



# 2026 PCI Coding & Documentation Insights

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# 2026 CPT® CHANGES Coronary PCI

- **Disclaimer**
- *The content presented reflects Current Procedural Terminology (CPT®) updates and coding guidance effective January 1, 2026, as published by the American Medical Association (AMA).*
- *At this time, CMS (Medicare) and other payers have not yet released their official policies, guidelines, or coverage determinations related to the 2026 coding and reimbursement changes. These are typically published during the first quarter of the calendar year.*
- *This presentation is intended for educational and informational purposes only and does not constitute official reimbursement advice. Content will be updated and revised as additional payer guidance, CMS rules, and policy clarifications become available.*

# 2026 PCI Coding Changes

## Overview

- 2 New codes – 1 for more complex coronary stents, 1 for CTO antegrade & 1 for CTO antegrade and retrograde
- Wording revisions to existing PCI codes to accommodate new codes and coding changes
- Deletion of previous “additional lesion” codes. (these were never acknowledged by Medicare and multiple other payors)
- Deletion of 2 thrombolysis codes (IC and IV)
- Wording changes to FFR/DFR/IFR
- Wording change to thrombectomy codes
- Addition of definitions in CPT for “Coronary lesions” and “Coronary segments”
- WRVU changes for PCI codes as a result of the “family of codes” being reviewed by the RUC

# PCI 2026 Impacts at a Glance

Note hierarchy of codes. **We still bill one intervention per coronary artery**

## “Additional” PCI Codes Deleted

CPT	Desc
92943	CTO
<b>92944</b>	<b>CTO Add'l - Deleted</b>
92941	AMI
92933	Stent + atherectomy
<b>92934</b>	<b>Stent/ather Add'l - Deleted</b>
92924	Atherectomy
<b>92925</b>	<b>Ather Add'l - Deleted</b>
92937	Bypass
<b>92938</b>	<b>Bypass Add'l - Deleted</b>
92928	Stent
<b>92929</b>	<b>Stent Add'l - Deleted</b>
92920	PTCA
<b>92921</b>	<b>PTCA Add'l - Deleted</b>

## WRVU Changes 2026

### PCI Base Codes

CPT	Desc	2025 WRVU	2026 WRVU
★ <b>92945</b>	<b>CTO Complex</b>	12.31	15.00
92943	CTO	12.31	13.69
92941	AMI	12.31	12.72
★ <b>92930</b>	<b>Stents Complex</b>		12.00
92933	Stent + atherectomy	12.29	11.94
92924	Atherectomy	11.74	10.13
92937	Bypass	10.95	11.30
92928	Stent	10.96	10.00
92920	PTCA	9.85	8.35

The 2 new codes are exempt from the add'l -2.5% decrease in WRVU, others are not exempt.

# 2026 Revisions

## Revisions impacting billing for services in 2026

**93571** – Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, *when performed*, initial vessel (list separately)

### Impact

We no longer need to add a “52” modifier when pharm stress is not performed

CPT	Desc	2025	2026
93571	FFR/IFR	1.38	1,80
93572	FFR/IFR Add'l	1.00	1.44

**92973** – Percutaneous transluminal coronary *mechanical aspiration* thrombectomy (list separately)

92941 – AMI PCI includes *aspiration* thrombectomy when performed (manual only per introductory language)

### Impact

Mechanical Devices = Angiojet, Penumbra, JETi, etc.

**Separately billable**

Manual aspiration Devices = Export, Pronto, Eliminate, etc **not billable**

CPT	Desc	2025	2026
92973	Mech Asp	3.28	1.75

# 2026 CORONARY LESION DEFINITION

New to 2026 CPT

## \*\*\*CPT® Guidance - For Purposes of Reporting

A single, distinct coronary lesion starts at the proximal end of the target lesion and ends at the distal end of the target lesion.

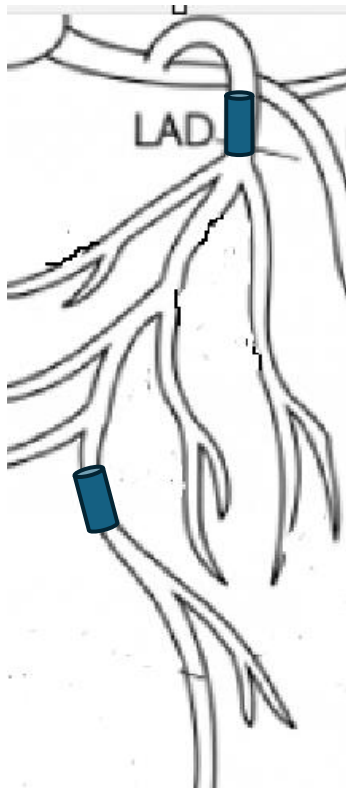
A single, distinct coronary lesion may involve multiple coronary segments and may extend from a major coronary artery into one of its branches or **from a bypass graft into the subtended vessel**

Two distinct coronary lesions within one major coronary artery are considered present when the first lesion is **geographically separated** from the second lesion

EXAMPLE, a diffuse, single coronary lesion extending from the mid to distal RCA treated with two stents constitutes a single, distinct coronary lesion. A coronary lesion in the proximal RCA treated with a single stent and a separate coronary lesion in the distal RCA treated with two stents would be considered **two** distinct lesions.

# Apply The Concepts

Sometimes a picture helps



# Definitions coronary arteries

## \*\*\*CPT® Guidance

New to 2026 CPT

### MAJOR

- No change from previous:
  - LM, LD, LC, RC, RI
- **Bypass graft access = separate major artery for reporting.**
- Example: Native LAD + LIMA graft to LAD = 2 interventions.

### BRANCHES

- No change - Up to two branches recognized per major artery:
- LAD → Diagonals (D1, D2)
- LCx → Marginals (OM1, OM2)
- RCA → PDA, PLV
- **No branches recognized for LM or Ramus.**

### SEGMENTS

- Recognized portions of each major coronary artery and its branches.
- Coding purposes - coronary segments are **defined using the established paradigm used in the NCDR® CathPCI database.**

### BYPASS

- Each bypass graft is a major coronary artery.
- Sequential or branching (Y) graft with > than one distal anastomosis = one graft.
- PCI performed on a major coronary artery or by access through a bypass graft is reported using the bypass PCI codes.

# What is **NOT** changing For 2026


## Reminder on **Billable Catheterizations With an Intervention**

### **Documentation must support:**

- No prior catheter based coronary angio study is available and a full diagnostic study is performed and a decision to intervene is based on the diagnostic angiography.
- A prior study is available, but as documented in the medical record:
  - a. The patient's condition with respect to the indication has changed
  - b. Inadequate visualization of anatomy and/or pathology
  - c. There is a clinical change during the procedure that requires new evaluation outside the target area of intervention

The appropriate modifier must be attached to the cath code to communicate that you meet one of these guidelines when billed with a PCI code


# Selecting the Correct PCI Code – The Basics




Codes are chosen using a progressive hierarchy with more intensive services including the less intensive service



**Only one base code from the PCI family may be reported for revascularization of a major artery and its branches.**



PCI base codes are defined as 92920, 92924, 92928, 92930, 92933, 92937, 92941, 92943, and 92945



The base code includes all of the work of accessing and selectively catheterizing the vessel, traversing the lesion, associated radiology S & I imaging related to the intervention and closure.



Use modifiers as appropriate to identify the major artery

# 92928 – Stent and **New For 2026 92930**

- Using the codes correctly requires application of the concepts of a “coronary segment” and the definition of a “coronary lesion” in addition to CPT code guidelines

CPT	Description
92928	Stent w/PTCA when performed single major coronary artery and/or its branch(es); 1 lesion involving 1 or more coronary segments
92930 NEW 2026	Stent w/PTCA when performed single major coronary artery and/or its branch(es); <u>2 or more <b>distinct</b> coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch</u>

We would now use 92930 if within 1 coronary artery 2 or more **distinct** lesions are treated.

For example: a proximal lesion in the LAD and a distal lesion in the LAD.

Another example: a proximal LAD and also a lesion within one of the diagonals

# Applying The PCI Codes - Stents 92928 & 92930

- Two codes for stent PCI.
  - Code 92928 is reported when 1 lesion is treated with 1 or more stents in a major coronary artery, whether the lesion is confined to 1 segment or extends across multiple coronary segments.
    - Example: Placement of stents to treat a single lesion that overlaps the mid and distal RCA segments may be reported with 92928
  - When **2 or more separate coronary lesions** are treated with **2 or more stents in 2 or more coronary segments in a major coronary artery and/or its branch(es), use 92930.**
    - Example: Treatment of two separate lesions by placement of stents in the first diagonal artery and the distal LAD may be reported with 92930
- If one lesion crosses from 1 vessel into another but can be treated with a single intervention (like 1 stent), report it with 1 PCI code.
  - Example, if a left main lesion extends into the left circumflex and one stent covers both, report it as one stent placement (92928).
- When bifurcation lesions are treated with at least 1 stent, 92930 is reported.
  - Example, when both branches of a bifurcation lesion involving the left anterior descending (LAD) artery and the first diagonal artery are treated and at least 1 stent is used, report 92930.

# Apply The Concepts

Sometimes a picture helps



92930

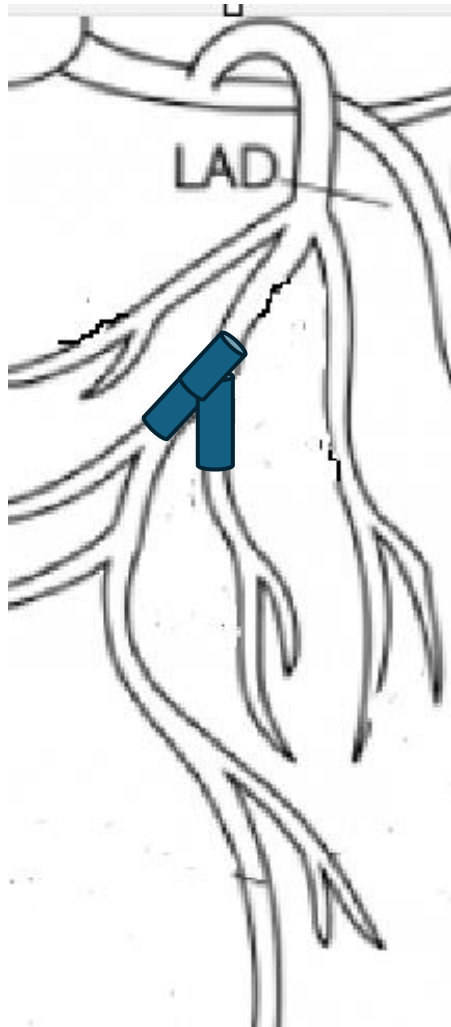


92928



92930

# Apply The Concepts - Bifurcation Lesions



92930



What if the light blue represents a balloon only?



# Apply The Concepts – One more

What if the light blue represents a balloon only?



# 92928 versus 92930

## • Applying the codes – Examples

- **92930** is understanding and applying the language within the code:
- **Stent w/PTCA when performed single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch**
- We still bill only one intervention per coronary artery – but will we use 92928 or 92930?
- Notice the two-part definition – 2 distinct and geographically separate lesions and or bifurcation requiring a stent in one and angioplasty and or stent in the other

- 1) Proximal LC into Mid LC with overlapping stents = 92928
- 2) Stenting Proximal LC and distal LC = 92930
- 3) Stenting mid LC and OM 1, 2 discrete – 92930
- 4) Stenting bifurcation lesion LC stent and OM2 balloon only or stent– 92930 (must have intervention, not wiring only)
- 5) Stenting LC distal and then an add'l PBA only in OM3 – 92928 (follow hierarchy of codes 1 per artery)
- 6) Stenting LIMA graft lesion to LC and then another in native LC – 92928 and 92937 (in or through bypass)
  - This is the only exception where 2 base codes can be billed in the same coronary artery

# APPLYING THE PCI CODES

- AMI “Any Method” (92941)

- Code 92941 is intended for situations in which PCI for acute MI, usually ST-elevation MI, is performed emergently.
- PCI of the culprit major coronary artery lesion(s) causing an AMI includes balloon angioplasty, atherectomy, stenting, nonmechanical **manual aspiration** thrombectomy, distal protection, and intracoronary rheolytic agent administration, when performed.
- **Mechanical aspiration coronary thrombectomy (92973) may be reported separately.**
- PCI for a non-emergent acute coronary syndrome (eg, late-presenting or non-ST-elevation MI without ongoing chest pain) should not be reported with 92941.
- Ensure the proper diagnosis (ICD10) code is billed

# Using The “During acute MI” Code: **must meet all 3 of the following:**

- **1)** Electrocardiographic changes consistent with acute myocardial infarction are recognized: for example, any of the following: ST elevation not attributable to BBB or pericarditis
- New or undetermined LBBB
- New or evolving Q waves
- Persistent horizontal ST depressions in anterior leads consistent with posterior ST elevation
- Ongoing VT, VF, pulseless elect activity, or asystole in a clinical scenario consistent with AMI

2) Emergent coronary angiography and PCI are performed. For example, once the dx of AMI is recognized, the patient is brought urgently to the lab during normal lab hours, or during off hours the lab is activated to treat pt urgently

3) PCI is performed on a target lesion that is totally (100% thrombolysis in myocardial infarction (TIMI grade flow of zero) or sub-totally occluded.

Procedure note should contain information to support all 3 of these requirements.

H & P and or consult note can also be considered on an appeal, but must still support all 3

**Often reports can be improved here**

# Guidance On What Does NOT Support AMI Code



- The following **does not** support AMI even with emergent activation of the cath lab
  - 1) Noncardiac chest pain
  - 2) Unstable angina
  - 3) **Non-ST elevation MI unless there are on-going symptoms prompting emergent activation with demonstration of subtotal or total culprit vessel**
  - 4) Completed MI undergoing non-emergent angio and PCI
  - 5) PCI of thrombotic lesions performed non-emergently after recent MI

## What Coder's Need To See

- Indication and or History is critical for these cases. Must be clear enough to support the previous 3 criteria.
- Indication sentence to support presentation to the ER.... With... Emergency/urgent cardiac catheterization protocol was activated
- “ EKG changes suggestive of Acute MI – taken emergently to the cath lab”

# APPLYING THE PCI CODES

## • BYPASS “Any Method” ( 92937)

- Coded as 92937 **In/Through** a Bypass Graft (Any Method) single major coronary artery and/or its branches
- Only 1 code should be reported for revascularization of a coronary artery bypass graft, its subtended coronary artery, and branches of the subtended coronary artery.
- If part of a major coronary artery is treated through the native vessel and another part of the same artery is treated through a bypass graft, **a separate base code may be reported for the bypass graft intervention.**
- PCI performed during the same session in additional major coronary artery(ies) or in/through an additional coronary artery bypass graft(s) may be reported using the applicable major coronary artery base code(s).

# Coronary PCI

# KEY documentation points

DOCUMENTATION ELEMENT	WHAT TO INCLUDE?
Clinical Context	Clarify the indication, primary diagnosis, co-morbidities, acute MI, non-STEMI, or CTO. Note is an emergent vs a staged procedure.
Diagnostic Angiography	If performed, state justification (no prior study, condition change, prior inadequate, or new anatomy evaluation).
Type of Intervention	Document all modalities (angioplasty, atherectomy, stent, lithotripsy). Identify the dominant/most intensive technique.
Vessel and Branch	Specify major coronary artery (LM, LAD, LCx, RCA, RI) and branch (e.g., D1, OM2, PDA, PLB). Indicate if treated via native vessel or bypass graft
Segment Mapping (NCDR Alignment)	Use NCDR segment terminology to align documentation with registry and CPT reporting.
Lesion Identification	<b>Describe each distinct lesion: start and end location, whether it crosses multiple segments or branches, and if lesions are geographically separate.</b>
Bifurcation / Multi-Vessel Clarity	Identify bifurcation lesions, number of PTCA and/or stents. Differentiate multi-vessel PCI (separate major arteries).
Add-On Technologies	Document use of IVUS/OCT, FFR/IFR, type of thrombectomy, lithotripsy, or brachytherapy, etc., and arteries.
Outcomes / Completion Imaging	Include residual stenosis %, TIMI flow grade, complications, and closure technique.

# APPLYING THE PCI CODES

## • CTO “Any Method” (92943 & 92945)

- PCI of CTOs is reported using 92943, 92945.
- CTO of a coronary vessel is present when there is no antegrade flow through the true lumen, accompanied by suggestive angiographic and clinical criteria (eg, antegrade “bridging” collaterals present, calcification at the occlusion site, no current presentation with ST elevation or Q wave acute myocardial infarction attributable to the occluded target lesion).
- Current clinical presentation with ST elevation or Q wave AMI attributable to the occluded target lesion, subtotal occlusion, or occlusion with dye staining at the site consistent with fresh thrombus **are not considered chronic total occlusion**.
- Some CTOs may be treated with antegrade advancement of a wire through the occluding calcified plaque or around this plaque in the subintimal space (92943).
- Some CTO lesions must be traversed in a combined antegrade and retrograde fashion (92945). In such cases, in addition to the antegrade approach, a wire is advanced via a non-occluded coronary artery and through collateral vessels to cross the occlusion in a retrograde fashion from its distal cap.
- **Code first coronary atherosclerosis (I25.1-, I25.7-, 125.81-) – Then the CTO code second**

# 2026 Coding CTO Procedures

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- 2026 brings a revision to the 2025 CTO code, and adds a new code for a more complex CTO procedure.
- The **CPT definition** and use of a CTO code has **not changed**:

*CTO of a coronary vessel is present when there is no antegrade flow through the true lumen, accompanied by suggestive angiographic and clinical criteria (eg, antegrade “bridging” collaterals present, calcification at the occlusion site, no current presentation with ST elevation or Q wave acute myocardial infarction attributable to the occluded target lesion).*

*Current clinical presentation with ST elevation or Q wave AMI attributable to the occluded target lesion, subtotal occlusion, or occlusion with dye staining at the site consistent with fresh thrombus **are not considered chronic total occlusion**.*

**Diagnosis Code reminder: Code first coronary atherosclerosis (I25.1-, I25.7-, 125.81-). This applies when you see the pt in the office as well.**

# 2 CTO Codes For 2026



We now need to know HOW the CTO is addressed, not just that it is a CTO

CPT	Description
92943	Percutaneous transluminal revascularization of chronic total occlusion, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; <b>antegrade approach</b>
<b>92945</b>	as above <b>combined antegrade and retrograde approaches</b>

## CPT Introductory Language

Some chronic total occlusions may be treated with antegrade advancement of a wire through the occluding calcified plaque or around this plaque in the subintimal space (92943). Some chronic total occlusion lesions must be traversed in a combined antegrade and retrograde fashion (92945).

In such cases, in addition to the antegrade approach, a wire is advanced via a non-occluded coronary artery and through collateral vessels to cross the occlusion in a retrograde fashion from its distal cap.

# CTO Techniques and Approaches

## Antegrade

- **AWE** – Antegrade wire escalation. Progressively stiffer wires are used to push through the lesion from the proximal entry point.
- **STAR** – Subintimal Tracking and Reentry – creating a channel in the subintimal space to cross the occlusion then reentering the “true lumen”
- **ADR** – Antegrade Dissection and reentry. - involves entering the subintimal space, followed by subintimal crossing of the CTO with subsequent reentry into the distal true lumen.

## Retrograde

- **RWE** – Retrograde wire escalation – accessing the lesion from the opposite/distal end of the blockage using collateral vessels
- **CART** – Controlled antegrade and retrograde subintimal tracking – combines elements of both antegrade and retrograde approaches. A retrograde balloon is used to create a subintimal space that is then entered by an antegrade wire.
- **Reverse CART** – as above but an antegrade balloon is used a retrograde wire entering the lesion

# CTO - Recommendations

Now that we need to know more about the procedure than just the fact it was a CTO, documentation may need enhancements

- 1) Documentation should support CPT definition of a CTO - *no antegrade flow through the true lumen, accompanied by suggestive angiographic and clinical criteria (eg, antegrade “bridging” collaterals present, calcification at the occlusion site, no current presentation with ST elevation or Q wave acute myocardial infarction attributable to the occluded target lesion).*
- 2) Documentation should support all information needed to determine if the approach was antegrade, retrograde, and or both
- 3) Simply stating - AWE, ADR, RWE, CART etc. will likely create risk for denials by the payors as well as coding errors by coders need more detail on the approach
- ★ 4) **Prior Authorization could be requested for both CTO codes to ensure the approach used is reimbursed.**

# Reference/Billing Tool

## LEFT HEART CATH- Cross Aortic Valve

- \_\_ 93458 - LHC with Cors w/wo LV
- \_\_ 93459 LHC, Cors w/wo LV & Graft(s)
- \_\_ 93567 - Supravalvular Aortography (root)

## CORONARY ANGIOGRAPHY

- \_\_ 93454 - Coronary Arteries
- \_\_ 93455 - Cors Plus Graft(s)
- \_\_ 93567 - Supravalvular Aortography (root)

## LV ONLY

- \_\_ 93452 - Left Ventriculography only

## RIGHT HEART CATH

- \_\_ 93451 - Right Heart Cath
- \_\_ 93566 - RA or RV Angiography
- \_\_ 93568 - Pulmonary Angiography
- \_\_ 93463 - Pharm Agent Assessment
- \_\_ 93464 - Exercise Study Assessment

## BILATERAL CATH - RHC & LHC

- \_\_ 93460 RHC & LHC (w/cors) w/wo LV
- \_\_ 93461 RHC & LHC (w/cors) w/wo LV+Grafts
- \_\_ 93567 Root Aorto \_\_ 93463 Pharm Agnt
- \_\_ 93566 RA/RV Ang \_\_ 93464 Exrcs Study
- \_\_ 93568 Pulm Angio

## RIGHT HEART CATH & CORS

- \_\_ 93456 RHC w Coronary Arteries (cors)
- \_\_ 93457 RHC with Cors and Graft(s)
- \_\_ 93567 Root Aorto \_\_ 93463 Pharm Agnt
- \_\_ 93566 RA/RV Ang \_\_ 93464 Exrcs Study
- \_\_ 93568 Pulm Angio

## PCI

Only one base code from the PCI family may be reported for revascularization of a major artery and its branches

\_\_ **92945 - CTO Retro/Anteg** LD LC RC LM RI

\_\_ **92943 - CTO Antegrade** LD LC RC LM RI

\_\_ 92941 - AMI LD LC RC LM RI

\_\_ **92930 - Stent 2 or more distinct lesions**  
LD LC RC LM RI

list placement location: \_\_\_\_\_

\_\_ 92933 - Stent + Atherectomy w or w/o PTCA  
LD LC RC LM RI

\_\_ 92924 - Atherectomy w or w/o PTCA  
LD LC RC LM RI

\_\_ 92937 - Bypass (In or Through)  
LD LC RC LM RI

\_\_ **92928 - Stent 1 lesion with or w/o PTCA**  
LD LC RC LM RI

\_\_ 92920 - PTCA only  
LD LC RC LM RI

\_\_ 92972 Lithotripsy (list in addition to primary)

## ADDITIONAL PROCEDURES

- \_\_ 92978 IVUS \_LAD \_LCX \_RCA
- \_\_ 92979 IVUS Add'l \_LAD \_LCX \_RCA
- \_\_ 33967 Balloon Pump
- \_\_ 93571 Frac Flow Rsrv \_LAD \_LCX \_RCA
- \_\_ 93572 Add'l Vessel \_LAD \_LCX \_RCA
- \_\_ 92973 Thrombectomy **mechanical**  
\_LAD \_LCX \_RCA

# 2026 Lower Extremity Coding Concepts

Straightforward = Stenosis

Complex = Occlusion

Vascular Territory	Method	Straightforward		Complex		Bilateral
		Initial Vessel WRVU	Add'l Vessel WRVU	Initial Vessel WRVU2	Add'l Vessel WRVU	
Femoral/Popliteal	PTA	37263 7.75	37264 3.00	37265 10.50	37266 4.00	report twice do not use modifier 50
Common femoral, profunda femoris, superficial femoral and popliteal	Stent (and PTA if performed)	37267 8.75	37268 3.73	37269 14.75	37270 5.00	report twice do not use modifier 50
	Atherectomy (and PTA if performed)	37271 9.00	37272 4.00	37273 12.63	37274 5.50	report twice do not use modifier 50
	Stent + Atherectomy (and PTA if performed)	37275 11.00	37276 4.25	37277 15.00	37278 6.00	report twice do not use modifier 50
	Lithotripsy	37279 4.00	-	-	-	can be reported up to 2 times per side (unilateal) - common femoarl/profunda femoris and superficial femoral/poplitrstl

- For coding purposes the Common Femoral and Profunda are considered a single vessel & the SFA and Popliteal are a single vessel
- Add-on codes reported for distinct lesions in different vessels, not distinct lesions within the same vessel.
- A lesion that crosses from one vessel to another is reported with a single treatment code.
- A max of **one** add on code may be reported in a unilateral case.
- A max of **two** lithotripsy add-on may be reported in a unilateral vascular territory here



Questions?

*Thank you For Your Time and Attention*

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# EFFECTIVE January 2026 IMPACTS TO PCI

## PCI (PTCA, Stent, Atherectomy)

HCPCS	Descriptor	CY 2025 Work RVU	Final CY 2026 Work RVU
92920	PTCA (Angioplasty), single major coronary artery <b>and/or its branch(es)</b>	9.85	<b>8.35</b>
92924	Atherectomy single major coronary artery <b>and/or its branch(es)</b>	11.74	<b>10.13</b>
92928	Stent w/PTCA when performed single major coronary artery <b>and/or its branch(es); 1 lesion involving 1 or more coronary segments</b>	10.96	<b>10.00</b>
92930	<b>Stent w/PTCA when performed single major coronary artery and/or its branch(es); 2 or more distinct coronary lesions with 2 or more coronary stents deployed in 2 or more coronary segments, or a bifurcation lesion requiring angioplasty and/or stenting in both the main artery and the side branch</b>	NEW	<b>12.00</b>
92933	Atherectomy + Stent single major coronary artery <b>and/or its branch(es)</b>	12.29	<b>11.94</b>

\*\*\*Red indicates 2026 CPT® Changes

# EFFECTIVE January 2026 IMPACTS TO PCI

## Any Method Coronary Interventions (AMI, Bypass, CTO)

HCPCS	Descriptor	CY 2025 Work RVU	Final CY 2026 Work RVU
92937	In/Through a Bypass Graft (Any Method) single <b>major coronary artery and/or its branches</b>	10.95	<b>11.30</b>
92941	Percutaneous transluminal revascularization of acute total/subtotal occlusion during AMI, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, <b>single major coronary artery and/or its branches or single bypass graft and/or its subtended branches</b>	12.31	<b>12.72</b>
92943	Percutaneous transluminal revascularization of CTO, <b>single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; antegrade approach</b>	12.31	<b>13.69</b>
<b>92945</b>	<b>Percutaneous transluminal revascularization of CTO, single coronary artery, coronary artery branch, or coronary artery bypass graft, and/or subtended major coronary artery branches of the bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; combined antegrade and retrograde approaches</b>	<b>NEW</b>	<b>15.00</b>

\*\*\*Red indicates 2026 CPT® Changes

# EFFECTIVE January 2026 IMPACTS TO PCI

## Add On Services to PCI

HCPCS	Descriptor	CY 2025 Work RVU	Final CY 2026 Work RVU
Add on - 92973	Percutaneous transluminal coronary <b>mechanical aspiration thrombectomy</b> (List separately in addition to code for primary procedure)	3.28	<b>1.75</b>
Add on - 93571	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, <b>when performed</b> ; initial vessel (List separately in addition to code for primary procedure)	1.38	<b>1.80</b>
Add on - 93572	Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress, <b>when performed</b> ; each additional vessel (List separately in addition to code for primary procedure)	1.00	<b>1.44</b>

\*\*\*Red indicates 2026 CPT® Changes

# Intracoronary Drug-Delivery Balloon

Effective & Published 1/1/2025

## ● 0913T

- Percutaneous transcatheter therapeutic drug delivery by intracoronary drug-delivery balloon (eg, drug-coated, drug-eluting), including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch
- **Do not report 0913T in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92973, 92978,** for interventions on the same target lesion in the same major coronary artery or graft as the target lesion treated with drug-delivery balloon intervention

## +0914T

- Add on code to 0913T for a separate target lesion from the target lesion treated with balloon angioplasty, coronary stent placement or coronary atherectomy, including mechanical dilation by nondrug-delivery balloon angioplasty, endoluminal imaging using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) when performed, imaging supervision, interpretation, and report, single major coronary artery or branch
- Report add-on code 0914T when a separately targeted lesion is treated as part of a separate intervention that is reported with existing code 92920, 92924, 92928, 92933, 92937, 92941, or 92943.