An Overview - 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
2016 Code changes

• IVUS – 37252 and 37253 – replaced 4 codes, 37250/51 and 75945/46
  – Non-coronary, venous and arterial
  – Bundle S&I

• Otherwise no real changes, only further explanation of guidelines and parentheticals.
CPT Guidelines

• 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 (37252, 37253)
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
Coding Rules

• Angioplasty is never coded 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
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 aid in vessel occlusion, in addition to embolization techniques (e.g. coils) code the embolization and do not code for the stent.
Coding Rules

• Carotid Stent Placement
  – 37215-Carotid cervical stent placement with embolic protection
  – 37216-Carotid cervical stent placement without embolic protection
  – 37217 – Retrograde common carotid or brachiocephalic stent placement via carotid cutdown
  – 37218 – antegrade – open or percutaneous
Rules for 37215, 37216

• 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)
Aortic Aneurysm
Endovascular Aneurysm Repair

- EVAR – Endovascular aneurysm repair
- FEVAR – Fenestrated endovascular aneurysm repair
- TEVAR – thoracic endovascular aneurysm repair.
What do we code?

- Exposure – this is an open exposure for endovascular procedure
- Device – regardless of TEVAR, EVAR or FEVAR the device, depending on the limbs will have a unique code
- Extensions – may or may not be added.
- S&I – for all types of grafts
Exposure

• 34812 – Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral
• 34820 – Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral
• 34833 – Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
• 34834 – Open brachial artery exposure to assist in the deployment of aortic or iliac endovascular prosthesis, by arm incision, unilateral
• Watch parentheticals!!
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.
In 2015 CPT Changes

Code 34839 – Physician planning of a patient specific fenestrated visceral aortic endograft requiring a minimum of 90 minutes physician time
Zenith Fenestrated graft
www.cookmedical.com
Fenestrated AAA Coding

- 34841 – Repair visceral aorta with fenestrated graft; including one **visceral** artery endoprosthesi
- 34842 – Including 2 **visceral** artery endoprosthesi
- 34843 - Including 3 **visceral** artery endoprosthesi
- 34844- Including four or more **visceral** artery endoprosthesi
  (superior mesenteric, celiac and/or renal arteries)
Fenestrated 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
• 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))
Aorta and Visceral Vessels
Fenestrated 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
Fenestrated 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
Fenestrated 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, IVUS, balloon angioplasty and
  – Separately code for catheter placement outside the stent graft deployment zone and exposure, open (34812)
Device

- Determine the device being used
- Fenestrated or not
- Uni-body, tube, # of docking limbs
- Many manufacturers have the CPT codes on their sites that correspond with their device
Extensions

• Does the graft cover the entire aneurysmal sac?
• If extensions are added, are the proximal or distal?
• Codes 33880 and 33881 for thoracic aneurysm repair INCLUDE placement of all distal extensions, but not proximal.
Fenestrated Grafts

- Fenestrated Stent-Graft
- Multi-branched Stent-Graft
- Iliac Branch Stent-Graft
S & I

- Remember we need to visualize our work
- 75952 – Endovascular repair of infrarenal AAA or dissection, radiologic supervision and interpretation
- 75953 – placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoeaneurysm, or dissection, radiological supervision and interpretation
• 75956 - Endovascular repair of descending thoracic aorta (e.g. aneurysm, psuedoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption); involving coverage of the left subclavian artery origin, initial radiological supervision and interpretation
  – 75957 – not involving coverage of the left subclavian artery origin, initial endoprosthesis plus descending thoracic aortic extension(s), if required, to the level of celiac artery origin, radiological supervision and interpretation
S & I

• 75958 – Placement of proximal extension prosthesis for endovascular repair of descending thoracic aorta (e.g. aneurysm, pseudoaneurysm, dissection, penetrating ulcer, intramural hematoma, or traumatic disruption), radiological supervision and interpretation

• 75959 - Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to the level of celiac origin, radiological supervision and interpretation
Additions....

• OUTSIDE TARGET AREA
• Code also for....
  – Renal artery angioplasty
  – IVUS
  – Arterial embolization
  – Angioplasty or stenting
Coil Embolization
Coil
Embolization Codes

• Codes 37241-37244
• Codes are based on the reason for embolization, understanding that there may be overlapping indications, i.e., bleeding of an aneurysm
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
Embollization 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)
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 chylosus effusion)
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
Coil
Stent supporting Coil
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

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

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

• Iliac – divided into three 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 three vessels that have the ability to be coded.
Femoral - Popliteal

Diagram showing the anatomical pathway from the Aorta, through the iliac arteries, common femoral artery, profunda femoris, superficial femoral artery, popliteal artery, peroneal artery, anterior tibial artery, posterior tibial artery, and finally to the dorsalis pedis at the ankle.
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 two lesions are treated in this territory, code the most complex service
Tibio-Peroneal Territory
Territories

• Tibial/Peroneal – Divided into three vessels: anterior tibial, posterior tibial and 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 two add-on codes could be used to describe services provided on a single leg, since there are three 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
  – 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 one 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 two 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
  – For example, Angiojet
<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 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 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 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-10 reflects your patients issue. Be sure you are practicing good habits by adding any other diagnosis that influences 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 two 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

Three 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/1\(^{st}\) 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 unidentifiable 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
ICD 10

• Vascular disease – I73.-
• Many of our patients will have both CAD and PVD – I25.-
• Native or bypassed vessel – I70.-
• Is there ulcer associated with PVD – I70.232(ulceration of right calf)
• Is there tobacco use/dependence – F17.-
• Co-morbidities – E11.-, E78.5, I10, N18.-
NCCI


- 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
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.
“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.”
“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??