Not "Cardio"- Vascular Coding

Caren J Swartz, CPC-I, CPC-H, CPMA, CPB

caren@practiceintegrity.com

Objectives

- Understand Anatomy for Vascular Coding
- Review the Rules for Vascular Procedures
- Review ICD-10 future coding
- Understand Documentation on Vascular Notes

2014 CPT Changes

Non-Carotid/Vertebral/Lower Extremity Stent Placement:

Codes 37205-37208 and 75960 have been deleted.

Codes 37236-37239 are the new codes. They include both open and percutaneous endovascular approaches.

2014 CPT Changes

- Venous Stent, percutaneous or open
  - 37238 – Stent placement, initial vein
  - +37239 – Stent placement, each additional vein

2014 CPT Changes

- Code per vessel treated, not per lesion.
- Code separately for the following..
  - Ultrasound guidance for vascular access(76937)
  - Catheter placement
  - Diagnostic Angiography (meeting rules for this)
  - IVUS (37250, 37251, 75945, 75946)

Rules For Coding

- Bridging Lesions are treated as one stent placement.
- Only one initial arterial stent is coded per encounter.
- Only one initial venous stent is coded per encounter.
- Additional arterial stent is coded with 37237 and is an add-on to 37236.
- Additional venous stent is coded with 37239 and is an add-on to 37238.

Rules For Coding

- Stent placement includes…
  - Access creation
  - Access closure
  - Guiding Shots
  - Follow-up Image
  - S&I

2014 Coding Rules

- Angioplasty is never coded for angioplasty at the same session when performed in the same vessel as a stent is placed.
- If angioplasty treats a stenosis in a segment of a vessel and a stent treats another stenosis in the same vessel, ONLY the stent is coded.
- Angioplasty may be coded if it is done in a separate vessel than a vessel treated with stenting.

2014 Coding Rules

- Code for stent placement if a stent or covered stent is used as the sole treatment for an aneurysm, pseudoaneurysm, vessel trauma, etc. Do not code this as an embolization.
- If a stent is placed to aide in vessel occlusion, in addition to embolization techniques (e.g. coils) code the embolization and do not code for the stent.

2014 Coding Rules

- Carotid Stent Placement
  - 37215-Carotid cervical stent placement with embolic protection
  - 37216-Carotid cervical stent placement without embolic protection
  - 37217 - New 2014 - Common Carotid or brachiocephalic stent placement via carotid cutdown

Rules for 37215, 37216, 37127

- These codes include..
  - Ipsilateral selective catheterizations
  - Ipsilateral carotid cervical and cerebral artery S&I
  - All other related S&I during stent placement procedures
  - All road-mapping, guiding shots and follow up images
  - All angioplasty to aide in stent placement
  (note these are inpatient C-status indicator procedures)

2014 New AAA Coding

- The following category III codes have been Deleted for 2014
  - 0078T

    Abdominal aortic stent graft involving visceral branches
    (celiac, SMA, and renal arteries)
  - 0079T

    Placement of visceral extensions device, each branch
 - 0080T & 0081T

    S&I component for 0078T and 0079T

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2014 New AAA Coding

- Fenestrated Stent Grafts for AAA
  - 34841-34844 – Fenestrated abdominal aortic stent graft involving visceral branches(celiac, SMA, and renal arteries) alone or with infrarenal aorta as well

What is a Fenestrated Graft?

The Zenith® Fenestrated AAA Endovascular Graft is made of a fabric tube supported by a metal framework. The fabric has carefully positioned holes to allow blood to continue to flow to the body's organs. The graft has three parts: an upper "main body", a lower "main body" and one "leg." It is made of a polyester material attached to a frame of stainless steel stents (or scaffolds). The stents support the graft and hold it open within the blood vessel. The adjunctive Zenith Alignment Stent is made of stainless steel and is used to help keep the holes in the graft lined up with the arteries that go to the organs.

Zenith Fenestrated graft
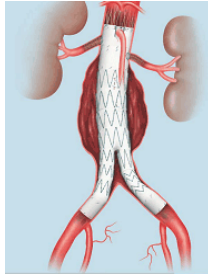
2014 New AAA Coding

- 34841 – Repair visceral aorta with fenestrated graft; including one **visceral** artery endoprosthesis
- 34842 – Including 2 **visceral** artery endoprosthesis
- 34843- Including 3 **visceral** artery endoprosthesis
- 34844-Including 4 or more **visceral** artery endoprosthesis

  (superior mesenteric, celiac and/or renal arteries)

2014 New AAA Coding

-Codes 34845-34848

Fenestrated abdominal aortic graft involving visceral aortic branches and infrarenal abdominal aorta requiring distal placement into the common iliac arteries.

2014 New AAA Coding

- 34845 – Repair visceral aorta and infrarenal aorta with fenestrated graft that extends into common iliacs including one visceral endoprosthesis
- 34846 – Including 2 visceral artery endoprosthesis
- 34847 - Including 3 visceral artery endoprosthesis
- 34848 - Including 4 visceral artery endoprosthesis
   (superior mesenteric, celiac and/or renal artery(s))

2014 New AAA Coding

- Codes 34842-34848 should NOT be used for chimneys, snorkels or periscopes. These procedures are unlisted and may not be covered by the carriers. Check with the carriers regarding any of these devices.

2014 New AAA Coding

- What's included –
  - Diagnostic imaging, guiding shots, follow-up angiography, angioplasty and stent placement in the stent graft deployment zone.
  - New bundling of **ALL** catheter placements in the stent graft deployment zone **AND** extensions with distal end termination in the common iliac arteries and proximal aortic extensions.

2014 New AAA Coding

- What's Not Included –
  - Separately code for extensions into the internal iliac, external iliac or common femoral arteries with 34825, 75953 and 34826, 75953.
  - Separately code for embolization
  - Separately code for catheter placement **outside** the stent graft deployment zone and exposure, open (34812)

2014 New Embolization Codes

- Codes 37204 and 37210 are DELETED
- New codes added 37241-37244
- Codes are based on the reason for embolization, understanding that there may be overlapping indications. (i.e. bleeding of an aneurysm)
- Note – No changes to existing CNS, head and neck embolization

2014 New Embolization Codes

- What's Included
  - S&I, do not code 75894 with the new embolization codes
  - Follow-up angiography, do not bill 75898 with these codes
  - **ONLY** report one embolization code for each surgical field

2014 New Embolization Codes

- 37241 – Embolization for venous conditions other than hemorrhage (i.e. venous malformations, hemangiomas, varices, varicocele and side branch of dialysis fistula)
- 37242 – Embolization of arterial conditions, other than hemorrhage or tumor (AVM, aneurysm and arteriovenous fistula)

2014 New Embolization Codes

- 37243 – For tumors or organ infarction or ischemia (benign or malignant tumors liver, kidney, uterus as well as fibroids)
- 37244 – For treatment of hemorrhage – arterial, venous or lymphatic extravasation.

  (GI bleed, post-partum bleed, hemorrhage secondary to trauma, thoracic duct for chylous effusion)

2014 New Embolization Codes

- Intravascular stents may be used as a part of embolization.
- Watch overlapping of reasoning for the stents.
  - Stent placed as "latticework" for deployment of coils? Don't report the stent
  - Stent placed as sole management of aneurysm, pseudoaneurysm, or vascular extravasation?
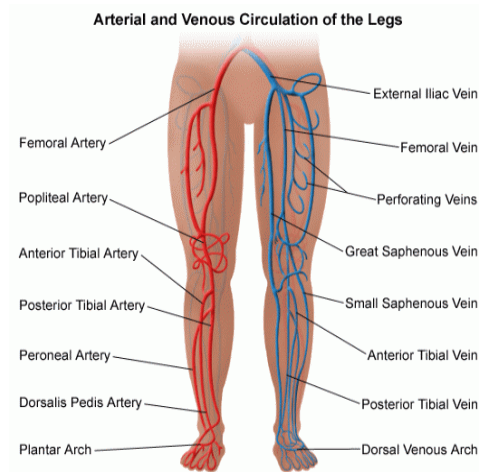
    Report stent only and not embolization

Lower Extremity Revascularization Open or Percutaneous, Transcatheter

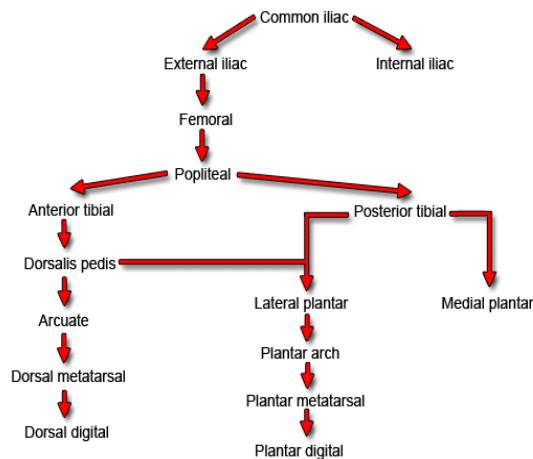**Figure 1. Overview of new technologies for lower extremity revascularization.**
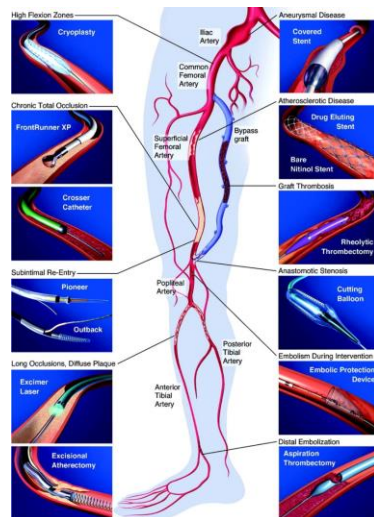
Rogers J H , and Laird J R *Circulation.* **2007;116:2072-2085**
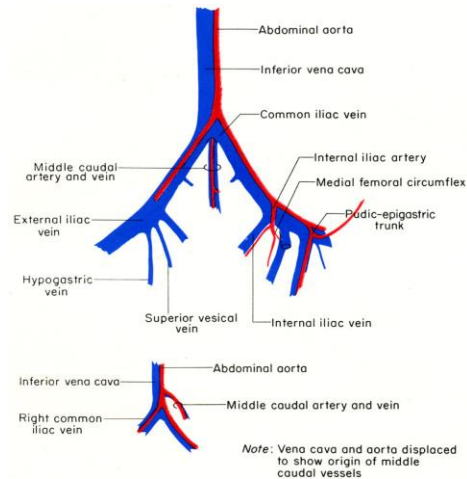
Territories

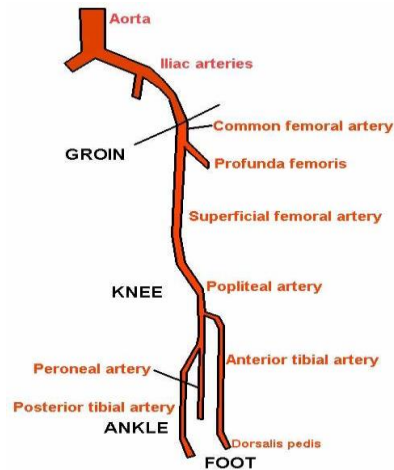# Territories by Name

Iliac Artery

Territories

- Iliac – divided into 3 vessels
  - Common
  - Internal
  - External
  - A single primary code is used for the initial vessel. If additional are treated the appropriate add-on code would be used since there are 3 vessels that have the ability to be coded.
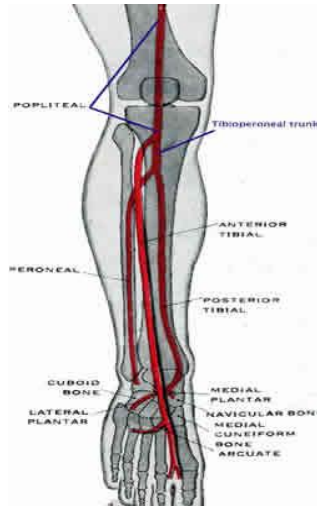
Femoral - Popliteal

Territories

- Femoral/Popliteal – A single intervention code would be used for this territory, regardless of what segments are treated.
  - There are no add on codes for additional vessels treated within the fem/pop territory.
  - When 2 lesions are treated in this territory, code the most complex service.

Tibio-Peroneal Territory

Territories

- Tibial/Peroneal – Divided into 3 vessels: anterior tibial, posterior tibial & peroneal
  - A single primary code is used for the initial tibial/peroneal artery treated.
  - If other vessels are treated in same leg, use appropriate add-on codes
  - Up to 2 add-on codes could be used to describe services provided on a single leg, since there are 3 tibial/peroneal vessels which could be treated.

Territories

- Tibial/Peroneal
  - Add-on codes are for different vessels, not different lesions within same vessel.
  - The Common tibio-peroneal trunk is considered part of the tibial/peroneal territory, but is not considered a 4th segment for CPT reporting purposes.
  - i.e. if lesion treated in common tibio/peroneal and lesion in posterior tibial artery a single code would be reported for treatment.

Guidelines

- When treating multiple territories in same leg, one primary code is used for **each** territory treated.

- Add-on codes would represent additional vessels within the iliac and tibial/peroneal areas.

- When more than 1 stent is placed in the same vessel, the code is reported once.

Guidelines

- If there is overlap between territories, and treated with a single therapy, report with a single code.

- For bifurcation lesions requiring therapy of 2 distinct branches, code a primary code with add-on (iliac and tibio/peroneal, only)

- When same territories of BOTH legs are treated, use modifier -59 to denote different legs.

Guidelines

- If mechanical thrombectomy is also required, this is separately reported.
  - i.e. Angiojet

Hierarchy By Vessel & Procedure

	ILIAC	Additional ipsilateral iliac vessel	Femoral/ Popliteal	Tibial/ Peroneal	Additional ipsilateral Tibial/Peroneal vessel
Angioplasty	37220	+37222	37224	37228	+37232
Stent	37221	+37223	37226	37230	+37234
Atherectomy w or w/o PTA	N/A	N/A	37225	37229	+37233
Atherectomy with Stent w or w/o PTA	N/A	N/A	37227	37231	

What's Included

- Moderate (conscious) sedation (99143-99145)
- All of the work of accessing and selectively catheterizing the vessel and traversing the lesion,
- Radiological S&I directly related to the intervention(s) performed
- Embolic protection, when performed
- Standard closure of arterial puncture site
- Imaging performed to document completion of the intervention in addition to the intervention(s) performed
- When performed in an <u>office</u>, all necessary supplies for the procedure, including guidewires, catheters, and angioplasty balloons

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Diagnostic Angiography

- Is there a time when they can be billed along with the intervention?
- What are the rules surrounding this?
- Are modifiers necessary?
- What needs to be documented?

Diagnostic Angiography with Intervention

- These services ARE separately reportable if:
  - No prior catheter –based angiographic study is available
  - A full diagnostic study is performed
  - The decision to intervene is based on these findings

  OR

Diagnostic Angiography with Intervention May be Billed if….

- A prior study is available, but:
  - The patient's condition with respect to the clinical indications has changed since the prior study
  - There is inadequate visualization of the anatomy and/or pathology OR
  - There is clinical change during the procedure that requires new evaluation outside the target area of intervention

Diagnostic Angiography with Intervention

- Modifier -59 would need to be added to the diagnostic angiography codes when performed during the same session as an interventional procedure. The modifier would be appended to the radiological supervision and interpretation code(s) to denote that diagnostic work was done following the above guidelines.

What Else Can I Report with Intervention

- Mechanical thrombectomy
- Thrombolytic Infusion
- Ultrasound guidance for vascular access
- Additional catheter access solely for diagnostic imaging purposes

Conclusion

- Doctors must be diligent about documenting territories and interventions done within a given territory.
- Must have a way of identifying if a prior study was done.
- Concise statements need to be documented when moving from one territory to the next and or left to right.

Bypass
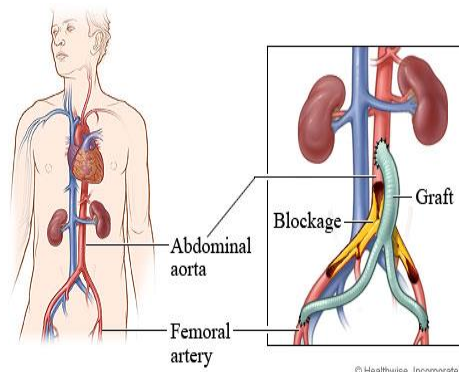
Bypass

- Where is the blockage?

- Is it native or in an existing graft?

- What vessel are you connecting to?

What is included?

- Harvesting (procurement per CPT language) of saphenous vein
- Completion angiography
- Vein valve lysis, physician may describe using a valvulotome.
  - Per CPT "Primary vascular procedure listings include establishing both inflow and outflow by whatever procedures necessary"

What's NOT included?

- Diagnostic arteriogram if there is NOT a recent prior <u>Clinically adequate</u> study OR patient has suffered recent change in vascular status.
- Harvest of upper extremity vein (+35500)
- Harvest of popliteal vein, 1 segment (+35572)
- Harvest and construction of autogenous composite grafts (+35682 or +35683)

What's NOT Included

- Adjuvant procedures (+35685 or +35686)
- Be careful to read parentheticals associated with codes. These give important information about how to properly use these add-on codes.
- Educate your physician…if you are in a situation that is an exception to the rules, be sure that the documentation supports your code, and that it is modified correctly!

Complications

- Excision of grafts
- Exploration
- New "jump grafts"
- Repairs
- Revision

Complications

- Be sure your ICD-9 reflects your patients issue. Be sure you are practicing good habits by adding any other diagnosis that influence their disease (think diabetes)
- Be sure you know which modifier to apply to reflect this coding scenario….is it -59, -78,-79
- Be sure the documentation is there to support

  (talk to your physicians)

Complications

- Be sure to code all procedures done when there are complications
  - i.e. if you are looking at a clotted graft that is revised, be sure you code for the revision as well as the thrombectomy.

The SVS 2013 Coding Guide gives an example of :

Patient with sudden onset thrombosis of femoral limb of an aorto-bifemoral bypass graft undergoes emergent thrombectomy of the graft limb.

It is discovered that a critical outflow stenosis caused the thrombosis. The femoral anastomosis is revised. How is this reported?

A: Report both codes 35883 and code 34201 (Embolectomy or thrombectomy, with or without catheter; femoropopliteal, aortoiliac artery, by leg incision

Complications

- If you were thinking about code 35875, thrombectomy of arterial or venous graft(other than dialysis graft or fistula) this code has 2 issues
    - First it is solely for a prosthetic graft originally placed
    - AND has a bundling edit with the revision codes, whereas the thrombectomy codes do not.
    - Per CPT Assistant – "Code 35875 describes the thrombectomy of arterial or venous bypass placed originally to relieve limb ischemia or to bypass a venous occlusion."

Vascular Ulcers

Vascular ulcers

- How are you treating these problems?
  - Debridement
  - Unna boot
  - Compression system
- Are you aware of the rules for documentation of lesions and the treatment?

Vascular Ulcers

- Do you know the global days?
- Are your physicians documenting appropriate size and depth of lesions?
- When follow-ups are made is there accurate information on size and status of lesion?
- For unna boots or compression system who is doing the work?
- What about EM with these services?

Vascular Ulcers

3 sections of codes
- 97597 – 97598 - Medicine Section – Wound Care Management
- 11042 – 11047 - Debridement Codes
- 29580 – 29584 - Unna Boot and Multi-layer Compression System

Active Wound Care Management

- Performed to remove devitalized and/or necrotic tissue and promote healing. Require direct, one-on-one contact with the patient.
- For debridement of skin (ie, epidermis and/or dermis), report 97597, 97598 as appropriate
- "0" global days
- -50 not approved

Active Wound Care Management

- 97597 –Any method, waterjet, scissor, scalpel, topical application, whirlpool
  - Per session/1st 20sq/cm or less
  - Dermis and /or epidermis

- +97598 – each additional 20sq/cm, or part thereof
- Global days "0"

Formal Debridement
11042 - 11047

- Pay attention to layers/levels/depth
- Be sure documentation supports these layers
- Pay attention to size, with anything over 20 sq/cm coded with the appropriate add-on codes.
- "0" global Days

Formal Debridement
11042 - 11047

- Debridement services may be reported for injuries, infections, wounds, and chronic ulcers.
- When performing debridement of a single wound, report depth using the deepest level of tissue removed.
- In multiple wounds, sum the surface area of those wounds that are at the same depth, but do not combine sums from different depths

Strapping

- 29580 – unna boot
  - Take Caution with E/M!!
    - May be billed with SEPARATELY indentifiable issue
  - Not included
    - Formal debridement - 11042 – 11047
    - Active Wound Care Management – 97597-97598
  - Includes
    - simple wound cleansing
    - (in office) all necessary supplies

Strapping

- 29581 – 29584 – Application multi-layer compression system
  - Included
    - Simple wound cleansing
    - (in office) all necessary supplies
  - Not Included
    - Formal debridement - 11042 – 11047
    - Active Wound Care Management – 97597-97598
  - "0" global days

Strapping

- 29581 – Leg, below the knee, including ankle and foot
- 29582 – thigh and leg, including ankle and foot, when performed
- 29583 – upper arm and forearm
- 29584 – upper arm, forearm, hand and fingers

3/24/2014

A look at ICD-10

- What will Our Codes for Vascular Surgery Look Like?
- What Other categories will impact our coding
- Have you compared your Physicians documentation with the New I-10 codes?
- How do they measure up?
- Start practicing NOW to identify documentation issues!!!

ICD-10

- Up to 7 digits – XXX.XXX X
  - First set of characters, Alpha and 2 numeric
    - Denotes category
  - Second set of characters, numeric
    - Denotes etiology, anatomic site, severity
  - 7th character
    - Denotes extension – encounter
      - Initial
      - Subsequent
      - Sequelae

ICD-10

- Chapter 9 – Diseases of the Circulatory System
- Chapter 4 – Endocrine, Nutritional and Metabolic diseases
- Chapter 18 – Symptoms, Signs and Abnormal Findings

ICD-10

- Chapter 9 – Diseases of Circulatory System
  - "our" alpha is "I"
  - **Diseases of arteries, arterioles and capillaries (I70-I79)**
    - **Example – we currently code Atherosclerosis of extremity w/ulceration as 440.23**
      - **No laterality specified**
      - **No location of ulcer specified**

ICD-10

- Where we are going..
- **I70.24 - Atherosclerosis of native arteries of left leg with ulceration**
- I70.241 - Atherosclerosis of native arteries of left leg with ulceration of thigh
  - Now laterality and specific location are captured

 Use additional code to identify severity of ulcer (L97.- with fifth character 2)

ICD-10

- Co-morbid Conditions
  - CKD – N18
- N18.6 - **End stage renal disease** (Chronic kidney disease requiring chronic dialysis)

    Use additional code to identify dialysis status (Z99.2)
  - Diabetes – Type 2 - E11.xxx
    - With Circulatory complications – E11.5x
- E11.52 - diabetic peripheral angiopathy with gangrene
- Z79.4 – long term/current use of insulin

NCCI

- http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

- A few words regarding the edits….
  - They are more than just columns with bundling edits
  - They contain language for correct coding
  - They are chapter specific for correct coding
  - Have you read these guidelines? Did you know they exist?

National Correct Coding Initiative

- NCCI includes a set of edits known as **Medically Unlikely Edits (MUEs)**

- An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a **single** Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.

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National Correct Coding Initiative

It is important to understand, however, that the NCCI **does not include** all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Should providers determine that claims have been coded incorrectly, they are responsible to contact their Medicare Carrier, Fiscal Intermediary (FI), or Medicare Administrative Contractor (MAC) about potential payment adjustments.

NCCI

"If a failed percutaneous vascular procedure is followed by an open procedure by the same physician at the same patient encounter (e.g., percutaneous transluminal angioplasty, thrombectomy, embolectomy, etc. followed by a similar open procedure such as thromboendarterectomy), only the HCPCS/CPT code for the completed procedure, which is usually the more extensive open procedure may be reported."

NCCI

"If a percutaneous procedure is performed on one lesion and a similar open procedure is performed on a separate lesion, the HCPCS/CPT code for the percutaneous procedure may be reported with modifier 59 only if the lesions are in distinct and separate anatomically defined vessels. If similar open and percutaneous procedures are performed on different lesions in the same anatomically defined vessel, only the open procedure may be reported."

Thank You!
Questions??
NAS