The term angioplasty literally means “blood vessel repair.” During an angioplasty procedure, the physician inserts a catheter, with a deflated balloon at its tip, into the affected vessel. Once she reaches the narrow part of the vessel, she inflates the balloon. This expansion within the vessel compresses the plaque build-up and dilates the narrowed vessel.

Atherectomy is a procedure to remove plaque, or fatty buildup, from arteries. The physician may choose atherectomy over angioplasty if the plaque has become too hardened to remove using a balloon, and it must be scraped away.

Stenting involves placing a small wire mesh tube (stent) in a vessel to help it remain open.

**Watch for Multiple Services Included in Angioplasty Codes**

CPT® lists several angioplasty codes as resequenced codes. Resequenced means you won’t find the codes in the manual in numerical order, but you will find them with similarly defined codes. CPT® identifies resequenced codes with a symbol: #.

Watch for language in the descriptors that clarifies the codes apply regardless of whether the service is open or percutaneous. These surgery codes specifically include all imaging and S&I required for the angioplasty.

**Arteries:** Note that the first two codes are for arteries. You use the first code for the initial artery and the second for each additional artery:

1. 37246, *Transluminal balloon angioplasty (except lower extremity artery[ies] for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit)*, open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery
2. +37247, ... each additional artery (List separately in addition to code for primary procedure).

**Veins:** The second set of codes applies to vein services. Again you have distinct codes for initial and additional veins:

1. 37248, *Transluminal balloon angioplasty (except dialysis circuit)*, open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein
2. +37249, ... each additional vein (List separately in addition to code for primary procedure).

**Work Back From List of Exceptions**

Be sure to note that the code descriptors list vessel services the codes do not apply to instead of listing the specific vessels the codes do apply to. This construction makes using your Index, being familiar with other code options, and reading guidelines that much more important.

You may have noticed that both the artery and vein code descriptors exclude angioplasty in the “dialysis circuit.” This is an important exclusion because CPT® includes separate codes specific to dialysis circuit services. Within the dialysis circuit codes you’ll find options for angioplasty as well as angiography, stent placement, thrombectomy, thrombolysis, and permanent vascular occlusion.

In addition to excluding dialysis circuit services, the new artery angioplasty codes exclude “lower extremity artery[ies] for occlusive disease, intracranial, coronary, pulmonary.” You have other codes that apply to these services, such as lower extremity codes 37220-+37239 and coronary codes 92920-92944.

CPT® created category III codes for atherectomy of vessels above the inguinal ligaments:

- 0234T — *Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and*
interpretation; renal artery

- 0235T — visceral artery (except renal), each vessel
- 0236T — abdominal aorta
- 0237T — brachiocephalic trunk and branches, each vessel
- 0238T — iliac artery, each vessel

The atherectomy codes above also include radiological supervision and interpretation. But the lower extremity revascularization codes described below have their own set of rules. The lower extremity revascularization codes apply to angioplasty, atherectomy, and stenting.

Here’s how the revascularization codes break down:

- **Iliac**: 37220-37223 — Revascularization, endovascular, open or percutaneous, iliac artery ...
- **Femoral/popliteal**: 37224-37227 — Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral ...
- **Tibial/peroneal**: 37228-37235 — Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral ...

**Heed Rules That Apply to All Codes in the 37220-37235 Range**

The general rule for 37220-37235 is that you should report the one code that represents the most intensive service (angioplasty, atherectomy, or stent) performed in a single lower extremity vessel. All lesser services are included in that code. (But see the individual sections below for exceptions.)

In some cases, a lesion may extend from one artery into another. If the cardiologist can treat that lesion with a single intervention, then you should choose a single code to report that service.

CPT® offers the example of stenosis that extends from a common iliac into the proximal external iliac. If the physician uses a single stent to treat the lesion, CPT® instructs you to report initial vessel code 37221. You should not also report additional vessel code +37223 (see code definitions below).

On the other hand, if the stenotic lesions consist of two separate iliac arteries divided by a bifurcation with a break in stenosis requiring multiple therapies, then you should report an “initial” code as well as an “additional” code.

**Unilateral**: The codes state that they are unilateral, which means they apply to a service on a single side of the body.

CPT® suggests that if the physician treats the identical territory (such as iliac) in both legs at the same session, you should use modifier 59 (Distinct procedural service) to show both legs are involved. This holds true even when the mode of therapy is different in each leg, such as angioplasty in the left leg, and both angioplasty and stent in the right leg. Keep alert for payers’ modifier preferences, though, as some may prefer you to use modifier 50 (Bilateral procedure), modifiers RT (Right side) and LT (Left side), or some combination of modifiers for procedures on both legs.

**Methods**: Whether the physician performs the procedure percutaneously, via open exposure, or via a combination of the two will not affect your code choice. The codes are appropriate for any of those methods.

CPT® guidelines indicate that the new revascularization codes apply to various possible methods. Examples include:

- Balloon angioplasty: low-profile, cutting balloon, cryoplasty
- Atherectomy: directional, rotational, laser

**Included services**: CPT® guidelines also explain that, in addition to the intervention performed the codes include:

- Accessing the vessel
- Selectively catheterizing the vessel
- Crossing the lesion
Radiological supervision and interpretation for the intervention performed

- Any embolic protection used
- Closure of arteriotomy (incision in the artery)
- Imaging performed to document the intervention was completed.

Report separately: If the physician performs mechanical thrombectomy (such as 37186), to help restore blood flow to the occluded area, CPT® states you may report this service separately.

Iliac: Watch Procedure and Vessel to Choose Among 37220-37223

The iliac service codes are as follows:

- **Initial angioplasty:** 37220 — Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
- **Initial stent (and angioplasty):** 37221 — … with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- **Additional angioplasty:** +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)
- **Additional stent (and angioplasty):** +37223 — … with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure).

Reading through the definitions, you see that the codes for iliac services differ based on whether you’re coding a service in an initial vessel or in an additional vessel. Your options also differ based on whether you’re reporting (1) angioplasty alone or (2) stenting, with angioplasty if performed.

For example: When the cardiologist performs a stent placement and angioplasty in the initial iliac vessel, you should report only 37221. That code covers both stent placement and angioplasty (when performed). You should not report 37220 (angioplasty) in addition to 37221 in this scenario.

If the cardiologist places a stent in an iliac artery but does not perform angioplasty, 37221 or +37223 is still appropriate because those codes specify that the angioplasty is included “when performed.” The codes do not indicate angioplasty is required.

**Atherectomy:** The femoral/popliteal and tibial/peroneal codes include options for reporting atherectomy. But iliac coding is a special case. When the physician performs iliac atherectomy in the same vessel as angioplasty or stent placement, you should report one code for atherectomy and a second code for the angioplasty and/or stent placement. CPT® has a Category III code (0238T, Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel) to capture the atherectomy service on an iliac vessel.

**Territory:** The codes (37220-37235) apply to different “territories.” Codes 37220-37223 fall under the iliac vascular territory. CPT® specifies that “the iliac territory is divided into 3 vessels: common iliac, internal iliac, and external iliac.”

As already discussed 37220 and 37221 are appropriate for the initial vessel treated. That means they apply to the first iliac artery treated in a single leg. If the physician treats one or two additional iliac vessels in the same leg, then you should choose from +37222 and +37223.

You may use up to two add-on codes per leg. The reason is that there are three iliac vessels in each leg, and you may report one code per vessel.

Be sure you catch that — because the codes apply per vessel — you should not report add-on codes for additional lesions in a single vessel. CPT® is very clear that “when more than one stent is placed in the same vessel, the code should be reported only once.”

**Femoral/Popliteal: Each Leg Counts as 1 Vessel**

The femoral/popliteal service codes are below. Note that all of the codes include angioplasty in the same vessel when that
service is performed:

- **Angioplasty**: 37224 — Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty
- **Atherectomy (and angioplasty)**: 37225 — ... with atherectomy, includes angioplasty within the same vessel, when performed
- **Stent (and angioplasty)**: 37226 — ... with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- **Stent and atherectomy (and angioplasty)**: 37227 — ... with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed.

**Territory**: Codes 37224-37227 fall under the femoral/popliteal vascular territory. CPT® states that “the entire femoral/popliteal territory in 1 lower extremity is considered a single vessel for CPT® reporting.”

As a result, you should report a single code even if the cardiologist performed various interventions for various lesions in the popliteal artery and in the common, deep, and superficial femoral arteries in the same leg at the same session.

In these situations, you should use the code for the most complex service.

**For example**: If the cardiologist performs angioplasty in the left popliteal artery and atherectomy in the left common femoral, you should report atherectomy code 37225 only.

**Tibial/Peroneal: Count This as Another 3-Vessel Territory**

Codes 37228-37235 fall under the tibial/peroneal vascular territory.

The first four codes apply to the initial tibial or peroneal vessel treated in a single leg:

- **Angioplasty**: 37228 — Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty
- **Atherectomy (and angioplasty)**: 37229 — ... with atherectomy, includes angioplasty within the same vessel, when performed
- **Stent (and angioplasty)**: 37230 — ... with transluminal stent placement(s), includes angioplasty within the same vessel, when performed
- **Stent and atherectomy (and angioplasty)**: 37231 — ... with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed.

The final four codes are add-on codes that you use to report services on each additional ipsilateral (same side) vessel treated in the tibial/peroneal territory:

- **Angioplasty**: +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) (use with 37228-37231)
- **Atherectomy (and angioplasty)**: +37233 — ... with atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure) (use with 37229-37231)
- **Stent (and angioplasty)**: +37234 — ... with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure) (use with 37230-37231)
- **Stent and atherectomy (and angioplasty)**: +37235 — ... with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure) (use with 37231).
The tibial/peroneal arteries include:

1. Anterior tibial (AT)
2. Posterior tibial (PT)
3. Peroneal.

As you can see, this list equates to three vessels in each leg for the tibial/peroneal territory. Because you may report one code per vessel, you may use one initial code and up to two add-on codes per leg (for a total of three vessels). The three-vessel approach is similar to the iliac territory, but it differs from the femoral/popliteal territory, which counts as a single vessel for coding.

**Mark this:** Work performed on the tibioperoneal (TP) trunk is bundled into the code you choose for peroneal or posterior tibial work. As the CPT® guidelines explain it, “The common tibial-peroneal trunk is considered part of the tibial/peroneal territory, but is not considered a separate, fourth segment of vessel in the tibioperoneal family for CPT® reporting of endovascular lower extremity interventions.” The guidelines go on to indicate that if the physician treats lesions in the TP trunk as well as in the PT artery, you should choose a single code.

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