Navigating the 2026 Lower Extremity CPT Code Restructure

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The 2026 revision of the Current Procedural Terminology (CPT) codes for lower extremity revascularization introduces important changes that are intended to better align code selection with contemporary endovascular practice.[1] In this article, I highlight several key updates and illustrate how I applied the revised codes to a case of chronic limb-threatening ischemia (CLTI) in the setting of multilevel occlusive peripheral artery disease (PAD).

OVERVIEW OF THE CHANGES

The 2026 lower extremity CPT restructure establishes a more clearly defined coding framework for lower extremity revascularization. The revised code set expands from 16 to 46 codes and classifies lesions as straightforward or complex based on occlusion status. The new code set also updates nonfacility (office-based lab) practice expense relative value units to incorporate the cost of drug-coated balloons (DCBs) for nearly all femoropopliteal procedures, so payment rates now reflect routine DCB use.

Code selection follows a stepwise hierarchy based on the highest-intensity intervention performed in a treated vessel (percutaneous transluminal angioplasty, stent placement, atherectomy, or combinations thereof) and on whether one or multiple vessels are treated within a given territory. For each territory, one primary code is reported, with add-on codes used when applicable to describe additional treated vessels. The 2026 framework specifies how vessels are defined within each territory, both how many distinct vessels exist in each territory and which arteries or segments belong to each vessel. These definitions govern whether multiple treated lesions are coded as one vessel or as separate vessels, warranting add-on codes.

These 2026 CPT code changes affect both physician and facility reporting alike, including physician practices, hospital outpatient departments, and ambulatory surgery centers. All providers will need to update charge capture tools, code references, and local policies, and also ensure that documentation workflows reliably collect the data elements required under the new definitions. In particular, accurate assignment of straightforward versus complex lesion codes depends on describing lesion type (stenosis vs occlusion), specific vessel and segment, percentage stenosis when relevant, and the therapeutic approach applied to each treated site. Procedure notes should explicitly name each vessel and location treated, summarize the diagnostic angiographic findings, and clearly link those findings to the interventions performed so that coding is both accurate and reproducible. The following case demonstrates these principles in a real-world intervention.

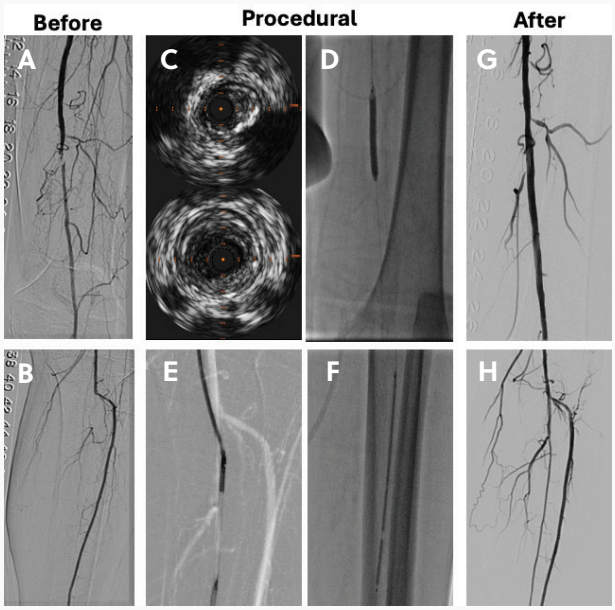

Figure 1. Pretreatment angiograms: Left SFA short total occlusion (A); left TPT, proximal-to-distal peroneal total occlusions and patent anterior tibial and atretic posterior tibial arteries (B). Procedural angiograms: IVUS images, with the bottom IVUS image showing the SFA occlusion (C); SFA occlusion treated with HawkOne™ directional atherectomy system (not shown) followed by IN.PACT™ Admiral™ drug-coated balloon (DCB) (D); TPT occlusion treated with HawkOne directional atherectomy system (E); TPT and peroneal artery treated with plain balloon angioplasty (F). Final angiograms: Left SFA (G); TPT and peroneal arteries (H).

CASE EXAMPLE

Patient Presentation

A man in his late 60s with hypertension, diabetes mellitus, dyslipidemia, and history of hepatitis C who is a current smoker presented with a 6-month history of left fourth- and fifth-toe gangrene, consistent with Rutherford 6 CLTI and

TABLE 1. SELECTED CPT CODES FROM THE 2026 REVISED LOWER EXTREMITY REVASCULARIZATION CODING SYSTEM

Territory/Vessel and Lesion type	Procedure/Service	CPT Code	CPT Code Description
Bilateral lower extremities	Angiography, extremity, bilateral	75716	Angiography, extremity, bilateral, radiological supervision and interpretation.
Distal SFA CTO	Atherectomy + DCB	37273	Revascularization, endovascular, open or percutaneous, femoral and popliteal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel.
Left TPT, CTO	Atherectomy + PTA	37290	Revascularization, endovascular, open or percutaneous, tibial and peroneal vascular territory, with transluminal atherectomy, including transluminal angioplasty when performed, including all maneuvers necessary for accessing and selectively catheterizing the artery and crossing the lesion, including all imaging guidance and radiological supervision and interpretation necessary to perform the atherectomy and angioplasty when performed, within the same artery, unilateral; complex lesion, initial vessel. Code choice: the more intensive treatment (atherectomy) and lesion complexity (total occlusion) drive the code selection in this instance, leading to 37290.
Left peroneal artery, CTO	PTA	N/A	The TPT is bundled with the peroneal; only one code is eligible for treatment of both the TPT and the peroneal arteries.
Left TPT and peroneal	IVUS	+37252	IVUS (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (list separately in addition to code for primary procedure).
Left SFA	IVUS	+37253	IVUS (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (list separately in addition to code for primary procedure).

Adapted from American Medical Association. CPT 2026 Professional Edition. American Medical Association Press; 2025.
Abbreviations: CPT, Current Procedural Terminology; CTO, chronic total occlusion; DCB, drug-coated balloon; IVUS, intravascular ultrasound; PTA, percutaneous transluminal angioplasty; SFA, superficial femoral artery; TPT, tibioperoneal trunk.

multilevel occlusive lower extremity PAD. Left lower extremity resting ankle-brachial indexes were 0.6 in the left dorsalis pedis and 0.3 in the left posterior tibial distributions. The patient underwent bilateral lower extremity angiography that confirmed a short total occlusion of the distal left superficial femoral artery (SFA) (Figure 1A) as well as total occlusions of the entire left tibioperoneal trunk (TPT) and origin-to-distal left peroneal arteries (Figure 1B). The left anterior tibial artery was patent. The dorsalis pedis artery was occluded. Distal outflow was further complicated by variant anatomy, including a congenitally absent posterior tibial artery and a plantar arch supplied by the dominant but occluded left peroneal artery. The goal of revascularization was to restore inline flow to the lateral plantar artery distribution.

Procedural Overview

After crossing all three occlusions with a guidewire and support catheter, intravascular ultrasound (IVUS) (Figure 1C) showed predominantly noncalcified lesions with reference vessel diameters of 5.5 mm in the SFA, 3.5 mm in the TPT, and approximately 2.2 mm in the peroneal artery. The SFA lesion was treated with the HawkOne™ directional atherectomy system (Medtronic), followed by DCB angioplasty (IN.PACT™ Admiral™ DCB, 5.0 X 40 mm; Medtronic) (Figure 1D); the TPT was treated with the HawkOne directional atherectomy system (Figure 1E) and plain balloon angioplasty; and the peroneal artery was treated with plain balloon angioplasty (Figure 1F).

Final angiography demonstrated marked improvements in perfusion, with all lesions treated to < 10% residual stenoses

(Figure 1G and 1H). Two-vessel inline flow was restored, with widely patent medial and lateral plantar arteries in the foot.

Patient Outcome

Overall, this case illustrates successful multilevel endovascular revascularization for Rutherford class 6 CLTI in the presence of challenging anatomy, with restoration of inline flow to support prompt wound healing and limb preservation.

The CPT codes used for this case under the newly restructured lower extremity revascularization coding system are shown in Table 1.

CONCLUSION

Accurate coding depends on clear documentation of the treated vessel, lesion characteristics, and therapies performed, as incomplete or incorrect documentation increases the risk of downcoding, claim denial, or rework. The 2026 CPT update more closely aligns with contemporary practice through refined territory definitions, a structured procedural hierarchy, and lesion/disease severity. ■

1. American Medical Association. CPT 2026 Professional Edition. American Medical Association Press; 2025.

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