Vascular Interventions in the Cardiac Cath Lab

AAPC Regional Meeting
Springfield, MA
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You are going to put a catheter where? And do what?
Why are we starting to do this?
General Recommendations for Physician Dictations

- State the history including prior diagnostic studies and medical necessity
- State the vascular access site(s) with laterality
- State the vessels catheterized (farthest point beyond the intervention; the wire doesn’t count)
- State the route of the catheter and the end position
- State any vascular anatomic variation (bovine arch, extra renal artery etc.)
- State the vessels injected and findings (exact location, % stenosis, presence of occlusions) of the areas imaged during the contrast injections
- State the interventions performed and any complications or additional treatments
- State the specific devices and specialty supplies used during the procedure

Special Rules for Extra Cardiac Angiography performed at the same time as a Cardiac Catheterization

- NHIC Medicare (LCD L29873) also requires:
  - A specific medical condition(s) that would be appropriate to require angiography independent of the Cardiac Catheterization being performed (e.g. blue toe)
  - The determination of Medical necessity requires that there are reasonably anticipated therapeutic implications for which the angiograms will be used (e.g. angioplasty/stent placement for blue toe)
  - Must be specifically requested by treating physician
No Dumb Questions!

My doc does every case by puncturing the right common fem. Is he using a canned template or something?

If you have a chance, check out the cath lab and see which way the patient faces. If the right side is closest to the operative station, he is going to always use right common fem … It’s a real pain to thread a catheter from the wrong side.
Interventional Coding

- Imaging – Code based on vessel or vascular system – 70000 series
  - Images taken
  - Contributed to study
  - Medically necessary
  - Findings must be documented to code
- Procedure 10000-69999

Vascular Systems

There are four basic systems
- Arterial
- Venous
- Pulmonary
- Portal

Don’t worry, the Cardiologist stick to the arteries in the cath lab
Vascular Families

• Vessel and all of its branches that originate from
  – Access vessel
  – Aorta
  – Vena Cava

Example: Common Iliac/Common Fem-
  Superficial Fem-Popliteal

Great Resource – Appendix L in CPT®

Catheter Placement Coding Rules

• Selective vs. Non-Selective
• Typically you would never have both on
  the same claim unless...two separate
  punctures
Selective vs. Non-Selective

Selective
• A branch off the vessel entered, aorta or vena cava

Only the furthest selective catheter placement in the same vascular family is coded

Non-Selective
• Direct Puncture
• Aorta or Vena Cava
• AV Shunt
• Right heart/main pulmonary
• Portal Vein
Included in selective placement

Selective Catheter Placement Codes

Arterial
• Arteries above the Diaphragm - 36215-36218
• Arteries below the Diaphragm - 36245-36248

Venous
• 36011-36012

Portal
• 36481

Pulmonary
• 36013-36015
Catheter Placement Codes

- Code to the highest order within a vascular family
- Use code 36218 or 36248 for each additional selection within the same vascular family
- Code for each vascular family using the guidelines
- Code separately for each access using the same guidelines

Most Common Thing You Will See

- Non-selective renal angiogram – G0275
  - Includes both catheter placement and S&I

- Non-selective ileo-femoral arteries (obliques of pelvis) – G0278
  - Includes both catheter placement and S&I
  - Do not code G0278 for sizing or roadmapping placement of a closure device (e.g. starclose)
Don’t code unless it’s selective. Requires documentation of catheter placement in the vessel.

- External Carotid 75660, 75662
- Renal Arteries/Veins 75722, 75724, 75831, 75833
- Adrenal Arteries 75731, 75733, 75840, 75842
- Visceral Arteries 75726
- Spinal Arteries 75705
- Pelvic Arteries 75736 (Internal Iliac)
- Pulmonary Arteries 75741, 75743
- Each Vessel After Basic Exam 75744

Coding Rules

- Do not code reforming catheters or wires
- 36200 trumps 36140, 36120
- Do not code 75774 for a staged run-off (stepper)
- You can code 75774 after completion of a basic study
  - Document run-off findings and decision to perform more selective catheter placement based on the findings in the basic study
Example

- Single placement of catheter at bifurcation, oblique views of the pelvis for ileofemoral runoff, catheter placement at RT popliteal would be coded 36247, 75716
- Single placement of catheter at bifurcation, complete run-off findings, catheter placement at RT popliteal would be coded 36247, 75716, 75774

The BIG Coding Challenge

- Abdominal Aorta (at level of renals or other viscerals) catheter placement and bifurcation catheter placement with interpretation of viscerals and lower extremities with medical necessity of both areas – 75625 and 75716. Please note any further catheter placements in the lower extremities would be completion of the 75716 (not 75774) if complete lower extremity imaging and interpretation was not accomplished from the initial catheter placement.

- Single shot lower abdominal aorta catheter placement with interpretation of viscerals and lower extremities to the level of iliacs (or more) with medical necessity of both areas – 75630. If the imaging is down to the knees or below from the second injection, then use separate 75625 and 75710/75716.
The BIG Coding Challenge, Cont.

- Single shot bifurcation catheter placement with interpretation of one or both lower extremities 75710 or 75716. Medical necessity noted for one or both lower extremities. No visceral notations. Any further catheter placements in the lower extremities would be completion of the 75716 (not 75774) if complete lower extremity imaging was not accomplished from the initial catheter placement. If complete interpretation and then a decision for further study, 75774 would be appropriate.

- Obliques of Pelvis – 75716
- Obliques of Pelvis including distal aorta – 75730 (with findings of both)
- Pelvic Angiography (selective internal iliac or branch) – 75736

Interventions

- This is the tough stuff!
- There are oodles of bundling rules!
- Best rule of thumb – Have your physician tell the story of why the service was medically necessary!
Coding Rule 1

- Interventional procedures include:
  - Injections, **angiography**, road-mapping, and fluoroscopic guidance
  - Vessel measurement
  - Post angioplasty/stent angiography

**WHAT? I can’t code angiography on the same day as a study?**

Coding Rule 2

- Diagnostic Angiography can be reported separately if
  - No prior catheter-based angiographic study is available and a full diagnostic study is necessary in order to determine the intervention to be performed
  - A prior study is performed but
    - The patient’s condition has changed
    - There is inadequate visualization of the anatomy
    - There is a clinical change during the procedure which requires further investigation*
  - You need to tell why you are performing the diagnostic study at the same time as the intervention or it will be deemed road-mapping or sizing
  - Modifier 59 will need to be used to indicate there was a medically necessary reason to perform the angiography
  - Some interventions bundle the angiography into the primary procedure

* Source CPT® Manual
“Medicare says…”

• “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.”

– Source NCCI manual

Angioplasty Rules

• Angioplasty is coded per vessel treated, not per stenosis

• A vessel is defined as an additional level of catheter placement selectivity
  – An exception to this rule is the external iliac and common femoral arteries, which are considered one level of catheter selectivity but two vessels for intervention

• Contiguous stenosis at the junction of two vessels is a single angioplasty

• Two separate lesions are reportable

• A graft is a single vessel – document angioplasty performed inside/outside

• Selective catheter placement is coded separately – Angiography follows the rules above

• Kissing balloon angioplasty should be coded as only one angioplasty and two catheter placements when the second balloon is inflated to prevent plaque movement
  – If there are associated stenoses in both vessels ballooned, then code for two angioplasties.
What Not to Do…

- Code for road-mapping, guiding shots, or other contrast injection during angioplasty
- Code for follow-up angiography post angioplasty, as it is included in the angioplasty code
- **Exception**: If there is a clinical change in symptoms post intervention (e.g., development of a cold leg once angioplasty is complete) then diagnostic angiography coding may be considered, as it is now medically necessary to determine cause
- Code angioplasty if done merely to "pre-dilate" a lesion for subsequent stent placement. If the balloon size is significantly smaller than the stent it will not give a good result (e.g., 3 mm balloon in an 8 mm artery gave "suboptimal" result, requiring an 8 mm stent. In this case, the balloon is not adequately sized to give anything but a bad result!). This is a pre-dilation and is considered part of the stent placement. "Aw shucks, Sherlock!"
- Code angioplasty to dilate or deploy (open) a stent
- Code angioplasty if intent of procedure was to place a stent. Look at the orders and consent
- Code angioplasty if angioplasty results in "no residual stenosis", but because this "lesion is prone to re-stenosis, a stent was placed anyway". Only code for the stent placement

Stent Rules

- Similar to Angioplasty
- A stent that traverses contiguous stenosis in two vessels, code once
- A single long stent that traverses two separate lesions in two vessels can be coded twice
Angioplasty and Stent on the Same Day?

- Document why the Angioplasty didn’t work…
  - Vessel rupture
  - 30% or greater residual stenosis (sub-optimal results are no longer the magic words!)
  - 5 mm residual gradient
  - Flow-limiting dissection
  - Acute occlusion

Thrombolysis

- Thrombolysis, 37201, is typically TPA (not heparin or nitroglycerin)
- Code 37202, non-thrombolysis, non-chemo, transcatheter therapy (vaso-spasm)
- Time should be documented
- Do not code 37201 for a bolus!
- CPT® code 37201 is used only once per surgical field treated (e.g., if one leg is treated use once)
  - E.g., bilateral legs – 37201-50, 75896, 75896-59
- If bilateral lower extremity arterial thrombosis is treated via a single catheter positioned in the aorta, only code for one thrombolysis
Thrombolysis Continued

- Do not code 37201 for *intra-procedural* thrombolysis utilized during percutaneous thrombectomy
  - It’s bundled
- Do code 37201 for *prolonged* infusion thrombolysis performed before or after percutaneous thrombectomy
  - Careful documentation is needed here
- Do not code 37201 for continuing thrombolysis after a catheter check
- Follow up angiograms, 75898, are chargeable (once per surgical field)
- There may be multiple catheter re-checks with stops and starts of thrombolysis over several days of therapy
  - Code 37201 is used only once for the entire therapy

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Thrombolysis Continued

- Do code 37209 and 75900 when a catheter exchange occurs during therapy
  - This applies to both arterial and venous catheters and both thrombolytic and non-thrombolytic infusions
  - 75900 is an inpatient only code
- Do not code 37209 and 75900 when a catheter is merely repositioned; these codes, a completely new catheter must be used after the old one has been removed. Insured during a follow-up
  - To
- Medicare allows use of code 37202 only once per session, regardless of how many different drugs or different vessels are infused
Thrombectomy

- Trellis device – Can be used for thrombolysis or thrombectomy (thrombolysis with suction)
  - Be sure to tell us if you suctioned the thrombus

- Occlusion balloons are not considered an angioplasty

- If your intent is to perform thrombectomy and you determine that you need to plasty or stent the stenosis afterward, then thrombectomy is primary procedure
  - All interventions are chargeable

- Thrombectomies do not include catheter placement or diagnostic angiography

- Follow-up angiography after thrombectomy is bundled

Special Thanks to Dr. Zielske who always takes the time to help a fellow coder

Get a coding guide
Take a course
Sit for the CIRCC