

Interventional Radiology Coding Case Studies
Prepared by
Stacie L. Buck, RHIA, CCS-P, RCC, CIRCC, AAPC Fellow
President & Senior Consultant

Week of January 8, 2018

**Diagnostic Cerebral Angiogram, Coil Embolization Internal
Maxillary Artery**

CLINICAL HISTORY: This 74 -year-old female has a right-sided TMJ ankylosis and is scheduled for right TMJ replacement. She was referred for diagnostic angiogram and embolization of the right internal maxillary artery.

ANESTHESIA: Monitored anesthesia care (MAC) was supervised by personnel from the department of anesthesia.

FLUOROSCOPY TIME: Approximately 20.9 minutes. **CONTRAST:** 45 mL LOCM 300-399 MG/ML

VESSEL SELECTION: INNOMINATE ARTERY, RIGHT EXTERNAL CAROTID ARTERY, RIGHT INTERNAL MAXILLARY ARTERY, RIGHT COMMON FEMORAL ARTERY

PROCEDURE: The rationale, risks and benefits of the procedure were discussed with the patient prior to the examination. After any questions were answered to her satisfaction, informed consent was obtained.

The bilateral inguinal regions were prepped and draped in the usual sterile fashion. A total of 1% buffered Lidocaine without epinephrine was used as local anesthetic to anesthetize the subcutaneous tissues overlying the right common femoral access site. A micropuncture kit was used to access the right common femoral artery and facilitate placement of a 5-French diagnostic arterial sheath over a 0.035 inch J-wire. The sheath was flushed and connected to a regulated pressurized heparinized saline infusion for the duration of the procedure. Attempts were made to canalize the right innominate artery with a 5-French Berenstein catheter which were ultimately unsuccessful. The Berenstein catheter was withdrawn and a Sim-2 catheter was reshaped in the left subclavian artery and used to access the right innominate artery. Contrast was injected for imaging. There was marked tortuosity precluding advancement of the catheter into the right common carotid artery. A Prowler Plus Select Microcatheter and Synchro 14 wire were deployed through the Simmons catheter and were directed into the right external carotid artery. Next there was advancement of the wire and microcatheter into the right internal maxillary artery for contrast injection and imaging. The Synchro wire was then withdrawn and

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the following coils were deployed into the internal maxillary artery being careful to preserve the superficial temporal artery:

1. A 3 mm X 6 cm eVJ Axium coil.
2. A 3 mm X 4 cm eVJ Axium coil.
3. A 3 mm X 4 cm eVJ Axiumcoil
4. A 3 mm X 8 cm eVJ Axium coil.
5. A 2 mm X 4 cm eVJ Axium coil.

The microcatheter was withdrawn and angiographic run through the Simmons catheter demonstrated successful occlusion of the internal maxillary artery at the desired level with preservation of the superficial temporal artery. Cranial runs demonstrated no thromboembolic complication and the Simmons catheter was withdrawn. Contrast injections through the angiographic sheath in the right common femoral artery demonstrated an appropriate level of puncture without evidence of vessel wall injury or dissection. Hemostasis was obtained by deploying a 6-French Star Close closure device at the level of arterial access. The patient tolerated the procedure well and there were no complications. She was forwarded back to the peri-operative care unit in stable condition.

DISCUSSION

Innominate Artery Cervical Images: There is marked tortuosity of the right innominate artery. There is no hemodynamically significant stenosis at the origin of the common carotid or major branches of the right subclavian. There is no hemodynamically significant stenosis at the level of the right carotid bifurcation.

Right Internal Maxillary Artery (Pre-embolization): There is an expected configuration of vessel branches with no visualization of arteriovenous malformation or fistula.

Right Internal Maxillary Artery (Post-embolization images): There is occlusion of the right internal maxillary artery at its proximal portion.

Innominate Artery (Post-embolization): There is occlusion of the internal maxillary artery at the level of the coil mass. There is no evidence of thromboembolic complication and no vessel occlusion intracranially. Within the right anterior circulation, grossly, there is no aneurysm, arteriovenous malformation or fistula.

Right Common Femoral Artery: There is an appropriate level of artery access without evidence of arterial wall injury or dissection.

IMPRESSION: Successful endovascular coil embolization of the right internal maxillary artery. No procedural complications including thromboembolic or intracranial complications.

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Interventional Radiology Coding Case Studies CPT Codes

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Diagnostic Cerebral Angiogram, Coil Embolization Internal Maxillary Artery

Procedure Codes:

- 61626 Embolization RT internal maxillary
- 75894 RS&I Embolization
- 75898 Post Embolization Angiogram
- 36222 Diagnostic Angiogram innominate and right carotid artery
- 36227 Diagnostic angiogram right internal maxillary artery
- G0269 StarClose (facility only)
- Q9967 x45 LOCM 300-399 MG/ML

Diagnosis Codes:

- M26.611 Adhesions and ankylosis of right temporomandibular joint

Applicable Coding Rules:

- Code 61626 is reported for extracranial and brachiocephalic branch embolizations (non-central nervous system). Code 61626 is commonly used for treatment of epistaxis via internal maxillary or sphenopalatine (nosebleed).
- Only one embolization code should be reported for each operative field. An operative field refers to the area immediately surrounding and directly involved in a treatment/procedure. Embolization procedures performed at a single setting and including multiple surgical fields such as multiple aneurysms may be reported separately.

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Applicable Coding Rules (continued):

- Code 75894 is reported as the transcatheter RS&I code for 61624 and 61626, which includes the following services: contrast injections, angiography, roadmapping, and fluoroscopic guidance for the intervention, vessel measurement, and completion angiography.
- Code 75898 is assigned for completion angiography to check results of the embolization procedure. This code is assigned once per operative field, with the exception of central nervous system embolizations, code 61624. It may be reported for each completion angiogram in the vessels of the central nervous system.
- An initial diagnostic angiogram may be reported when performed. If a prior diagnostic angiogram has been performed, diagnostic angiography should only be reported separately in accordance with guidelines established for reporting with transcatheter procedures. Diagnostic angiography/venography performed during the same session as a therapeutic intervention may be reported separately when:
 - ❖ No prior catheter-based diagnostic angiography/venography study has been performed or if a prior study was performed but it is not available.
 - ❖ The prior diagnostic study is inadequate.
 - ❖ There has been a change in the patient's condition since the diagnostic study.
 - ❖ There is a clinical change during the procedure that requires further evaluation beyond the target area of the intervention.
- Diagnostic angiography/venography performed at a separate setting from an interventional therapeutic procedure is separately reported.
- Code 36222 describes a unilateral selective catheter placement in the innominate or common carotid artery, followed by contrast injection and imaging of the common carotid. It also includes an arch study when performed.

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Applicable Coding Rules (continued):

- Add-on code +36227 describes a unilateral catheter placement in the external carotid artery, followed by contrast injection and imaging of the external carotids. This add on code is used in conjunction with 36222, 36223 or 36224. It is important to note that +36227 is assigned only one time for each side even when multiple branches of the external carotids are catheterized and imaged. Since +36227 is an add-on code, it cannot be utilized when only external carotid imaging is performed. When no base code (36222-36224) is assigned, imaging of the external carotid should be reported with code 37799.

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