Interventional Radiology Coding Case Studies

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Week of March 12, 2018

CT Guided Perihepatic Fluid Drainage

CLINICAL HISTORY: Patient is a 69 -year-old female with nuclear medicine study demonstrating a bile leak with a likely biloma in the perihepatic region. She is referred for drainage.

INFORMED CONSENT: The patient's diagnosis, treatment plan/procedure, risks and benefits, treatment alternatives, complications, and prognosis with and without treatment were explained to the patient and/or patient's family in plain language. Informed consent was obtained and we were asked to proceed with the procedure. A verbalized timeout was performed before the procedure with the required team present. The patient's name, date of birth, procedure, site, and equipment, as well as pertinent labs, medications, and allergies were reviewed. All elements of a maximal sterile barrier technique were utilized during this procedure including cap, mask, sterile gown, sterile gloves, large sterile sheet, hand hygiene, and 2% chlorhexidine for cutaneous antisepsis.

SEDATION: The IV moderate/conscious sedation was supervised by the operating physician(s) using fentanyl and Versed for 54 minutes. The patient was independently monitored by the IVR nurse. There were no complications.

PROCEDURE: The patient was brought to the CT suite and was placed in the supine position on the CT gantry table. A scout CT of the abdomen was completed for surgical planning purposes.

Once a reasonable site of approach to a perihepatic fluid collection was identified, the patient was prepped and draped in the usual sterile fashion. The skin and subcutaneous tissues were generously infiltrated with 2% Lidocaine for local anesthesia and then a small incision was made in the skin. A Yueh needle was advanced into the perihepatic fluid collection under CT guidance and then the Yueh catheter was advanced off the needle. The needle was removed. A 0.035 Torque wire was then placed through the Yueh catheter and confirmed in position with a limited CT image. The Yueh catheter was removed and then serial dilations of 6-French and 8-French were performed over the wire. An 8-French pigtail catheter was then placed into the fluid collection. At this point approximately 280 mL of greenish-yellow viscous fluid were aspirated.

The pigtail catheter was formed and the catheter was sutured in position. The patient tolerated the procedure well and remained and remained hemodynamically stable throughout. Final CT image demonstrates small amount of residual fluid and the reason for leaving the drain behind. No complications were encountered and no significant blood loss was encountered.

DISCUSSION: Initial CT image demonstrates perihepatic fluid collection similar to what was demonstrated on a prior CT. Images during the case demonstrate safe placement of a pigtail catheter into the perihepatic fluid collection in the region adjacent to segment 6. Final CT image demonstrates significant decreased volume of fluid in the perihepatic region.

IMPRESSION: Status post image-guided 8-French pigtail catheter placement into perihepatic fluid collection. A sample was sent to the laboratory for complete analysis.

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CPT Codes

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Procedure Codes:

- 49406 Perihepatic Fluid Drain
- 99152 Moderate sedation first 15 minutes
- 99153 x3 Moderate sedation each additional 15 minutes

Diagnosis Codes:

- R18.8 Perihepatic Fluid Collection

Comments:

- Drainage procedures are distinguished from aspiration procedures in that following placement of the catheter it is sutured to the skin and left in place where as following an aspiration procedure the needle/catheter is removed.
- Code 49406 is assigned for drainage of the perihepatic fluid collection. Code 49405 is not assigned because that is utilized for drainage of the liver.
- CT guidance is bundled with code 49406.
- 54 minutes of moderate conscious sedation noted, billed in 15 minute increments. (99152, 99153)

Applicable Coding Rules:

- Code 49406 describes percutaneous drainage of an abscess, hematoma, seroma, lymphocele or cyst of the **peritoneal or retroperitoneal space**.
  - Code 49406 requires that an indwelling catheter is left in place. Placement of a drainage catheter that is used to drain/aspirate the fluid and then is removed before or at the conclusion of the procedure does not meet the criteria for the bundled abscess drainage codes. If a catheter is not left in place see the aspiration codes.
  - Imaging guidance is included with code 49406 and is not coded separately.
  - Code 49406 is assigned for **non-tunneled peritoneal catheters.**