

# RCC Update



## From the President



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

As we head into the summer, the Radiology Coding Certification Board reminds all radiology and interventional radiology coders that you can now **take the RCCB exams via on-line proctoring in the comfort of your home or office or take the exam at a physical testing center.**

The RCCB is delighted to announce the awarding of three Susan Gregg and Shannon Murray Memorial Scholarships for the 2026 scholarship year. Each scholarship covers the entire application and examination costs to pursue certification for the selected recipients. We congratulate the winners and wish them great success on their exams – Leslie Duffin, Laura Zettel, and Senthil V. Please click [HERE](#) if you would like to donate to the scholarship fund.

On a final note, if any certificant is having difficulty with your recertification requirements, please contact us at [info@rccb.org](mailto:info@rccb.org) at any point during your 2-year certification period so we can help you renew successfully. Thank you sincerely for continuing to support RCCB. I wish everyone a safe and pleasant summer.

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

## New ICD-10-CM Code When Reporting US AAA Screening

CMS has updated the Medicare Claims Processing Manual, Chapter 18, Preventive and Screening Services, Section 110.3.2 HCPCS Codes and ICD-10 Diagnosis Codes, specifically for coding ultrasound (US) screening for abdominal aortic aneurysm (AAA).

Effective April 20, 2026, ICD-10-CM code Z13.6, *Encounter for screening for cardiovascular disorders*, has been added as covered diagnosis code for AAA screening with CPT® code 76706, *Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)*.

Reminder – when billing Medicare for AAA US screenings, providers must report ICD-10-CM code Z13.6, *Encounter for screening for cardiovascular disorders*, and either Z87.891, *Personal history of nicotine dependence*, F17.210, *Nicotine dependence, cigarettes, uncomplicated*, F17.211, *Nicotine dependence, cigarettes, in remission*, F17.213, *Nicotine dependence, cigarettes, with withdrawal*, F17.218,

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*Nicotine dependence, cigarettes, with other nicotine-induced disorders* and, F17.219, *Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders*, or Z84.89, *Family history of other specified conditions*.

It is recommended to review if there are any additional ICD-10-CM codes which may be required by the Medicare Administrative Contractor (MAC) for your jurisdiction.

## Coding for Inferior Vena Cava (IVC) Stenting Procedures

A lot of focus is spent on coding for arterial procedures, but coding for venous procedures deserves attention too. IVC stenting for occlusions can be performed in either the inpatient or outpatient setting. For the hospital, the coding will vary depending upon the status of the patient, but for the physician it will be the same regardless of whether the patient was inpatient or outpatient.

### Diagnosis Coding

Typically, a patient with IVC occlusion without emboli or thrombosis will have a diagnosis code of I87.1, *Compression of vein*.

### Outpatient Coding

The transcatheter placement of the intravascular stent into the vein is reported with 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*) and 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)*).

Venous stent placement is reported once per vessel, even if multiple stents are placed in that vessel. When the stenosis involves two separate and distinct lesions, it may be reported with two stent placement codes. (*CPT® Assistant*, March 2025)

Code 37238 is used for the initial vein, and add-on code 37239 is used for each additional vein treated during the same session. In the case of paired vessels, treatment of the left and right sides should be reported with the base code and the add-on code rather than by applying modifier 50 to the base code. (*Clinical Examples in Radiology*, Fall 2017)

Codes 37238 and 37239 do not include nonselective and/or selective catheterizations. Therefore, CPT® codes 36010 (*Introduction of catheter, superior or inferior vena cava*) and 36011 (*Selective catheter placement, venous system; first order branch (eg, renal vein, jugular vein)*) can also separately be reported.

Medicare reimburses physicians and office-based labs (OBLs) for codes, 37238, 37239, 36010, and 36011. Additionally, there are established rates for the physician working in the facility setting. Outpatient hospitals are paid separately for code 37238, which is part of a comprehensive ambulatory payment classification (C-APC) and the assigned rate by Medicare includes all of the ancillary services (e.g., 37239, 36010, 36011) which are reported on the claim but not paid separately.

## Cautions on Coding for Peripheral Vascular Procedures

The Office of Inspector General (OIG) recently released their report *Utilization Trends and Medicare Part B Billing for Office-Based Peripheral Vascular Procedures Raise Questions About Program Integrity*, which revealed some very concerning trends and is a caution related to these procedures.

The OIG listed several reasons for their review, some of the most startlingly reasons included,

- Medicare Part B paid over \$1 billion in 2022 for peripheral vascular procedures (i.e., angioplasty, stenting, and atherectomy) that are intended to relieve leg pain due to the narrowing or blockage of arteries.
- Medicare Part B payments to physicians are higher when they perform peripheral vascular procedures in office-based laboratories (OBLs) compared to other settings.

The report listed several findings and recommendations to CMS for addressing the concerns and potential inappropriate billing and reimbursement for services.

### Findings include:

- During the years 2019 -2023 the Medicare rate for peripheral vascular procedures paid under Medicare Part B decreased, there was a shift in where procedures were performed. The work shifted to OBLs from outpatient hospital setting. The OIG indicated the reimbursement in the OBL was higher than in the

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outpatient department of the hospital and ambulatory surgical center (ASC).

Related and specific to 2023, the OIG found the following.

- Despite routine use of atherectomy and tibial artery procedures being controversial due to potential complication risks and poor outcomes, physicians used these procedures often in OBLs (75 percent and 47 percent of procedures, respectively).
- Of payments made to physicians for peripheral vascular procedures performed in OBLs, \$105 million may indicate billing for medically unnecessary procedures.
- 26 OBL physicians accounted for 61 percent of the concerning payments we identified.

The OIG recommended CMS perform two actions which could have future impacts and CMS agreed with the recommendations. The two action items were,

1. Monitor billing to identify peripheral vascular procedures that may be medically unnecessary, which may indicate fraud, waste, or abuse.
2. Follow up on the physicians OIG identified with concerning billing for peripheral vascular procedures.

One of the factors which could have some turning a blind eye to this report is the CPT® codes reported for iliac, femoral, and tibial arterial regions from 2019 – 2023 have been deleted and replaced with forty-six (46) new lower extremity revascularization codes. This report should be given the attention it deserves.

Even with the recent coding changes and the implementation of CPT® codes 37254-37299 effective January 1, 2026, CMS will be monitoring utilization of this family of codes. It is important for coders to ensure they understand and are educated on how to appropriately code for lower extremity revascularizations.

The medical necessity to support these procedures for patients will always be under scrutiny, especially based on the findings of this report. The other item which comes up often of the new codes set centers around understanding, or lack thereof, related to differentiating straightforward vs. complex lesions.

For lower extremity endovascular revascularization treatment, the CPT® manual defines a **straightforward** lesion as a **stenosis** and a **complex** lesion as an **occlusion**. From a clinical standpoint, **stenosis** refers to a narrowing of a blood vessel in which blood can still flow past the

lesion. In contrast, an **occlusion** is a complete blockage, meaning no blood passes beyond the lesion. Stenosis represents anything less than 100 percent obstruction, while occlusion indicates a full 100 percent blockage. Therefore, even a “near-total “ or “subtotal” blockage is classified as stenosis, not occlusion. (*CPT® Assistant*, April 2026) Some payers may require physicians to indicate the percentage of stenosis within their documentation. This further supports the appropriate coding and state of the patient.

As this new code family continues, it is expected that CMS will provide additional guidance and/or create additional rulemaking around reimbursement for these procedures to offset any potential abuse. Stay tuned for updates!

## Process for Category III Codes

Category III codes are created and maintained by the AMA and end in the letter “T”. A Category III code varies from Category I CPT® codes which are 5-digit numerical codes used for billing. Category III codes undergo a similar process through the AMA, but these codes are used to represent emerging and/or experimental technologies and services. Establishment as a Category III code can be a gateway into transition to Category I but is not a guarantee.

Due to the experimental nature of Category III codes, payers may have distinct requirements for reporting. Two Medicare Administrative Contractors (MACs), First Coast Service Solutions and Novitas Solutions, both have specific requirements regarding a select list of Category III codes.

Per the MACs, when billing for the selected Category III codes, providers should ensure the following documentation is also submitted with the initial claim submission for the selected codes.

- History and physical examination
- Lab or Diagnostic test results, if applicable
- Progress or office notes for the service performed
- Operative or procedure report, if applicable
- Full text peer reviewed articles
- Society guidelines
- Any additional documentation that supports the need for the service

A table of the codes applicable to radiology which require submission of documentation to support is provided below, the full list can be found on either MAC’s website.

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Code	Description
0422T	Tactile breast imaging by computer-aided tactile sensors, unilateral or bilateral
0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report
0686T	Acoustic energy destruction of malignant liver tissue using imaging guidance
0888T	Histotripsy (ie, non-thermal ablation via acoustic energy delivery) of malignant renal tissue, including imaging guidance
0901T	Placement of bone marrow sampling port, including imaging guidance when performed
0905T	Algorithmically generated 12-lead ECG from a reduced-lead ECG, interpretation and report only
0944T	3D contour stimulation of target liver lesion(s) and margin(s) for image-guided microwave destruction through skin
0981T	Transcatheter implantation of wireless inferior vena cava sensor for long-term hemodynamic monitoring, including deployment of the sensor, radiological supervision and interpretation, right heart catheterization, and inferior vena cava venography, when performed
0982T	Remote monitoring of implantable inferior vena cava pressure sensor, physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial set-up and patient education on use of equipment
0983T	Remote monitoring of an implanted inferior vena cava sensor for up to 30 days, including at least weekly downloads of inferior vena cava area recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional
0984T	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)

0985T	Intravascular imaging of extracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)
0986T	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; initial vessel (List separately in addition to code for primary procedure)
0987T	Intravascular imaging of intracranial cerebral vessels using optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention, including all associated radiological supervision, interpretation, and report; each additional vessel (List separately in addition to code for primary procedure)
0994T	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic road mapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; percutaneous
0995T	Endovascular delivery of aortic wall stabilization drug therapy through a sheath positioned within an abdominal aortic aneurysm, with aortic road mapping, balloon occlusion, imaging guidance, and radiological supervision and interpretation; open
1022T	Percutaneous tissue displacement, any method, including imaging guidance; intraabdominal/pelvic structures (List separately in addition to code for primary procedure)
1023T	Percutaneous tissue displacement, any method, including imaging guidance; intrathoracic structures (List separately in addition to code for primary procedure)
1024T	Percutaneous tissue displacement, any method, including imaging guidance; soft tissue (List separately in addition to code for primary procedure)
1025T	Diagnostic imaging for computed tomography and magnetic resonance imaging simulation imported into the therapy treatment-planning system may be reported in addition to the alternating electric fields dosimetry. Alternating electric fields dosimetry and delivery-simulation modeling, creation and selection of patient-specific array layouts, and placement verification



## Studying for the RCC or RCC-IR Exam?

Check out the full suite of exam prep resources developed in partnership with RCCB and RCCS at <https://store.rccsinc.com>



## RCCB CODING CORNER

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](mailto:RCCBQA@RCCSinc.com).



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