2017 Cardiology Survival Guide

Chapter 1: Angiography and Aortography

Angiography describes imaging to visualize the inner opening of blood filled structures, including the arteries and veins. You may see artery imaging called arteriography and vein imaging called venography.

CPT® lists angiography codes by location, and a quick look at the CPT® index will help you narrow your code choices quickly. For instance, for angiography of the brachial artery, you should select 75658 (Angiography, brachial, retrograde, radiological supervision and interpretation) for the RS&I portion of the service.

In some cases, CPT® will provide a range of choices in the index from which you must further select the appropriate code. For example, non-catheter angiography of the head may be reported using 70496 (Computed tomographic angiography, head, with contrast material[s], including noncontrast images, if performed, and image postprocessing) or 70544-70546 (Magnetic resonance angiography, head ...), depending on the method used to produce the images.

Aortogram vs. Angiogram

An aortogram is simply an angiogram of the aorta. CPT® offers a variety of CPT® codes for aortograms, depending on which part of the aorta the physician studies, whether he studies it by catheter or by CT exam, and whether he performs the exam with cardiac catheterization. For radiological supervision and interpretation (RS&I) of a catheter (invasive) aortogram, look to 75600-75630 (Aortography ...).

Catheter-Based Angiography: Component Coding or All-in-One Code?

For many years, the general rule for catheter-based angiography has been that you should report a code for the placement of the catheter used to take the image and a code for the supervision, interpretation, and report related to the imaging. In recent years, CPT® has added many codes intended to describe the full service. In other words, you report a single code to capture both the catheter placement and the imaging services.

Renal angiography example: Before 2012, you reported two codes for renal angiography procedures. Beginning Jan. 1, 2012, you should report a single code that includes both catheter placement and radiological supervision and interpretation.

For example, if you're reporting selective catheter placement for renal study and bilateral radiologic imaging of these arteries, you should choose only a single code i.e. 36252.

36252: Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral

You'll also have to be careful about modifiers when reporting 36252. Because 36252 is a bilateral code, you won't be able to report it with any of the bilateral modifiers (such as 50, LT, or RT). Clinically, the code represents the cardiologist engaging both renal arteries (right and left) and visualizing them.

Double-Check Your Diagnoses

Make sure you report a diagnosis code that accurately reflects the indication for the study (if the study is negative) or the study's findings (if the study is positive).

You should report findings of peripheral vascular disease with the appropriate diagnosis code (such as I70.1, Atherosclerosis of renal artery). Many practices inadvertently report the diagnosis of coronary artery disease (I25.1x), which is appropriate for heart catheterization-specific codes.
Determine if Decision Is Made Because of Angiogram

If your cardiologist performs an intervention due to a diagnostic angiogram, you'll need to tread carefully. CPT® instructions state that you should report a diagnostic angiography separately at the time of a transcatheter procedure if:

- No prior catheter angiogram is available
- The cardiologist performs a full exam
- The cardiologist bases his decision to intervene on the current exam.

You must append modifier 59 (Distinct procedural service) or another appropriate modifier and include documentation in the procedure note of the decision to intervene.

**Warning:** If your cardiologist had a prior catheter angiogram available, you should not report another diagnostic angiogram unless you meet the exceptions below. And keep in mind that you don't need to worry about a specific timeframe for the prior angiogram.

**Investigate These Intervention Exceptions**

If a prior catheter angiogram meets one of the following three exceptions, you can report a second diagnostic angiogram at the time of an intervention (if the intervention code doesn’t specifically include diagnostic angiogram).

- **Exception 1**: The patient's condition has changed since the prior study. For example, two months ago, an angiogram showed moderate arteriosclerosis in the legs. The patient now returns with new onset of rest pain and loss of pulses. Because the condition has changed, you can report a new diagnostic angiogram if performed.
- **Exception 2**: The cardiologist has inadequate visualization on the prior study. For example, the patient transfers from another facility with poor quality images. The cardiologist cannot make a treatment decision without performing additional imaging. In this case, you can report a new diagnostic angiogram.
- **Exception 3**: The cardiologist detects a clinical change during the procedure that necessitates new evaluation outside the target intervention area. For example, imaging during a renal artery stent placement suggests severe stenosis of the superior mesenteric artery (SMA) not seen on prior exam. The cardiologist performs a selective exam of the SMA, which you can separately report.

**Beware Coding Angiogram Cath With Lower Extremity Revascularization**

CPT® includes a series of codes for lower extremity revascularization (angioplasty, atherectomy, and stenting), which include catheterization (see Chapter 2). As a result, CPT® guidelines for Vascular Procedures (located after 75574 in the manual) explain that you should not report a catheterization code “for diagnostic lower extremity angiography when performed through the same access site as the therapy (37220-37235) performed in the same session.” But if the physician must use a different arterial puncture site for the angiogram, then you may report a code for that catheterization separately.

**4 Questions Simplify Abdominal Angiography Coding**

If you're not confident about an abdominal angiography code, you should base your choice on one key factor — location, location, location. Consider the following scenarios to guide your angiography code selection:

1. **True or false**: When a physician performs an abdominal angiography, she can perform a “flush aortography” or an abdominal runoff from the same catheter position.

   **Answer**: True. When you see "flush aortography" in the physician's documentation, you should report 75625 (Aortography, abdominal, by serialography, radiological supervision and interpretation). For "abdominal with runoff," you should report 75630 (Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation). Before reporting these codes, however, make sure the flush aortogram isn’t included in the code for a larger service performed at the same session.

   **Tip**: You don't need to know the size of the catheter or how much dye the physician used — but you do need to know where the physician placed the catheter.

2. **Question**: What is the correct code for runoff imaging?
**Answer:** You can't choose a code simply on "runoff imaging" — you need more information. Catheter placement is key here.

For instance, you should report runoff imaging from a single injection in the proximal abdominal aorta (suprarenal) as 75630-26 (*Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation; Professional component*) with proper interpretation of the abdominal aorta and bilateral extremities.

In another example, when the cardiologist interprets information of the bilateral extremities when the runoff imaging is from the distal (above bifurcation) aorta, you should report 75716-26 (*Angiography, extremity, bilateral, radiological supervision and interpretation; Professional component*).

These scenarios focus on lower extremities, but the terminology can also apply to higher areas of the aorta — even the individual extremities.

**Hint:** Keep in mind that you can't separately report subsequent studies from the same catheter position, such as a complete runoff study.

**3. Code this scenario:** The physician performs imaging of the abdominal aorta in one catheter location and bilateral vessels runoff from another position in the aorta.

**Answer:** Again, you need to know the catheter's exact location. If the cardiologist places it at the suprarenal abdominal aorta and performed an angiogram, then reposition it to the distal aorta just above the bifurcation for a bilateral iliofemoral angiogram, you should report 75625-26. For the extremity angiography, you would report 75716-26. The key, once again, is location.

If the physician performs the imaging from two different sites, you usually can report the extremity code (75716) separately. But if she sticks to one location for the aorta and runoff vessels, report 75630 only.

**Tip:** Be sure the physician's documentation supports billing for both the abdominal aortography and the extremity angiography by indicating that she injected dye at two separate locations. Keep in mind that certain "abdominal-only" studies — such as an abdominal aortic aneurysm evaluation — allow for a complete abdominal study.

**4. Code this scenario:** The physician performs an abdominal aortogram with runoff study. Following the study, she moves the catheter from the nonselective location in the aorta to a selective location in the contralateral common iliac artery and performs selective imaging.

**Answer:** For these procedures, you would report both 75630 and +75774 (*Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation [List separately in addition to code for primary procedure]*). Remember that you can use +75774 in addition to both selective and nonselective codes. When the doctor performs a basic examination and then selectively places the catheter to obtain extra imaging, add +75774.

Also, make sure you report the selective catheter placement service with 36245 (*Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family*).

Suppose the physician starts the imaging at the femoral level, and then shifts the catheter to the popliteal level to image the tibioperoneal vessels. Your code for this situation would be +75774.

**Warning:** Don't report +75774 unless you're certain the physician performed additional selective catheter movement.

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