The Real-World Impact of 2026 Coding Changes on Interventional Cardiology and ASCs

Operational, documentation, and reimbursement considerations for interventional teams navigating 2026 coding and payment changes.

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As of January 1, 2026, a significant overhaul of American Medical Association Current Procedural Terminology (CPT) codes and related Centers for Medicare & Medicaid Services (CMS) fee schedules has taken effect, aimed at aligning procedural coding with contemporary clinical practice. These changes have broad implications for interventional cardiologists, peripheral vascular specialists, electrophysiologists, practice administrators, and coders alike.

For cath lab teams, the 2026 CPT code updates, CMS Physician Fee Schedule (PFS) final rule changes, and CMS Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System final rule changes are not abstract billing revisions. They directly reflect what happens in the lab, in real time, during coronary and peripheral interventions. Decisions made by interventional cardiologists, nurses, and technologists regarding access, lesion selection, vessel treatment sequence, devices used, and procedural complexity now carry greater coding and reimbursement implications than ever before.[1]

The 2026 restructuring of percutaneous coronary intervention (PCI) codes introduces clearer differentiation between standard and complex interventions. Whether a case qualifies for higher-complexity reporting depends on details that must be recognized, documented, and supported by the cath lab team at the time of the procedure. Factors such as multivessel treatment, bifurcation work, atherectomy use, or prolonged procedural effort are often evident to cath lab staff long before a coder ever reviews the operative report.[1,2]

Similarly, the complete overhaul of lower extremity revascularization (LER) coding shifts reporting from broad procedural categories to specific vascular territories and individual vessels.[2] Accurate code assignment hinges on precise identification of which arteries were treated, how many distinct territories were involved, and whether interventions occurred above, at, or below the knee or in newly recognized inframalleolar vessels. This level of detail requires close alignment between physicians and cath lab staff who document wire placement, angiographic findings, and treatment endpoints during the case.

Beyond coding mechanics, the 2026 updates also influence how cath labs plan and deliver care. Changes in payment policy and the expansion of approved cardiovascular procedures in ambulatory surgery centers (ASCs), particularly for electrophysiology (EP) and ablation, are prompting health systems to reevaluate site-of-service decisions, staffing models, room utilization, and case scheduling.[3] Cath lab leaders and frontline staff play a critical role in operationalizing these shifts while maintaining patient safety and procedural efficiency.

When cath lab teams understand how care delivery decisions made during the case intersect with CPT definitions and Medicare payment rules, documentation

becomes a shared operational responsibility that helps ensure (1) procedural complexity is accurately reflected in documentation; (2) vascular territories and treated vessels are clearly and consistently identified; (3) compliance risk is minimized through standardized reporting; and (4) the full clinical scope and associated financial value of cath lab services are captured.

This article aims to provide an overview of code changes affecting interventional cardiology and ASCs, highlighting a key reality for interventional and ASC teams: Accurate reimbursement and regulatory compliance begin at the site of service, not at the coding desk.

CORONARY INTERVENTION: PCI CODING CHANGES

A central focus of the 2026 CPT updates for interventional cardiology is the restructuring of PCI coding. Historically, PCI reporting relied on a narrow set of codes that failed to fully capture the procedural complexity, time commitment, and resource use associated with contemporary PCI practice.

Changes and updates from the 2026 CPT revisions include the following:

- New category I PCI codes are introduced, including a complex PCI code (92930) designed to better capture procedures involving multiple lesions, bifurcations, or more extensive stenting. Cardiologists report this code provides enhanced relative value unit (RVU) recognition compared with older codes.[1]
- In addition, a new category I code (92945) for chronic total occlusion (CTO) PCI formally recognizes the added technical complexity, procedural time, and resource intensity associated with CTO interventions, aligning coding more closely with contemporary interventional practice.
- Established PCI codes, such as 92928, experienced reduced reimbursement, while newly created codes for more complex cases received higher work RVUs.[4]

These revisions aim to improve payment accuracy for complex coronary interventions and align coding with procedural effort. Physicians and practices will need to closely review code descriptors to ensure correct code selection.[1]

PERIPHERAL VASCULAR: OVERHAUL OF LER CODING

Perhaps the most sweeping changes in the cardiovascular domain are in LER coding, traditionally one of the most confusing and outdated areas in vascular CPT. Updates for 2026 include the following:

- The existing code set of 16 codes has been completely replaced with 46 new CPT codes (37254-37299). These new codes are organized by vascular territory rather than broad procedure type (eg, angioplasty, stenting), fostering more precise reporting.[2]
- A new inframalleolar vascular territory (below the ankle) is now recognized, expanding procedural capture for pedal and foot artery interventions, an area of increasing clinical activity in patients with chronic limb-threatening ischemia.[5]
- Detailed guidance defines distinct vessels and lesion complexity, enabling coders to differentiate straightforward versus complex treatments and apply the correct base/add-on codes per vessel.

Collectively, these revisions modernize vascular coding and are anticipated to reduce ambiguity, improve reimbursement accuracy, and better reflect clinical microanatomy and therapeutic complexity.[6]

OTHER CARDIOVASCULAR CPT CHANGES OF NOTE

In addition to PCI and LER updates, the 2026 CPT code set brings other cardiovascular coding changes that may indirectly affect practitioners.

Coronary plaque assessment received a category I code, replacing temporary category III codes and recognizing artificial intelligence–augmented imaging analyses more fully.[2] Additionally, new remote physiologic monitoring codes expand capacity to report device data capture and interaction requirements, which can influence cardiology practices managing patients with implanted or wearable technologies.[7]

Together, these updates underscore an ongoing trend to incorporate technologic innovation into procedural reporting.

MEDICARE PFS FINAL RULE: PAYMENT POLICY CHANGES

The 2026 Medicare PFS final rule establishes payment policies that apply to the updated CPT codes and also introduces system-wide adjustments. For example, the conversion factor that determines Medicare fee-for-service payment rates increased for 2026, with the qualifying alternative payment model (APM) conversion factor rising to $33.57 and the non-APM to $33.40, providing a modest overall payment increase.[4]

CMS also finalized changes to the practice expense methodology, introducing "efficiency adjustments" that shift payment weights between facility- and nonfacility-

based services, influencing how procedural code reimbursements, including PCI and peripheral interventions, are valued.[8]

In response to broader stakeholder input, CMS calibrated RVUs for many newly created and revised codes, including cardiovascular service codes. Some codes see increased valuation, while others may be offset by crosswalk methodologies or efficiency adjustments.[3]

These Medicare PFS provisions, along with CPT changes, may result in significant net payment shifts for cardiology practices, emphasizing the need for proactive revenue cycle preparation and financial modeling.[9]

EXPANSION OF APPROVED PROCEDURES IN THE ASC SETTING

An important non-CPT update in 2026 involves the ASC Covered Procedures List (CPL) under the Hospital Outpatient Prospective Payment System final rule.

CMS finalized the addition of cardiac catheter ablation procedures to the ASC CPL, expanding the range of cardiovascular services that can be performed and reimbursed in the ASC setting.[10] This decision responds to long-standing advocacy by professional societies like the American College of Cardiology and Heart Rhythm Society and signifies a regulatory shift toward broader ambulatory care access for EP procedural services.[10]

The inclusion of EP ablation in the ASC setting is poised to reduce costs for payers and patients, while also potentially increasing procedure volume in outpatient facilities. Providers should update their operational workflows and compliance protocols to capture these opportunities.

PRACTICAL IMPACTS FOR CLINICIANS AND PRACTICES

The combined CMS and CPT policy changes for 2026 require cardiovascular practices to:

- Educate clinical and coding teams on new CPT codes, especially for PCI and LER codes, to ensure accurate claims submission
- Update billing software and electronic health records with revised 2026 CPT code sets before January 1 implementation
- Engage finance and operational leaders to project reimbursement impacts of the Medicare PFS adjustments on procedure revenue and practice sustainability
- Provide targeted education for physicians, coders, and auditors on 2026 CPT changes, with a focus on documentation requirements that support procedural complexity and coding
- Evaluate and prepare for expanded EP services added to the ASC CPL, including operational, documentation, and billing considerations necessary to safely and compliantly shift EP procedures to the outpatient setting

CONCLUSION

The 2026 CPT code updates and Medicare PFS final rule changes represent one of the most consequential sets of coding and payment transformations for cardiovascular services in recent years. With granular PCI updates, an expanded LER code set, and newly covered ASC procedures such as cardiac ablation, practices must act now to align clinical documentation, coding strategy, and reimbursement workflows with this evolving regulatory landscape. Staying ahead of these changes not only ensures compliance but positions cardiovascular teams to optimize payment in a shifting reimbursement environment. ■

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