

Interventional Radiology Coding Case Studies

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Week of September 24, 2018

Angioplasty & Stent Placement Iliac Artery

EXAM DESCRIPTION: Pelvic arteriogram with iliac angioplasty and stent placement.

INDICATION: The patient is a 55-year-old male with chronic left hip claudication. Outside CTA evaluation shows a segmental occlusion of the left common iliac artery.

PROCEDURAL STEPS

1. Percutaneous access of the left common femoral artery.
2. Selective left external iliac arteriogram.
3. Percutaneous access of the left brachial artery.
4. Selective catheterization of the descending thoracic and abdominal aorta.
5. Limited abdominal aortogram.
6. Transcatheter traversal of the occluded left common iliac artery.
7. Percutaneous transluminal angioplasty and stenting of the left common iliac artery.
8. Follow-up post-stenting iliac arteriogram.
9. Follow-up abdominal aortogram with pelvic arteriography.

TOTAL CONTRAST: 71 mL Visipaque 320.

TOTAL FLUOROSCOPIC TIME: 24.9 minutes.

TECHNIQUE: After informed consent was obtained, the patient was placed supine on the angiography table. The left groin was sterilely prepped and draped. Skin and underlying soft tissues were locally anesthetized with buffered 1% Lidocaine. A small skin nick was then made. Using a Seldinger technique, the left common femoral artery was percutaneously accessed, followed by placement of a 5-French sheath. Over a guidewire, a 5-French KMP catheter was passed proximally. This was then injected at the level of the external iliac artery, showing an abrupt occlusion of the left common iliac artery. With the aid of the KMP catheter, multiple unsuccessful attempts were made to pass a guidewire across the occluded left common iliac arterial segment.

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Attention was then paid to the left arm. The left upper arm was sterilely prepped and draped and locally anesthetized with buffered 1% Lidocaine. A small skin nick was then made. Under ultrasound guidance, using a micropuncture needle set, the left brachial artery was percutaneously accessed, and a 0.018-inch guidewire was passed centrally. Over this, a tract was serially dilated, followed by placement of a 4-French sheath. Over a guidewire, a 4-French Berenstein catheter was passed centrally and selectively placed in the descending thoracic aorta. This was then advanced to the level of the abdominal aorta. With the aid of the Berenstein catheter, a 0.035-inch guidewire was successfully passed across the left common iliac artery and into the left external iliac artery.

Via the left groin sheath, the guidewire positioned from above in the left external iliac artery was then snared and pulled out through the sheath. Over the wire, the sheath was removed and exchanged for a 7-French sheath. Over the wire, an 8 x 59 mm iCAST atrium stent was passed and deployed across the occluded left common iliac artery. This was further ballooned in place using a 10 mm balloon catheter.

Follow-up pelvic arteriogram was obtained, showing improved appearance to the left iliac inflow, but with residual filling defect seen in the proximal left external iliac artery. Over the wire, an 8 x 60 mm Smart stent was passed and deployed across the proximal left external iliac artery. This was further ballooned in place using a 7 mm balloon catheter. Follow-up digital arteriogram was obtained, with catheterization of the distal aorta. This showed brisk flow throughout both iliac inflows bilaterally without residual flow-limiting lesions. Guidewires were then removed.

The left groin sheath was exchanged for a short 8-French sheath, through which a hemostasis device was applied using an Angio-Seal. Once hemostasis was obtained, a sterile bandage was then placed. The left arm sheath was then removed, and manual pressure was held until hemostasis was obtained. A sterile bandage was then applied. The patient was then observed in the short stay recovery area for a period of 8 hours. He tolerated the procedure well with no immediate complications and was discharged home in stable condition.

FINDINGS: Initial arteriogram showed a segmental occlusion of the left common iliac artery. Follow-up imaging obtained showed gradual opening of the left common iliac and left external iliac arteries, followed by stenting, with brisk flow now demonstrated through the left iliac inflow. No right-sided iliac inflow lesions are identified.

CONCLUSION: Segmental occlusion of the left common iliac artery. Status post technically successful angioplasty and stenting of the left common iliac and external iliac arteries with restoration of brisk flow throughout the left iliac inflow.

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Procedure Codes:

- 37221 Angioplasty and stent left common iliac artery
- 75710 (59)* Left extremity imaging
- Q9967 x71 LOCM, 300-399 mg/ml iodine concentration, per ml

Diagnosis Codes:

- I70.212 Atherosclerosis of native arteries of extremities with intermittent claudication, left leg

Comments:

- Code 37221 is assigned for angioplasty and stenting of the left common iliac artery. There is no clear documentation of a separate and distinct lesion being treated in the external iliac; therefore an add-on code for the external iliac is not assigned.
- Although the procedure was performed via two separate access sites, both were utilized to carry out the therapeutic intervention, therefore code 36200 is NOT coded for the catheter placed into the aorta through the left arm. See “Coding Rules” section below for those scenarios in which catheter codes may be assigned in addition to lower extremity revascularization codes.
- *Regarding the left extremity imaging, there was a prior CTA that confirmed the diagnosis prior to the intervention. More information is needed to determine whether or not the left leg angiogram should be reported. See “Coding Rules” section below for further explanation.
- Code Q9967 is assigned for the contrast material administered. Note this is reported by the facility and not for professional component billing.

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Coding Rules:

Diagnostic Angiography/Venography & Therapeutic Interventions

CPT® has specific requirements for reporting diagnostic angiography or diagnostic venography performed during the same session as a therapeutic intervention. Below is a summary of those rules. 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.

Diagnostic angiography/venography is not separately reported when it is specifically included in the interventional code descriptor.

Note that there is a slight difference in the guidance provided in CPT® and the instruction provided in the NCCI Manual which states:

*“Diagnostic angiography (arteriogram/venogram) performed on the same date of service by the same provider as a percutaneous intravascular interventional procedure should be reported with modifier -59. If a diagnostic angiogram (**fluoroscopic or computed tomographic**) was performed prior to the date of the percutaneous intravascular interventional procedure, a second diagnostic angiogram cannot be reported on the date of the percutaneous intravascular interventional procedure unless it is medically reasonable and necessary to repeat the study to further define the anatomy and pathology. Report the repeat angiogram with modifier -59. If it is medically reasonable and necessary to repeat only a portion of the diagnostic angiogram, append modifier -52 to the angiogram CPT® code. If the prior diagnostic angiogram (**fluoroscopic or computed tomographic**) was complete, the provider should not report a second angiogram for the dye injections necessary to perform the percutaneous intravascular interventional procedure.” – NCCI Manual, Chapter 9*

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Coding Rules (continued):

Lower Extremity Revascularization Coding Rules

Catheterization Codes

- As a general rule, accessing the vessel, selective catheterization of the vessel and crossing of the lesion is bundled into the lower extremity revascularization codes. All catheter placements related to performance of the therapeutic intervention, including catheter placements for any diagnostic angiography associated with the therapeutic intervention should not be coded separately.
- There are a few instances in which catheterization codes may be reported in conjunction with a lower extremity revascularization code:
 - Diagnostic angiography for the revascularization is performed at the same time as revascularization from a separate access.
 - Example: Catheterization of the aorta for an aortogram may be performed via a left groin puncture, yet the revascularization is performed on the right iliac via a right groin puncture. The catheterization of the aorta (36200) via the left groin is reported with modifier -59.
 - Diagnostic angiography performed at the same time as the intervention requires a higher degree of selectivity than does than the one used for the lower extremity intervention. This applies when the catheter is manipulated beyond the vessel treated through the aorta and into the contralateral extremity for additional imaging.
 - Example: Access at the right common femoral artery, revascularization of right internal iliac, catheterization and imaging of contralateral (left) leg (36245-36247). Modifier -59 will be needed on the selective catheterization code for imaging of the left extremity.
- ❖ Another catheterization is performed through the same access for another diagnostic or therapeutic procedure requiring catheterization in a different vascular bed.
 - Example: Performance of a renal PTA in conjunction with a lower extremity revascularization. Modifier -59 will be needed on the selective catheterization code for the renal PTA.

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Coding Rules (continued):

- A separate vessel punctured for an additional access that is not part of the revascularization procedure (different vascular bed) and another vessel is selectively catheterized for another purpose.
- Another procedure is performed on the same date of service at a different session.
- Remember in the lower extremities, the external iliac and common femoral are considered one vessel for coding purposes.

Diagnostic Angiography

- 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.

Revascularization Codes

- The revascularization codes include transluminal angioplasty, atherectomy and stent placement in the lower extremities.
- CPT® has designated three distinct vascular territories: iliac, femoral/popliteal, and tibial/peroneal.
- The revascularization codes are unilateral; therefore both a primary code and an add-on code may be reported once for each side in each territory.
- Use of an embolic protection device for performance of the services as described by the revascularization codes should not be reported separately.
- The closure of the arteriotomy through any means when associated with a revascularization procedure should not be coded separately.
- **Single vs. Multiple Vessels.** Revascularization codes are assigned one time per vessel (lesion) treated, with the exception of the femoral/popliteal territory. Note that the common iliac and external iliac are two different arteries, however the external iliac and common femoral arteries are considered a single vessel for interventional coding purposes.
- **Multiple Stents.** When there are multiple stents placed in the same vessel, only one stent placement is reported.

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Coding Rules (continued):

- **Multiple Lesions.** When there are multiple lesions treated within the same vessel, only one revascularization code is reported for that vessel.
- **“Bridging” Lesions.** At times a “bridging lesion” may be encountered. This is a single lesion that spans two vessels. Only one revascularization code should be assigned in these instances.
- **“Kissing” Angioplasty.** This term is used when angioplasty is performed on both the left and right common iliac arteries into the distal aorta. This technique is used to treat aortoiliac occlusive disease. Angioplasty is reported for each vessel.
- **“Kissing” Stents.** This term is used when stenting is performed on both the left and right common iliac arteries with the stents meeting in the distal aorta. This technique is used to treat aortoiliac occlusive disease. Stent placement is reported for each vessel.
- **Unsuccessful Revascularization or Unacceptable Outcome.** If a revascularization is unsuccessful because the lesion cannot be crossed, then the appropriate access and/or selection and imaging only should be coded. On the other hand, if the lesion is crossed and the revascularization is performed but with an unacceptable outcome, then the revascularization is coded since all the work of the revascularization was done. If the revascularization has been initiated and it is discontinued, assign the revascularization codes with the appropriate modifiers (-53, -73, -74).
- Administration of Heparin, Nitroglycerin, etc., during the procedure is not coded separately.

RS&I Codes

- **Bundled Components.** All RS&I work directly related to the intervention is bundled into the surgical codes for lower extremity revascularization. This work includes the following services: contrast injections, angiography, roadmapping, and fluoroscopic guidance for the intervention, vessel measurement, and completion angiography.

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Coding Rules (continued):

Choosing the Correct Code

- Lower extremity revascularization codes are assigned for each vascular territory.
- To select the appropriate codes for these therapeutic interventions determine the following for each vascular territory:
 - (1) each vessel that was treated
 - (2) the intervention(s) performed in each vessel
 - (3) the most extensive procedure performed.
- The most extensive procedure performed in each territory will determine the primary CPT® code for each territory as well as the appropriate add on codes.
- The Society for Interventional Radiology has established the following hierarchy to determine the most extensive procedure. The list is ordered from lowest to highest:
 - ❖ Angioplasty
 - ❖ Stent
 - ❖ Atherectomy
 - ❖ Stent with atherectomy
- **Iliac Territory.** The iliac territory is made up of the common iliac, internal iliac and external iliac arteries.
 - ❖ Each artery is considered a separate vessel for coding purposes.
 - ❖ Up to three codes may be reported for this territory – one primary code to describe the most extensive procedure, followed by up to two add on codes for two additional vessels.

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