Interventional Radiology Coding Case Studies

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CT Guided Lymph Node Biopsy & Fluid Collection Aspiration

CLINICAL HISTORY: Patient is a 66 year old female with a history of renal cell carcinoma on the right who is status post nephrectomy and has an enlarging right paracaval lymph node. In addition, the patient has recent abdominal hernia repair with a seroma present in her anterior subcutaneous soft tissues.

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.

The IV moderate/conscious sedation was supervised by the operating physician(s) using fentanyl and Versed for 65 minutes. The patient was independently monitored by the IVR nurse. There were no complications.

PROCEDURE: The patient was placed in the prone position in initially CT scan performed demonstrating the enlarged right paracaval lymph node to be biopsied. Angled approach was decided upon and the skin was marked, prepped, and draped in the sterile fashion. After local anesthetic with 1% Lidocaine, a 17-gauge coaxial needle was directed down into the periphery of this enlarged lymph node. Inner stylet was removed and two 22-gauge and two 20-gauge fine-needle biopsies were obtained. This was followed by three 18-gauge core needle biopsies. Samples were sent to pathology for complete histopathologic analysis. The tract was embolized with Gelfoam torpedoes and the needle was removed. A bandage was placed over the site. The patient was rotated into supine position and CT scan performed to localize the anterior abdominal wall collection. After local anesthetic with 1% Lidocaine, a Yueh needle was directed into this collection and a total of 85 mL of serosanguineous fluid was able to be aspirated. The Yueh catheter was removed. Final CT scan obtained demonstrated complete resolution. The patient left the IR suite in stable condition after a bandage was placed over the site.

DISCUSSION: Stored CT images throughout the procedure demonstrate the right paracaval node, which was biopsied. Intraprocedural images demonstrate needle position within this lymph node. Final images demonstrate Gelfoam within the node and evidence of post biopsy changes. There is an anterior abdominal soft tissue fluid collection, which after aspiration has completely resolved.

IMPRESSION:

1. Biopsy of an enlarged right paracaval lymph node.
2. Aspiration of patient's superficial anterior abdominal wall fluid collection with removal of 85 mL of serosanguineous fluid and samples sent for laboratory/microanalysis.

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CPT Codes

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Procedure Codes:

- 49180 Paracaval Lymph Node Biopsy (retroperitoneal)
- 10160 Aspiration Abdominal Wall Seroma
- 77012 CT Guidance
- 99152 Moderate sedation first 15 minutes
- 99153 x3 Moderate sedation each additional 15 minutes

Diagnosis Codes:

- R59.0 Enlarged paracaval lymph node
- Z85.528 History of renal cell carcinoma
- Z90.5 Absence of kidney (acquired)
- L76.34 Post-operative abdominal wall seroma

Comments:

- Code 49180 is assigned for biopsy of the paracaval lymph node. Code 38505 is assigned for biopsy of superficial lymph nodes. The paracaval lymph node is a deep biopsy and is assigned code 49180. Fine needle aspirations performed prior to the core biopsy are bundled.
- Code 10160 is assigned for aspiration of an abdominal wall seroma. Code 49083 is assigned for an aspiration of the abdominal cavity.
- When a catheter/needle is removed at the end of a procedure, this is considered an aspiration. A catheter must be left in place at the conclusion of a drainage procedure to be reported with a drainage code.
- The Gelfoam tract embolization is included with the procedures performed.
- Code 77012 is assigned for CT guidance. In accordance with NCCI rules, this code may only be assigned one time per session.
- 65 minutes of moderate conscious sedation noted, billed in 15 minute increments. (99152, 99153)

Applicable Coding Rules:

Needle Core Biopsy Coding

- For core needle biopsies assign both the surgical code based on the anatomical site as well as the corresponding guidance code.

- The surgical codes for core biopsy procedures are assigned one time per lesion. Do not code for multiple passes of the same lesion.

- According to the NCCI Manual, the RS&I codes for guidance are reported one time per session:

    - *"CPT® codes 76942, 77002, 77003, 77012, 77021 describe radiological guidance for needle placement by different modalities. CMS payment policy allows only 1 unit of service for any of these codes at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not the number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations." –NCCI Manual Chapter 9*

Aspiration Coding

- As stated in the *ACR--SIR-SPR Practice Parameter for Specifications and Performance of Image-Guided Percutaneous Drainage/Aspiration of Abscesses and Fluid Collections:*

    - **Image-guided percutaneous aspiration** is defined as evacuation or diagnostic sampling of a fluid collection using either a catheter or a needle during a single imaging session, *with removal of the catheter or needle immediately after the aspiration.*

    - **Image-guided percutaneous drainage** is defined as the placement of a catheter using image guidance to provide *continuous drainage of a fluid collection.*

- For aspiration procedures, assign the code corresponding to the anatomical location of the aspiration.

- If there is no specific code corresponding to the anatomical site of the aspiration, assign code 10160. Note that codes 10021 & 10022 are assigned for fine needle aspirations.

Applicable Coding Rules (continued):

- Codes 49082 and 49083 describe a puncture of the abdominal cavity with insertion of a needle or catheter to remove fluid. The catheter/needle is removed at the end of the procedure. An abdominal wall aspiration is reported with either code 10160 or 10021/10022.

Fine Needle Aspiration & Core Biopsy Same Session

- Typically an FNA is not reported in conjunction with a core biopsy of the same lesion, however if the aspirate is not adequate for diagnosis, the FNA may be reported with the core needle biopsy. The NCCI manual states the following:

  - *"Fine needle aspiration (FNA) (CPT® codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier."*-NCCI Manual Chapter 5

  - *"The unit of service for fine needle aspiration (CPT codes 10021 and 10022) is the separately identifiable lesion. If a physician performs multiple "passes" into the same lesion to obtain multiple specimens, only one unit of service may be reported. However, a separate unit of service may be reported for separate aspiration(s) of a distinct separately identifiable lesion."*- NCCI Manual Chapter 3