Fall 2025

RCC Update

RCCB RADIOLOGY CODING CERTIFICATION BOARD

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From the President

Renée Engle, RCC, FRBMA, President, RCCB Board of Directors

As we head into the fall, the Radiology Coding Certification Board reminds all RCCs and RCCIRs that we will be opening applications for the 2026 RCCB Susan Gregg and Shannon Murray Memorial Scholarship in October. **Please share this announcement with any medical or radiology coders that you feel may** need assistance to become certified. We will send out the details via email in October. To contribute to the scholarship fund, please click here: Donate

Also, please be mindful of the importance of staying current with your continued education requirements. There are still two free opportunities to earn CEUs available exclusively for RCCB certificants:

- Revenue Cycle Coding Strategies is offering a cost-free live webcast on October 23rd at 12:00 pm EDT *"2026 ICD-10-CM Updates and Other Changes on the Horizon"* (1 CEUs total). Watch our upcoming emails for more details; and
- There is still time to take the MedLearn free on-demand course: *"2025 Genitourinary IR Coding"* which is available through April 30, 2026 (2 CEUs). Register here: 2025 GI Radiology Coding (RCCB).

On a final note, I wish to remind everyone that coders can now **take the RCCB exams in the safety and comfort of your home or office**. Visit www.rccb.org or contact us at info@rccb.org for questions or information about the RCCB programs.

Sincerely,
Renée C. Engle, RCC, RCCIR, FRBMA

Navigating the ICD-10-CM Update

The Center for Medicare and Medicaid Services (CMS) and National Center for Health Statistics (NCHS) have announced the FY 2026 ICD-10-CM update which introduces 487 new diagnosis codes, 38 code revisions, and 28 code deletions. Effective for dates of service October 1, 2025 through September 30, 2026, the FY 2026 update spans multiple chapters and can be found on the CMS website or the CDC website.

Radiology updates of interest

Key areas of interest relevant to Radiology include greater specificity for reporting the following conditions: multiple sclerosis, non-pressure chronic ulcers, neurodevelopmental disorders, abdominal and pelvic pain, and open wounds of the abdomen, lower back, pelvis and external genitals.

ICD-10-CM Updates...
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In This Issue

RCC Update is a quarterly publication reporting on radiology coding developments and the latest news from the Radiology Coding Certification Board (RCCB). RCC Update is made possible with our partners at Revenue Cycle Coding Strategies LLC.
Tell us what you think at info@rccb.org

ICD-10-CM Updates...
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Multiple Sclerosis: There are 10 new codes for reporting unspecified, relapsing-remitting, primary progressive, and secondary progressive multiple sclerosis.
Non-pressure Chronic Ulcers: There are 130 new codes for reporting chronic non-pressure ulcers based on anatomical site and severity.

Neurodevelopmental Disorders: A new 3-digit category code QA0 has been created for reporting neurodevelopmental disorders related to specific genetic pathogenic variants. 19 new codes are available for reporting these conditions.

Abdominal and Pelvic Pain: Signs and symptoms of the digestive system and abdomen have been expanded with the addition of 16 new codes under 3-digit category code R10. For example, there are now codes for identifying patients presenting with flank pain and abdominal tenderness laterality. Also, pelvic pain can now be identified by location (e.g. left, right, suprapubic).

Open wounds of the abdomen, lower back, pelvis and external genitals: 36 new codes have been added under 3-digit category code S31 for more specified reporting of these injuries including lacerations, puncture wounds, and open bites of the abdominal wall, which are further specified as either with or without a foreign body.

Conclusion

The FY 2026 ICD-10-CM update marks a continued expansion toward more clinically precise coding for better patient care and smoother billing operations. By proactively adopting these changes with system updates, focused training, auditing, and teamwork, Radiology practices can improve reimbursement accuracy and decrease compliance risks.

Next Steps for RCCB Readers
Join our upcoming webinar on October 16, 2025, from 12:00pm -1:00pm EST where we'll walk through the new codes specific to radiology. Register for free today **here**.

Revascularization Coding Changes

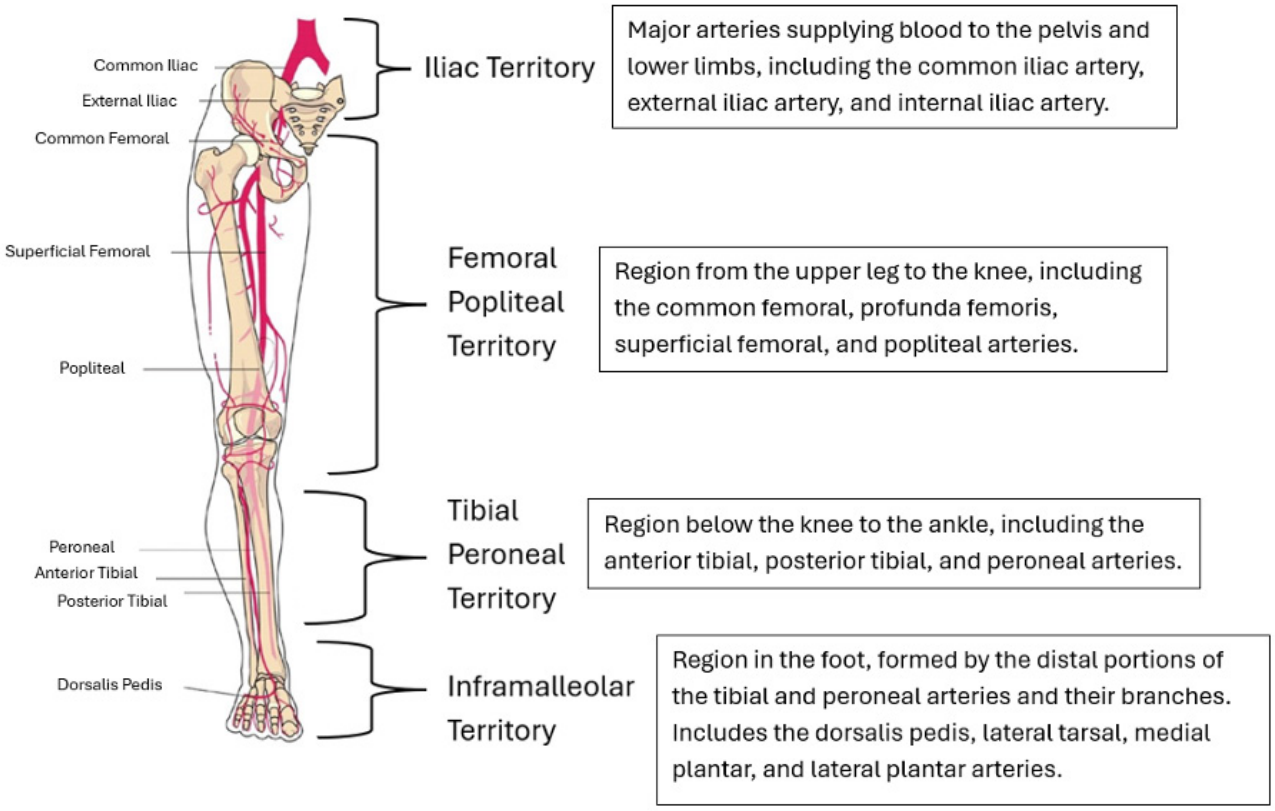
As we approach the 2026 CPT® code updates, interventional radiology billing professionals must prepare for significant changes in lower extremity (LE) revascularization procedure coding. The expansion of CPT® codes for reporting lower extremity revascularization will impact documentation, coding, and revenue cycle processes across all organizations where these procedures are performed.

What's Changing: Lower Extremity Revascularization Code Overhaul

The 2026 CPT® update brings one of the most comprehensive restructurings in years for LE revascularization.

- The existing series of 16 CPT® codes (37220–37235) currently used to report LE revascularization procedures will be deleted.
- 46 new codes will be added, organized by vascular territory.
- In addition to the existing vascular territories (iliac, femoral/popliteal, tibial/peroneal), a fourth vascular territory (inframalleolar) will be added.

Vascular Territories
The **iliac territory** encompasses the major arteries supplying blood to the pelvis and lower limbs, including the common iliac artery, external iliac artery, and internal iliac artery. There are 9 new codes for the iliac territory. The **femoral popliteal** territory encompasses the region from the upper leg to the knee, including the common femoral, profunda femoris, superficial femoral, and popliteal arteries. There are 17 new codes for the femoral popliteal territory. The **tibial peroneal territory** encompasses the region below the knee to the ankle, including the anterior tibial, posterior tibial, and peroneal arteries. There are 16 new codes for the tibial peroneal territory. The **inframalleolar territory** encompasses the region in the foot that is formed by the distal portions of the tibial and peroneal arteries and their branches. This territory includes the dorsalis pedis, lateral tarsal, medial plantar, and lateral plantar arteries. There are 4 new codes for the inframalleolar territory.



Code Selection

The 46 new LE revascularization codes are effective January 1, 2026. Code selection is determined based on vascular territory, laterality, procedure(s) performed, and the type and number of lesion(s) treated.

All revascularization codes are unilateral. The **iliac territory** codes represent angioplasty procedures, and stent placement with angioplasty. The **femoral popliteal territory** and the **tibial peroneal territory** codes represent angioplasty, stent placement with angioplasty, atherectomy, atherectomy with angioplasty, and stent placement with atherectomy and angioplasty. The **iliac territory** and the **femoral popliteal territory** additionally have an add-on code for reporting any intravascular lithotripsy(ies). The **inframalleolar territory** codes represent angioplasty only. The following table may be helpful in understanding LE revascularization code selection.

Code	Vascular Territory	Procedure	Type of Lesion	Number of lesion(s)
37XX1 – 37X09	Iliac	Angioplasty	Straightforward vs Complex	Initial vessel + Each additional vessel
		Stent placement + Angioplasty		
37X10 – 37X26 37X27 – 37X42	Femoral Popliteal Tibial Peroneal	Angioplasty		
		Stent placement + Angioplasty		
		Atherectomy		
		Atherectomy + Angioplasty		
		Stent Placement + Atherectomy + Angioplasty		
37X43 – 37X46	Inframalleolar	Angioplasty		

Note: The Iliac Territory and the Femoral Popliteal Territory additionally have an add-on code for reporting any lithotripsy(ies)

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Preparation

Territory-specific coding requires meticulous documentation. Successful adaptation of the new codes requires early preparation and clear communication. Leadership should begin to update workflows, train necessary staff on territory coding, and prioritize system changes and testing. Providers and coders must collaborate closely to ensure the necessary procedure details, such as vessel(s) treated and laterality, are properly documented to support the new LE revascularization procedures.

Billing for Diagnostic vs Interventional Radiology Services

As radiology continues to evolve as both a diagnostic and therapeutic specialty, Interventional Radiology (IR) leads the charge in minimally invasive procedures. It is essential from a medical billing and coding standpoint to understand the differences between Diagnostic Radiology (DR) and Interventional Radiology (IR) procedures. While both fall under the radiology specialty, the coding, billing, and compliance considerations differ significantly. Misunderstanding these differences can lead to denied claims, compliance risks, or lost reimbursement.

Diagnostic Radiology involves the use of non-invasive imaging services, which are performed to identify, monitor, or rule out disease. These studies are interpretive in nature and may include modalities such as X-ray, Ultrasound, Mammography, CT, MRI, Nuclear Medicine, or PET scans. These services are primarily reported with CPT® codes in the 70000 series. Coders must apply modifiers to separate the technical component (TC) from the professional component (PC), when applicable. Documentation should clearly establish medical necessity and link to the appropriate ICD-10-CM codes to support the clinical indication for the exam. Every effort should be made to code these exams to the highest degree of specificity; however, if there is no definitive diagnosis documented in the Radiologist's final report, it is not uncommon for a sign or symptom to be assigned as the first-listed ICD-10-CM diagnosis code for these exams.

Interventional Radiology involves minimally invasive, image-guided procedures that are typically performed to either treat a previously diagnosed condition, or to confirm a suspected diagnosis. IR procedures combine imaging guidance with therapeutic or diagnostic interventions—such as biopsy, angioplasty, embolization, or ablation. From a coding perspective, CPT® and HCPCS coding is more complex, often involving comprehensive codes that cover access, guidance, and intervention. Coding guidelines for specific interventions must be closely followed, for example, bundling guidelines dictate when catheter placements, imaging guidance, or follow-up imaging are separately billable. Modifier use is common when reporting IR procedures, especially when multiple interventions are performed in a single session. IR documentation must be accurate and complete, capturing all components to support accurate reporting for the totality of the services provided. For example, best practice includes documentation of the following:

- Patient history
- Clinical indication
- Prior imaging
- Access site(s)
- Vessel(s) catheterized (if applicable)
- Imaging modality utilized (e.g. fluoroscopy, ultrasound, CT)
- Findings of any diagnostic intra-procedure imaging (e.g. angiograms) necessary to complete the intervention
- Intervention(s) performed
- Material used to complete intervention(s) (e.g. coils, foam, stent, etc.)
- Outcome of the intervention(s)

Billing...
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Revenue Cycle Workflow Implications

For billing teams and leadership, understanding the distinction between diagnostic and interventional radiology is critical to designing effective revenue cycle workflows:

- **Front-end:** Clear order entry and clinical documentation help ensure services are coded correctly from the start. In diagnostic radiology, the focus is on establishing medical necessity; in IR, the emphasis is on capturing procedure details and consent.
- **Mid-cycle:** Coders must be trained to navigate complex IR coding guidelines, including bundling rules and modifier use. Diagnostic radiology requires vigilance in linking diagnoses to imaging orders.
- **Back-end:** Denial management teams often see higher denial rates in IR due to coding complexity. Creating targeted workflows for appeals and payer education can help protect reimbursement.

Leadership Considerations

For practice leaders, the difference between diagnostic and IR billing impacts both compliance risk and financial performance:

- **Staff Training:** Ongoing coder education reduces rework and denials, directly improving revenue cycle efficiency.
- **Resource Allocation:** IR billing requires more specialized coding resources and auditing tools.
- **Strategic Planning:** Leadership can use coding and billing data to identify trends, forecast revenue more accurately, and invest in areas with higher reimbursement potential.

Why It Matters

Accurate coding ensures radiology practices capture appropriate reimbursement while minimizing compliance risk. By aligning coding accuracy with revenue cycle workflows, practices can improve efficiency, reduce denials, and provide leadership with the data needed for smarter financial planning.

RCCB CODING CORNER

Question: Can you provide guidance regarding coding or not coding the CT Cone Beam charges with IR Y-90 procedures?

Answer: According to *CPT® Assistant*, March 2019, a cone beam CT performed during the treatment procedure to evaluate pre-embolization arterial phases of the hepatic artery is separately reportable with 76380. If the imaging is performed as part of the intra- or post-embolization procedure, it is included in the embolization and is not separately reportable.

Do you have a billing and coding question you would like an answer to in the upcoming newsletter? Submit your questions for possible selection to RCCBQA@RCCSinc.com.