and repair of tissues divided for initial surgical exposure, partial or complete

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Complex wound closure, or closure requiring local or distant flap coverage and/or skin graft, when appropriate

Medicare Payment Rules

Global Period	**090**
Work RVUs	**18.97**
Total RVUs - OFFICE	**32.14**
Total RVUs - FACILITY	**32.14**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37617

Ligation, major artery (eg, post-traumatic, rupture); abdomen

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Closure of wound and repair of tissues divided for initial surgical exposure, partial or complete

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Complex wound closure, or closure requiring local or distant flap coverage and/or skin graft, when appropriate

Medicare Payment Rules

Global Period	**090**
Work RVUs	**23.79**
Total RVUs - OFFICE	**39.03**
Total RVUs - FACILITY	**39.03**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37618

Ligation, major artery (eg, post-traumatic, rupture); extremity

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Closure of wound and repair of tissues divided for initial surgical exposure, partial or complete

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Complex wound closure, or closure requiring local or distant flap coverage and/or skin graft, when appropriate

Medicare Payment Rules

Global Period	**090**
Work RVUs	**6.03**
Total RVUs - OFFICE	**11.15**
Total RVUs - FACILITY	**11.15**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37619

Ligation of inferior vena cava

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Closure of wound and repair of tissues divided for initial surgical exposure, partial or complete
- Exploratory laparotomy (49000)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Complex wound closure, or closure requiring local or distant flap coverage and/or skin graft, when appropriate

Medicare Payment Rules

Global Period	**090**
Work RVUs	**30.00**
Total RVUs - OFFICE	**47.48**
Total RVUs - FACILITY	**47.48**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 37619 describes open surgical ligation of the IVC. Percutaneous delivery of an IVC filter is reported with 37191.

CPT Code 37620

(37620 has been deleted. To report, see 37191 for endovascular placement of intravascular filter or 37619 for open surgical ligation of the inferior vena cava)

CPT Code 37650

Ligation of femoral vein

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**8.49**
Total RVUs - OFFICE	**13.54**
Total RVUs - FACILITY	**13.54**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Do not report 37650 in conjunction with 35572 when harvesting femoral vein.

CPT Code 37660

Ligation of common iliac vein

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**22.28**
Total RVUs - OFFICE	**37.92**
Total RVUs - FACILITY	**37.92**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37700

Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**3.82**
Total RVUs - OFFICE	**7.29**
Total RVUs - FACILITY	**7.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Do not report 37700 when vein is harvested as an autogenous conduit and the saphenofemoral junction is ligated

CPT Code 37718

Ligation, division, and stripping, short saphenous vein

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Stab phlebectomy of varicose veins, if performed (37765, 37766)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**7.13**
Total RVUs - OFFICE	**12.79**
Total RVUs - FACILITY	**12.79**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37722

Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Stab phlebectomy of varicose veins, if performed (37765, 37766)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**8.16**
Total RVUs - OFFICE	**13.99**
Total RVUs - FACILITY	**13.99**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37735

Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.90**
Total RVUs - OFFICE	**17.16**
Total RVUs - FACILITY	**17.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 37760

Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open,1 leg

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, in ipsilateral leg (37761)
- Ultrasound guidance (76937, 76942, 76998, 93971)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**10.78**
Total RVUs - OFFICE	**17.95**
Total RVUs - FACILITY	**17.95**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Ligation of venous perforating veins can be accomplished by different surgical techniques:

Code 37760 describes a radical open surgical approach.

Code 37500 describes an endoscopic approach.

Code 37761 describes subfascial ligation through a limited skin exposure.

CPT Code 37761

Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ultrasound guidance (76937, 76942, 76998, 93971)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Stab phlebectomy (37765, 37766)
- Saphenous vein ligation (37700, 37780)
- Saphenous vein stripping (37718, 37722)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**9.13**
Total RVUs - OFFICE	**16.27**
Total RVUs - FACILITY	**16.27**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Ligation of venous perforating veins can be accomplished by different surgical techniques:

Code 37760 describes a radical open surgical approach.

Code 37500 describes an endoscopic approach.

Code 37761 describes subfascial ligation through a limited skin exposure.

CPT Code 37765

Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including compression stockings

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Saphenous vein ligation (37700, 37780)
- Saphenous vein stripping (37718, 37722)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**7.71**
Total RVUs - OFFICE	**18.84**
Total RVUs - FACILITY	**13.15**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

There is no specific CPT code for stab phlebectomy of less than 10 incisions leaving the unlisted vascular procedure code (37799) as the only option to report less than 10 stab incisions.

Coding Tips

When ligating, dividing, or excising a limited varicose vein cluster, report 37785.

CPT Code 37766

Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including compression stockings

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Saphenous vein ligation (37700, 37780)
- Saphenous vein stripping (37718, 37722)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**9.66**
Total RVUs - OFFICE	**22.37**
Total RVUs - FACILITY	**16.04**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 37766 is per extremity. If more than 20 stabs are performed in each lower extremity, report 37766-50.

FAQs

Q: **Patient undergoes lower leg stab phlebectomy with 14 stabs in the right leg and 25 stabs in the left leg. How is this reported?**

A: Report code 37766 for left leg treatment and 37765-59 for right leg treatment.

CPT Code 37780

Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**3.93**
Total RVUs - OFFICE	**7.52**
Total RVUs - FACILITY	**7.52**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Do not report 37780 when short saphenous vein is harvested as an autogenous conduit and the saphenopopliteal junction is ligated.

Do not report 37780 in conjunction with 37718 or 37735 when performed in the same lower extremity.

CPT Code 37785

Ligation, division, and/or excision of varicose vein cluster(s), 1 leg

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including compression wrap

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**3.93**
Total RVUs - OFFICE	**10.36**
Total RVUs - FACILITY	**7.71**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report 37785 for treatment of a limited cluster of varicose veins

Hemodialysis Access

Hemodialysis Access

Central Venous Access (36555-36598)

Central Venous Access (36555-36598)

CPT Code 36555

Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**2.68**
Total RVUs - OFFICE	**7.23**
Total RVUs - FACILITY	**3.37**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 36556

Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including the central venous catheter

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Moderate (conscious) sedation (99143-99145)
- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**2.50**
Total RVUs - OFFICE	**6.66**
Total RVUs - FACILITY	**3.49**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 36557

Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**5.14**
Total RVUs - OFFICE	**29.13**
Total RVUs - FACILITY	**9.55**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36558

Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**4.84**
Total RVUs - OFFICE	**22.30**
Total RVUs - FACILITY	**8.03**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36560

Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter and port

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**6.29**
Total RVUs - OFFICE	**30.51**
Total RVUs - FACILITY	**10.24**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36561

Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter and port

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**6.04**
Total RVUs - OFFICE	**33.50**
Total RVUs - FACILITY	**10.27**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36563

Insertion of tunneled centrally inserted central venous access device with subcutaneous pump

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter and pump

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**6.24**
Total RVUs - OFFICE	**38.06**
Total RVUs - FACILITY	**11.04**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36565

Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheters

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**6.04**
Total RVUs - OFFICE	**27.52**
Total RVUs - FACILITY	**10.10**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36566

Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheters and pump(s)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**6.54**
Total RVUs - OFFICE	**157.56**
Total RVUs - FACILITY	**11.21**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36568

Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**1.92**
Total RVUs - OFFICE	**8.65**
Total RVUs - FACILITY	**2.87**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 36569

Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including the central venous catheter

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)
- Moderate (conscious) sedation (99143-99145)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**1.82**
Total RVUs - OFFICE	**7.12**
Total RVUs - FACILITY	**2.66**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 36570

Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter and pump

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**5.36**
Total RVUs - OFFICE	**33.88**
Total RVUs - FACILITY	**8.83**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36571

Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter and pump

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**5.34**
Total RVUs - OFFICE	**37.26**
Total RVUs - FACILITY	**9.37**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36575

Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including the central venous catheter repair kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This central access catheter repair is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services
- Moderate (conscious) sedation (99143-99145)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.67**
Total RVUs - OFFICE	**4.73**
Total RVUs - FACILITY	**1.01**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36576

Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter repair kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This central access catheter repair is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**010**
Work RVUs	**3.24**
Total RVUs - OFFICE	**11.08**
Total RVUs - FACILITY	**5.72**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36578

Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including the central venous catheter repair kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**3.54**
Total RVUs - OFFICE	**14.88**
Total RVUs - FACILITY	**6.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36580

Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for this procedure, including the central venous catheter and replacement kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)
- Moderate (conscious) sedation (99143-99145)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**1.31**
Total RVUs - OFFICE	**6.14**
Total RVUs - FACILITY	**1.95**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 36581

Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for this procedure, including the central venous catheter and replacement kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**3.48**
Total RVUs - OFFICE	**21.87**
Total RVUs - FACILITY	**5.70**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The catheter being replaced may be tunneled or non-tunneled. The exchange occurs through the pre-existing access and results in placement of a new tunneled central venous catheter without port or pump.

CPT Code 36582

Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for this procedure, including the central venous catheter and replacement kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**5.24**
Total RVUs - OFFICE	**31.26**
Total RVUs - FACILITY	**8.87**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The catheter being replaced may be tunneled or non-tunneled. The exchange occurs through the pre-existing access and results in placement of a a new tunneled central venous catheter with subcutaneous port.

CPT Code 36583

Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for this procedure, including the central venous catheter and replacement kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**5.29**
Total RVUs - OFFICE	**38.92**
Total RVUs - FACILITY	**9.79**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The catheter being replaced may be tunneled or non-tunneled. The exchange occurs through the pre-existing access and results in placement of a new tunneled central venous catheter with subcutaneous pump.

CPT Code 36584

Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for this procedure, including the central venous catheter and replacement kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)
- Moderate (conscious) sedation (99143-99145)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**1.20**
Total RVUs - OFFICE	**5.82**
Total RVUs - FACILITY	**1.91**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 36585

Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for this procedure, including the central venous catheter and replacement kit

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance to gain access to the venous entry site (76937)
- Fluoroscopic guidance for manipulating the catheter into final central position (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**4.84**
Total RVUs - OFFICE	**33.00**
Total RVUs - FACILITY	**8.23**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36589

Removal of tunneled central venous catheter, without subcutaneous port or pump

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for catheter removal

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Fluoroscopic guidance (77001)
- Moderate (conscious) sedation (99143-99145)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**2.28**
Total RVUs - OFFICE	**4.72**
Total RVUs - FACILITY	**3.99**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Removal of a non-tunneled central venous catheter does not have a specific CPT code. This work would be included as part of the work of an E/M visit. Note that code 36589 requires that the catheter be tunneled.

Coding Tips

Do not report 36589 or 36590 when a catheter is replaced through the same venous access site because the removal is included in the replacement code.

CPT Code 36590

Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for catheter and pump removal

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Fluoroscopic guidance (77001)

Medicare Payment Rules

Global Period	**010**
Work RVUs	**3.35**
Total RVUs - OFFICE	**8.38**
Total RVUs - FACILITY	**5.93**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Do not report 36589 or 36590 when a catheter is replaced through the same venous access site because the removal is included in the replacement code.

Coding Tips

Removal of a non-tunneled central venous catheter does not have a specific CPT code. This work would be included as part of the work of an E/M visit. Note that code 36590 requires that the catheter be tunneled.

CPT Code 36595

Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for this procedure, including the snare kit and guidewire

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Venous catheterization (36010-36012)
- Radiological S&I (75901)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**3.59**
Total RVUs - OFFICE	**16.68**
Total RVUs - FACILITY	**5.36**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient with gastric cancer and a subcutaneous port presents with a poorly functioning port. Infusion/injection can be made but blood cannot be aspirated. Pericatheter obstructive material is removed through a separate venous access. How is this reported?**

A: Report codes 36595 for removal of the obstructive material and 75901 for radiological S&I. Also report appropriate venous access code (eg, 36010-36012).

CPT Code 36596

Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including lumen brush

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological S&I (75902)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.75**
Total RVUs - OFFICE	**3.79**
Total RVUs - FACILITY	**1.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient with gastric cancer and a subcutaneous port presents with a poorly functioning port. Infusion/injection can be made but blood cannot be aspirated. Pericatheter obstructive material is removed through the device lumen. How is this reported?**

A: Report codes 36596 for removal of the obstructive material and 75902 for radiological S&I.

CPT Code 36597

Repositioning of previously placed central venous catheter under fluoroscopic guidance

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including guidewire

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Fluoroscopic guidance (76000)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**1.21**
Total RVUs - OFFICE	**3.63**
Total RVUs - FACILITY	**1.78**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient had a single lumen left subclavian central venous catheter placed for central pressure monitoring. Chest radiograph following insertion of the catheter revealed malposition of the catheter tip in the right internal jugular vein. Repositioning of the central venous catheter to the superior vena cava is performed. How is this reported?**

A: Report codes 36597 for repositioning the catheter and 76000 for radiological S&I.

CPT Code 36598

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

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Fluoroscopic guidance (76000)
- When performed in an office, all necessary supplies for the procedure, except the contrast agent

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.74**
Total RVUs - OFFICE	**3.13**
Total RVUs - FACILITY	**1.07**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If a complete venogram is performed, report 75820 (extremity), 75825 (inferior vena cava), or 75827 (superior vena cava) as appropriate, INSTEAD of 36598.

FAQs

Q: **The oncology staff is no longer able to draw blood from a two-month old tunneled central venous catheter. It is not clear whether the catheter tip remains in the vein, and the staff is unable to administer the chemotherapy without knowing the location of the catheter tip. The patient is referred for imaging of the catheter to determine its position and patency. How is this reported?**

A: Report only code 36598. Radiological S&I is included in 36598, so you would not report additional S&I codes. If repositioning, replacement or any other treatment of the catheter is required during the same session, it would be reported separately.

Hemodialysis Access (36818-36870)

Hemodialysis Access (36818-36870)

CPT Code 36818

Arteriovenous anastomosis, open; by upper arm cephalic vein transposition

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This fistula creation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services

Medicare Payment Rules

Global Period	**090**
Work RVUs	**12.39**
Total RVUs - OFFICE	**20.36**
Total RVUs - FACILITY	**20.36**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Use code 36818 when two SEPARATE incisions are required, and the vein is passed under a skin bridge to accomplish the anastomosis. If no skin bridge is required, report 36821.

FAQs

Q: **A patient requires hemodialysis for chronic renal failure. On physical exam there are no visible superficial veins on either side at the wrist, forearm, antecubital fossa, or upper arm. Duplex ultrasound identifies a normal diameter cephalic vein 1 cm under the skin on the lateral aspect of her upper arm. In order to create an autogenous hemodialysis access, the vein must be rerouted through a superficial tunnel to reach the brachial artery on the medial aspect of her arm, just above the elbow. A cephalic vein transposition is performed. How is this reported?**

A: Report code 36818.

CPT Code 36819

Arteriovenous anastomosis, open; by upper arm basilic vein transposition

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This fistula creation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services

Medicare Payment Rules

Global Period	**090**
Work RVUs	**13.29**
Total RVUs - OFFICE	**21.56**
Total RVUs - FACILITY	**21.56**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If a complete basilic vein transposition is accomplished in a single stage, report 36819.

If the patient requires two stages to accomplish a basilic vein transposition, the first stage is a direct brachial artery to basilic vein AV fistula, reported by 36821.

The second stage is a superficialization of the basilic vein, which is a revision of an existing AV access and would be reported as code 36832. IF the second stage occurs within the global period of the first procedure, report 36832 with modifier 58.

FAQs

Q: **A patient requires hemodialysis for chronic renal failure due to diabetic nephropathy. She has no superficial veins of adequate size to perform an arteriovenous Cimino type fistula at the wrist. A basilic vein transposition is performed to provide a fully autogenous dialysis access. How is this reported?**

A: If this procedure is performed in one stage, report code 36819.

CPT Code 36820

Arteriovenous anastomosis, open; by forearm vein transposition

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This fistula creation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services

Medicare Payment Rules

Global Period	**090**
Work RVUs	**13.07**
Total RVUs - OFFICE	**21.41**
Total RVUs - FACILITY	**21.41**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Use code 36820 when two SEPARATE incisions are required in the forearm, and the vein is passed under a skin bridge to accomplish the anastomosis. If no skin bridge is required during a direct forearm AV fistula, report 36821.

Coding Tips

Unlike the upper arm where there are separate codes to report cephalic or basilic vein transposition, in the forearm, code 36820 is used to report any forearm vein transposition (eg cephalic, basilic or any other branch).

FAQs

Q: **A patient requires hemodialysis for chronic renal failure due to diabetic nephropathy. She had a traditional arteriovenous Cimino-type fistula at the wrist that failed to mature. Preoperative duplex ultrasound vein mapping demonstrates a 3 mm diameter vein on the medial aspect of the forearm, but it is too far from the radial artery to perform a direct arteriovenous anastomosis. Transposition of the forearm vein through a subcutaneous tunnel is performed. How is this reported?**

A: Report code 36820.

CPT Code 36821

Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open fistula creation is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services

Medicare Payment Rules

Global Period	**090**
Work RVUs	**11.90**
Total RVUs - OFFICE	**19.53**
Total RVUs - FACILITY	**19.53**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

This code may be appropriate for anastomosis at the wrist or elbow.

FAQs

Q: **A patient requires hemodialysis for chronic renal failure due to diabetic nephropathy. Duplex ultrasound vein mapping demonstrates that the only vein of adequate size to perform a fistula lies in the antecubital fossa. A direct brachial artery to cephalic vein arteriovenous fistula is performed adjacent to the antecubital skin crease. How is this reported?**

A: Report code 36821.

CPT Code 36825

Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Vein harvest, any superficial site

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Femoropopliteal vein harvest, if used (35572)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**14.17**
Total RVUs - OFFICE	**23.55**
Total RVUs - FACILITY	**23.55**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The work of this procedure includes vein harvest from any superficial site including upper or lower extremity, (e.g. greater saphenous vein) If deep vein harvest is required, it would be separately reportable (e.g. 35572).

FAQs

Q: **A patient undergoes chronic hemodialysis for long-standing renal failure due to renovascular occlusive disease. He has undergone 4 prior native arteriovenous fistulas over the last 8 years, all of which eventually failed. Placement of a new arteriovenous hemoaccess is undertaken in his forearm using greater saphenous vein. How is this reported?**

A: Report a single code, 36825.

Q: **Question**

A: Answer

CPT Code 36830

Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- This open hemodialysis graft placement is typically reported with a single CPT code, although unusual clinical circumstances may require additional separately reportable services.

Medicare Payment Rules

Global Period	**090**
Work RVUs	**12.03**
Total RVUs - OFFICE	**19.63**
Total RVUs - FACILITY	**19.63**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Use code 36830 to report patients who undergo forearm loop graft, upper arm bridge graft, or thigh loop graft.

FAQs

Q: **A patient with hypertension and insulin dependent diabetes has chronic renal failure. He has never had a previous hemoaccess procedure. Neither cephalic vein is an acceptable conduit for an AV fistula access. He undergoes arm A-V graft using PTFE. How is this reported?**

A: Report code 36830.

CPT Code 36831

Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**090**
Work RVUs	**11.00**
Total RVUs - OFFICE	**18.16**
Total RVUs - FACILITY	**18.16**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

FAQs

Q: **A patient, on hemodialysis for one year, presents with thrombosis of her arteriovenous dialysis graft after an episode of hypotension. The graft is dissected and opened, followed by a balloon catheter thrombectomy. Examination reveals no venous outflow hyperplasia or other intrinsic graft problems that might have contributed to graft failure. The graftotomy is closed, blood flow reestablished, and hemostasis achieved. Wounds are closed. How is this reported?**

A: Report code 36831

CPT Code 36832

Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**090**
Work RVUs	**13.50**
Total RVUs - OFFICE	**22.28**
Total RVUs - FACILITY	**22.28**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Removal of fat (eg, lipectomy) to bring the AV access closer to the surface for ease of cannulation is reported with 36832. Excision of an aneurysm within the access and interposition grafting, open patch angioplasty of an access stenosis, and/or re-tunneling to bring the access more superficial (superficialization) can all be reported with 36832

Coding Tips

If the patient requires a single stage to accomplish a basilic vein transposition, report only 36819. If the patient requires two stages to accomplish a basilic vein transposition, the first stage is a direct brachial artery to basilic vein AV fistula, reported by 36821. The second stage is a superficialization of the basilic vein, which is a revision of an existing AV access and would be reported as code 36832. IF the second stage occurs within the global period of the first procedure, report 36832 with modifier 58.

FAQs

Q: **An obese patient required revision of an AV access because the hemodialysis nurses could not successfully cannulate his fistula. Excess subcutaneous fat needed to be removed to superficialize the vein and make it accessible for cannulation. How is this reported?**

A: You would correctly report only code 36832.

CPT Code 36833

Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**090**
Work RVUs	**14.50**
Total RVUs - OFFICE	**23.82**
Total RVUs - FACILITY	**23.82**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

The work of 36831 and 36832 is included in 36833. Therefore do not report 36831 or 36832 in conjunction with 36833.

FAQs

Q: **A patient on hemodialysis for one year presents with thrombosis of her arteriovenous dialysis graft. The graft is dissected and opened, followed by a balloon catheter thrombectomy. Examination reveals a venous outflow stenosis that might have contributed to graft failure. A synthetic patch angioplasty is performed, blood flow is reestablished, and hemostasis is achieved. How is this reported?**

A: Report code 36833.

CPT Code 36838

Distal revascularization and interval ligation (DRIL, upper extremity hemodialysis access (steal syndrome)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Revision of AV fistula (36832)
- Ligation or banding of AV fistula (37607)
- Ligation of extremity artery (37618)
- Brachial-brachial bypass, vein conduit (35525)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**090**
Work RVUs	**21.69**
Total RVUs - OFFICE	**33.67**
Total RVUs - FACILITY	**33.67**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes***
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 36838 may only be reported in the upper extremity. Do not report code 36838 for treatment of steal syndrome in the lower extremity in the setting of a functioning AV access.

CPT Code 36870

Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure, including guidewire(s), catheter(s), and percutaneous thrombolytic device

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization of an AV access including radiological S&I (36147, 36148)
- Arteriovenous shunt angiography through a separate access site (ie, other than puncture site for AV access) (75791)
- Venous angioplasty, percutaneous and radiological S&I (35476, 75978)

Medicare Payment Rules

Global Period	**090**
Work RVUs	**5.20**
Total RVUs - OFFICE	**52.19**
Total RVUs - FACILITY	**8.74**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

Code 75791 would correctly be reported only when imaging is performed through a separate catheter access or when catheter access was not performed by the provider who performs the angiogram.

FAQs

Q: **A patient on chronic hemodialysis presents for dialysis and is noted to have no flow in his forearm dialysis graft. He is referred immediately for restoration of flow through his graft so that no dialysis treatments will be missed. The AV access is catheterized. Diagnostic imaging is performed. A second catheter access is established. A percutaneous graft thrombectomy is then performed. How is this reported?**

A: Report code 36870 for percutaneous thrombectomy. Also report code 36147 for initial access and diagnostic imaging PLUS add-on code 36148 for the second access.

Q: **A patient has catheter access established for dialysis in the hemodialysis center by Dr. A. Then later the patient is transferred to the angiography suite with the catheter capped. Dr. B injects contrast through the already established access catheter for complete AV access imaging. How does Dr. B report his work?**

A: Dr. B reports 75791 for performing the angiography.

Intraperitoneal Catheter (49324-49422)

Intraperitoneal Catheter (49324-49422)

CPT Code 49324

Laparoscopy, surgical; with insertion of tunneled intraperitoneal catheter

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**010**
Work RVUs	**6.32**
Total RVUs - OFFICE	**11.24**
Total RVUs - FACILITY	**11.24**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

Coding Tips

Code 49324 describes laparoscopic insertion of a peritoneal dialysis catheter, whereas code 49421 describes open surgical placement

CPT Code 49325

Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**010**
Work RVUs	**6.82**
Total RVUs - OFFICE	**12.00**
Total RVUs - FACILITY	**12.00**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**yes**
Team Surgery (mod 66)	**no**

CPT Code 49421

Insertion of tunneled intraperitoneal catheter for dialysis, open

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**000**
Work RVUs	**4.21**
Total RVUs - OFFICE	**6.65**
Total RVUs - FACILITY	**6.65**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 49324 describes laparoscopic insertion of a peritoneal dialysis catheter, whereas code 49421 describes open surgical placement

CPT Code 49422

Removal of tunneled intraperitoneal catheter

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**010**
Work RVUs	**6.29**
Total RVUs - OFFICE	**10.96**
Total RVUs - FACILITY	**10.96**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Radiology

Radiology

Vascular Injection (36002-36500)

Vascular Injection (36002-36500)

35472

CPT Code 36002

Injection procedures (eg, thrombin) for percutaneous treatment of extremity pseudoaneurysm

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Local anesthesia, introduction of needles or catheter, and necessary pre- and postinjection care specifically related to the injection procedure
- When performed in an office, all necessary supplies for the procedure

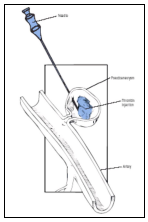
Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Imaging guidance (76942, 77002, 77012, 77021)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**1.96**
Total RVUs - OFFICE	**4.64**
Total RVUs - FACILITY	**3.10**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Images



Coding Tips

When ultrasound guided compression repair of pseudoaneurysms is performed report 76936 INSTEAD OF 36002.

FAQs

Q: **A patient s/p cardiac catheterization develops an expanding painful hematoma not controlled by compression, with groin tenderness, and a femoral bruit. A duplex scan was performed previously and demonstrated a pseudoaneurysm arising from the common femoral artery. The patient is referred for percutaneous therapy. How is this reported?**

A: Report code 36002 along with 76942 for ultrasound guidance of needle placement. (When performed in an office, guidance is reported without a modifier.)

CPT Code 36005

Injection procedure for extremity venography (including introduction of needle or intracatheter)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Local anesthesia, introduction of needles or catheter, injection of contrast media with or without automatic power injection, and/or necessary pre- and postinjection care specifically related to the injection procedure.
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

-
  - Radiological guidance (75820, 75822, 75825, 75827)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.95**
Total RVUs - OFFICE	**9.19**
Total RVUs - FACILITY	**1.42**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

An intracatheter is a sheathed combination of needle and short catheter.

Coding Tips

For one arm, report codes 36005; 75820 (Venography, extremity, unilateral, S&I) and 75827-59 (Venography, caval, superior, with serialography, S&I).

For both right and left arms, report codes 36005; 36005- 59; 75822 (Venography, extremity, bilateral, S&I) with 75827-59 (Venography, caval, superior, with serialography, S&I).

For legs, report as above, EXCEPT use 75825-59 INSTEAD of 75827-59 because the legs are imaged with the inferior vena cava instead of the superior vena cava.

FAQs

Q: **A patient on dialysis with two failed AV access sites in the left arm undergoes a diagnostic venogram of the left upper extremity and superior vena cava. A venous catheter is place in the dorsum of the left hand. How is the catheterization reported?**

A: Report code 36005 for the catheter insertion and 75820 and 75827-59 for radiological S&I. If advancement of a catheter into the superior vena cava is required to obtain adequate central imaging, report 36010 INSTEAD of 36005.

CPT Code 36010

Introduction of catheter, superior or inferior vena cava

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- IVC venography, when recent venogram has not been performed (75820,75825)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**2.43**
Total RVUs - OFFICE	**14.25**
Total RVUs - FACILITY	**3.55**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient with head trauma suffers a pulmonary embolism. A vena cave filter is inserted. How is this reported?**

A: Report 37191 for introduction of catheter into the inferior vena cava, deployment of the vena cava filter, and IVC venography. Code 37191 bundles all venous non-selective and selective catheterization(s) required to insert an IVC filter, as well as radiological S&I and all imaging guidance. Do NOT report 36010 in addition to 37191.

CPT Code 36011

Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Local anesthesia, introduction of needles or catheter, injection of contrast media with or without automatic power injection, and/or necessary pre- and postinjection care specifically related to the injection procedure
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

-
  - IVC or selective venography, when recent venogram has not been performed (75825, 75831, 75832)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**3.14**
Total RVUs - OFFICE	**23.76**
Total RVUs - FACILITY	**4.59**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report the highest order selective venous catheterization that is performed. Do not report simultaneous lower order venous catheterization unless performed in a different vascular family.

For example, a catheter is introduced into the inferior vena cava and the left renal vein is selected. The highest order catheterization would be a first order representing the left renal vein. Therefore, only report code 36011

FAQs

Q: **A patient with head trauma suffers a pulmonary embolism. A vena cave filter is inserted. A selective catheter placement is performed to locate the right renal vein prior to filter deployment. How is this reported?**

A: Report code 37191 for introduction of catheter into the inferior vena cava, deployment of the vena cava filter, and IVC venography. Code 37191 bundles all venous non-selective and selective catheterization(s) required to insert an IVC filter, as well as radiological S&I and all imaging guidance. Do NOT report 36011 in addition to 37191.

CPT Code 36012

Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Local anesthesia, introduction of needles or catheter, injection of contrast media with or without automatic power injection, and/or necessary pre- and postinjection care specifically related to the injection procedure
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- IVC or selective venography, when recent venogram has not been performed (75825, 75831, 75832)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**3.51**
Total RVUs - OFFICE	**24.56**
Total RVUs - FACILITY	**5.08**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report the highest order selective venous catheterization that is performed. Do not report simultaneous lower order venous catheterization unless performed in a different vascular family.

For example, a catheter is introduced into the inferior vena cava, the left renal vein is selected, and then the left gonadal vein is selected. The highest order catheterization would be a second order representing the left gonadal vein. Therefore, only report code 36012.

CPT Code 36100

Introduction of needle or intracatheter, carotid or vertebral artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation for diagnostic angiography performed through this needle or intracatheter

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**3.02**
Total RVUs - OFFICE	**13.96**
Total RVUs - FACILITY	**4.47**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 36120

Introduction of needle or intracatheter; retrograde brachial artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation for diagnostic angiography performed through this needle or intracatheter

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**2.01**
Total RVUs - OFFICE	**11.96**
Total RVUs - FACILITY	**2.93**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 36120 if the catheter remains in the arm. If you advance the catheter into the aorta, you would report 36200 INSTEAD of 36120. Note that 36200 includes the work of 36120.

CPT Code 36140

Introduction of needle or intracatheter; extremity artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure
- Moderate (conscious) sedation (99143-99145)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation for diagnostic angiography performed through this needle or intracatheter

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**2.01**
Total RVUs - OFFICE	**12.42**
Total RVUs - FACILITY	**2.98**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

When femoral artery catheterization is performed with imaging but an iliac artery lesion prevents retrograde entry into the aorta, report 36140.

Code 36140 if the catheter remains in the leg. If you advance the catheter into the aorta, you would report 36200 INSTEAD of 36140. Note that 36200 includes the work of 36140.

CPT Code 36147

Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Fluoroscopy (76000, 76001)
- Venography, radiological S&I (75820)
- Introduction of catheter, superior or inferior vena cava (36010)
- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Interventional treatment performed during the same session as this diagnostic study

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**3.72**
Total RVUs - OFFICE	**23.79**
Total RVUs - FACILITY	**5.43**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 36147 bundles radiological S&I with the AV access catheterization.

Coding Tips

Advancing the catheter centrally into the SVC or IVC does not alter the coding (ie, report 36147).

If the catheter is advanced retrograde into the proximal inflow artery, report 36215 and 75791 INSTEAD of 36147.

Selective catheterization of a branch draining vein off the dialysis access circuit would be reported with 36011 and 75791 INSTEAD of 36147 because the additional work of branch catheterization is not inherent to 36147.

FAQs

Q: **A patient with ESRD is referred for evaluation because of increased difficulty puncturing the AV shunt for dialysis. He has been on hemodialysis for 5 years, and this is his second AV shunt. He has an AV fistula in the left upper arm, and was most recently studied 10 months ago, at which time a 2 cm stenosis of the arteriovenous anastomosis and immediate outflow was found and treated with balloon angioplasty. He now undergoes AV shunt puncture under local anesthesia and a diagnostic study is performed from the arterial anastomosis to the superior vena cava. How is this reported?**

A: Report only code 36147.

CPT Code 36148

Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Interventional treatment performed during the same session as this diagnostic study

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**1.00**
Total RVUs - OFFICE	**7.43**
Total RVUs - FACILITY	**1.42**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

If a second catheterization is required for diagnostic evaluation, do not report 36148 because 36148 can only be used during a therapeutic intervention.

If a second catheterization is required to help perform a therapeutic intervention, report code 36148 in addition to 36147.

FAQs

Q: **A patient with ESRD is referred for study of a dialysis access (either graft or fistula) that is not performing well. The AV shunt is punctured under local anesthesia and a diagnostic study demonstrated significant stenosis just below the puncture site that requires balloon angioplasty. A second puncture is required to reach the lesion. How is this reported?**

A: Report code 36147 for the first access puncture and add-on code 36148 for the additional puncture. Also, report 35476 for the venous PTA and radiological S&I code 75978 for the venous PTA. A radiological S&I code would not be reported in addition to 36147 because S&I is bundled into this code.

CPT Code 36160

Introduction of needle or intracatheter, aortic, translumbar

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Aortography, abdominal (75625)
- Aortography, spine (75705)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**2.52**
Total RVUs - OFFICE	**14.09**
Total RVUs - FACILITY	**3.60**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 36160 is appropriate for nonselective translumbar aortic access whereas 36200 would be reported for non-selective transfemoral aortic access.

FAQs

Q: **A patient status post EVAR has evidence by follow-up imaging for a Type II endoleak. Diagnostic translumbar aortography is performed. How is this reported?**

A: Report 36160 for the catheterization and 75625 for the aortogram.

FAQs

Q: **A patient status post EVAR has evidence by follow-up imaging for a Type II endoleak. Diagnostic translumbar aortography is performed. An endoleak is identified and selective lumbar artery catheterization is performed. How is this reported?**

A: Report 36245 for the catheterization and 75625 for the aortogram and 75705 for selective spinal angiography. [Note that 36245 includes the work of 36160 plus selective catheterization]

CPT Code 36200

Introduction of catheter, aorta

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation for diagnostic angiography performed through this catheter

Medicare Payment Rules

Global Period	**000**
Work RVUs	**3.02**
Total RVUs - OFFICE	**17.78**
Total RVUs - FACILITY	**4.46**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

For non-selective catheterization of aorta from both groins, report 36200-50 or 36200 and 36200-59.

For non-selective catheterization of aorta from one groin and another non-selective catheterization of aorta from the brachial artery, report 36200 and 36200-59.

Coding Tips

Report 36140 if the catheter remains in the leg (or 36120 for brachial artery). If you extend the catheter into the aorta, you would report 36200 INSTEAD of 36120 or 36140. Note that 36200 includes the work of 36120 and 36140.

CPT Code 36215

Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation for diagnostic angiography performed through this catheter

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**4.67**
Total RVUs - OFFICE	**32.06**
Total RVUs - FACILITY	**6.87**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Selective catheterization is reported based on the highest order positioning of the catheter in a given vascular family. When a selective catheterization is performed, do not report a non-selective catheterization. For example, if a first order selective catheterization above the diaphragm is performed, report code 36215 and do not report the non-selective code 36200.

Do not use RT/LT modifiers or modifier 50 (bilateral) for brachiocephalic catheterization (eg, carotid, subclavian arteries).

FAQs

Q: **Patient undergoes left subclavian and left common carotid artery. How is this reported?**

A: Because each procedure is first order and performed at different sites, report 36215 and 36215-59.

CPT Code 36216

Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation for diagnostic angiography performed through this catheter

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**5.27**
Total RVUs - OFFICE	**33.34**
Total RVUs - FACILITY	**7.97**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Selective catheterization is reported based on the highest order positioning of the catheter in a givenvascular family. When a selective catheterization is performed, do not report a non-selective catheterization. For example, if a second order selective catheterization above the diaphragm is performed, report code 36216 and do not report the non-selective code 36200 or first order selective codem 36215.

For selective catheterization of the carotid or vertebral arteries, see codes 36222-36228.

FAQs

Q: **Patient undergoes aortic arch and right upper extremity angiography from a femoral puncture with right subclavian artery selective catheterization. How is this reported?**

A: Report code 36216-59 for right subclavian 2nd order catheterization, 75710 for right upper extremity angiography, and 36221 for the aortic arch angiogram. Selective arterial catheterizations outside the carotid and vertebral arteries is separately reportable with modifier 59 appended.

CPT Code 36217

Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation for diagnostic angiography performed through this catheter

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**6.29**
Total RVUs - OFFICE	**53.90**
Total RVUs - FACILITY	**9.44**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

For selective catheterization of the carotid or vertebral arteries, see codes 36222-36228.

Coding Tips

Selective catheterization is reported based on the most selective (highest order) positioning of a catheter in a given vascular family.

Examples:

Left raial artery from femoral:

1st order = subclavian not reported

2nd order = brachial not reported

3rd order = radial (report 36217)

Right brachial from femoral:

1st order = Innominate not reported

2nd order = subclavian not reported

3rd order = brachial (report 36217)

FAQs

Q: **Patient undergoes bilateral internal carotid artery and left vertebral catheterization. How is this reported?**

A: Report code 36217-59 for right brachial 3rd order catheterization; 75710 for right upper extremity angiography and 36221 for the aortic arch angiogram. Selective arterial catheterizations outside the carotid and vertebral arteries is separately reportable with modifier 59 appended.

CPT Code 36218

Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological supervision and interpretation for diagnostic angiography performed through this catheter

Medicare Payment Rules

Global Period	***ZZZ***
Work RVUs	**1.01**
Total RVUs - OFFICE	**5.26**
Total RVUs - FACILITY	**1.53**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **Following a selective left radial artery catheterization, the surgeon backs the catheter into the brachial artery then selectively catheterizes the ulnar artery. How is this reported?**

A: Report code 36217 as the primary procedure for catheterization of the left radial artery and 75710 for right upper extremity angiogram. Also report add-on code 36218 for the additional third order catheterization of the ulnar artery (in the same vascular family) and 75774 for additional vessel S&I.

CPT Code 36221

Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Placement of closure device at the vascular access site
- Follow-up additional selective angiography (75774)
- Non-selective aortic catheterization (36200)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, embolization, etc.)
- Selective catherization of vascular families outside the carotid and vertebral arteries
- 3D rendering (76376, 76377)
- Ultrasound guidance for vascular access (76937)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**4.17**
Total RVUs - OFFICE	**31.14**
Total RVUs - FACILITY	**6.26**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient undergoes a diagnostic arch aortogram and abdominal aortogram. How is this reported?**

A: Report code 36221 for the arch aortogram and code 75625 for the abdominal aortogram. Non-selective aortic catheterization (36200) is included in the bundled code 36221 and is therefore not separately reported.

FAQs

Q: **Patient undergoes aortic arch and right upper extremity angiography from a femoral puncture with right subclavian artery selective catheterization. How is this reported?**

A: Report code 36216-59 for right subclavian 2nd order catheterization, 75710 for right upper extremity angiography, and 36221 for the aortic arch angiogram. Selective arterial catheterizations outside the carotid and vertebral arteries is separately reportable with modifier 59 appended.

CPT Code 36222

Selective catheter placement, **common carotid or innominate artery**, unilateral, any approach, with angiography of the ipsilateral **extracranial** carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Non-selective arterial catheter placement and aortic arch angiography (36221)
- Selective catherization of the common carotid or innominate artery (36215, 36216)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, embolization, etc.)
- Selective catherization of vascular families outside the carotid and vertebral arteries
- 3D rendering (76376, 76377)
- Ultrasound guidance for vascular access (76937)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.53**
Total RVUs - OFFICE	**36.06**
Total RVUs - FACILITY	**8.59**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report only one code (36222-36224) for each ipsilateral carotid territory, using a hierarchy based on intensity of service: 36224>36223>36222.

Non-selective arterial catheter placement and aortic arch angiography (36221) is included in the work of 36222-36226.

For diagnostic bilateral extracranial carotid artery selective catheterization and extracranial carotid imaging, report 36222-50.

FAQs

Q: **A 75-year-old male with a prior right carotid endarterectomy three years ago presents with ultrasound evidence for a >80% asymptomatic internal carotid artery restenosis. A diagnostic carotid arteriogram is performed. How is this reported?**

A: If the arteriogram demonstrates a stenosis that does not require immediate treatment, code 36222 would be reported.

If the arteriogram confirms a critical stenosis, and a carotid stent is deployed during the same session, 37215 or 37216 would be the only code reported.

CPT Code 36223

Selective catheter placement, **common carotid or innominate artery**, unilateral, any approach, with angiography of the ipsilateral **intracranial** carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Non-selective arterial catheter placement and aortic arch angiography (36221)
- Selective catherization of the common carotid or innominate artery (36215, 36216)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, embolization, etc.)
- Selective catherization of vascular families outside the carotid and vertebral arteries
- 3D rendering (76376, 76377)
- Ultrasound guidance for vascular access (76937)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.00**
Total RVUs - OFFICE	**43.29**
Total RVUs - FACILITY	**9.40**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report only one code (36222-36224) for each ipsilateral carotid territory, using a hierarchy based on intensity of service: 36224>36223>36222.

Non-selective arterial catheter placement (36221) is included in the work of 36222-36226.

Diagnostic angiography of carotid and vertebral arteries without selective catheterization of the great vessels is reported with code 36221.

FAQs

Q: **A 66-year-old female smoker presents with left upper extremity numbness and weakness. A diagnostic cerebral arteriogram is performed with selective catherization of both common carotid arteries. Extracranial views are obtained bilaterally and detailed intracranial views are obtained only on the right.**

A: Report code 36223 for the right common carotid selection and both extra- and intracranial imaging. Report code 36222-59 for the left common carotid selection and extracranial imaging. If bilateral intracranial imaging had been obtained, the service would be reported with 36223-50.

CPT Code 36224

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

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Non-selective arterial catheter placement and aortic arch angiography (36221)
- Selective catherization of the internal carotid, common carotid, or innominate artery (36215, 36216, 36217)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, embolization, etc.)
- Selective catherization of vascular families outside the carotid and vertebral arteries
- 3D rendering (76376, 76377)
- Ultrasound guidance for vascular access (76937)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.50**
Total RVUs - OFFICE	**53.98**
Total RVUs - FACILITY	**10.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report only one code (36222-36224) for each ipsilateral carotid territory, using a hierarchy based on intensity of service: 36224>36223>36222.

Code 36224 includes extracranial imaging if performed, but extracranial imaging is not required to report this code.

Non-selective arterial catheter placement (36221) is included in the work of 36222-36226.

Diagnostic angiography of carotid and vertebral arteries without selective catheterization of the great vessels is reported with code 36221.

CPT Code 36225

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

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Non-selective arterial catheter placement and aortic arch angiography (36221)
- Selective catherization of the subclavian or innominate artery (36215, 36216)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, embolization, etc.)
- Selective catherization of vascular families outside the carotid and vertebral arteries
- 3D rendering (76376, 76377)
- Ultrasound guidance for vascular access (76937)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.00**
Total RVUs - OFFICE	**41.78**
Total RVUs - FACILITY	**9.37**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report only one code (36225-36226) for each ipsilateral vertebral territory, using a hierarchy based on intensity of service: 36226>36225.

Non-selective arterial catheter placement (36221) is included in the work of 36222-36226.

Diagnostic angiography of carotid and vertebral arteries without selective catheterization of the great vessels is reported with code 36221.

For diagnostic unilateral vertebral artery imaging, report code 36225 or 36226. However, extracranial vertebral artery stent placement (0075T) includes ipsilateral vertebral imaging, and therefore 36225 or 36226 are not separately reportable with 0075T.

CPT Code 36226

Selective catheter placement, **vertebral artery**, unilateral, with angiography of the ipsilateral **vertebral** circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Non-selective arterial catheter placement and aortic arch angiography (36221)
- Selective catherization of the vertebral, subclavian, or innominate artery (36215, 36216, 36217)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, embolization, etc.)
- Selective catherization of vascular families outside the carotid and vertebral arteries
- 3D rendering (76376, 76377)
- Ultrasound guidance for vascular access (76937)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.50**
Total RVUs - OFFICE	**52.72**
Total RVUs - FACILITY	**10.54**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report only one code (36225-36226) for each ipsilateral vertebral territory, using a hierarchy based on intensity of service: 36226>36225.

Non-selective arterial catheter placement (36221) is included in the work of 36222-36226.

Diagnostic angiography of carotid and vertebral arteries without selective catheterization of the great vessels is reported with code 36221.

For diagnostic unilateral vertebral artery imaging, report code 36225 or 36226. However, extracranial vertebral artery stent placement (0075T) includes ipsilateral vertebral imaging, and therefore 36225 or 36226 are not separately reportable with 0075T.

CPT Code 36227

Selective catheter placement, **external carotid artery**, unilateral, with angiography of the ipsilateral **external carotid** circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Selective catherization of the external carotid artery (36216, 36217, 36218)
- Follow-up additional selective angiography (75774)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- 3D rendering (76376, 76377)
- Ultrasound guidance for vascular access (76937)

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	**2.09**
Total RVUs - OFFICE	**7.47**
Total RVUs - FACILITY	**3.38**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 36227 is reported only once per side regardless of the number of branch vessels selected and imaged.

Code 36227 can only be reported with codes 36222, 36223, or 36224.

For bilateral external carotid artery catheterization and imaging, report 36227-50 in addition to the primary procedure (36222, 36223, 36224).

CPT Code 36228

Selective catheter placement, **each intracranial branch of the internal carotid or vertebral arteries**, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)
- Selective catherization of the internal carotid artery or verteral artery branch(s) (36217, 36218)
- Follow-up additional selective angiography (75774)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- 3D rendering (76376, 76377)
- Ultrasound guidance for vascular access (76937

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**4.25**
Total RVUs - OFFICE	**35.88**
Total RVUs - FACILITY	**6.85**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code 36228 can only be reported with codes 36223, 36224, 36225, or 36226.

Report code 36228 for selective catheter placement and diagnostic imaging of the initial and each additional intracranial branch of the internal carotid or vertebral arteries.

However, code 36228 can only be reported a maximum of twice per side, with a maximum number of total units of four per session.

FAQs

Q: **Patient undergoes unilateral left MCA and right vertebral selective catheterization and imaging. How is this reported?**

A: Report code 36224 and 36228 for the left carotid and MCA catheterization and imaging. Report code 36226 for the selective right vertebral artery catheterization and imaging.

CPT Code 36245

Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Selective renal angiography (75724)
- Selective renal angiography (36251)
- Selective visceral angiography (75726)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**4.90**
Total RVUs - OFFICE	**38.95**
Total RVUs - FACILITY	**7.36**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Non-selective aorta from both groins. Report 36200-50 or 36200 and 36200-59.

Non-selective aorta from one groin and another non-selective aorta from the brachial artery. Report 36200 and 36200-59.

Non-selective from one groin and first order selective from the other groin. Report: 36245 and 36200-59

FAQs

Q: **Patient undergoes first order superior mesenteric artery catheterization with selective visceral angiography. How is this reported?**

A: Report code 36245 for the catheterization and 75726 for related radiological S&I.

Note that the basic aortogram (75625) is included in selective visceral angiography (75726).

CPT Code 36246

Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Selective renal angiography (36252, 36254)
- Aortography, abdominal (75625)
- Aortography, extremity (75710, 75716)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.27**
Total RVUs - OFFICE	**25.40**
Total RVUs - FACILITY	**7.83**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **Patient undergoes an aortogram with unilateral lower extremity angiography with catheterization of the contralateral external iliac artery. How is this reported?**

A: Report code 36246 for the second order catheterization; 75625 for the aortogram; and 75710 for unilateral leg angiogram.

CPT Code 36247

Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Selective renal angiography (36252, 36254)
- Aortography, abdominal (75625)
- Aortography, extremity (75710, 75716)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.29**
Total RVUs - OFFICE	**44.88**
Total RVUs - FACILITY	**9.27**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **Patient undergoes an aortogram with unilateral lower extremity angiography with catheterization of the contralateral superficial femoral artery. How is this reported?**

A: Report code 36247 for the third order catheterization; 75625 for the aortogram; and 75710 for unilateral leg angiogram.

CPT Code 36248

Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- When performed in an office, all necessary supplies for the procedure (eg, guidewire, catheter)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Selective renal angiography (36252, 36254)
- Selective angiography, additional vessel, radiological S&I (75774)

Medicare Payment Rules

Global Period	***ZZZ***
Work RVUs	**1.01**
Total RVUs - OFFICE	**4.34**
Total RVUs - FACILITY	**1.43**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Remember that the additional second or third order catheter placement must be in the SAME vascular family.

Code 36248 cannot be reported by itself and must be reported with either 36246 or 36247.

CPT Code 36251

Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Placement of closure device at the vascular access site
- Aortography, abdominal, by serialography, radiological S&I (75625)
- Catheterization

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.35**
Total RVUs - OFFICE	**40.49**
Total RVUs - FACILITY	**8.20**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **Patient undergoes an intravascular percutaneous renal stent. How is this reported?**

A: If no prior angiogram is available, report code 36251, which bundles a first order selective catheterization, flush aortography, and selective unlateral renal arteriography. Additionally report 37236 for stent deployment.

If prior angiogram is available, then report 36245 INSTEAD of 36251 because angiography is inherent to 36251. Additionally report 37236 for stent deployment.

CPT Code 36252

Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Placement of closure device at the vascular access site
- Aortography, abdominal, by serialography, radiological S&I (75625)
- Catheterization

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**6.99**
Total RVUs - OFFICE	**43.96**
Total RVUs - FACILITY	**10.89**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **An 80-year-old female with Stage III chronic kidney disease and hypertension, which requires three medications to control, is being evaluated for renal artery stenosis. How is a diagnostic bilateral renal catheter arteriogram reported?**

A: Report 36252. Do not report selective arterial catheterization code 36245 or abdominal aortography code 75625. Also, do not separately report any accessory renal catheterization and/or imaging codes.

CPT Code 36253

Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Placement of closure device at the vascular access site
- Aortography, abdominal, by serialography, radiological S&I (75625)
- Catheterization

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**7.55**
Total RVUs - OFFICE	**64.51**
Total RVUs - FACILITY	**11.00**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient with a 2.5 cm aneurysm in the upper pole branch of the left main renal artery. The patient undergoes pre-operative diagnostic renal angiography requiring placement of the catheter in the second order renal artery branch. How is this reported?**

A: Report 36253. Do not report selective arterial catheterization code 36246 or abdominal aortography code 75625. Also, do not separately report any accessory renal catheterization and/or imaging codes.

CPT Code 36254

Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Placement of closure device at the vascular access site
- Aortography, abdominal, by serialography, radiological S&I (75625)
- Catheterization

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**8.15**
Total RVUs - OFFICE	**62.72**
Total RVUs - FACILITY	**12.64**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 36468

Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Vein ligations, stab avulsions or stripping

Medicare Payment Rules

Global Period	**000**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

CPT Code 36470

Injection of sclerosing solution; single vein

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance, radiological S&I (76942)
- Vein ligations, stab avulsions or stripping

Medicare Payment Rules

Global Period	**010**
Work RVUs	**1.10**
Total RVUs - OFFICE	**4.25**
Total RVUs - FACILITY	**2.42**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient presents with a single symptomatic varicose vein on her left lower extremity. She complains of burning and aching with standing. The left greater saphenous vein has previously been surgically ablated. A trial of compression stockings has failed to provide relief. Compressive injection sclerotherapy is performed. How is this reported?**

A: Report only 36470.

CPT Code 36471

Injection of sclerosing solution; multiple veins, same leg

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- When performed in an office, all necessary supplies for the procedure, including sclerosing solution and elastic wrap

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Ultrasound guidance, radiological S&I (76942)
- Vein ligations, stab avulsions or stripping

Medicare Payment Rules

Global Period	**010**
Work RVUs	**1.65**
Total RVUs - OFFICE	**4.97**
Total RVUs - FACILITY	**2.89**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

FAQs

Q: **A patient presents with multiple symptomatic varicosities on her left lower extremity. She complains of burning and aching with standing. The left greater saphenous vein has previously been surgically ablated. A trial of compression stockings has failed to bring relief. Compressive injection sclerotherapy is performed. How is this reported?**

A: Report only code 36471.

CPT Code 36475

Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ultrasound guidance (76942, 76937)
- Duplex scan (93970-93971)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, and any type of compression stockings

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Vein stab phlebectomy if performed during the same operative session (37765).

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.30**
Total RVUs - OFFICE	**43.76**
Total RVUs - FACILITY	**8.18**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

If it is necessary for endovenous ablation therapy to be coupled with stab phlebectomy and/or sclerotherapy, these services are separately reportable using existing codes.

FAQs

Q: **A patient presents with painful, unilateral leg swelling that increases during the course of the day. She has been diagnosed with great saphenous vein insufficiency with resultant superficial varicosities by way of history, physical examination, and non-invasive ultrasound testing. The patient chooses to undergo percutaneous endovenous radiofrequency ablation therapy of the insufficient saphenous vein. How is this reported?**

A: Report 36475 for treatment of the greater saphenous vein with radiofrequency.

CPT Code 36476

Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ultrasound guidance (76942, 76937)
- Duplex scan (93970, 93971)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, and any type of compression stockings

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Vein stab phlebectomy if performed during the same operative session (37765, 37766).

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	2.65
Total RVUs - OFFICE	8.45
Total RVUs - FACILITY	3.95
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	yes
Assistant (mods 80-82)	no
Co-Surgeons (mod 62)	no
Team Surgery (mod 66)	no

Coding Tips

Code 36476 is an add-on code and therefore cannot be reported by itself.

Coding Tips

Code 36476 can only be reported ONCE PER SESSION no matter how many veins are treated in the same extremity.

FAQs

Q: **A patient presents with painful, unilateral leg swelling that increases during the course of the day. She has been diagnosed with great and small saphenous vein insufficiency with resultant superficial varicosities by way of history, physical examination, and non-invasive ultrasound testing. The patient chooses to undergo percutaneous endovenous radiofrequency ablation therapy of the insufficient great and small saphenous veins. How is this reported?**

A: Report 36475 for treatment of the first saphenous vein and add-on code 36476 for treatment of the second vein in the same extremity.

CPT Code 36478

Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ultrasound guidance (76942, 76937)
- Duplex scan (93970-93971)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, and any type of compression stockings

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Vein stab phlebectomy if performed during the same operative session (37765-37766).

Medicare Payment Rules

Global Period	**000**
Work RVUs	**5.30**
Total RVUs - OFFICE	**34.16**
Total RVUs - FACILITY	**8.13**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**yes**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

If it is necessary for endovenous ablation therapy to be coupled with stab phlebectomy and/or sclerotherapy, these services are separately reportable using existing codes.

FAQs

Q: **A patient presents with painful, unilateral leg swelling that increases during the course of the day. She has been diagnosed with great saphenous vein insufficiency with resultant superficial varicosities by way of history, physical examination, and non-invasive ultrasound testing. The patient chooses to undergo percutaneous endovenous laser ablation therapy of the insufficient saphenous vein. How is this reported?**

A: Report 36475 for treatment of the greater saphenous vein with a laser.

CPT Code 36479

Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Ultrasound guidance (76937, 76942)
- Duplex scan (9397093971)
- When performed in an office, all necessary supplies for the procedure, including guidewires, catheters, and any type of compression stockings

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Vein stab phlebectomy if performed during the same operative session (37765-37766).

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	2.65
Total RVUs - OFFICE	8.78
Total RVUs - FACILITY	3.97
Multiple Procedure (mod 51)	no
Bilateral Surgery (mod 50)	yes
Assistant (mods 80-82)	no
Co-Surgeons (mod 62)	no
Team Surgery (mod 66)	no

Coding Tips

Code 36479 is an add-on code and therefore cannot be reported by itself.

Coding Tips

Code 36479 can only be reported ONCE PER SESSION no matter how many veins are treated in the same extremity.

FAQs

Q: **A patient presents with painful, unilateral leg swelling that increases during the course of the day. She has been diagnosed with great and small saphenous vein insufficiency with resultant superficial varicosities by way of history, physical examination, and non-invasive ultrasound testing. The patient chooses to undergo percutaneous endovenous laser ablation therapy of the insufficient great and small saphenous veins. How is this reported?**

A: Report 36478 for treatment of the first saphenous vein and add-on code 36479 for treatment of the second vein in the same extremity.

CPT Code 36500

Venous catheterization for selective organ blood sampling

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Venous catheterization (36011, 36012)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological S&I (75893)

Medicare Payment Rules

Global Period	**000**
Work RVUs	**3.51**
Total RVUs - OFFICE	**5.25**
Total RVUs - FACILITY	**5.25**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Report code 36500 only if you advance the catheter selectively into a branch vein.

Coding Tips

Report code 36500 INSTEAD of the selective venous catheterization codes (36011, 36012).

FAQs

Q: **Patient undergoes bilateral renal vein renin sampling. How is this reported?**

A: Report codes 36500, 36500-59, 75893 and 75893-59

Discussion: Aorta and Arteries S&I

Aorta and Arteries – Radiological Supervision & Interpretation

CPT coding for percutaneous diagnostic angiographic procedures (arteriography and venography) has been undergoing transition. Most of these diagnostic studies are still reported with traditional component coding that entails the use of a combination of non-selective and selective catheterization codes in the 36000-37000 CPT range plus diagnostic radiological supervision and interpretation (S&I) codes in the 75000-76000 CPT range. Thus, the typical diagnostic angiographic procedure is reported with at least one catheterization code and one S&I code, while a complete multi-vessel diagnostic procedure will be reported with one or more catheterization codes plus one or more S&I codes.

The original vascular interventional CPT codes employed component coding in a manner parallel to diagnostic coding in that each intervention is typically reported with a procedure code in the 34000-38000 range plus an S&I code in the 75000-76000 range. Since 2005, however, new interventional procedure codes have been created that bundle the intervention and associated S&I. In the recent past, separate procedure and S&I codes have been developed only in situations where different providers are likely to be performing the procedure and the S&I work.

This historical trend has resulted in different coding conventions for diagnostic and interventional procedures depending on the anatomic setting or type of procedure performed. For example:

· Percutaneous diagnostic renal angiography is reported by using one of a family of four codes that bundle catheterization, imaging and all radiological S&I. Renal angioplasty and stent placement will be reported using traditional component coding conventions with an interventional code and an interventional S&I code. If it is appropriate to report a diagnostic angiogram at the time of renal artery endovascular intervention, the new bundled code is submitted to the insurance carrier along with the stent or angioplasty codes. If a prior diagnostic exam exists, only the selective catheterization code (eg, 36245) would be reported with the stent or angioplasty codes along with the interventional S&I.

· Percutaneous diagnostic hemodialysis access angiography is reported with a single code.

· All other purely diagnostic angiographic studies will be reported with traditional component coding by using a combination of procedure codes and radiologic S&I codes.

· Aortic, visceral, brachiocephalic, and venous angioplasty and stent procedures are reported with traditional component coding that will include a non-selective or selective catheterization code, an interventional procedure code, and an interventional S&I code. A diagnostic S&I code may be added if 1) the patient has not had a recent diagnostic angiogram, 2) the patient's clinical condition has changed after the most recent diagnostic angiogram, or 3) a recent diagnostic angiogram is technically insufficient to base an intervention.

· Cervical carotid angioplasty and stent is reported as a single procedure code (37215 or 37216). Selective catheterization, diagnostic angiography and radiological S&I are not separately reportable.

· Retrograde intrathoracic common carotid and/or innominate artery angioplasty and stent is reported as a single procedure code (37217). Selective catheterization, diagnostic angiography and radiological S&I are not separately reportable.

· Antegrade intrathoracic common carotid and/or innominate artery angioplasty and stent is reported as a single procedure code (37218). Selective catheterization, diagnostic angiography and radiological S&I are not separately reportable. Femoropopliteal and tibial angioplasty, stent, atherectomy and stent plus atherectomy are reported as single interventional procedures based on the anatomic location. There are no separately reportable S&I codes and catheterization is not separately reportable. Diagnostic S&I codes are separately reportable if the patient has not undergone a recent diagnostic angiographic study.

· Iliac angioplasty and stent interventions are reported the same as just noted for femoropopliteal and tibial interventions, but iliac atherectomy is reported with Category III T-codes

· Atherectomy in the aorta, visceral, renal and brachiocephalic vessels is reported with Category III T-codes

· Endovascular stent placement with or without angioplasty (outside the carotid, vertebral, intracranial, coronary, and lower extremity arteries) is reported as a single interventional procedure. There are no separately reportable S&I codes. However, unlike in the lower extremity arterial system, catheterization is separately reportable. Diagnostic S&I codes are separately reportable if the patient has not undergone a recent diagnostic angiographic study

At the time of an endovascular intervention, diagnostic angiography is separately reportable only when the interventionalist has no prior catheter-based angiogram available for review, a complete diagnostic evaluation of the arterial bed in question is performed, and a decision to proceed with endovascular therapy is based on this imaging. The imaging codes would require modifier 59 be appended to certify these conditions.

Alternatively, a prior diagnostic study may be available, but the patient may experience a clinical change in his/her vascular exam; the prior evaluation may be of inadequate quality to define the anatomy; or a change may occur in the middle of the intervention in a vascular bed separate and distinct from the treatment zone. If any of these three scenarios are documented, the imaging codes are also reportable, but again would require modifier 59 be appended.

Aortography S&I (75600-75630)

Aortography S&I (75600-75630)

CPT Code 75600

Aortography, thoracic, without serialography, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.49**
Total RVUs	**5.62**
Total RVUs (mod26)	**0.73**
Total RVUs (mod TC)	**4.89**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

CPT Code 75605

Aortography, thoracic, by serialography, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**3.90**
Total RVUs (mod26)	**1.60**
Total RVUs (mod TC)	**2.30**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Report 75605 for evaluation of the descending aorta from the left subclavian to the celiac artery.

FAQs

Q: **Patient is evaluated for traumatic aortic disruption after a motor vehicle accident by angiography in both the aortic arch and the descending thoracic aorta. How is this reported?**

A: Report code 36221 when the aortic arch is evaluated. Report 75605 for evaluation of the entire descending thoracic aorta from the left subclavian artery to the celiac artery.

CPT Code 75625

Aortography, abdominal, by serialography, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**3.91**
Total RVUs (mod26)	**1.62**
Total RVUs (mod TC)	**2.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Renal artery catheterization and imaging codes (36251-36254) bundle the work of selective renal angiography as well as flush aortography (75625). Visceral angiography (75726) also includes flush aortography (75625). Therefore, a basic abdominal aortogram (75625) would never be coded at the same time as a selective renal arteriogram (36251-36254) or visceral arteriogram (75726) since the renal/visceral study includes the work for interpreting the aortogram as well as the selective images.

CPT Code 75630

Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Aortography, abdominal, by serialography, radiological S&I (75625)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.79**
Total RVUs	**4.84**
Total RVUs (mod26)	**2.54**
Total RVUs (mod TC)	**2.30**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Report code 75630 when the catheter is left in a non-selective position and bilateral lower extremity imaging is captured using a bolus-chase or imaging includes the aorta and only the proximal thigh (ie, not entire lower extremity).

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Angiography S&I (75650-75791)

Angiography S&I (75650-75791)

CPT Code 75650

(75650 has been deleted. To report, see 36221-36226.)

CPT Code 75658

Angiography, brachial, retrograde, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization (36120)
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.31**
Total RVUs	**4.68**
Total RVUs (mod26)	**1.86**
Total RVUs (mod TC)	**2.82**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

This is a limited procedure to evaluate the distal upper extremity runoff.

CPT Code 75660

(75660 has been deleted. To report, use 36227.)

CPT Code 75662

(75662 has been deleted. To report, use 36227 and append modifier 50.)

CPT Code 75665

(75665 has been deleted. To report, see 36223, 36224.)

CPT Code 75671

(75671 has been deleted. To report, see 36223 and 36224 and append modifier 50 as appropriate.)

CPT Code 75676

(75676 has been deleted. To report, see 36222-36224.)

CPT Code 75680

(75680 has been deleted. To report, see 36222-36224 and append modifier 50 as appropriate.)

CPT Code 75685

(75685 has been deleted. To report, see 36225, 36226.)

CPT Code 75705

Angiography, spinal, selective, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Descending thoracic or abdominal aortography (75605,75625)
- Therapeutic interventions and associated radiological S&I as required (ie, embolization)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**2.18**
Total RVUs	**6.64**
Total RVUs (mod26)	**3.03**
Total RVUs (mod TC)	**3.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 75705 requires selective catheterization of the spinal artery.

FAQs

Q: **Patient S/P EVAR has a Type II endoleak identified by ultrasound. Translumbar aortic catheterization is performed with selection of a patent lumbar artery. What imaging codes are reported?**

A: Report code 75625 for the initial aortogram and 75705 for the selective lumbar arteriogram.

CPT Code 75710

Angiography, extremity, unilateral, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**4.52**
Total RVUs (mod26)	**1.54**
Total RVUs (mod TC)	**2.98**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

CPT Code 75716

Angiography, extremity, bilateral, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.31**
Total RVUs	**5.25**
Total RVUs (mod26)	**1.84**
Total RVUs (mod TC)	**3.41**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

CPT Code 75722

(75722 has been deleted. To report, see 36251, 36253)

CPT Code 75724

(75724 has been deleted. To report, see 36252, 36254)

CPT Code 75726

Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Aortography, abdominal, by serialography, radiological S&I (75625)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**4.21**
Total RVUs (mod26)	**1.60**
Total RVUs (mod TC)	**2.61**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 75726 includes flush aortography and requires selective catheterization of a visceral artery (eg, celiac, superior mesenteric, or inferior mesenteric artery).

Coding Tips

For superselective angiography, each additional visceral vessel studied after the basic examination, report 75774.

FAQs

Q: **A patient with mesenteric ischemia undergoes AP and lateral aortography, followed by selective catheterization and imaging of both the celiac and SMA. How is this reported?**

A: Report code 36245 for celiac catheterization and 36245-59 for the SMA catheterization. Additionally, report 75726 and 75726-59 for imaging. Do not additionally report 75625 (flush aortogram).

CPT Code 75736

Angiography, pelvic, selective or supraselective, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**4.58**
Total RVUs (mod26)	**1.66**
Total RVUs (mod TC)	**2.92**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 75736 requires selective catheterization of a hypogastric (internal iliac) artery.

CPT Code 75774

Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	ZZZ
Work RVUs	**0.36**
Total RVUs	**2.46**
Total RVUs (mod26)	**0.51**
Total RVUs (mod TC)	**1.95**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

FAQs

Q: **A patient undergoes lower extremity diagnostic angiography from a contralateral femoral approach. After a full angiogram is performed, the interventionalist advances the catheter to the below knee popliteal artery and performs additional selective imaging. How is this reported?**

A: Report code 36247 for the catheterization; 75710 for the basic lower extremity angiogram; and 75774 for the additional imaging obtained after popliteal catheterization.

CPT Code 75791

Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.71**
Total RVUs	**9.00**
Total RVUs (mod26)	**2.33**
Total RVUs (mod TC)	**6.67**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 75791 describes AV access imaging through an existing access or from a catheter that is not a direct puncture of the shunt. For example, a patient may have a fistula cannulated in the hemodialysis center and the catheter left in place with a stopcock. After transport to the imaging suite, contrast is injected into the already present access. Alternatively, a retrograde femoral arterial puncture is performed and the catheter is placed into the aortic arch, then into the left subclavian artery, and finally into the brachial artery near the arterial anastomosis of the AV access. In both of these scenarios, contrast injection does not involve direct AV access puncture, so code 75791 would be reported.

Venography S&I (75820-75842)

Venography S&I (75820-75842)

CPT Code 75820

Venography, extremity, unilateral, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, thrombolysis, or mechanical thrombectomy, etc.)
- IVC angiography (75825)
- SVC angiography (75827)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.70**
Total RVUs	**3.25**
Total RVUs (mod26)	**1.00**
Total RVUs (mod TC)	**2.25**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

If performed bilaterally, report 75822

Coding Tips

If performed in one upper extremity and one lower extremity, report code 75820 and 75820-59.

FAQs

Q: **A patient has undergone a prior A-V fistula creation for hemodialysis. She presents with concern for outflow stenosis and undergoes direct access puncture and imaging of all outflow veins to the SVC. How is this reported?**

A: Do not report 75820. Instead report 36147, which includes both the catheterization and the imaging from the arterial anastomosis through the outflow veins including the SVC.

CPT Code 75822

Venography, extremity, bilateral, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, thrombolysis, or mechanical thrombectomy, etc.)
- IVC angiography (75825)
- SVC angiography (75827)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.06**
Total RVUs	**3.85**
Total RVUs (mod26)	**1.48**
Total RVUs (mod TC)	**2.37**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

If performed unilaterally, report 75820

FAQs

Q: **A patient who has undergone multiple dialysis access procedures, now all known to have failed, presents with bilaterally swollen arms. She undergoes bilateral upper extremity venography, including SVC angiography. How is this reported?**

A: Report code 75822 for the bilateral venography; code 75827 for the SVC angiography; and code 36005-50 (or 36005 and 36005-59, per carrier instructions) for bilateral extremity catheterization.

CPT Code 75825

Venography, caval, inferior, with serialography, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, thrombolysis, or mechanical thrombectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**3.86**
Total RVUs (mod26)	**1.63**
Total RVUs (mod TC)	**2.23**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code

Coding Tips

AV access angiogram includes imaging from the arterial anastomosis of the access to the superior vena cava in the arm and from the arterial anastomosis to the inferior vena cava in the leg. Therefore, inferior cava venography (75825) and superior cava venography (75827) are never appropriate to report with 36147 regardless of catheter manipulation unless a completely separate puncture outside the access circuit is obtained

FAQs

Q: **A patient who has previously undergone thigh loop A-V graft presents with concern for outflow stenosis. A direct access puncture and imaging of all outflow veins to the IVC is performed. How is this reported?**

A: Report 36147, which includes both the catheterization and the imaging from the arterial anastomosis through the outflow veins including the IVC. Do not additionally report 75825.

CPT Code 75827

Venography, caval, superior, with serialography, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, thrombolysis, or mechanical thrombectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**3.88**
Total RVUs (mod26)	**1.59**
Total RVUs (mod TC)	**2.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

AV access angiogram includes imaging from the arterial anastomosis of the access to the superior vena cava in the arm and from the arterial anastomosis to the inferior vena cava in the leg. Therefore, inferior cava venography (75825) and superior cava venography (75827) are never appropriate to report with 36147 regardless of catheter manipulation unless a completely separate puncture outside the access circuit is obtained.

FAQs

Q: **A patient presents with multiple failed dialysis access procedures and undergoes bilateral upper extremity venography, including SVC angiography. How is this reported?**

A: Report code 75822 for the bilateral venography; code 75827 for the SVC angiography; and code 36005-50 (or 36005 and 36005-59, per carrier instructions) for bilateral extremity catheterization

CPT Code 75831

Venography, renal, unilateral, selective, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization (36011 or 36012)
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, thrombolysis, or mechanical thrombectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**3.95**
Total RVUs (mod26)	**1.55**
Total RVUs (mod TC)	**2.40**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 75831 requires selective catheterization of a renal vein, reported separately with code 36011 or 36012.

Coding Tips

If renal veins are imaged during nonselective IVC catheterization, do not report 75831. Instead report code 75825.

CPT Code 75833

Venography, renal, bilateral, selective, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization (36011 or 36012)
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, thrombolysis, or mechanical thrombectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.49**
Total RVUs	**4.72**
Total RVUs (mod26)	**2.17**
Total RVUs (mod TC)	**2.55**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code

Coding Tips

Code 75833 requires selective catheterization of bilateral renal veins, reported separately with codes for bilateral selective venous catheterization.

Coding Tips

If renal veins are imaged during nonselective IVC catheterization, do not report 75833. Instead report code 75825.

CPT Code 75840

Venography, adrenal, unilateral, selective, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization (36011 or 36012)
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, thrombolysis, or mechanical thrombectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.14**
Total RVUs	**4.18**
Total RVUs (mod26)	**1.64**
Total RVUs (mod TC)	**2.54**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 75840 requires selective catheterization of an adrenal vein, reported separately with code 36011 or 36012.

CPT Code 75842

Venography, adrenal, bilateral, selective, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization (36011 or 36012)
- Therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, thrombolysis, or mechanical thrombectomy, etc.)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.49**
Total RVUs	**5.07**
Total RVUs (mod26)	**2.14**
Total RVUs (mod TC)	**2.93**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 75842 requires selective catheterization of bilateral adrenal veins, reported separately with codes for bilateral selective venous catheterization.

Venous Sampling S&I (75893)

Venous Sampling S&I (75893)

CPT Code 75893

Venous sampling through catheter, with or without angiography (eg, for parathyroid hormone, renin), radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Venous catheterization for selective organ blood sampling (36500)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.54**
Total RVUs	**3.33**
Total RVUs (mod26)	**0.77**
Total RVUs (mod TC)	**2.56**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Selective venography is included in code 75893.

FAQs

Q: **A patient requires venous sampling and undergoes puncture of the right common femoral vein with selective catheterization of both the right and left renal veins. Diagnostic imaging is performed prior to sampling. The catheter is then repositioned in the suprarenal and infrarenal IVC for samples from these positions. How is this reported?**

A: Report code 36500-50 for selective catheterization of the right and left renal veins prior to sampling and report codes 75893 and 75893-59 for bilateral venous sampling through the catheter (with or without angiography).

Transcatheter Therapy S&I (75960-75978)

Transcatheter Therapy S&I (75960-75978)

CPT Code 75896

Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Transcatheter therapy, infusion other than for thrombolysis (37202)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**1.96**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

If a patient requires transcatheter infusion other than for thrombolysis for more than one day, report 75896 on the first day of thrombolytic infusion and 75898 for the diagnostic angiography on the second and subsequent days.

For procedures involving thrombolytic infusion therapy, see codes 37211, 37212, 37213, 37214.

CPT Code 75898

Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**2.43**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

If a patient requires transcatheter infusion other than for thrombolysis for more than one day, report 75896 on the first day of thrombolytic infusion and 75898 for the diagnostic angiography on the second and subsequent days.

For procedures involving thrombolytic infusion therapy, see codes 37211, 37212, 37213, 37214.

FAQs

Q: **A patient with DVT undergoes extremity catheterization, ascending venography, placement of an infusion catheter and thrombolysis overnight. The following day, diagnostic imaging is performed to assess the adequacy of clot dissolution. How is the diagnostic imaging on the second day reported?**

A: Report code 37213 or 37214 as clinically appropriate. Do NOT report 75898 for follow-up imaging through the existing catheter as this is bundled into 37213 and 37214.

CPT Code 75900

(75900 has been deleted. For exchange of a previously placed intravascular catheter during thrombolytic therapy with contrast monitoring, radiological supervision and interpretation, see 37211-37214).

CPT Code 75901

Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access, radiologic supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Venous catheterization (36010)
- Mechanical removal of pericatheter obstructive material (eg, fibrin sheath) from central venous device via separate venous access (36595)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.49**
Total RVUs	**4.92**
Total RVUs (mod26)	**0.66**
Total RVUs (mod TC)	**4.26**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

FAQs

Q: **A patient with gastric cancer and a subcutaneous port presents with a poorly functioning port. Infusion/injection can be made but blood cannot be aspirated. Pericatheter obstructive material is removed through a separate venous access. How is this reported?**

A: Report code 36595 for removal of the obstructive material and 75901 for radiological S&I. Also report appropriate venous access code (eg, 36010-36012).

CPT Code 75902

Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen, radiologic supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Mechanical removal of intraluminal (intracatheter) obstructive material from central venous device through device lumen (36596)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.39**
Total RVUs	**2.00**
Total RVUs (mod26)	**0.54**
Total RVUs (mod TC)	**1.46**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

FAQs

Q: **A patient with gastric cancer and a subcutaneous port presents with a poorly functioning port. Infusion/injection can be made but blood cannot be aspirated. Pericatheter obstructive material is removed through the device lumen. How is this reported?**

A: Report code 36596 for removal of the obstructive material and 75902 for radiological S&I.

CPT Code 75940

(75940 has been deleted. To report, use 37191)

CPT Code 75945

Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)
- Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (37250)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**0.57**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 37250 includes the work of positioning the ultrasound catheter and 75945 includes the work of interpreting the acquired images.

CPT Code 75946

Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization codes
- Additional therapeutic interventions and associated radiological S&I as required (ie, angioplasty, stent, atherectomy, etc.)
- Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (37251)

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**0.57**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 37251 includes the work of positioning the ultrasound catheter in an additional vessel and 75946 includes the work of interpreting the acquired images for the additional vessel.

CPT Code 75952

Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping
- Aortography, abdominal, by serialography, radiological S&I (75625)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Implantation of endovascular grafts (34800-34805)
- Stent graft extensions (34825, 34826) and associated S&I (75953)
- Radiologic S&I for all interventions performed outside the target zone for the endoprosthesis

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**6.51**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Report Code 75952 for: Angiography of the aorta and its branches for diagnostic imaging prior to EVAR deployment Fluoroscopic guidance in the delivery of the endovascular components Intraprocedural arterial angiography (to confirm position, detect endoleak, evaluate runoff)

CPT Code 75953

Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping
- Aortography, abdominal, by serialography, radiological S&I (75625)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Implantation of endovascular grafts (34800-34805)
- Stent graft extensions (34825, 34826)
- Radiologic S&I for all interventions performed during deployment of the primary endoprosthesis (75952)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**1.97**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code

Coding Tips

Report Code 75953 for angiography and fluoroscopic guidance in the delivery and placement of extension prostheses (not for the routine components of modular devices)

CPT Code 75954

Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping
- Aortography, abdominal, by serialography, radiological S&I (75625)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Implantation of endovascular grafts (34900)
- Stent graft extensions (34825, 34826, 0254T) and associated S&I (75953, 0255T)
- Radiologic S&I for all interventions performed outside the target zone for the endoprosthesis

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**3.31**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

CPT Code 75956

Endovascular repair of descending thoracic aorta (eg, 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, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping
- Aortography, radiological S&I (75600, 75605, 75625)
- Distal stent graft extension radiological S&I

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Implantation of endovascular grafts (33880)
- Proximal stent graft extensions (33883, 33884) and associated S&I (75958)
- Radiologic S&I for all interventions performed outside the target zone for the endoprosthesis

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**10.14**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

When the initial thoracic aortic endoprosthesis is placed distal to the left subclavian artery and proximal extensions are deployed covering the left subclavian report 75956. Code 75957 is only reported when the left subclavian origin is not covered. Report 75958 in conjunction with 75956 if a proximal stent graft extension is placed after left subclavian origin is covered.

CPT Code 75957

Endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); not involving coverage of left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to level of celiac artery origin, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping
- Aortography, radiological S&I (75600, 75605, 75625)
- Distal stent graft extension radiological S&I

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Implantation of endovascular grafts (33881)
- Proximal stent graft extensions (33883, 33884) and associated S&I (75958)
- Radiologic S&I for all interventions performed outside the target zone for the endoprosthesis

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**8.72**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Code 75957 is only reported when the left subclavian origin is not covered. Report 75958 in conjunction with 75957 if a proximal stent graft extension does not cover the left subclavian origin.

CPT Code 75958

Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (eg, aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping
- Aortography, radiological S&I (75600, 75605, 75625)
- Distal stent graft extension radiological S&I

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Proximal stent graft extensions (33883, 33884)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**5.80**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

If a patient requires 2 proximal stentgraft extensions during TEVAR, report code 75958 twice. This radiological S&I code is reported with either 33883 or 33884.

Coding Tips

Report 75958 in conjunction with 75956 if a proximal stent graft extension is placed after left subclavian origin is covered. Report 75958 in conjunction with 75957 if a proximal stent graft extension does not cover the left subclavian origin.

CPT Code 75959

Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping
- Aortography, radiological S&I (75600, 75605, 75625)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Implantation of distal endovascular extension (33886)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**5.00**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Unlike the radiology S&I code for proximal stentgraft extensions, the distal stentgraft extension radiology S&I code is only reported once per session.

Coding Tips

Report code 75959 only if performed in an operative session subsequent to the initial thoracic endograft placement.

CPT Code 75960

(75960 has been deleted. Please see 37236-37239.)

CPT Code 75961

(75961 has been deleted. To report, see 37197.)

CPT Code 75962

Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological S&I for transluminal balloon angioplasty in iliac, femoral, popliteal, and tibial/peroneal arteries (37220-37235)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.54**
Total RVUs	**3.89**
Total RVUs (mod26)	**0.73**
Total RVUs (mod TC)	**3.16**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Report code 75962 for radiological S&I when performing angioplasty in the aorta, carotid arteries, or upper extremity arteries.

Coding Tips

Report code 75962 once for the initial vessel only. Code 75964 would be reported for each subsequent vessel.

CPT Code 75964

Transluminal balloon angioplasty, each additional peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Radiological S&I for transluminal balloon angioplasty in iliac, femoral, popliteal, and tibial/peroneal arteries (37220-37235)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**0.36**
Total RVUs	**2.42**
Total RVUs (mod26)	**0.49**
Total RVUs (mod TC)	**1.93**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code

Coding Tips

Report code 75964 for radiological S&I when performing angioplasty in the aorta, carotid arteries, or upper extremity arteries.

Coding Tips

Report code 75962 once for the initial vessel only. Code 75964 would be reported for each subsequent vessel.

CPT Code 75966

Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Angioplasty of renal or visceral vessel (35450, 35471)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.31**
Total RVUs	**4.81**
Total RVUs (mod26)	**1.82**
Total RVUs (mod TC)	**2.99**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity*.

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

The initial renal and visceral PTA permits billing 75966 while all subsequent renal or visceral PTA require the add-on code 75968.

CPT Code 75968

Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Angioplasty of renal or visceral vessel (35450, 35471)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**0.36**
Total RVUs	**2.49**
Total RVUs (mod26)	**0.51**
Total RVUs (mod TC)	**1.98**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

Report code 75966 once for the initial vessel only. Code 75968 would be reported for each subsequent vessel.

CPT Code 75978

Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Road mapping

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Angioplasty of vein (35460, 35476)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.54**
Total RVUs	**3.85**
Total RVUs (mod26)	**0.74**
Total RVUs (mod TC)	**3.11**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

For reporting purposes, an upper extremity hemodialysis access graft or fistula is considered one continuous vein from the arterial anastomosis up to and including the axillary vein.

FAQs

Q: **An ESRD patient is referred for treatment of graft or fistula stenosis. The access is punctured under local anesthesia and a diagnostic study demonstrated significant stenoses in the basilic and subclavian veins. Both lesions are treated with balloon angioplasty. How is this reported?**

A: Report code 36147 for the access puncture and fistulogram. Report 35476 and associated radiological S&I code 75978 for the basilic vein PTA. Report 35476-59 and associated radiological S&I code 75978-59 for the subclavian vein PTA.

Vascular laboratory

Vascular laboratory

Ultrasound Guidance (76936-76942)

Ultrasound Guidance (76936-76942)

CPT Code 76936

Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Diagnostic ultrasound evaluation
- Duplex scan of the upper or lower extremity (93925, 93926, 93930, 93931)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.99**
Total RVUs	**7.73**
Total RVUs (mod26)	**2.85**
Total RVUs (mod TC)	**4.88**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26.

CPT Code 76937

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

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**ZZZ**
Work RVUs	**0.30**
Total RVUs	**0.90**
Total RVUs (mod26)	**0.42**
Total RVUs (mod TC)	**0.48**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

Coding Tips

CPT code 76937 describes the evaluation of the veins or arteries for puncture and guidance of the needle entry during the endovenous access. Reimbursement is predicated on digital archiving or placement of a hard copy printout in the medical record in addition to the dictated angiography report.

FAQs

Q: **Patient A is morbidly obese requiring ultrasound guidance to gain arterial access for percutaneous intervention.**

Patient B has a femoral artery pseudoaneurysm that is about to undergo thrombin injection. How is ultrasound guidance reported for each patient?

A: Patient A: Code 76937 describes guidance for a needle that is placed to access a vessel via the Seldinger technique.

Patient B: Code 76942 describes the guidance for direct injection of thrombin into the pseudoaneurysm

CPT Code 76942

Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.67**
Total RVUs	**1.71**
Total RVUs (mod26)	**0.95**
Total RVUs (mod TC)	**0.76**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the procedure is performed in a facility setting, append modifier 26 to the radiological S&I code.

FAQs

Q: **Patient A A is morbidly obese requiring ultrasound guidance to gain arterial access for percutaneous intervention.**

Patient B has a femoral artery pseudoaneurysm that is about to undergo thrombin injection. How is ultrasound guidance reported for each patient?

A: Patient A: Code 76937 describes guidance for a needle that is placed to access a vessel via the Seldinger technique.

Patient B: Code 76942 describes the guidance for direct injection of thrombin into the pseudoaneurysm.

Vascular Lab Studies (93880-93990)

Vascular Lab Studies (93880-93990)

CPT Code 93880

Duplex scan of extracranial arteries; complete bilateral study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- B-mode Doppler and color flow analysis of cervical carotid and vertebral arteries
- Duplex scan of extracranial arteries; unilateral or limited study (93882)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Duplex scan of upper extremity arteries or arterial bypass grafts 93930, 93931)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.80**
Total RVUs	**5.72**
Total RVUs (mod26)	**1.12**
Total RVUs (mod TC)	**4.60**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Code 93880 describes a "complete bilateral" study that generally involves cross sectional evaluation of the plaque for morphology and luminal compromise as well as Doppler spectral analysis withm velocity measurements of the blood flow at several locations. The absolute measurements at peak systole and end diastole combined with the ratio of internal carotid to common carotid artery velocities are used through validated criteria to help determine degree of stenosis. When the evaluation based on the validated institutional requirements is satisfactory on both sides of the neck, the study may be classified as "bilateral and complete" for reporting purposes.

CPT Code 93882

Duplex scan of extracranial arteries; unilateral or limited study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- B-mode Doppler and color flow analysis of cervical carotid and vertebral arteries

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Duplex scan of upper extremity arteries or arterial bypass grafts 93930)
- Duplex scan of upper extremity arteries or arterial bypass grafts 93930, 93931)

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.50**
Total RVUs	**3.64**
Total RVUs (mod26)	**0.70**
Total RVUs (mod TC)	**2.94**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26

Coding Tips

Measurement of common carotid intima-media thickness (IMT) is increasing in popularity, but remains a Category III service in CPT.

CPT Code 93886

Transcranial Doppler study of the intracranial arteries; complete study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.91**
Total RVUs	**8.12**
Total RVUs (mod26)	**1.32**
Total RVUs (mod TC)	**6.80**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

A complete transcranial Doppler (TCD) study (93886) includes ultrasound evaluation of the right and left anterior circulation territories plus the posterior circulation territory (to include vertebral arteries and basilar artery).

Coding Tips

Code 93886 is used to report TCD studies performed with a "blind" Doppler as well as studies performed with color flow duplex scanners.

CPT Code 93888

Transcranial Doppler study of the intracranial arteries; limited study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.50**
Total RVUs	**4.22**
Total RVUs (mod26)	**0.72**
Total RVUs (mod TC)	**3.50**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

In a limited TCD study (93888) there is ultrasound evaluation of two or fewer of the intracranial territories. For TCD, ultrasound evaluation is a reasonable and concerted attempt to identify arterial signals through an acoustic window.

Coding Tips

Code 93888 is used to report limited TCD studies performed with a "blind" (non-imaging) Doppler as well as those performed with color flow duplex scanners.

CPT Code 93922

Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with transcutaneous oxygen tension measurements at 1-2 levels)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Duplex ultrasound services

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.25**
Total RVUs	**2.53**
Total RVUs (mod26)	**0.35**
Total RVUs (mod TC)	**2.18**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Significant changes were made in the non-invasive physiologic arterial codes in 2011. For code 93922, there are three specific test combinations, and at least one of these combinations must be done to meet the minimum service. The combinations are: ABI by Doppler at both PT and AT sites, plus bidirectional Doppler waveform recording and analysis, OR ABIs by Doppler plus volume plethysmography, OR ABIs by Doppler plus transcutaneous oxygen tension measurements.

Code 93922 requires bilateral evaluation at 1 or 2 levels. If a patient has undergone major leg amputation, report 93922 with modifier 52 for evaluation of the remaining limb at 1 or 2 levels. However, if a unilateral study is performed at 3 or more levels, code 93922 can be appropriately reported.

CPT Code 93923

Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.45**
Total RVUs	**3.92**
Total RVUs (mod26)	**0.63**
Total RVUs (mod TC)	**3.29**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Reporting code 93923 necessitates three or more levels of evaluation (ABI by Doppler plus bidirectional Doppler waveform recording and analysis; OR ABI by Doppler plus volume plethysmography; OR ABI by Doppler plus transcutaneous oxygen tension measurements.) bilaterally.

Alternatively, 93923 can be used for a single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia).

When simultaneous upper and lower extremity evaluations are submitted, the second or lesser code must append the 59 modifier (eg, 93923 and 93922-59).

CPT Code 93924

Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.50**
Total RVUs	**4.90**
Total RVUs (mod26)	**0.70**
Total RVUs (mod TC)	**4.20**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity*.

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Code 93924 includes pressure indices by Doppler and either bidirectional Doppler waveform or volume plethysmography recording and analysis, both at rest and at timed intervals following performance of a standardized protocol on a motorized treadmill, plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery in both legs.

Because the treadmill is specifically listed in the description, alternative exercises such as toe lifts are not sufficient to justify use of 93924 but may qualify as a provocative functional maneuver as described in 93923.

FAQs

Q: **A patient reports pain in both calves after ambulating for 2 city blocks. He has no palpable femoral or pedal pulses. He also has a history of spinal stenosis. Bilateral non-invasive arterial physiologic testing is requested at rest and then after treadmill exercise to evaluate whether neurogenic or vascular claudication is the etiology for his discomfort. How is this reported?**

A: Report code 93924.

CPT Code 93925

Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Limited lower extremity duplex scan (93926)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.80**
Total RVUs	**7.40**
Total RVUs (mod26)	**1.12**
Total RVUs (mod TC)	**6.28**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Report code 93926 for a unilateral complete study OR a limited bilateral study OR unilateral study. Code 93925 is only reported for a complete AND bilateral study (ie, not complete OR bilateral).

FAQs

Q: **If a patient with bilateral femoral-tibial lower extremity bypass grafts undergoes a complete bilateral study of both arterial reconstructions. How is this reported?**

A: Report code 93925 if all of the following structures are evaluated in each leg: common femoral, proximal deep femoral, entire bypass graft, distal anastomosis, and outflow tibial artery. Anything less than this would be reported with code 93926 (ie, limited bilateral or unilateral study).

CPT Code 93926

Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.50**
Total RVUs	**4.35**
Total RVUs (mod26)	**0.71**
Total RVUs (mod TC)	**3.64**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Report code 93926 for a unilateral complete study OR a limited bilateral study OR unilateral study. Code 93925 is only reported for a complete AND bilateral study.

FAQs

Q: **If a patient with unilateral femoral-tibial lower extremity bypass graft undergoes a complete study of the arterial reconstruction. How is this reported?**

A: Report code 93926 because only one leg was evaluated

CPT Code 93930

Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Limited upper extremity duplex scan (93931)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.80**
Total RVUs	**5.93**
Total RVUs (mod26)	**1.12**
Total RVUs (mod TC)	**4.81**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

A complete bilateral upper extremity study requires assessment of all of the following structures in both arms: subclavian, axillary, and brachial arteries, plus the innominate and forearm arteries (when appropriate), and bypass graft(s) if present. Anything less than this would be reported with code 93931 (ie, limited bilateral or unilateral study).

CPT Code 93931

Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.50**
Total RVUs	**3.67**
Total RVUs (mod26)	**0.71**
Total RVUs (mod TC)	**2.96**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Do not report 93931 when evaluating the arterial anastomosis of a hemodialysis access graft. INSTEAD report code 93990, which is specific for assessment of a hemodialysis graft or fistula.

CPT Code 93965

Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.35**
Total RVUs	**3.40**
Total RVUs (mod26)	**0.49**
Total RVUs (mod TC)	**2.91**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26

Coding Tips

Report code 93965 for physiologic evaluation (eg, impedance plethysmography). This code is NOT to be reported as part of a duplex exam.

CPT Code 93970

Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study (93971)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.70**
Total RVUs	**5.59**
Total RVUs (mod26)	**0.99**
Total RVUs (mod TC)	**4.60**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

For the lower extremity, a completem bilateral duplex scan of extremity veins requires, at a minimum, assessment of all of the following structures in both legs: Common femoral, saphenofemoral junction, femoral (proximal, mid, distal), popliteal, posterior tibial and peroneal veins. Other veins would be included as clinically indicated. Anything less than this would be reported with code 93971 (ie, limited bilateral or unilateral study).

CPT Code 93971

Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.45**
Total RVUs	**3.42**
Total RVUs (mod26)	**0.64**
Total RVUs (mod TC)	**2.78**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Report 93971 for vein mapping performed in one extremity

CPT Code 93975

Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study (93976)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**1.16**
Total RVUs	**7.99**
Total RVUs (mod26)	**1.63**
Total RVUs (mod TC)	**6.36**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Report code 93975 for a complete mesenteric duplex scan that includes assessment of celiac origin, splenic and hepatic artery (when appropriate), superior mesenteric artery origin and proximal vessel, and inferior mesenteric artery, when identified. The portal venous outflow must also be evaluated.

Coding Tips

Report code 93975 for a complete renal duplex scan that includes assessment of both main renal arteries from the aorta to the kidney, accessory renal arteries (when present), and gray scale pole-to-pole renal length measurement. The venous outflow from both kidneys must also be evaluated

CPT Code 93976

Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.80**
Total RVUs	**4.62**
Total RVUs (mod26)	**1.13**
Total RVUs (mod TC)	**3.49**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26

Coding Tips

Report code 93976 for a limited study such as a unilateral renal (eg, status post stent placement).

CPT Code 93978

Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study (93979)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.80**
Total RVUs	**5.42**
Total RVUs (mod26)	**1.12**
Total RVUs (mod TC)	**4.30**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26

Coding Tips

A complete duplex scan of the aorta (93978) includes evaluation at the proximal, mid, and distal infrarenal aorta, as well as the common iliac artery origins

CPT Code 93979

Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.50**
Total RVUs	**3.40**
Total RVUs (mod26)	**0.70**
Total RVUs (mod TC)	**2.70**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26

Coding Tips

Report code 93979 for a limited study such as a unilateral iliac (eg, status post stent placement).

CPT Code 93990

Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.50**
Total RVUs	**4.55**
Total RVUs (mod26)	**0.71**
Total RVUs (mod TC)	**3.84**
Multiple Procedure (mod 51)	**yes**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26

Coding Tips

Routine screening of A-V access by duplex exam is not covered by Medicare.

Coding Tips

Code 93990 is governed by a CMS program memorandum transmittal which requires one of the following criteria for coverage:

• Elevated dynamic venous pressure

• Access recirculation of =12%

• Unexplained urea reduction ratio < 60%

• Access with a palpable pulse on examination.

HCPCS G-Codes (G0269, G0288, G0365, G0389)

HCPCS G-Codes (G0269)

Occlusive Device in Vein or Artery (G0269)

Occlusive Device in Vein or Artery (G0269)

CPT Code G0269

Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., angioseal plug vascular plug)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

Coding Tips

Code G0269 is bundled into the work of codes 37220-37235.

Reconstruction CTA for Surgical Plan (G0288)

Reconstruction CTA for Surgical Plan (G0288)

CPT Code G0288

Reconstruction, computed tomographic angiography of aorta for surgical planning for vascular surgery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.92**
Total RVUs - FACILITY	**0.92**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Carrier Discretion on Coverage Note: Special considerations apply. SVS recommends consulting your regional Carrier Medical Director prior to using this code

Vessel Mapping for Hemodialysis Access (G0365)

Vessel Mapping for Hemodialysis Access (G0365)

CPT Code G0365

Vessel mapping of vessels for hemodialysis access (services for pre-operative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study (93931)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.25**
Total RVUs	**5.62**
Total RVUs (mod26)	**0.35**
Total RVUs (mod TC)	**5.27**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26

Coding Tips

Carrier Discretion on Coverage Code G0365 is a unilateral study. If bilateral mapping is performed, report G0365 and G0365-59.

Coding Tips

Code G0365 is only for use in patients who have never had a prior surgically created A-V access. If the patient has had a failed or "nonmaturing" prior A-V access previously constructed, refer to the venous duplex scan codes 93970 and 93971 for pre-operative vein mapping.

AAA Screening (G0389)

AAA Screening (G0389)

CPT Code G0389

Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- n/a

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.58**
Total RVUs	**3.25**
Total RVUs (mod26)	**0.81**
Total RVUs (mod TC)	**2.44**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

If the interpretation is performed in a facility setting, append modifier 26.

Coding Tips

Special Coverage Instructions apply.

Category III Codes (0075T-0081T, 0234T-0238T, 0388T-0389T)

Category III Codes (0075T-0081T, 0234T-0238T, 0388T-0389T)

Percutaneous Carotid Stent (0075T-0076T)

Percutaneous Carotid Stent (0075T-0076T)

CPT Code 0075T

Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Roadmapping
- Catheterization
- Diagnostic imaging

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**0.00**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Note: Special considerations apply. SVS recommends consulting your regional Carrier Medical Director prior to using this code

Coding Tips

Codes 0075T and 0076T are similar to the carotid stenting codes (37215 and 37216) as "bundled" work. They include extracranial vertebral selective catheterization, diagnostic angiography of those vessels, stent placement, and all associated radiologic S&I.

CPT Code 0076T

Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Completion angiography
- Roadmapping
- Catheterization
- Diagnostic imaging

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**XXX**
Work RVUs	**0.00**
Total RVUs	**0.00**
Total RVUs (mod26)	**0.00**
Total RVUs (mod TC)	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Code 0076T cannot be reported by itself and must be reported with code 0075T

Coding Tips

Codes 0075T and 0076T are similar to the carotid stenting codes (37215 and 37216) as "bundled" work. They include extracranial vertebral selective catheterization, diagnostic angiography of those vessels, stent placement, and all associated radiologic S&I.

Endovascular AAA Repair with Prosthesis (0078T-0081T)

Endovascular AAA Repair with Prosthesis (0078T-0081T)

CPT Code 0078T

(0078T-0081T have been deleted. to report, see 34841-34848)

CPT Code 0079T

(0078T-0081T have been deleted. to report, see 34841-34848)

CPT Code 0080T

(0078T-0081T have been deleted. to report, see 34841-34848)

CPT Code 0081T

(0078T-0081T have been deleted. to report, see 34841-34848)

Transluminal Peripheral Atherectomy (0234T-0238T)

Transluminal Peripheral Atherectomy (0234T-0238T)

CPT Code 0234T

Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Radiological S&I directly related to the intervention(s) performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, predilatation and post-dilatation)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Bundled endovascular arterial intervention codes 37220-37235 are used to report infrainguinal transluminal atherectomy. Supra-inguinal atherectomy is reported with Category III codes 0234T-0238T.

CPT Code 0235T

Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Radiological S&I directly related to the intervention(s) performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, predilatation and post-dilatation)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Bundled endovascular arterial intervention codes 37220-37235 are used to report infrainguinal transluminal atherectomy. Supra-inguinal atherectomy is reported with Category III codes 0234T-0238T.

CPT Code 0236T

Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Radiological S&I directly related to the intervention(s) performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, predilatation and post-dilatation)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Bundled endovascular arterial intervention codes 37220-37235 are used to report infrainguinal transluminal atherectomy. Supra-inguinal atherectomy is reported with Category III codes 0234T-0238T.

CPT Code 0237T

Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; brachiocephalic trunk and branches, each vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Radiological S&I directly related to the intervention(s) performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, predilatation and post-dilatation)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF:

  1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR

  2. A prior study is available, but as documented in the medical record:

  a. The patient's condition with respect to the clinical indication has changed since the prior study, OR

  b. There is inadequate visualization of the anatomy and/or pathology, OR

  c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Bundled endovascular arterial intervention codes 37220-37235 are used to report infrainguinal transluminal atherectomy. Supra-inguinal atherectomy is reported with Category III codes 0234T-0238T.

CPT Code 0238T

Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Radiological S&I directly related to the intervention(s) performed
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- All angioplasty in the same vessel (ie, predilatation and post-dilatation)

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- Catheterization
- Ultrasound guidance for vascular access, including documentation, with permanent recording and reporting (76937)
- Diagnostic angiography performed at the time of an interventional procedure IF: 1. No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study, OR 2. A prior study is available, but as documented in the medical record: a. The patient's condition with respect to the clinical indication has changed since the prior study, OR b. There is inadequate visualization of the anatomy and/or pathology, OR c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention
- Mechanical thrombectomy and/or thrombolysis
- Extensive repair, endarterectomy, or replacement of an artery (35226, 35286, 35371)

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**yes***
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

** Supporting documentation required to establish medical necessity.*

Coding Tips

Bundled endovascular arterial intervention codes 37220-37235 are used to report infrainguinal transluminal atherectomy. Supra-inguinal atherectomy is reported with Category III codes 0234T-0238T.

Transcatheter Renal Sympathetic Denervation (0388T-0389T)

Transcatheter Renal Sympathetic Denervation (0388T-0389T)

CPT Code 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

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catherization
- Dignostic angiogram
- Radiologic S&I

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**

CPT Code 0339T

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; bilateral

Services INCLUDED (NOT SEPARATELY REPORTABLE)

- Moderate (conscious) sedation (99143-99145)
- Catheterization
- Diagnostic angiogram
- Radiologic S&I

Services NOT INCLUDED (SEPARATELY REPORTABLE, WHEN PERFORMED)

- n/a

Medicare Payment Rules

Global Period	**YYY**
Work RVUs	**0.00**
Total RVUs - OFFICE	**0.00**
Total RVUs - FACILITY	**0.00**
Multiple Procedure (mod 51)	**no**
Bilateral Surgery (mod 50)	**no**
Assistant (mods 80-82)	**no**
Co-Surgeons (mod 62)	**no**
Team Surgery (mod 66)	**no**