2015 Radiology Coding Survival Guide
Chapter 11: Vascular Procedures (75600-76499)

CPT® divides the "Vascular Procedures" subsection into the following groups, several of which include guidelines:

- Aorta and Arteries (75600-75791)
- Veins and Lymphatics (75801-75893)
- Transcatheter Procedures (75894-75989)

Become a Nonselective Cath Coding Pro with This Arterial and Venous Primer

Component coding for individual interventional procedure elements increases your risk of missing a code for your claim — and reimbursement for your practice. Take control with this advice on nonselective procedures.

Tackle Tough Arterial Claims with These CPT® Skills

You should consider either of the following to be nonselective arterial catheter placement:

- The radiologist places the catheter or needle directly into an artery and does not manipulate or move it into a branch
- The radiologist moves the catheter or needle into the aorta from any approach with no further manipulation.

Remember: You should code each vascular access separately. (But watch out. An increasing number of procedure codes specifically include all catheter placement and manipulation related to the larger procedure, so in many cases you should not report catheterization separately.)

The codes you'll use for separately reportable nonselective arterial catheterization include the following:

- 36100 — Introduction of needle or intracatheter, carotid or vertebral artery
- 36120 — Introduction of needle or intracatheter; retrograde brachial artery
- 36140 — ... extremity artery
- 36147 — Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)
- +36148 — ... additional access for therapeutic intervention (List separately in addition to code for primary procedure).
- 36160 — Introduction of needle or intracatheter, aortic, translumbar
- 36200 — Introduction of catheter, aorta.

Example: The radiologist performs an abdominal aortogram (from a femoral or brachial approach), placing the catheter in the upper abdominal aorta. You should report 36200 and 75625 (Aortography, abdominal, by serialography, radiological supervision and interpretation).

Common mistake: Don't let the term "serialography" confuse you and convince you not to use 75625 when appropriate. Serialography is the technique of taking radiographic images in rapid sequence for the study of high-speed phenomena, such as blood flow through an artery. You may see this referred to as multiple rapid sequence imaging.

Discover How Options Change With Vena Cava

Nonselective venous catheter placement involves either of the following:

- The radiologist places the catheter or needle directly into a peripheral vein and does not manipulate or move the catheter or needle further into a branch
- The radiologist moves the catheter or needle into the vena cava (inferior or superior) from any approach with no further manipulation.
The codes you'll use for separately reportable nonselective venous catheterization include the following:

- **36000** — Introduction of needle or intracatheter, vein
- **36005** — Injection procedure for extremity venography (including introduction of needle or intracatheter)
- **36010** — Introduction of catheter, superior or inferior vena cava
- **36147** — Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)
- **+36148** — ... additional access for therapeutic intervention (List separately in addition to code for primary procedure).
- **36400-36425** — Venipuncture...

**Example:** The radiologist documents a unilateral extremity venography. You should report 36005 and 75820 (Venography, extremity, unilateral, radiological supervision and interpretation).

**Watch Your Step With Selective — Here’s Why**

You shouldn't assign nonselective catheter placement codes when the radiologist subsequently performs selective catheterization via the same access route, according to interventional radiology component coding conventions. For example, don't assign a code for catheter placement in the aorta when the physician goes on to selectively catheterize a branch vessel such as the left common carotid artery.

**Watch out:** Certain angiography supervision and interpretation codes include abdominal aortography as part of the code definition, so you should carefully read the code descriptor to know for sure before reporting the abdominal aortography.

**Example:** Selective renal angiography includes any accompanying abdominal aortogram (which is nonselective by definition).

So you should include flush aortogram code 75625 (Aortography, abdominal, by serialography, radiological supervision and interpretation) in a selective renal study.

**Analyze Aortogram Vs. Angiogram**

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

For CT aortogram with lower-extremity runoff, report code 75635 (Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing).

Angiograms have a long list of possible codes, as you'll see in the CPT® index under the "Angiography" entry. You should choose the code that matches your documentation — and don't miss that some codes which state "angiography" may be in other parts of the "Radiology" section. Example: The physician documents pelvic CT angiography meeting all the requirements for 72191 (Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing).

**Careful:** Review the selective angiography examinations' code descriptors to determine which include aortography performed during the same study.

**Example:** If the physician introduces the catheter into the aorta with injection procedures for thoracic aortography, and abdominal aortography, you would report, 75605 and 75625.

**Demystify Same-Session Abdominal/Extremity Angiography**

You will need to report multiple codes when your radiologist performs abdominal and extremity angiographies at the same session, but you have to work extra hard to be certain your claim fully reflects what your radiologist did. Keep an eye on what matters most with these tips.
Acquaint Yourself With Aortogram Codes

To report an abdominal aortogram, use 75625 (Aortography, abdominal, by serialography, radiological supervision and interpretation). This procedure is also known as “flush aortography.”

Think of it this way: You will use this code alone when the radiologist views only the abdominal aorta.

If the physician performs an abdominal aortogram and lower-extremity runoff, you would instead report 75630 (Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation). This procedure is often called “abdominal with runoff.”

In other words: You’ll use this code when the radiologist places the catheter in the aorta and does not reposition it. Also, the radiologist views the lower extremity along with the abdominal aorta.

Difference: The difference between the abdominal angiography codes is that 75630 includes a runoff study (the physician visualizes the downstream vessels) but 75625 does not. However, keep in mind that either 75625 or 75630 might be applicable from the same catheter position. Specifically, the physician could image just the abdominal aorta or the aorta and the downstream vessels from the same catheter position.

Grasp These Imaging Codes

Next, you should understand what imaging codes you will report.

Key: You’ll report your imaging codes based on catheter position.

For instance, you can report 75710 (Angiography, extremity, unilateral, radiological supervision and interpretation) for one extremity and 75716 (Angiography, extremity, bilateral, radiological supervision and interpretation) for both extremities.

Tip: Provided the catheter is not moved, you should include all imaging studies, regardless of view, in 75710 or 75716, when applicable. Other options include 75736 (Angiography, pelvic, selective or supraselective, radiological supervision and interpretation) or +75774 (Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation [List separately in addition to code for primary procedure]) for an additional selective procedure after basic study.

Capture These Code Combinations

75625, 75710: If your physician performs an abdominal aortogram and repositions the catheter to image a unilateral lower extremity, you should report 75625 and 75710.

75625, 75716: If the radiologist does an abdominal aortogram, repositions the catheter, and then performs a bilateral lower-extremity angiogram, you would report 75625 and 75716. In other words, 75625 and 75716 are for imaging of the aorta and bilateral runoff vessels when the physician images the aorta at one cath position and performs the runoff after moving the catheter to another location.

Be wary of catheter movements: You’ve learned how catheter position makes a difference. However, catheter movement will not always support billing for a separate study, because some “abdominal only” studies (such as abdominal aortic aneurism evaluation) may include more than one catheter position. The operative note should reflect catheter movement, abdominal, and extremity study findings before you bill for the extremity study in addition to the abdominal study, coding experts say.

When to add +75774: If the physician performs additional imaging after a basic exam, you can report +75774. When the physician needs to see something better, and he moves the catheter to a more selective position and obtains further images, he can use this code.

Example 1: The physician performs a bilateral, non-selective lower-extremity runoff study (75716, Angiography, extremity, bilateral, radiological supervision and interpretation) from a distal aortic position. He then moves the catheter from the nonselective location in the aorta to a selective location in the iliac or femoral artery and performs additional selective imaging beyond basic. You should report +75774.
**Example 2:** If the physician moves the catheter after imaging at the femoral level to the popliteal to image the tibioperoneal vessels, you would use +75774 in addition to the basic imaging procedure (75710, Angiography, extremity, unilateral, radiological supervision and interpretation), experts say.

Apply the Rules: Watch Cath Repositioning for Aortogram

**Scenario:** The interventional radiologist performed an abdominal aortogram with iliofemoral runoffs with lower extremity visualization. Can you report both 75630 (Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation) and 75710 (Angiography, extremity, unilateral, radiological supervision and interpretation)?

**Answer:** If the radiologist repositions the catheter within the aorta (for instance, he performs one study from high in the abdominal aorta and then repositions the catheter at the aorto-iliac bifurcation), you typically should report 75625 (Aortography, abdominal, by serialography, radiological supervision and interpretation).

Depending on whether he studied one or both extremities, assign 75710 or 75716 accordingly. Note that the Society of Interventional Radiology (SIR) supports reporting 75716 without modifier 52 (Reduced services) even if imaging is done only to the knee level.

**75630:** If the radiologist does not reposition the catheter, you should report only 75630.

According to SIR, you also may report 75630 when the radiologist repositions the catheter but performs only limited examination of the legs.

**Rationale:** Code 75630 includes visualization of the same anatomic territory as described by the combined work of 75625 and 75716.

Add Your Cath Placement Codes

You should use the correct surgical catheter placement codes in addition to the appropriate imaging codes.

**Bulletproof Your Brachioccephalic Coding: Ace Selective Vs. Nonselective**

CPT® and the AMA offer cut-and-dried rules about including nonselective procedures in selective ones. But applying them in the real world can be tricky. Get a leg up with this look at the essentials, using the brachiocephalic family as an example.

See What Selective Means for Brachioccephalic

Vascular catheterization procedures are either selective or nonselective. You use nonselective codes when the radiologist places the catheter in the aorta, vena cava, or the vessel punctured and does not move the catheter further, explains AMA’s CPT® Assistant (October 2000).

Selective catheterization, on the other hand, means the radiologist advances the catheter into a first-, second-, or third-order or higher vessel, CPT® Assistant states.

**Above the diaphragm application:** In normal human anatomy, there are three "great vessels" arising from the aortic arch: the innominate (or brachioccephalic) artery, the left common carotid artery, and the left subclavian artery. These vessels originating from the aorta are first-order vessels. A branch of a first-order vessel is second order, and so on.

Note the relationship among the first-, second-, and third-order arteries involved in the procedure in the sample report in "Case Study: Selective Cath Coding Step-by-Step" below:

**First Order (Vascular Family) Innominate or Brachioccephalic**

<table>
<thead>
<tr>
<th>Second Order</th>
<th>Second Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right common carotid</td>
<td>Right subclavian/axillary</td>
</tr>
</tbody>
</table>
Tip: For a more detailed list of vascular families, see Appendix L of your CPT® manual.

Rule: You should include catheter introduction and all lesser-order selective catheter positions within the same vascular family and accessed through the same approach in your selective vascular catheter code.

In other words, if the radiologist uses a nonselective procedure for part of a service, and then a selective catheter placement using the same access, you should report only the selective catheter placement, CPT® Assistant instructs.

Case Study:

Selective Cath Coding Step-by-Step

CPT®'s guidelines for "Aorta and Arteries" vascular procedures explain "selective vascular catheterizations should be coded to include introduction and all lesser order selective catheterizations used in the approach." The guidelines go on to explain that "additional second and/or third order arterial catheterizations within the same family of arteries supplied by a single first order artery should be expressed by +36218 (Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family [List in addition to code for initial second or third order vessel as appropriate]) or +36248 (Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family [List in addition to code for initial second or third order vessel as appropriate])."

Reality: Differentiating a second-order from a third-order placement can be a challenge. To help you navigate interventional coding, make your way through this how-to lesson using the brachiocephalic family as an example.Read the Cath Report

Review the rules in "Bulletproof Your Brachiocephalic Coding: Ace Selective Vs. Nonselective" in this chapter. Then analyze this report. Your goal is to determine the appropriate code for each injection procedure performed, assuming the full report meets all documentation requirements.

Procedure: The right femoral artery is utilized for vascular access and a 5 French H1 catheter was introduced into the right vertebral, right internal carotid and right external carotid arteries, and multiple injection runs performed. Images show no vascular abnormality associated with vertebral circulation or the external carotid artery circulation. On internal carotid artery injection there is a small dilated venous structure that corresponds to the abnormality seen on CT angiography performed on [date omitted]. This is in the medial cranial fossa on the right just medial to the tip of the temporal lobe. This fills in the normal mid venous phase and has the appearance of a small venous angioma. No other vascular anomalies are identified.

ID Access Point to Start the Trip

Properly identifying the vascular access site is a common documentation trouble spot.

The sample report gets an "A" for identifying the right femoral artery as the vascular access site. You need to know this site as a first step to choosing between selective and nonselective codes.

Three other areas that the radiologist needs to document carefully are the following:

1. Where the catheter terminated in each vessel
2. The catheter's location for injection procedures
3. The vessels targeted for angiography.

Benefit: If you know this information, you’ll be able to distinguish billable imaging from roadmapping, guiding shots, and other nonbillable services.

Read on to see how knowing this information affects your choice of codes for the sample procedure.
Choose Code Based on Highest Order

In the sample report, the next site the radiologist documents after femoral access is the right vertebral artery.

You can trace the path from the right femoral artery introduction to the right vertebral artery. The radiologist would advance the catheter through the aorta and then into the brachiocephalic (aka innominate) artery (see the diagram below).

If the radiologist terminated the procedure in the brachiocephalic artery, you would report 36215 (Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family).

But the radiologist advanced the catheter into the right subclavian artery. If he had terminated the procedure here, you would report 36216 (... initial second order thoracic or brachiocephalic branch, within a vascular family).

Instead, though, the radiologist documents moving into the right vertebral artery, performing an injection and finding no vertebral circulation abnormalities in the imaging.

Coding point: With the right vertebral, you have your first reportable codes. You should report the vertebral catheter placement with initial third-order code 36217 (Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family).

Avoid 'Additional' Code Confusion

The radiologist next documents injection and imaging in the right internal carotid. To reach this artery, he must move the catheter back into the subclavian and then into the brachiocephalic. From here, he moves the catheter into the right common carotid. If he terminated the procedure here, you would report +36218 (... additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family [List in addition to code for initial second or third order vessel as appropriate]) because the right common carotid is an additional second-order vessel in the same vascular family (brachiocephalic) as the right subclavian and vertebral arteries.

Careful: The radiologist did not stop in the common carotid, though.

Coding point: He moved the catheter into the internal carotid and for the placement, you should report +36218.

Reason: You reported the right vertebral with an initial code (36217). So you need to report an “additional” code. And +36218 is appropriate whether you’re in an additional second- or third-order artery.

End With External Carotid

Finally, the radiologist discusses the right external carotid, describing a small venous structure. To reach the right external carotid artery, the radiologist would pull the catheter from the right internal carotid, into the right common carotid, and then would advance into the right external carotid artery.

Coding point: For the right external carotid catheter placement, you should again report +36218. And follow your payer’s preference for reporting the code twice on the same claim.

Coding roundup: The appropriate codes for the procedures performed are the following:

- 36217 for right vertebral artery catheter placement
- +36218 for right internal carotid artery cath placement
- +36218 for right external carotid artery cath placement

Untangle Angiogram Reporting by Learning 3 Key Exceptions

Don't let angiograms trip up your radiology claims. As long as you know the bundles and medical-necessity rules to watch for, you'll code angiography services like an ace.
Size Up CCI’s Effect on Diagnostic Angiograms

The Correct Coding Initiative (CCI) limits your angiogram coding options, but the good news is that a few of the bundles are fairly obvious.

**Example:** CCI bundles a unilateral extremity angiogram (75710, *Angiography, extremity, unilateral, radiological supervision and interpretation*) into a bilateral extremity angiogram (75716, *Angiography, extremity, bilateral, radiological supervision and interpretation*). However, you can override this edit by appending modifier 59 (Distinct procedural service) to 75710 under appropriate circumstances.

For instance, if your radiologist performs the extremity angiograms during different encounters, you can add modifier 59 to 75710 — the lesser- valued code. Also, if your radiologist examines three extremities (both legs, 75716; and one arm, 75710), you can add modifier 59 to 75710.

**Remember:** Anytime you use modifier 59, you must have documentation to support your choice.

For example, your radiologist must document that he performed these services at different encounters or different anatomic sites.

You can also bill 75716 two times, one for upper extremities and one for lower extremities, but you'll have to appeal it to get paid because most carrier systems will deny it as duplicate.

**Angio-Based Decision? Watch Your Step**

If your radiologist performs an intervention due to a diagnostic exam, you'll need to tread carefully.

CPT® instructions state that you should separately report a diagnostic angiography at the time of a transcatheter procedure if:

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

Again, you must append modifier 59 and include documentation of the decision to intervene in the op report.

**Example:** Your radiologist has no prior films for a patient. He performs a lower- extremity arteriogram, diagnoses superficial femoral artery (SFA) stenosis, and decides to perform an angioplasty. Because the diagnostic exam indicated the SFA lesion and was the basis for his decision to perform the angioplasty, you should charge for both the arteriogram (75710-59) and the angioplasty.

**Red flag:** If your radiologist had a prior catheter angiogram available, you should not report another diagnostic angiogram (unless you meet the exceptions below). Keep in mind: You don't have to take into account the time that has passed since the prior angiogram.

**Don't Ignore 3 Intervention Exceptions**

If the prior catheter angiogram meets one of three exceptions, you can report a second 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 the new onset of rest pain and loss of pulses. Because the condition has changed, you can report a new diagnostic angiogram.

**Exception 2:** The radiologist has inadequate visualization on the prior study of anatomy or pathology. For example, the patient transfers from another facility with poor-quality films. The radiologist cannot make a treatment decision without performing additional imaging. In this case, you can report a new diagnostic angiogram.

**Exception 3:** The radiologist 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 the prior exam. The radiologist performs a selective exam of the SMA, which you can separately report.
Key Concepts:

Check for More Appropriate Code Before Using Modifiers

If a descriptor specifies a bilateral procedure, but no code describes an equivalent unilateral procedure and the physician provides the service on one side only, append modifier 52 (Reduced services). In such a case, you must be certain that there is no designated CPT® code to describe the lesser procedure.

**Example:** For a unilateral extremity angiography, you should report 75710 (Angiography, extremity, unilateral, radiological supervision and interpretation) rather than 75716-52 (Angiography, extremity, bilateral, radiological supervision and interpretation; Reduced services).

Similarly, you should not apply modifier 52 to a “complete” exam code when you have a “limited” code available.

**Example:** If the patient has a left upper quadrant ultrasound, you should report 76705 (Ultrasound, abdominal, real time with image documentation; limited [e.g., single organ, quadrant, follow-up]), not 76700-52 (... complete; Reduced services).

If Possible, Use CPT® Codes Instead of Modifier 22

Instead of immediately attaching modifier 22 (Increased procedural services) when a procedure is above and beyond its normal scope, you should look for a CPT® code that more specifically explains why the procedure was prolonged or increased.

**Example:** A physician attempts to catheterize the aorta from a left femoral artery vascular access site but has difficulty advancing the catheter. He performs a sheath injection to visualize the artery but then abandons the initial access site before obtaining a separate access from the right femoral artery.

In this case, you should report 36140 (Introduction of needle or intracatheter; extremity artery) and 75710 (Angiography, extremity, unilateral, radiological supervision and interpretation) in addition to the procedure codes that reflect the work performed from the second access site. Reporting these two codes, rather than applying modifier 22 to others, is more accurate and less of a hassle.

**+75774 in Focus: Look for More Selective Position**

**Scenario:** Your physician performs peripheral angiograms on the lower extremities and does two different views of one vessel, such as the tibial vessel. Does each view get a separate +75774 (Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation [List separately in addition to code for primary procedure]) charge?

**Answer:** No, add-on code +75774 describes an additional angiogram performed from a more selective catheter position, not additional views taken with the catheter in the same position.

**Example:** With the catheter in the distal aorta, the physician injects contrast and performs imaging over the bilateral lower extremities (75716, Angiography, extremity, bilateral, radiological supervision and interpretation). To obtain more detail in the distal lower extremity, the physician then passes the catheter down into the contralateral superficial femoral artery (36247, Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family) and performs another study of the contralateral leg. You should report the additional contralateral leg study with +75774.

Because +75774 is an add-on code, you must report it alongside the code for the initial angiogram. In this case, you add +75774 to 75716.

The physician should document the reason why the additional selective exam was necessary (for example, to better define a distal lesion).

**Watch for:** You frequently use +75774 for studies of the visceral vessels. For example, you should report +75774 if the physician performs a celiac arteriogram (75726, Angiography, visceral, selective or supraselective [with or without flush aortogram], radiological supervision and interpretation) with the catheter in the celiac axis, and then advances the catheter into the common hepatic artery (36246, Selective catheter placement, arterial system; initial second order
abdominal, pelvic, or lower extremity artery branch, within a vascular family) and performs additional imaging.

Case Study:

**Sharpen Your Component Coding Skills With This Embolization Report**

CPT® may be adding more all-inclusive codes every year — covering a procedure and guidance in a single code — but capturing every element of an interventional procedure still takes some serious sleuthing.

Kick your embolization skills up a notch by seeing how the coding rules apply to this case.

**Indications:** Internal bleeding due to severe pelvic trauma

**Report:** Right femoral artery punctured. Catheter used to cross over the aortic bifurcation into the left iliac system. Left common iliac artery was selected. Subselection was made of the left internal iliac artery. DSA performed in two projections. Embolization was carried out using Gelfoam. Completion angiography was performed in the left internal iliac artery.

The catheter was pulled back into the right common iliac, followed by selection of the right internal iliac artery. Right internal iliac angiography was performed in two projections. Embolization was carried out using Gelfoam as well. Completion angiography was performed.

Review Selective Catheterization Rules

You have to work your way through the report’s first few sentences to find the first reportable code. You should submit 36246 (Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family) to reflect the left internal iliac artery subselection.

**Reason:** You should choose second-order code 36246 because the first-order artery is the common iliac.

CPT® guidelines for vascular injection procedures instruct that “selective vascular catheterization should be coded to include introduction and all lesser order selective catheterization used in the approach.” Translation: Don’t report the right femoral artery puncture and left common iliac artery selection separately.

Decide When RS&I Codes Are Appropriate

You should report 75736 (Angiography, pelvic, selective or supraselective, radiological supervision and interpretation) for the DSA performed in two projections. Term tip: “DSA” stands for “digital subtraction angiography.”

**Don’t forget:** If you’re reporting only the physician’s services, append modifier 26 (Professional component) to the radiological supervision and interpretation (RS&I) services.

Capture Reportable Angiography and Embolization

For the completion angiography in the left internal iliac artery, you should report 75898 (Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis).

Again, append modifier 26 (Professional component) to the RS&I codes (75894 and 75898) if you report the professional component only.

Face the First- and Second-Order Question

For the right internal iliac artery selection, you should report 36245 (Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family). This is a separate vascular family from the left leg (which you reported earlier), so you should code a second catheter placement. You should report a first-order code because it’s a branch of the vessel punctured.

**CPT® guideline:** The notes for vascular injection procedures state that you should separately code “additional first-order or higher catheterization in vascular families supplied by a first-order vessel different from a previously selected and coded family.”
Tip: Append modifier 59 (Distinct procedural service) to 36245 to prevent payers from bundling it into the 36246 you reported for the left internal iliac. Without modifier 59, payers may assume that both codes refer to the same vascular family and won't cover the lesser code.

Add Another Angiography Code

You should report 75736 (Angiography, pelvic, selective or supraselective, radiological supervision and interpretation) for the right internal iliac angiography.

Again, append modifier 26 if you only report the professional component.

Checkpoint: Watch Angiography Guidelines

The rule: According to CPT® guidelines for aorta and artery procedures, you should report diagnostic angiography performed with an interventional procedure only if you meet one of the following two requirements:

1. No prior catheter-based angiography is available, the provider performs a full diagnostic study and decides to intervene based on the diagnostic study; or
2. A prior study is available, but documentation shows one of the following three requirements:
   a. The patient's condition has changed
   b. The prior study offers inadequate visualization
   c. A clinical change during the procedure requires new evaluation outside the intervention area.

Before you report 75736 for our sample report, you need to look further into the documentation. Check the history and findings to determine whether 75736 is appropriate.

Tackle Second Embolization and Angio

You should not charge the second Gelfoam embolization and completion angiography separately. You should report them only once per operative field per session. The AMA confirmed this in the December 2007 CPT® Assistant.

The Society of Interventional Radiology (SIR) also recommends that you report one unit of 75898 (Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis) per embolization procedure except for central nervous system embolization. This is a change from SIR's earlier guidance that called for multiple units.

Remember: Payers and the AMA, which publishes CPT® codes, offer authoritative guidance. Professional societies' advice is not authoritative, but it does indicate what they believe is clinically correct and can guide you in the absence of authoritative guidance.

CPT® roundup: Assuming the history and findings support reporting 75736 (Angiography, pelvic, selective or supraselective, radiological supervision and interpretation) twice, you should submit the following codes on your claim:

- 36246 for the initial second-order arterial system
- 36245-59 for the first-order arterial system
- 75898-26 for the follow-up angiography
- 75894-26 for the transcatheter therapy supervision and interpretation
- 75736-26 x 2 for the pelvic artery S&I.

Don't Miss Angioplasty With 36870

You may report vascular angioplasty separately from 36870 on the same claim. The Correct Coding Initiative (CCI) considered bundling these services but decided not to.

Rationale: According to the AMA's CPT® Assistant (May 2001), 36870 (Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft [includes mechanical thrombus extraction and intra-graft thrombolysis]) "includes all the work required to remove the thrombus from the access, declot the graft, and restore flow to the access."

You should use the appropriate component codes describing other portions of the percutaneous procedure separately, CPT® Assistant states.
Key Concepts:

**Match Modifier 25 With Its Proper Home on Your Claim**

Mistakenly appending modifier 25 to a procedure instead of an E/M code is a simple enough error, but it can lead to plenty of appeals headaches.

Submit clean claims the first time with this step-by-step guide for properly reporting a modifier 25 interventional claim to Medicare.

Consider the OIG’s Take on Modifier 25

You should always be concerned and careful when you use modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service). The OIG has really cracked down on this modifier and collected huge sums of money for inappropriate coding.

The OIG has homed in on three main problems with modifier 25 claims. Here's how to avoid them:

- Use 25 only with a significant and separately identifiable E/M service. The E/M should be above and beyond the usual preoperative and postoperative care associated with the procedure.
- Verify that you have complete documentation of both the procedure and the separate E/M.
- Don't append modifier 25 if an E/M is the only service your physician provides the patient that day.

**Bottom line:** The physician must document a separate identifiable service above and beyond what is considered inclusive in the procedure.

See What CMS Says About Global

CMS has clarified that you should use modifier 25 for an E/M service "above and beyond the usual pre- and postoperative work of a procedure with a global fee period performed on the same day as the E/M service."

**Pitfall:** Don't report a separate E/M for obtaining informed consent and the basic history and physical exam needed for a previously scheduled interventional procedure.

Apply Your 25 Savvy to This Example

Now that you know the rules, decide how you would report the appropriate CPT® codes and modifiers on the CMS-1500 form for the following example.

**Example:** The radiologist performs an inpatient consultation for acute ischemia of the foot. The radiologist advises that the patient should undergo angiography with possible intervention. Later that day, the radiologist performs angiography and mechanical thrombectomy of the popliteal artery on the patient.

In this case, the CPT® codes and modifiers you should use include:

- An E/M code, such as 99253 (*Inpatient consultation for a new or established patient ...*) if the payer accepts consult codes.
- Modifier 25 attached to the E/M code to show that the service was significant and separate from the procedures performed the same day.
- An angiography code, such as 75716 (*Angiography, extremity, bilateral, radiological supervision and interpretation*).
- Modifier 26 (Professional component) appended to the angiography code (75716) to indicate that you're coding only the professional component of the angiography, which is the only service the radiologist performed that has separate professional and technical components.
- Popliteal artery thrombectomy code 37184 (*Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft ...*).
- A catheter placement code, such as 36247 (*Selective catheter placement, arterial system; initial third order or more selective ...*).

**Note:** Code 37184 has a zero-day global period, so according to CMS rules, you should append modifier 25 to any
separate E/M service. Remember: A zero-day global and an XXX global (no global) are not the same.

Place the Codes Properly on CMS-1500

   On the CMS-1500 form, you should enter:

1. The CPT® codes in box 24-D under "CPT®/HCPCS"
2. Modifiers 25 and 26 in box 24-D under "Modifier." Key: Put modifier 25 and 99253 together on one line, and put 75716 and 26 together on another line.

   24. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)

   CPT®/HCPCS MODIFIER
   37184
   36247
   75716 26
   99253 25

**Shuntogram? Turn to 75809**

Your radiologist may use an implanted pump catheter dye study to evaluate a pain patient's intrathecal catheter to rule out any leakage or kinking. She injects contrast through the catheter using fluoroscopic guidance.

You should submit 75809 (Shuntogram for investigation of previously placed indwelling nonvascular shunt [e.g., LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump], radiological supervision and interpretation) for the radiologic supervision and interpretation, and then move to the study itself.

Add 61070 (Puncture of shunt tubing or reservoir for aspiration or injection procedure) for the catheter dye study. This code covers shunt access and the injection procedure.

**Use TIPS' 0-Day Global Period to Your Advantage**

**Good news:** TIPS (transvenous intrahepatic portosystemic shunt) has a 0-day global period for Medicare physician payment.

Codes 37182 (Insertion of transvenous intrahepatic portosystemic shunt[s] [TIPS] ...) and 37183 (Revision of transvenous intrahepatic portosystemic shunt[s] [TIPS] ...) don't include E/M work performed before and after the day of the procedure. What this means for you: You may code medically necessary E/M services separately from the TIPS.

**Remember:** Check for appropriate documentation of E/M requirements before you code. Obtaining consent before the procedure and reviewing records to support the procedure do not count as separately reportable services. You need documentation of higher-level decision-making to code an E/M.

And, as always, check your payer's policy to be sure you're following its specific guidelines.

The limited global period also means that procedures necessary to correct a shunt complication (such as shunt revision) usually fall outside of the global period and therefore are separately payable and do not require a modifier.

Once the TIPS is in place, the patient may require portal angiography to monitor the shunt patency on separate dates of service. Report catheterization of the portal vein via the TIPS shunt with 36481 (Percutaneous portal vein catheterization by any method), and the imaging service, as appropriate, with 75885 (Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation) or 75887 (Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation). Caution: Don't report an angiography performed just to prove the TIPS is intact at the completion of the procedure.

**Pair 36500, 75893 for Venous Sampling**
For adrenal vein sampling, you should report 36500 (Venous catheterization for selective organ blood sampling) if the radiologist performs the procedure. You should report 75893 (Venous sampling through catheter, with or without angiography [e.g., for parathyroid hormone, renin], radiological supervision and interpretation) for the radiological supervision and interpretation.

**Vessel or Device Matters for Thrombolysis**

When a report describes TPA infusion of a device, rather than a vessel, tread carefully. For example, suppose a patient has a poorly functioning permacatheter, as in the sample report.

**Procedure:** 5 mg of TPA were dripped in two divided doses, one through each port of the catheter over a three-hour period. Upon completion of the TPA infusion, blood was rapidly aspirated through both ports of the catheter. Both ports were flushed with saline and locked with heparin, 1000 units per cc.

**Impression:** Status post catheter thrombolysis using a three hour TPA infusion with a total of 5 mg of TPA. Excellent flow was noted in each port of the catheter upon completion.

**What to do:** This procedure gives you the chance to report code 36593 (Declotting by thrombolytic agent of implanted vascular access device or catheter).

You should not report 37201 (Transcatheter therapy, infusion for thrombolysis other than coronary) and 75896 (Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation). These codes describe thrombolytic therapy of a vessel.

**Take Charge of IVUS Claims With 3 Expert Tips**

Reporting the proper intravascular ultrasound (IVUS) code won’t do you any good unless you know to report it with a primary procedure. And you could be foregoing hard-earned cash if you forget to report supervision and interpretation, too.

**The service:** Physicians use IVUS in peripheral arteries to diagnose problems such as the amount of plaque burden and the amount of calcium in the vessel wall. Physicians may use IVUS during interventions (such as atherectomy or stent placement) or to assess treatment results. During an IVUS, the physician places a special ultrasound catheter in the vessel to visualize its structure.

**Tip 1: Pair IVUS With Primary Procedures**

Peripheral IVUS codes are add-on codes, so don’t try reporting them without the accompanying primary service or you’ll face denials.

Add peripheral vessel IVUS codes +37250 (Intravascular ultrasound [non-coronary vessel] during diagnostic evaluation and/or therapeutic intervention; initial vessel [List separately in addition to code for primary procedure]) and +37251 (... each additional vessel), as appropriate, to peripheral interventions.

If you’re not sure which peripheral vessel the radiologist performed the IVUS in, ask the physician, because this must be in the notes for insurers to pay.

**Tip 2: Report S&I Separately**

Peripheral IVUS codes +37250 and +37251 do not include imaging supervision and interpretation (S&I).

So if the radiologist interprets peripheral IVUS images, bill 75945 (Intravascular ultrasound [non-coronary vessel], radiological supervision and interpretation; initial vessel) for the initial vessel interpretation with +37250, and add +75946 (... each additional non-coronary vessel [List separately in addition to code for primary procedure]) to +37251 to report the additional vessel interpretation.

**Note:** If you are coding coronary artery — rather than peripheral vessel — IVUS, you should use a single code to report both IVUS catheter placement and imaging supervision and interpretation.

Choose from +92978 (Intravascular ultrasound [coronary vessel or graft] during diagnostic evaluation and/or therapeutic
intervention including imaging supervision, interpretation and report; initial vessel [List separately in addition to code for primary procedure]) or +92979 (…each additional vessel [List separately in addition to code for primary procedure]).

Tip 3: Stay Alert for IVUS Reason

Although an IVUS has obvious diagnostic applications, some carriers may be reluctant to pay for this study. If you demonstrate appropriate medical necessity for the visualization service with a primary procedure, however, you may have an easier time convincing payers to reimburse.

Example: A physician may note that an angiography study does not clearly reveal whether plaque is significantly narrowing a vessel and may document that the IVUS yields a more accurate assessment of the degree of narrowing.

In addition, IVUS can give more information about plaque pathology, such as the presence of significant calcium, a thrombus, or dissection within the artery. Your physician can use these details to guide the appropriate interventional therapy, so you should look for this information in the procedure note.

Key Concepts:

Append Mod 62 for True 2-Physician Procedures

Many of the examples you’ll see for interventional procedures explain that the radiologist should report the radiological supervision and interpretation code and whichever physician performed the surgical procedure should report the surgical code. But sometimes, your radiologist will work with another physician on a procedure where both are primary surgeons.

CPT® states that you should append modifier 62 (Two surgeons) when two surgeons work as primary surgeons performing distinct parts of a procedure. Both physicians should report the same code and any associated add-on codes for the procedure, and append modifier 62 to each.

As a radiology coder, one report you may see that requires modifier 62 is endovascular repair, as described in this example.

Scenario: In an AAA (abdominal aortic aneurysm) procedure, a surgeon performs bilateral femoral cutdowns, and you need to code for the interventional radiologist who places the catheters bilaterally into the aorta and performs radiological supervision and interpretation. Both physicians place the modular bifurcated prosthesis.

What CPT® codes should you report for the radiologist?

Report the radiologist’s work in this team AAA service with:

- 36200 (Introduction of catheter, aorta) and append modifier 50 (Bilateral procedure)
- 34802 (Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis [1 docking limb]) and append 62 (Two surgeons) to acknowledge both surgeons.
- 75952 (Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation) and append 26 (Professional component) if you need to alert the payer that the radiologist only provided the professional component of the service.

Tip: You should only report the RS&I code once per AAA procedure.

The surgeon should report:

- 34812 (Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral) and append modifier 50

34802-62 (Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis [1 docking limb])-Two surgeons).

Protect yourself: Make sure that both physicians report the two-surgeon service with the same code and that both append modifier 62. Not doing so can lead to denials and reimbursement delay.

Try Triple Codes for Liver Biopsy
Suppose you need to code a transjugular liver biopsy. The code for a transcatheter biopsy is 37200 (Transcatheter biopsy).

A note with 37200 directs you to 75970 (Transcatheter biopsy, radiological supervision and interpretation) for radiological supervision and interpretation.

**Don't miss:** You also should report 36011 (Selective catheter placement, venous system; first order branch [e.g., renal vein, jugular vein]). Choose this first-order code because the radiologist moves the catheter into the vena cava and then into the hepatic. (See diagram below.) Regardless of whether the physician takes the sample from the left, right, or middle hepatic vein, you should report a first-order catheterization because all of these veins empty into the vena cava.

**Procedure:** The radiologist inserts a catheter into the jugular vein and threads it into the hepatic vein. He passes a needle through the tube and uses a suction device to collect the liver samples.

---

**Watch These 75980/75982 Subtleties**

You typically report 75980 (Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation) with 47510 (Introduction of percutaneous transhepatic catheter for biliary drainage).

In the 47510 procedure, often called "external drainage," the physician introduces a catheter into the liver, positioned above the obstruction. This position allows the bile to drain outside the body. The physician uses fluoroscopy and contrast for guidance, such as visualizing the intrahepatic bile ducts.

You typically report 75982 (Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation) with 47511 (Introduction of percutaneous transhepatic stent for internal and external biliary drainage).

The procedure described by 47511, also known as “internal-external drainage,” requires the physician to introduce a catheter into the liver, but the physician places the catheter past the obstruction, allowing bile to drain into the small intestine. Part of the catheter may also extend outside the body.

**75989 Is Accurate for Abscess and More**

The key to 75989 (Radiologic guidance [i.e., fluoroscopy, ultrasound, or computed tomography], for percutaneous drainage [e.g., abscess, specimen collection], with placement of catheter, radiological supervision and interpretation) is not one specific modality. As the descriptor indicates, you may use the code for fluoro, ultrasound, or CT. Instead, watch for percutaneous drainage with catheter placement.

Apply the Code to Abscess Drainage

For CT imaging guidance of abscess drainage, 75989 is more accurate than 77012 (Computed tomography guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], radiological supervision and interpretation).

**Tip:** If the radiologist performs the surgical part of the procedure as well, you may report that separately.

**75989 Serves 32551, Too**

A second physician may perform a chest tube insertion for a patient with a diagnosis such as a non-traumatic hemothorax. To report the radiologist's fluoroscopy, you typically report 75989 (Radiological guidance [i.e., fluoroscopy, ultrasound, or computed tomography], for percutaneous drainage [e.g., abscess, specimen collection], with placement of catheter, radiological supervision and interpretation).

The other physician will report 32551 (Tube thoracostomy, includes connection to drainage system (eg, water seal) when Performed, open [separate procedure]). This code includes a note to use 75989 for imaging guidance with this procedure.

**Bonus tip:** For our example, you should link 75989 to ICD-9 code 511.89 (Other specified forms of effusion, except tuberculous), which includes a note that the code covers hemothorax.