Not “Cardio”- Vascular Coding

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Objectives

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

- 2011 – New codes were added to CPT for revascularization
- Includes any method, open or percutaneous
- Grouped by territory
- Built on progressive hierarchy
  - Only one code should be billed per family for each lower extremity treated
Territories

Arterial and Venous Circulation of the Legs

- External Iliac Vein
- Femoral Vein
- Perforating Veins
- Great Saphenous Vein
- Small Saphenous Vein
- Anterior Tibial Vein
- Posterior Tibial Vein
- Dorsal Venous Arch

- Femoral Artery
- Popliteal Artery
- Anterior Tibial Artery
- Posterior Tibial Artery
- Peroneal Artery
- Dorsalis Pedis Artery
- Plantar Arch
Illiac Artery

Note: Vena cava and aorta displaced to show origin of middle caudal vessels.
Territories

• Illiac – 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 could be coded.
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, use 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.
## Hierarchy By Vessel & Procedure

<table>
<thead>
<tr>
<th></th>
<th>Iliac</th>
<th>Additional ipsilateral iliac vessel</th>
<th>Femoral/Popliteal</th>
<th>Tibial/Peroneal</th>
<th>Additional ipsilateral Tibial/Peroneal vessel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angioplasty</td>
<td>37220</td>
<td>+37222</td>
<td>37224</td>
<td>37228</td>
<td>+37232</td>
</tr>
<tr>
<td>Stent</td>
<td>37221</td>
<td>+37223</td>
<td>37226</td>
<td>37230</td>
<td>+37234</td>
</tr>
<tr>
<td>Atherectomy w or w/o PTA</td>
<td>N/A</td>
<td>N/A</td>
<td>37225</td>
<td>37229</td>
<td>+37233</td>
</tr>
<tr>
<td>Atherectomy with Stent w or w/o PTA</td>
<td>N/A</td>
<td>N/A</td>
<td>37227</td>
<td>37231</td>
<td></td>
</tr>
</tbody>
</table>
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 office, all necessary supplies for the procedure, including guidewires, catheters, and angioplasty balloons
Diagnostic Angiography

• Is there a time when it 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 Be Reported 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

• 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 \textit{clinically adequate} 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 have 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 patient’s issue. Be sure you are practicing good habits by adding any other diagnoses 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 their 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?
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.
• Codes 11040, 11041 were deleted in 2011. For debridement of skin (i.e. 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
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
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 identifiable issue
  – Not included
    • Formal debridement - 11042 – 11047
    • Active Wound Care Management – 97597-97598
  – Includes
    • simple wound cleansing
    • all necessary supplies (in office)
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
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?
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
Now Let’s Code

The Notes
Thank You!
Questions??