Clinical Criteria – CPT® 93596 & 93597 right-and-left cardiac catheterization for congenital heart disease (cardiac catheterization for congenital heart defects)

Subject: 93596 & 93597 right-and-left cardiac catheterization for congenital heart disease (cardiac catheterization for congenital heart defects)	**Renewed Effective:** 10/31/2025
	Review Schedule: Annual

Summary of codes

- CPT 93596 — Right and left heart catheterization for congenital heart defect(s) including imaging guidance to advance the catheter(s) to target zone(s); used when native cardiac connections are normal.
- CPT 93597 — Right and left heart catheterization for congenital heart defect(s) including imaging guidance to advance the catheter(s) to target zone(s); used when native cardiac connections are abnormal.

(Use the code whose descriptor correctly describes the patient's underlying anatomic connections; when in doubt, coder should confirm the anatomic characterization documented by the proceduralist.)

Clinical Criteria for Medical Necessity- General Rule

Right-and-left diagnostic cardiac catheterization (93596 / 93597) is medically necessary for pediatric members when all of the following are satisfied:

1. Ordered or approved by a pediatric cardiologist (or congenital heart disease specialist) or performed after direct consultation with such a specialist; and
2. One or more of the indications below are present (see Indications section); and
3. Noninvasive testing (echocardiography, chest CT/CTA or MR/CMR, nuclear lung perfusion when applicable, ECG, chest x-ray, and/or relevant labs) is inadequate to answer key clinical questions required for diagnosis, management, or planning an intervention — *unless the patient's condition requires immediate invasive hemodynamic assessment* (e.g., hemodynamic instability).

Indications (examples — *at least one required)*

Right-and-left diagnostic congenital cardiac catheterization may be approved for pediatric members for one or more of the following clinical reasons:

- Evaluation of suspected or known complex congenital heart disease where noninvasive imaging cannot define anatomy sufficiently for surgical or catheter intervention planning (e.g., complex biventricular vs single-ventricle physiology, heterotaxy, unbalanced atrioventricular canal).
- Hemodynamic assessment when accurate intracardiac pressures, pressure gradients, or direct cardiac output measurements are required to guide management (e.g., pulmonary vascular resistance calculation in suspected pulmonary vascular disease or pulmonary hypertension not definable by noninvasive tests).
- Evaluation of suspected or confirmed anomalous coronary arteries when noninvasive imaging is inconclusive and precise coronary origin/relationship is required prior to surgery or intervention.

- Shunt evaluation or quantification when noninvasive estimates are inconsistent with clinical findings (e.g., significant differential saturations, unexplained cyanosis, suspected intracardiac shunt requiring accurate Qp:Qs).
- Pre-procedural anatomic/physiologic assessment prior to planned surgical or catheter interventions (e.g., before valve repair/replacement, branch pulmonary artery interventions, or complex re-operations).
- Unexplained cardiopulmonary signs or symptoms in a child with suspected cardiac etiology when prior noninvasive workup is nondiagnostic (e.g., unexplained syncope with structural concern, progressive exercise intolerance with inconclusive imaging).
- Postoperative or postintervention evaluation when clinical deterioration or concern for residual/recurrent lesion cannot be resolved by noninvasive imaging.

Not routinely covered / NOT medically necessary

Catheterization (93596/93597) is not routinely covered when any of the following apply:

- Noninvasive imaging (complete transthoracic echocardiogram, CMR, CTA) and clinical evaluation sufficiently answer the diagnostic/management question and no additional invasive hemodynamic or angiographic information is required.
- Routine surveillance after uncomplicated repair when there is no clinical change, no new symptoms, and no imaging concern that warrants invasive assessment.
- Use solely for convenience or to obtain routine follow-up images when noninvasive modalities would suffice.

Prior authorization / documentation required

When requesting authorization, submit the following clinical documentation (in the chart or request) to support medical necessity:

- History and physical exam showing the presenting problem and current clinical signs/symptoms.
- Consult note from the pediatric cardiologist (or documentation of discussion with congenital heart specialist) indicating why noninvasive testing is inadequate and how catheterization results will affect management.
- Results (reports/images) of recent noninvasive testing: transthoracic echo, transesophageal echo (if performed), chest CT/CTA, CMR, ECG, chest x-ray, lung perfusion study (if applicable). Include dates.
- Specific clinical question(s) to be answered by catheterization (for example: measure pulmonary vascular resistance; define coronary origin; measure Qp:Qs; define gradient across suspected obstruction).
- Indication for selecting 93596 versus 93597 (documentation of whether native connections are normal vs abnormal, if known).
- Prior procedures/surgeries and current anatomic status (operative notes or summaries if available).
- If urgent or emergent, documentation of the urgent status and why immediate catheterization is needed.

Incomplete requests (missing noninvasive test results or cardiology rationale) may be returned for additional information and delay authorization.

Frequency limits

- No arbitrary routine repeat interval should be applied; repeat diagnostic catheterization is covered only when clinical status changes, a new question arises that cannot be answered noninvasively, or pre-/post-intervention planning requires updated invasive hemodynamics.

Additional considerations

- Whenever possible, multidisciplinary planning (pediatric cardiology, cardiac surgery, anesthesia) should be documented for complex cases.
- Consideration should be given to minimally invasive or imaging alternatives (CMR/CTA with advanced 3D reconstruction) when those modalities can provide equivalent diagnostic information without catheterization.

References (supporting material)

- CPT® code descriptions for 93596 and 93597. AAPC+1
- Society for Cardiovascular Angiography & Interventions (SCAI) — general coding guidance for congenital catheterizations. SCAI
- American College of Cardiology summary of 2022 CPT changes for congenital heart catheterization codes. American College of Cardiology
- CMS / Medicare billing guidance referencing related code relationships (e.g., 93462 with 93596/93597).