Optum

Complete Guide for Interventional Radiology

An in-depth guide to interventional radiology coding, billing and reimbursement for facilities and physicians

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Contents

Introduction

The purpose of the *Complete Guide for Interventional Radiology* is to provide a reference for hospitals and physicians to accurately report interventional radiology and cardiology procedures in the context of today's complex requirements for coding, billing, and reimbursement. Coding for these types of procedures is widely recognized as one of the most complex and challenging under Medicare's reimbursement programs, especially the ambulatory payment classification (APC) program.

This guide is intended to help the technical, professional, and coding staff select the appropriate codes to accurately report the services performed in the interventional radiology and cardiology settings.

CPT and Medicare have continued to revise reporting requirements for interventional radiology services to keep up with technological changes, techniques, and methods for performing procedures. Certain components of an interventional procedure, such as contrast media, supplies and devices, or additional imaging procedures, have increased both the complexity and cost. In order for Medicare to keep up with these changes in terms of billing and payment, specific HCPCS codes and other unique coding requirements such as surgical component codes may be required.

Accuracy in reporting interventional radiology procedures requires a good basic understanding of CPT® coding. Providers are expected to report each procedure component by revenue code, CPT/HCPCS code related description, modifiers if applicable, and the number of units used or performed.

The most common components of an interventional radiology procedure are the surgical intervention, imaging, supplies, contrast media, and pharmacy. Complexity of a procedure may require reporting several CPT codes. Where appropriate, this book includes CPT codes that are not necessarily cardiovascular or radiology-related.

Case examples of procedures are provided in this publication as a guide to learning and understanding the various aspects of the service. The case examples in this publication follow basic Medicare guidance for reporting; however, many payers accept these guidelines. Standardized reporting should be the goal of all providers with specific exceptions from individual payers on a case-by-case basis. With few exceptions, coding for the professional components should match the coding submitted for the technical components.

Documentation for each procedure must be in the medical record and must include detailed descriptions of each component of the procedure, such as advancement and exact placement of catheters, surgical component descriptors, the type and amount of low osmolar contrast media, all medications given, and the special devices used. These documentation requirements hold true for both radiology and cardiology interventions.

Providers should review their process for reporting interventional services at least semi-annually and in conjunction with newly released Medicare transmittals to ensure proper claims processing.

Coding described throughout this publication is for normal anatomy and transfemoral percutaneous approach unless otherwise specified.

CPT Codes and Descriptions

Physicians' Current Procedural Terminology (CPT) was developed by the American Medical Association and is used to report medical services and procedures performed by physicians and some allied health providers. The codes are updated every year. The CPT code set is used by both hospitals and physicians.

Indented Procedures

CPT descriptions are developed to stand alone, but sometimes they appear to be incomplete. The format is employed to conserve space on the printed page. Some CPT codes that share a common procedure are grouped together and the common procedure is listed fully only with the first code. The codes that follow are indented to indicate that a portion of their description is found in a previous code.

CPT code descriptions appear in bold text followed by the lay description of the service provided.

For example:

37224 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**

37225 **with atherectomy, includes angioplasty within the same vessel, when performed**

The common portion of these codes precedes the semicolon (;) in the full description of 37224. The complete description of 37225 is:

37225 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral with atherectomy, includes angioplasty within the same vessel, when performed**

When the information for an indented code is the same as the information for the code with the full description, these codes will be grouped together in a range. When the information varies greatly, they will be listed separately.

Procedure Codes

Following the specific CPT code and its narrative, you will find a combination of the following features:

Illustrations

The illustrations accompanying the *Complete Guide for Interventional Radiology* provide readers a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. The depictions usually include a labeled view of the affected body area, and occasionally tools and devices pertinent to the referenced procedure. Since many codes within a given set are similar in nature, graphics have been developed to highlight differences for clearer code selection.

The illustrations are almost always simplified schematic representations, oftentimes of complex and delicate medical procedures. In many instances, proper anatomical detail is minimized to present a clearer picture of coding the procedure. As such, only a lay knowledge of a given procedure can be obtained from any depiction. All graphic material was computer generated by Optum staff. Valuable reference was drawn from a broad spectrum of surgical, clinical, and anatomic publications.

Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the reader with sufficient information to make a proper code selection. In the *Complete Guide for Interventional Radiology*, you will find a step-by-step clinical description of the procedure, in simple terms. Technical language potentially used by the physician is included and defined.

The *Complete Guide for Interventional Radiology* describes the most common method or methods for performing each procedure, using key words often found in operative reports. If our description varies too greatly from the operative report, another code might be more appropriate. If a satisfactory code description cannot be matched to the patient's record, consult the physician.

Coding Tips

Coding tips provide information on how the code should be used, modifier assignment, HCPCS codes reported instead of or in addition to the procedure, offer other codes frequently reported with the procedures, and information regarding when not to use the code. A chart is usually provided as a quick glance at the component codes typically reported for the procedure. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book.

The coding tips have been expanded to include physician-specific indications, such as when to append modifier 26 to radiology procedures and CPT codes reported by physicians when a code is specific to facilities.

HCPCS Level II Codes

HCPCS is an acronym (pronounced "hick-picks") for the Healthcare Common Procedural Coding System. This field presents Level II (national) codes that provide a uniform method for reporting medical supplies and equipment, as well as select services provided on an outpatient basis. Level II codes were developed and are maintained by the Centers for Medicare and Medicaid Services (CMS) for Medicare reporting. CPT codes are considered Level I codes of HCPCS.

CMS mandates the use of HCPCS codes on outpatient Medicare claims and many states also require them on Medicaid forms.

Check with specific payers regarding their policy on accepting specific HCPCS codes.

ICD-10-CM Diagnosis Codes

ICD-10-CM diagnosis codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to radiology or cardiology.

Several conventions specific to the *Complete Guide for Interventional Radiology* must be understood for effective use of this feature.

"Code First" and "Code Also" Instructions

Notes and rules in ICD-10-CM sometimes instruct the coder to use a second code when reporting specific diagnoses. For instance:

J95.Ø2 **Infection of tracheostomy stoma**
Use additional code to identify type of infection, such as:
cellulitis of neck (LØ3.221)
sepsis (A4Ø, A41.-)

In our list of clinical indications, a note would be attached to J95.Ø2 to include this information:

J95.Ø2 **Infection of tracheostomy stoma – (Use additional code to identify type of infection: A4Ø, A41.-, LØ3.221)**

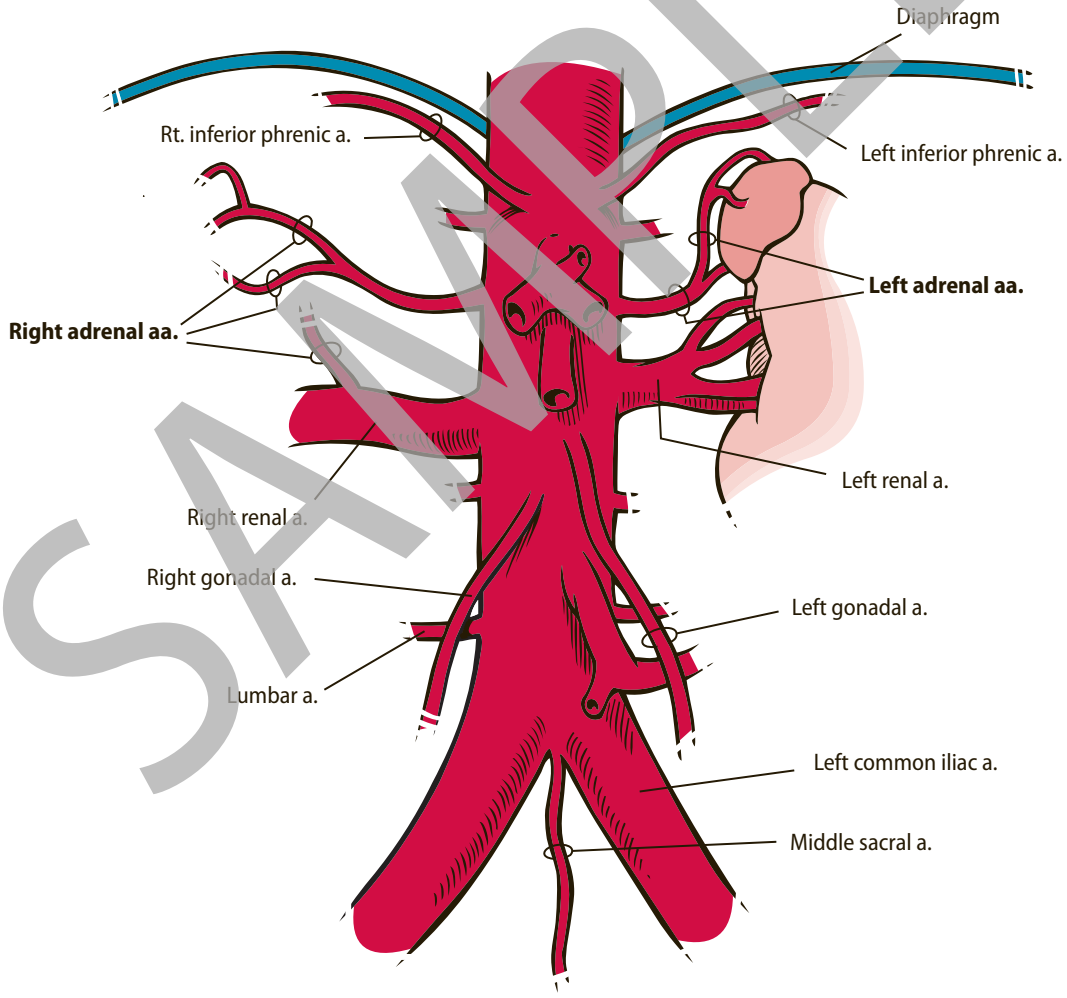
Adrenal Angiography

Angiography of the adrenal arteries involves selectively catheterizing one or both of the adrenal arteries and imaging the adrenal glands. Unilateral and bilateral codes exist for adrenal angiography.

75731 **Angiography, adrenal, unilateral, selective, radiological supervision and interpretation**
The left or right adrenal gland, located on top of the upper end of each kidney is examined radiologically by injecting contrast material. A local anesthetic is applied over the common femoral artery. The artery is percutaneously punctured with a needle and a guidewire inserted and fed through the artery, the aorta, and then further into the renal artery. A catheter is threaded over the guidewire until it, too, reaches the point of study and the guidewire is removed. Contrast medium is injected through the catheter and a series of x-rays or fluoroscopic images taken to visualize the vessels and evaluate any abnormalities such as blockages, narrowing, or aneurysms. The catheter is removed and pressure applied to the site. This code reports the radiological supervision and interpretation. Use separately reportable code for the catheterization.

75733 **Angiography, adrenal, bilateral, selective, radiological supervision and interpretation**
The adrenal glands located on top of the upper end of each kidney are examined radiologically by injecting contrast material. A local anesthetic is applied over the common femoral artery. The artery is percutaneously punctured with a needle and a guidewire inserted and fed through the artery, the aorta, and then further into the renal arteries. A catheter is threaded over the guidewire until it, too, reaches the point of study and the guidewire is removed. Contrast medium is injected through the catheter and a series of x-rays or fluoroscopic images taken to visualize the vessels and evaluate any abnormalities such as blockages, narrowing, or aneurysms. The catheter is removed and pressure applied to the site. This code reports the radiological supervision and interpretation. Use separately reportable code for the catheterization.

Other Visceral Arterial Anatomy—Adrenal Arteries



CPT Coding for Adrenal Angiography

Service Performed	Catheter Placement Code	Radiology S&I Component
Unilateral adrenal angiogram	**Varies**	**75731**
Bilateral adrenal angiogram	**Varies**	**75733**
Each additional artery		**75774**

Coding Tips

1. Report both components of the procedure: the catheter placement code and the technical radiology S&I codes.
2. Unilateral and bilateral codes exist for adrenal arteriography. Do not use modifier 50 and do not report 75731 twice.
3. The adrenal glands could have more than one artery providing blood supply. There are many congenital variations of artery origin; therefore catheter placement coding will vary. A catheter placement code is reported for each artery selected. Use modifier 59 (or XS) to denote the separate catheterization. Report CPT code 75774 for each additional artery imaged.
4. Do not report CPT codes 75731 or 75733 unless selective catheterization and imaging is performed and documented.
5. Abdominal x-rays are included. Do not separately report codes 74018–74022.
6. Conscious sedation is not included in these codes. Separately report 99151–99157 per payer policy and coding guidelines. Hospitals may choose to include the costs associated with the service as part of the procedure rather than reporting them separately.
7. Report all applicable HCPCS Level II codes. Refer to the HCPCS section for possible codes.
8. Hospitals are requested to continue reporting LOCM separately with HCPCS codes Q9965–Q9967. Report contrast media by milliliter rather than by bottle or other unit.
9. Physician Reporting: Procedures 75731 and 75733 have both a technical and professional component. To report only the professional component, append modifier 26. To report only the technical component, append modifier TC. To report the complete procedure (i.e., both the professional and technical components), submit without a modifier.
10. Angiograms performed after angioplasty, stent, and atherectomy procedures are included in the interventional codes and are not reported separately.
11. Diagnostic angiography performed during the same surgical encounter as an interventional procedure may be reported separately if no previous catheter-based angiogram has been performed. A complete diagnostic exam must also be performed, and the decision to perform an interventional procedure should be based on diagnostic exam results. When a previous diagnostic exam was performed, documentation must indicate that the condition of the patient has changed since that exam, anatomy was not optimally identified in the previous exam, or a change during the surgical encounter required another evaluation beyond the area being treated during the intervention. Under these circumstances, append modifier 59 (or appropriate X [XE, XS, etc.] modifier for CMS) to the code for the diagnostic evaluation.
12. Codes 36245–36248 are flagged for RAC (recovery audit contractor) review to determine if the encounter meets Medicare coverage criteria and coding guidelines and whether the service provided is medically reasonable and necessary. Facilities and professional providers should take extra steps to make sure the coding meets guidelines.

Facility HCPCS Coding

Some applicable codes may include but are not limited to:

C1760 Closure device, vascular (implantable/insertable)
C1769 Guidewire
C1894 Introducer/sheath, other than guiding, other than intracardiac electrophysiological, non-laser
G0269 Placement of occlusive device into either a venous or arterial access site, post surgical or interventional procedure (e.g., AngioSeal plug, vascular plug)
Q9965 LOCM, 100-199 mg/ml iodine concentration, per ml
Q9966 LOCM, 200-299 mg/ml iodine concentration, per ml
Q9967 LOCM, 300-399 mg/ml iodine concentration, per ml

Note: See appendix B for a complete listing of reportable HCPCS Level II codes.

ICD-10-CM Coding

C74.ØØ Malignant neoplasm of cortex of unspecified adrenal gland
C74.Ø1 Malignant neoplasm of cortex of right adrenal gland
C74.Ø2 Malignant neoplasm of cortex of left adrenal gland
C74.1Ø Malignant neoplasm of medulla of unspecified adrenal gland
C74.11 Malignant neoplasm of medulla of right adrenal gland
C74.12 Malignant neoplasm of medulla of left adrenal gland
C74.9Ø Malignant neoplasm of unspecified part of unspecified adrenal gland
C74.91 Malignant neoplasm of unspecified part of right adrenal gland
C74.92 Malignant neoplasm of unspecified part of left adrenal gland
C79.7Ø Secondary malignant neoplasm of unspecified adrenal gland
C79.71 Secondary malignant neoplasm of right adrenal gland
C79.72 Secondary malignant neoplasm of left adrenal gland
C7A.1 Malignant poorly differentiated neuroendocrine tumors
C7A.8 Other malignant neuroendocrine tumors
C7B.ØØ Secondary carcinoid tumors, unspecified site
C7B.Ø9 Secondary carcinoid tumors of other sites
C7B.8 Other secondary neuroendocrine tumors
DØ9.3 Carcinoma in situ of thyroid and other endocrine glands
DØ9.8 Carcinoma in situ of other specified sites
D18.ØØ Hemangioma unspecified site
D18.Ø3 Hemangioma of intra-abdominal structures
D35.ØØ Benign neoplasm of unspecified adrenal gland
D35.Ø1 Benign neoplasm of right adrenal gland
D35.Ø2 Benign neoplasm of left adrenal gland
D44.1Ø Neoplasm of uncertain behavior of unspecified adrenal gland
D44.11 Neoplasm of uncertain behavior of right adrenal gland
D44.12 Neoplasm of uncertain behavior of left adrenal gland
D49.7 Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
E24.Ø Pituitary-dependent Cushing's disease
E24.2 Drug-induced Cushing's syndrome
E24.3 Ectopic ACTH syndrome
E24.4 Alcohol-induced pseudo-Cushing's syndrome
E24.8 Other Cushing's syndrome
E24.9 Cushing's syndrome, unspecified
E25.Ø Congenital adrenogenital disorders associated with enzyme deficiency
E25.8 Other adrenogenital disorders
E25.9 Adrenogenital disorder, unspecified
E26.Ø1 Conn's syndrome
E26.Ø2 Glucocorticoid-remediable aldosteronism
E26.Ø9 Other primary hyperaldosteronism
E26.1 Secondary hyperaldosteronism
E26.81 Bartter's syndrome
E26.89 Other hyperaldosteronism
E26.9 Hyperaldosteronism, unspecified
E27.Ø Other adrenocortical overactivity
E27.1 Primary adrenocortical insufficiency
E27.2 Addisonian crisis
E27.3 Drug-induced adrenocortical insufficiency
E27.4Ø Unspecified adrenocortical insufficiency
E27.49 Other adrenocortical insufficiency
E27.5 Adrenomedullary hyperfunction
E27.8 Other specified disorders of adrenal gland
E27.9 Disorder of adrenal gland, unspecified
E27.Ø Other adrenocortical overactivity
E27.1 Primary adrenocortical insufficiency
E27.2 Addisonian crisis
E27.3 Drug-induced adrenocortical insufficiency
E27.4Ø Unspecified adrenocortical insufficiency
E27.49 Other adrenocortical insufficiency
E27.5 Adrenomedullary hyperfunction
E27.8 Other specified disorders of adrenal gland
E27.9 Disorder of adrenal gland, unspecified

ICD-10-PCS Coding

Section: B Imaging
Body System: 4 Lower Arteries
Type: 1 Fluoroscopy
Body Part: B Intra-Abdominal Arteries, Other

Case Example

Clinical History:
The patient was a 69-year-old male who presented with possible bleeding in the right suprarenal region. He presented for evaluation of the adrenal artery.

Technique:
The right groin was prepped and draped in usual fashion. Using a 5-French micropuncture set, the **right common femoral artery was accessed**. A 5-French sheath was placed in the right common femoral artery. Through the sheath a 5-French C2 catheter was advanced into the abdominal aorta. **Selective catheterization of the right inferior adrenal artery** was then performed. **This artery was a branch off the renal artery**. Angiography demonstrated two branch vessels of the adrenal artery that had extravasation of contrast material on the run. Embolization was recommended. A total of 85cc of Omnipaque 300 were used during the procedure.

CPT/HCPCS Code(s) Reported: 36246, 75731, Q9967 x 85

ICD-10-PCS Code(s) Reported: B41B1ZZ