

Interventional Radiology Coding Case Studies

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Lower Extremity Arteriogram, Angioplasty & Stent

EXAM DESCRIPTION: Left lower extremity arteriogram with angioplasty and stenting.

INDICATION: The patient is a 72-year-old male with a known left popliteal aneurysm.

PROCEDURAL STEPS:

1. Ultrasound-guided antegrade percutaneous access of the left common femoral artery.
2. Selective catheterization of the left superficial femoral artery with arteriogram.
3. Fluoroscopic-guided stent graft placement within the popliteal artery times 2.
4. Follow-up angioplasty.
5. Post-stenting left lower extremity arteriogram.

ANESTHESIA: Conscious sedation using Versed and fentanyl (see separate report); local anesthesia using buffered 1% lidocaine.

TOTAL CONTRAST: 110 mL Visipaque 320.

TOTAL FLUOROSCOPIC TIME: 15.2 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. Under ultrasound guidance, a micropuncture needle was advanced percutaneously into the left common femoral artery antegrade and a 0.018-inch guidewire was passed into the profunda femoral artery.

Over this, a 4-French coaxial dilator was passed. The guidewire and inner dilator were exchanged for a 0.035-inch guidewire, over which a 5-French rim catheter was passed. This was used to redirect the guidewire into the superficial femoral artery. Over this, the catheter was then exchanged for a 5-French KMP catheter. Subsequent power injection of contrast was carried out via the KMP catheter for a lower extremity digital runoff arteriogram. Using a digital roadmap technique, a 0.035-inch guidewire was then passed across the popliteal artery and positioned in the proximal peroneal artery. Over the wire, the catheter was removed and a Perclose device was put in place to position arterial

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sutures at the access site. Once sutures were set in place, an 11-French Bright-Tip sheath was passed via the groin site with the tip positioned in the proximal superficial femoral artery. Over the wire, an 8 x 100 mm Viabahn stent graft was passed and deployed across the popliteal aneurysm. This was extended superiorly using a 10 x 50 mm Viabahn stent overlapping the first, covering a total of approximately 13 cm length. At least 2 cm of landing zone were selected both above and below the aneurysm. The stent graft was then further angioplastied in place using a 6 x 4 mm balloon distally and an 8 x 4 mm balloon proximally. The balloon catheter was removed, and a subsequent lower extremity arteriogram was obtained, showing interval occlusion of the popliteal aneurysm with an otherwise unremarkable appearance to the popliteal artery and brisk flow throughout. No interval change in the appearance of the trifurcation vessels was demonstrated. At that point, the groin sheath was removed, and using the Perclose sutures, the suture was tied shut and manual pressure was held until hemostasis was obtained. The patient was then sent to the post cath lab recovery area for further care. He tolerated the procedure well with no immediate complications.

FINDINGS: Technically successful popliteal artery stent graft placement as described.

CONCLUSION: Initial runoff examination shows a widely patent superficial femoral artery throughout. The popliteal artery is tortuous and the lumen is dilated, compatible with a known aneurysm over its proximal 1/2. The distal most popliteal artery is normal in course and caliber. There is 2-vessel runoff to the left foot via the posterior tibial and peroneal arteries. The anterior tibial artery shows a long-segment occlusion over the mid calf. Distal peroneal collaterals reconstitute flow in the dorsalis pedis. The plantar arch is intact.

Post angioplasty images show interval stent grafting of the popliteal artery with good stent graft positioning and successful exclusion of the popliteal aneurysm. Brisk flow is demonstrated throughout. There is no interval change in the appearance of the trifurcation vessels.

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Procedure Codes:

- 36246 Catheterization of popliteal artery
- 37236 Stent placement popliteal artery aneurysm
- *75710 (59) Left extremity angiogram
- Q9967 x110 LOCM, 300-399 mg/ml iodine concentration, per ml

Diagnosis Codes:

- I72.4 Aneurysm of artery of lower extremity (popliteal)

Comments:

- Code 36246 is assigned for catheter placement into the popliteal for stent.
- Code 37236 is assigned for stent placement in the popliteal artery because an aneurysm was treated. Angioplasty is bundled with stent placement. Revascularization code 37226 is assigned when occlusive disease is treated.
- *Regarding the left extremity imaging, the diagnosis was known prior to the procedure. An angiogram needs to be medically necessary and diagnostic in nature. More information is needed to determine whether or not the left leg angiogram should be reported.
- Documentation requirements are not met to assign code +76937 for US guidance.
- Documentation is not present to assign moderate sedation coded accurately.
- 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:

Stent Coding Rules

Catheterization Codes

- When performing stent placement the catheter must be manipulated through the arterial or venous system to perform the procedure. Catheterization codes should be assigned in accordance with the rules for reporting non-selective and selective catheterization unless otherwise bundled into the code for the stent procedure such as for extracranial and intracranial stent (37215-37218, 61635, 0075T-0076T).
- It is important to note that the site of the stent placement alone is not the sole factor in determining catheterization selectivity. There may be instances when it is necessary to place the catheter beyond the vessel that is the site of the stent placement. Remember, catheter selectivity is based on the most distal catheter placement.

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.

Arterial Stent Codes (37236-37237)

- Stent codes 37236-37237 describe stent placement in the upper extremity arteries, visceral arteries and renal arteries. These codes are also used to report stent placement in lower extremity arteries for clinical indications other than occlusive disease.
 - ❖ Code 37236 is reported once per session for the initial stent placed in an artery.
 - ❖ Code +37237 is reported for each additional stent placed in an artery.
- When an aneurysm, pseudoaneurysm, or vascular extravasation is treated via stent placement in the lower extremity arteries use codes 37236-37237. Treatment of occlusive disease (stenosis) will be reported with the lower extremity revascularization codes 37220-37235.
 - ❖ Codes 37236 and 37237 are not reported with 34848, for bare metal covered stents placed into visceral branches within the endoprosthesis target zone.

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Coding Rules (continued):

- Stent codes 37236-37237 include angioplasty (pre and post-dilation) when performed in the same vessel. Angioplasty is not coded in addition to these stent codes unless an angioplasty is performed in a separate and distinct vessel from the stent placement.

RS&I Codes

- **Bundled Components.** All RS&I work is bundled into the surgical code for stent placement. This work includes the following services: contrast injections, angiography, roadmapping, and fluoroscopic guidance for the intervention, vessel measurement, and completion angiography.

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.

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